

RFP 30-190029-DHB

V. Scope of Services

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V. Scope of Services

A. Administration and Management

1. Program Administration

- a. In the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. 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. In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland.
- b. During the term of the contract, and in future years, the Department will modify its Medicaid and NC Health Choice programs, including Medicaid Managed Care and the supporting technical and operational infrastructure, in order to conform with the Federal and State requirements or Department policies and goals.
- c. The Department will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs, and will delegate the direct management of certain health services, including physical health, behavioral health and pharmacy services, and financial risks to the PHP as defined in the Contract. The PHP will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the PHP has an adequate provider network, delivers high quality care, and operates a successful Medicaid Managed Care program.
- d. The PHP shall work cooperatively with the Department to be good stewards of Department funds and Department personnel time and to ensure effective administration of Medicaid Managed Care.
- e. In partnership with the Department, the PHP shall develop processes and procedures to ensure the PHP is soliciting stakeholder input, including input from Members and providers, to drive continual improvement in the overall program.
- f. The PHP shall provide certification concurrently with the submission of all data, documentation, or information required under federal and state law and under this Contract to the Department in accordance with 42 C.F.R. § 438.606.

2. Entity Requirements

- a. A PHP operating a contract through the Department for the provision of Medicaid Managed Care services shall hold a valid and current PHP license issued by the Department of Insurance for the duration of the contract.
 - i. A PHP license is not required as a condition of award.

- ii. The PHP shall have a PHP license no later than ninety (90) calendar days prior to open enrollment for Phase 1 of Medicaid Managed Care, regardless of the Region the PHP serves. At the discretion of the Department, failure to obtain a license may result in termination of the Contract between the PHP and the Department.
 - iii. Upon request by the Department, the PHP shall share with the Department any information related to its Medicaid business that was provided to DOI.
- b. PLE Governance and Operations
- i. The majority of voting members on the governing body of each PLE shall be licensed in North Carolina as physicians, physician assistants, nurse practitioners or psychologists, and have treated beneficiaries of North Carolina Medicaid or NC Health Choice.
 - ii. A minimum of twenty-five percent (25%) of voting members on each PLE governing body shall be providers who have received reimbursement for the treatment of at least one (1) Medicaid Managed Care eligible beneficiary in the previous twenty-four (24) months (e.g., a provider joining a PLE's governing body on June 1, 2018, must have received reimbursement in the twenty-four (24) months leading up to June 1, 2018, which would be May 31, 2016 through May 31, 2018).
 - iii. Voting providers shall play a meaningful role in strategic decisions and day-to-day operations of PLEs to ensure the PLE advances high-value care, improving population health, and engaging and supporting providers.
 - iv. The PLE shall make available and submit for review to the Department, upon request,
 - a) The bylaws of their governing body;
 - b) Information to explain the operations and authority of the governing body, (e.g., the types of decisions that will and will not be subject to a board vote);
 - c) PLE Governance Plan outlining the role of physicians and other health team members in the day-to-day operations of the PLE including, but not limited to:
 - 1. List of clinical staff positions and roles;
 - 2. List of individuals in executive or other leadership positions with clinical experience, and a description of roles and responsibilities.
 - 3. List and description of all provider advisory and consultative committees (e.g., quality committee, advanced medical home advisory committee);
 - 4. List and description of provider relations or provider partnership initiatives;
 - 5. Descriptions of how providers will be held accountable for clinical and financial program outcomes; and
 - 6. Description of any other ways that physicians and other health team members will be involved in the day-to-day business operations of the PLE.
 - v. The PHP shall submit the PLE Governance Plan to the Department for review and approval:
 - a) Within thirty (30) days after award;
 - b) Annually, on June 30 of the calendar year; and
 - c) Within three (3) business days after request from the Department.
 - vi. The PHP must provide written notice to the Department within ten (10) business days of any material changes to the PLE Governance Plan.
 - vii. The PLE shall provide a signed attestation affirming that a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts or North Carolina Medicaid and NC Health Choice providers as described under the Contract. A nonprofit entity bidding as a PLE shall provide a signed attestation affirming that the primary business purpose of the entity is the operation of one or more capitated contracts or North Carolina Medicaid and

NC Health Choice providers. The attestation must be signed by a Corporate Officer with authority to bind the PLE.

- b. Ownership and Control and PHP Operating Plan
 - i. The Department seeks the most qualified health plans to serve North Carolina Medicaid Managed Care whom the Department may entrust the care of its Medicaid and NC Health Choice beneficiaries.
 - ii. As defined in 42 C.F.R. § 455.101, the PHP shall provide information, including corporate or other legal entity name, address, telephone number, and nature of relationship, regarding all entities, including parent entities, subsidiaries and business partners who:
 - a) Meet the definition of an ownership or controlling interest in the PHP; and
 - b) Do not meet the definition of ownership or controlling interest.
 - iii. The PHP shall develop and maintain an up-to-date PHP Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care services.
 - a) Core Medicaid operations shall include but are not limited to:
 - 1. Managing Medicaid Managed Care beneficiary lives (including Member services and the administration of clinical benefits and services);
 - 2. Provider network management;
 - 3. Performing care management functions;
 - 4. Processing and paying claims; and
 - 5. Assuming risk through capitated contract.
 - b) Entities included in the plan shall include subcontractors, partners, subsidiaries, and any other entities involved in core Medicaid operations.
 - c) The PHP Operating Plan shall:
 - 1. Identify each entity by corporate or other legal entity name, address, and telephone number;
 - 2. Describe generally roles, responsibilities and functions that the entity performs;
 - 3. Describe the PHP's legal or contractual relationship with each entity;
 - 4. Describe how the PHP manages each entity; and
 - d) After the first year and annually thereafter provide a report for each entity providing evidence of the PHP's oversight activities, and describing entity performance including key metrics, corrective actions taken, and sanctions.
 - iv. The PHP shall respond to any additional requests for information pursuant to this subsection as directed by the Department.
 - v. The PHP shall submit the current PHP Operating Plan to the Department for review and approval:
 - a) Within thirty (30) days after award;
 - b) Annually, on June 30 of the calendar year; and
 - c) Within three (3) business days after request from the Department.
 - vi. The PHP must provide written notice to the Department within ten (10) business days of any material changes to the PHP Operating Plan.
 - a) Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
 - b) At the Department's discretion, the PHP will be subject to a reevaluation and readiness review prior to approval of the amended PHP Operating Plan.
 - c) The PHP may be responsible for any cost to the Department of such review.

3. National Committee for Quality Assurance (NCQA) Accreditation

- a. The PHP shall achieve accreditation by NCQA by the end of Contract Year 3.
- b. The PHP shall achieve NCQA accreditation for LTSS by the end of Contract Year 3.
- c. In accordance with, 42 C.F.R. § 438.332(b)(1) - (3), the PHP shall submit accreditation information to the Department, including:
 - i. Accreditation status;
 - ii. Accreditation level;
 - iii. Accreditation survey type, if applicable;
 - iv. Accreditation results (corrective action plans, summaries of findings), if applicable; and
 - v. Accreditation expiration date.
- d. The PHP shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO for all accredited PHPs.

4. PHPs and Related Providers

- a. The Department expects the PHP to collaborate with other PHPs and with providers to advance the health of North Carolinians. The payment strategy of the PHP to its owned or related providers has the potential to introduce behaviors that may be considered anti-competitive or self-dealing and, therefore, detrimental to both North Carolina's health care delivery system, generally, and Medicaid Managed Care, specifically.
- b. The PHP shall not pay for similar services rendered by any provider or subcontractor that is "related to" the PHP more than the PHP pays to providers and subcontractors that are not "related to" the PHP.
 - i. In this context, "related to" is defined as providers or subcontractors:
 - a) With a direct or indirect ownership interest or ownership or control interest in the PHP,
 - b) An affiliate of the PHP, or
 - c) The PHP's management company with a direct or indirect ownership interest or ownership or control interest in a provider or subcontractor.
- c. Any payments made by the PHP to owned or related providers that exceed the limitations set forth in this Contract shall be considered non-allowable expenses for covered services and will be excluded from medical expenses reported in the Medical Loss Ratio (MLR) report and future capitation rate calculations.

5. Implementation

- a. The Department intends to use this competitive procurement process to partner with PHPs best suited to meeting the Medicaid Managed Care administrative functions and provide high quality care to North Carolina Medicaid and NC Health Choice Members. The Department requires the PHP to have the resources, expertise, and technology to support the Department's Medicaid Managed Care implementation schedule and the ongoing operations and clinical objectives.
- b. The PHP shall have a fully assembled implementation team ready to begin work at Contract Award. The team should include an implementation manager and separate implementation resources for, at a minimum, the following work streams:
 - i. Account and Project Management;

- ii. Members;
 - iii. Benefits (including contact for transition of care);
 - iv. Care Management;
 - v. Providers;
 - vi. Quality and Value;
 - vii. Stakeholder Engagement;
 - viii. Program Operations;
 - ix. Claims and Encounter Management;
 - x. Financial Requirements;
 - xi. Compliance; and
 - xii. Technology.
- c. Additional resources to support the implementation of all workstreams identified as part of the services and requirements of the RFP must be added to the implementation team no later than twenty (20) calendar days after the Contract Award.
- d. PHP shall be responsible for developing Business Requirements documents, Implementation Plans and test plans for each work stream. Documents must be approved by Department. The Assistant Secretary for Medicaid Transformation or designee is authorized to approve these documents for the Department.
- e. The PHP shall provide to the Department a draft Implementation Plan fourteen (14) calendar days after Contract Award that defines, at a minimum, the following tasks and milestones:
- i. PHP licensure and other DOI requirements;
 - ii. Provider network development, including provider education, training and contracting;
 - iii. Member engagement program, including educational materials, welcome and enrollment materials, and community outreach;
 - iv. Service Line operations;
 - v. Utilization management development and implementation;
 - vi. Care management program development and implementation, including AMH/PCP assignment;
 - vii. Transition of care data exchange;
 - viii. Quality management infrastructure;
 - ix. Member and provider enrollment systems;
 - x. Claims and encounter systems;
 - xi. Required system interfaces; and
 - xii. Other administrative supports.

6. Readiness Requirements

- a. The Department is committed to ensuring the PHP is prepared and able to serve as a good administrator of Medicaid Managed Care. The Department will engage in a thorough readiness review of the following functions immediately after Contract Award through the first six (6) months, or a different period as determined by the Department, after Medicaid Managed Care launch. The Readiness Review shall include all areas identified in 42 C.F.R. 438.66 and others to be identified by the Department.
- b. The Department and its partners will conduct a readiness review to verify the PHP, its staff, providers, subcontractors and other individuals and organizations are prepared to provide

Medicaid Managed Care services on behalf of the Department prior to opening new lines of business, accepting new eligibility populations or at the Department's discretion.

- c. The PHP shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a readiness review.
 - i. The PHP shall participate in readiness review(s) conducted by the Department to review the PHP's readiness to begin and sustain operations throughout the term of the contract.
 - a) The requirements covered within the readiness review shall be determined by the Department and communicated to the PHP at least fifteen (15) calendar days prior to the readiness review.
 - b) The PHP must meet these readiness review requirements and contract requirements in the time frame specified by the Department.
 - ii. Readiness reviews must include, but are not limited to, onsite reviews, desktop reviews, policy reviews, system demonstrations, staff interviews and self-audit evaluations.
- d. The Department maintains the discretion to conduct readiness reviews on an ongoing basis as new program requirements are implemented or prior to the PHP effectuating, for example, a material program, operational or technical change.
- e. Readiness reviews are different and distinct from program integrity, program audits, quality reviews or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.
- f. Based upon results of the readiness review(s), the Department reserves the right to:
 - i. Offer acceptance to allow the PHP to commence full operations;
 - ii. Offer conditional acceptance to allow the PHP to commence operations if the PHP is found not to meet certain requirements of the readiness review(s) upon receipt of a corrective action plan from the PHP which demonstrates how it will meet readiness review criteria within the timeframe specified by the Department;
 - iii. Offer limited acceptance to limit PHP's level of participation in Medicaid Managed Care based on the results of the readiness review and any resulting corrective action plans; or
 - iv. Terminate this Contract in accordance with the termination provisions of the Contract.
- g. Prior to allowing a PHP to participate in open enrollment or be assigned membership through the auto-assignment function, the PHP shall demonstrate compliance with the Department's licensure and solvency requirements specified in the Prepaid Health Plan Licensing Act.¹
- h. The PHP shall submit to the Department all policies and procedures that require review and/or approval as requested by the Department within this RFP and defined in the Contract.
 - i. A complete list of policies and procedures which require Department prior review and approval before implementation as defined within this RFP.

7. Non-discrimination

- a. The PHP shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:
 - i. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;

¹ Section 1 of Session Law 2018-49 codifies the Prepaid Health Plan Licensing Act in Article 93 of Chapter 58 of the General Statutes.

- ii. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
 - iii. Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
 - iv. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
 - v. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
 - vi. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
 - vii. Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;
 - viii. The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;
 - ix. The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;
 - x. The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and
 - xi. Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017 by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression.
- b. The PHP shall not discriminate against Members, providers, or employees, or in the provision of services or administration of the program.
 - c. The PHP shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3)
 - d. The PHP shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.
 - i. At a minimum, the non-discrimination policy shall include:
 - a) The definition of discrimination under federal law and regulation, as amended;
 - b) How the PHP will collaborate with all of the Department's thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (example: DSDHH);
 - c) How the PHP's policy will apply to clinical, marketing, and care management programs offered to Members;
 - d) The PHP's internal complaint process for Members and employees including penalties;
 - e) The legal recourse, investigative, and complaint process available for Members through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and

- f) Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.
- ii. The PHP shall make the non-discrimination policy available for Department review, upon request.
- iii. The PHP shall make updates to its non-discrimination policy as necessary, and, at a minimum, the PHP shall review its non-discrimination policy for updates annually.
- iv. The PHP shall make the non-discrimination policy available to Members and employees of the PHP.

8. Advance Directives

- a. The PHP shall comply with all state and federal laws and regulations related to advanced directives, including Article 23 of Chapter 90 of the General Statutes.
- b. The PHP shall reflect changes in state law in its written advance directives information as soon as possible, but no later than ninety (90) days after the effective date of the change. 42 C.F.R. § 438.3(j)(4)
- c. The PHP shall maintain written policies and procedures on advance directives for all adult Members receiving medical care by or through the PHP. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a).
- d. The PHP shall not prohibit from conditioning the provision of care or otherwise discriminating against an Member based on whether or not the Member has executed an advance directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).
- e. The PHP shall educate staff concerning their policies and procedures on advance directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).
- f. The PHP shall provide adult Members with written information on advance directives policies, and include a description of applicable state law. 42 C.F.R. § 438.3(j)(3).

9. Staffing and Facilities

- a. The PHP shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The PHP shall provide qualified persons in numbers appropriate to the PHP's size of enrollment and consistent with the requirements to successfully operate Medicaid Managed Care.
- b. Unless otherwise specified, the PHP may combine or split the listed responsibilities among the PHP's personnel if the PHP demonstrates that the responsibilities are being met and that someone is accountable. Similarly, the PHP may contract with a third party (subcontractor) to perform one or more of these responsibilities.
- c. The PHP shall be responsible for screening all employees and subcontractors to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
 - i. The PHP shall not employ or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610 (a) and (b)].
- d. Key PHP Personnel

- i. The PHP shall hire Key Personnel to be assigned, unless otherwise indicated, exclusive to the North Carolina Medicaid market and for the duration of this Contract. Key Personnel shall be identified and mapped to the Staffing Roles provided in Attachment O.6. PHP Key Personnel. The PHP shall indicate the name of the proposed individual to perform each role.
- ii. Key personnel include:
 - a) Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care/Project Director;
 - b) Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care;
 - c) Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care;
 - d) Chief Compliance Officer (CCO) of North Carolina Medicaid Managed Care;
 - e) Chief Information Security Officer (CISO)/Chief Risk Officer of North Carolina Medicaid Managed Care;
 - f) Quality Director of North Carolina Medicaid Managed Care;
 - g) Provider Network Director of Medicaid Managed Care Operations;
 - h) Pharmacy Director of Medicaid Managed Care Operations; and
 - i) Behavioral Health Director of Medicaid Managed Care Operations.
- iii. The PHP shall:
 - a) Ensure that Key Personnel hold no more than one (1) position that is required by the Contract.
 - b) Ensure all Key Personnel reside in North Carolina.
 - c) Ensure the CMO:
 - 1. Is fully licensed to practice in NC;
 - 2. Has a minimum of five (5) years' experience in a health clinical setting; and
 - 3. Has a minimum of two (2) years' experience in managed care.
 - d) Ensure the Behavioral Health Director:
 - 1. Is fully licensed, as a psychiatrist or psychologist, by the State of North Carolina;
 - 2. Has a minimum of five (5) years' experience in a behavioral health clinical setting; and
 - 3. Has a minimum of two (2) years' experience in managed care.
- iv. Key Personnel shall be available to meet at the Department's requested location within twenty-four (24) hours' notice from the Department.
- v. The Department may, at its sole discretion, reject a potential candidate or require the removal of any Key Personnel providing services under this Contract.
- vi. The PHP shall not substitute Key Personnel to the performance of this Contract without prior written approval by the Department. The PHP shall inform the Department in writing within seven (7) calendar days of staffing changes in Key Personnel. The PHP shall fill Key Personnel roles with permanent qualified replacements within ninety (90) calendar days of the departure of the former staff member. At no time, however, shall a Key Personnel Role be vacant. It is the PHP's responsibility to keep the role filled until the Department approves a substitution.
- vii. Upon filling a Key Personnel vacancy, the PHP shall demonstrate that PHP staff proposed as Key Personnel have the proper credentials and experience to perform all duties and responsibilities of that role. The PHP shall include:
 - a) Name;
 - b) Role;
 - c) Experience relevant to the services to be provided under this Contract;
 - d) Resume;

- e) Proof of North Carolina Residency (when applicable); and
 - f) Any certifications, licenses or credentials for the role where requested by the Department.
- e. Organization Roles and Positions
- i. The PHP shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Attachment A. PHP Organization Roles & Positions*.
 - ii. Member Services Staffing
 - a) The PHP shall adequately staff and operate its Member Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related with North Carolina Medicaid Managed Care.
 - b) The PHP shall ensure that unlicensed Member Services staff are prohibited from providing health-related advice to Members requesting clinical information and instead shall triage/refer such requests to staff with appropriate clinical expertise in treating the Member's condition or disease.
 - iii. Fraud, Waste and Abuse Staffing
 - a) The PHP shall establish a single point of contact to serve as a liaison with the Department and MID and to facilitate timely response to Department requests for information, including claims data.
 - b) The PHP shall establish a custodian of records to authenticate the business records of the PHP, provide the business records of the PHP to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:
 - 1. Made at or near the time of the events by a person with knowledge;
 - 2. Kept in the normal course of regularly conducted business activity; and
 - 3. Made in the regular practice of the PHP's business activity.
- f. The PHP shall submit resumes for any employee or subcontracted employee upon request by the Department.
- g. The PHP shall provide a detailed Staffing Contingency Plan in the event of public health emergencies, natural disasters, or sudden and unexpected increases in enrollment, with a description on how the plan shall be implemented and coordinated with the Department.
- h. Physical Presence in North Carolina
- i. The PHP shall have a physical presence in North Carolina by having one or more offices located in the State.
 - a) The PHP shall establish an office in North Carolina at least ninety (90) days after Contract Award that shall be maintained for the duration of the contract.
 - b) The PHP shall establish call center(s) and staff in North Carolina at least ninety (90) days after Contract Award.
 - c) The Department requires the PHP establish an office in each of the six (6) Regions that it serves.
 - ii. Additionally, the following personnel, at a minimum, shall be located in and operate from within the State of North Carolina:
 - a) Behavioral Health (BH) Managers;
 - b) Care Management Managers, Supervisors and Staff;
 - c) Member Complaint, Grievance, and Appeal Coordinator;
 - d) Member Services and Service Line Staff;
 - e) Provider Relations and Service Line Staff;

- f) Quality Assessment and Improvement and Utilization Management Coordinator;
 - g) Tribal Provider Contracting Specialist;
 - h) Liaison to the Division of Mental Health;
 - i) Liaison to the Division of Social Services;
 - j) Liaison between the Department and the North Carolina Attorney General’s Medicaid Investigation Division;
 - k) Care Management Housing Specialist;
 - l) Utilization Management Managers; and
 - m) Pharmacy and Service Line Staff.
- i. Conflict of Interest
- i. The PHP shall verify that its employees, directors, and contractors comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C.
 - ii. The PHP shall undertake reasonable actions to verify that employees or contractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the Medicaid Managed Care, North Carolina Medicaid or NC Health Choice programs, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.
 - iii. The PHP and its employees and directors shall:
 - a) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee (or such employee’s spouse or minor child) if such Department employee participated personally and substantially in the procurement of the PHP’s contract or the oversight of such contract as a Department employee.
 - b) Not promise or give a gift to any Department employee or any family member of a Department employee.
 - c) Fully and completely disclose to the Department any situation that may present a conflict of interest.
 - d) Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.
 - e) Not solicit or obtain from the Department any non-public information relating to the Department’s criteria or processes for evaluating bids to enter into or renew a PHP contract.
 - iv. The PHP shall ensure that financial considerations do not influence decisions to provide medically appropriate care.
 - v. The PHP shall validate that all its employees, directors, subcontractors or owners who are licensed providers abide by their professional obligations to their patients and Members and shall not take any actions which conflict with such obligations.
 - vi. The PHP shall not serve as a legal guardian for any of its Members.
 - vii. As required by N.C. Gen. Stat. § 143B-139.6C, the PHP shall not use a former Department employee, director, or contractor in the administration of its PHP contract for six (6) months after such person’s employment or contract with the Department is terminated, if such person personally participated in the following activities:
 - a) The award of the contract to the PHP,
 - b) An audit, decision, investigation, or other action affecting the PHP, or
 - c) Regulatory or licensing decisions that applied to the PHP.

- viii. The PHP shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices.
- ix. The PHP shall submit its written Conflict of Interest Policy for its employees to the Department for review.

B. Members

1. Eligibility for Medicaid Managed Care

- a. Pursuant to Session Law 2015-245, as amended, the Department was directed to transition certain North Carolina Medicaid and NC Health Choice populations from a Medicaid Fee-for-Service structure to a Medicaid Managed Care structure. The Department will maintain authority in determining North Carolina Medicaid and NC Health Choice eligibility and defining populations to be transitioned into Medicaid Managed Care.
- b. The Department shall maintain sole authority for performing, managing, and maintaining all eligibility and cost sharing determinations.
- c. The PHP shall be responsible for adhering to eligibility and cost sharing determinations made by the Department.
- d. Medicaid Managed Care eligibility:
 - i. The Department shall be responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt, or mandatory at any point in time.
 - ii. The PHP shall be responsible for adhering to Medicaid Managed Care eligibility and enrollment determinations made by the Department.
 - iii. In accordance with Section 4.(5) of Session Law 2015-245, as amended,² the following populations shall be excluded from Medicaid Managed Care:
 - a) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
 - b) Qualified aliens subject to the five-year bar for means- tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
 - c) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
 - d) Medically needy Medicaid beneficiaries;
 - e) Presumptively eligible beneficiaries, during the period of presumptive eligibility;
 - f) Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program;
 - g) Beneficiaries enrolled under the Medicaid Family Planning program;
 - h) Beneficiaries who are inmates of prisons;
 - i) Beneficiaries being served through the Community Alternatives Program for Children (CAP/C);
 - j) Beneficiaries being served through the Community Alternatives Program for Disabled Adults (CAP/DA); and
 - k) Beneficiaries with services provided through the Program of All Inclusive Care for the Elderly (PACE).³

² Section 4.(5) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, Section 5.(a) of Session Law 2018-49, and Session Law 2018-48.

³ The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to Section 4.(4)d. of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, which excludes all PACE program services from Medicaid Managed Care.

- iv. In accordance with Section 4.(5)e. of Session Law 2015-245, as amended,⁴ the following population shall be exempt from Medicaid Managed Care:
 - a) Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians (EBCI).
- v. In accordance with Section 4.(5)m. of Session Law 2015-245, as amended,⁵ the following populations are temporarily excluded, for a period not to exceed five (5) years from Contract Year 1, and shall be treated as excluded until the Department includes them in Medicaid Managed Care:
 - a) Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA. If an individual enrolled in a PHP resides in a nursing facility for ninety (90) days or more, such individual shall be disenrolled from the PHP on the first day of the month following the ninetieth (90th) day of the stay and enrolled in the Medicaid Fee-for-Service program.
 - 1. The Department considers (i) beneficiaries residing in a state-owned Neuro-Medical Center operated by the Division of State Operated Healthcare Facilities (DSOHF) or a Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) at Medicaid Managed Care implementation and (ii) beneficiaries determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after Medicaid Managed Care implementation to be temporarily excluded until the beneficiary is discharged and determined eligible for Medicaid Managed Care.
 - 2. For Members of a PHP determined eligible for and transferred for treatment to a state-owned Neuro-Medical Center or Veterans Home after Medicaid Managed Care implementation, the PHP shall disenroll the Member in accordance with the Medicaid Managed Care Enrollment policy and the Contract.
 - b) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding beneficiaries served through CAP/DA.
- vi. In accordance with Section 4.(5). of Session Law 2015-245, as amended,⁶ the following populations shall be exempt from Medicaid Managed Care until such point that Behavioral Health Intellectual/Developmental Disability (BH I/DD) Tailored Plans (TP) are available:
 - a) Beneficiaries with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact (except beneficiaries enrolled in the foster care system, formerly enrolled in foster care system up to age 26, or receiving Title IV-E adoption assistance, who will be excluded from Medicaid Managed Care during this time).
- vii. All other North Carolina Medicaid and NC Health Choice populations shall be mandatorily enrolled in Medicaid Managed Care during Contract Year 1.
- viii. Pursuant to Section 4.(5a) of Session Law 2015-245, as amended by Session Law 2018-49, populations excluded from Medicaid Managed Care or populations who have been temporarily excluded from Medicaid Managed Care may be enrolled at any time, as

⁴ Section 4.(5) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121.

⁵ Section 4.(5) of Session Law 2015-245, as amended by Section 5.(b) of Session Law 2018-49.

⁶ Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

determined by the Department, if eligible to receive a service that is not available in Medicaid Fee-for-Service but is offered by the PHP.

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

2. Medicaid Managed Care Enrollment and Disenrollment

- a. The Department has sole authority to direct enrollment and disenrollment of beneficiaries into and out of Medicaid Managed Care. In partnership with an Enrollment Broker, the Department will educate beneficiaries on Medicaid Managed Care, support their selection of a PHP, and transmit enrollment selections and approved disenrollment requests to the PHP to effectuate.
- b. All information related to North Carolina Medicaid and NC Health Choice eligibility and cost sharing shall be transmitted to the PHP via the standard Medicaid Managed Care eligibility file format to be defined by the Department.
- c. The PHP shall to accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1)
- d. The PHP shall have staff with sufficient knowledge about the North Carolina Medicaid and NC Health Choice programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment Member information as defined by the Department.
- e. The PHP shall notify the Department within five (5) business days when it identifies information in a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, such as out-of-state claims, or the death of the Member. 42 C.F.R. § 438.608(a)(3).
- f. The PHP shall ensure automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).
- g. The PHP shall only process enrollment for beneficiaries who are Medicaid Managed Care mandatory or exempt.
 - i. The PHP shall notify the Department of the receipt of enrollment information for any beneficiary that is excluded or delayed.
- h. The PHP shall adhere to the Department's Medicaid Managed Care enrollment approach as defined in *Attachment M. 1. North Carolina Medicaid Managed Care Enrollment Policy* and consistent with federal regulations, including but not limited to:
 - i. PHP enrollment processes; and
 - ii. PHP auto-assignment algorithm.
- i. PHP auto-assignment:
 - i. Pursuant to 42 C.F.R. § 435.54, Members who do not select a PHP as part of the North Carolina Medicaid or NC Health Choice application process will be auto-assigned to a PHP.
 - ii. The PHP shall adhere to the PHP auto-assignment logic as defined by the Department.
 - a) The Department will share the auto-assignment logic with the PHP annually and any time there is a material change to the logic methodology.
 - b) The Department, at its sole discretion, may choose to modify or choose to not use the auto-assignment algorithm.

- j. The PHP shall direct the beneficiary to the NC FAST online portal or perform a warm transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.) other than choice of PHP or AMH/PCP or, if applicable, prescriber.
 - i. The PHP shall ensure as outlined in *Section V.G. Program Operations*. that its telephone system will have the capacity to transfer beneficiaries and authorized representatives from the call center to local DSS office without disconnecting the call.
 - ii. If a Member's demographic information is not updated during the next Member reconciliation cycle with the PHP and the Department, the PHP shall follow up with Members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.
- k. The PHP shall, if a Member contacts the PHP to change their PHP, perform a warm transfer to the Enrollment Broker.
- l. Beneficiary Disenrollment
 - i. The PHP shall adhere to the Department's Medicaid Managed Care disenrollment approach as defined in *Attachment M. 1 NORTH CAROLINA MEDICAID MANAGED CARE ENROLLMENT POLICY* and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
 - a) Member disenrollment requests;
 - b) PHP disenrollment requests; and
 - c) PHP disenrollment processes (including special populations transitions out of Medicaid Managed Care).
 - ii. In limited instances and consistent with Medicaid Managed Care Enrollment Policy and federal law, the PHP, with approval from the Department, shall be allowed to request Member disenrollment from the PHP in limited instances as defined in the Medicaid Managed Care Enrollment Policy and consistent with federal requirements under 42 C.F.R § 438.56(b)(2).
 - iii. The PHP shall refer Members to the Department, or an entity designated by the Department to manage waiver eligibility, who may meet eligibility criteria for an applicable waiver program.
- m. The PHP shall accept and process all PHP enrollment and disenrollments within twenty-four (24) hours of receipt of the standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
- n. The PHP shall comply with the Department's membership reconciliation process as defined in *Section V. K. Technical Specifications*.
- o. The PHP shall develop and maintain a Member enrollment and disenrollment policy ninety (90) days after the Contract Award to be submitted to the Department for review and approval. The PHP shall submit to the Department for review any material updates to the policy.

3. Member Engagement

- a. Members, their families, and caregivers need support in the transition to Medicaid Managed Care and as Members in the Medicaid Managed Care program. The PHP will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting Members and their families with understanding Medicaid Managed Care, navigating the health

care system, improving overall Member health through various avenues including maintaining a Member Services department, conducting Member and community outreach, and providing education before, during, and after Medicaid Managed Care implementation. The Department strongly encourages the PHP to develop innovative approaches, including the use of electronic mechanisms for Member education and outreach.

- b. The PHP shall be responsible for engaging Members and their authorized representatives to provide assistance with understanding Medicaid Managed Care and their rights and responsibilities and accessing available benefits and services in-person, telephone, by mail, and online/electronically. 42 C.F.R. 438.10(c)(7).
- c. The PHP shall utilize various engagement strategies and communication mediums to engage, educate, and assist Members. The engagement strategy shall include the operation of a dedicated Member Services Department which, at a minimum, shall:
 - i. Maintain a Member call center and a Member services website;
 - ii. Engage with local community and county organizations;
 - iii. Provide written and oral educational materials, activities and programs; and
 - iv. Collaborate with other entities operating within the Medicaid Managed Care delivery system.
- d. The PHP shall use standard managed care terminology in all communications with Members and potential Members as defined in *Attachment L: Managed Care Terminology Provided* to PHPs pursuant to 42 C.F.R. § 438.10.
- e. Member Services Department
 - i. The PHP shall have and implement Member Services policies and procedures that address all Member Services activities.
 - ii. The PHP shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to Members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
 - iii. The Member Services staff shall be responsible, at a minimum, for the following functions:
 - a) Explaining operation of the PHP, including the role of the PCP and what to do in an emergency or urgent medical situation;
 - b) Assisting with arranging non-emergency transportation for Members;
 - c) Assisting Members in selecting or changing AMH/PCP;
 - d) Educating and assisting Members with obtaining services under Medicaid Managed Care, including out-of-network services;
 - e) Explaining transition of care requirements and care management services offered by the PHP;
 - f) Fielding and responding to Members' questions and complaints;
 - g) Clarifying information in the Member Handbook;
 - h) Advising Members of and assisting Members with the appeals, grievance, and State Fair Hearing processes;
 - i) Referring Members to the Department's Enrollment Broker if an individual requests information regarding how to enroll in or select a new PHP; and
 - j) Referring Members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues.
 - iv. The PHP shall operate and maintain the following three (3) Member facing Service Lines:
 - a) Member Services Line,
 - b) Behavioral Health Crisis Line, and

- c) Nurse Line.
- v. The PHP shall conduct ongoing quality assurance of its Member Services Department via Member surveys and internal audits of departments to ensure Member satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - a) Member surveys shall be made available after each web, call center or in-person interaction;
 - b) Surveys and internal audits are intended to measure Member's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
 - c) Reports, including the results of provider surveys and the PHP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- f. Member Services Website
 - i. The Department encourages the PHP to utilize processes, procedures or technology which improve the member experience and effectively reduce or ease administrative burdens on the Member.
 - ii. The PHP shall develop and maintain a dedicated, interactive North Carolina Medicaid and NC Health Choice Member services website that, at a minimum, has the functionality to allow the Member to search for in-network providers and search through the drug formulary.
 - iii. The PHP shall also include on its website within two (2) "clicks" from the homepage, at a minimum:
 - a) An up-to-date copy of the Member Handbook;
 - b) Information on hours of operation;
 - c) How to contact the Member Services staff, and care managers;
 - d) Appeals, grievances, and State Fair Hearing policies and processes;
 - e) Information regarding the Ombudsman program;
 - f) Health promotion and educational materials;
 - g) Any specific prevention, population health, or care management programs offered by the PHP; and
 - h) Other information the PHP believes would support Member and their families.
 - iv. The PHP shall meet the same literacy standards identified for written materials in any materials made available electronically.
 - v. The PHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
 - vi. The PHP website shall be accessible via mobile devices.
 - vii. The PHP website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's Systems that impact the ability for the website to operate correctly.
 - a) The PHP shall notify the Department and Members of scheduled downtime at least fourteen (14) calendar days in advance and publish on its website at least seven (7) calendar days in advance.
 - b) The PHP shall notify the Department and Members of unscheduled downtime within one (1) hour and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the PHP.

- g. Communications with Members and Potential Members
 - i. The PHP shall ensure all contacts with Members/authorized representatives are culturally competent and provides effective communication, with deference to the method requested by the Member, to the Member, including sign language interpreters, and occurs in a timely manner that protects the privacy and independence of the individual with a disability.
 - ii. The PHP shall ensure that Members and potential Members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and N.C. Gen. Stat. § 58-3-191(b)(5) in a culturally competent manner and format that may be easily understood and is readily accessible.
 - iii. The PHP shall address the following in the development of Member materials:
 - a) The population size and geographic/regional needs and differences throughout each of the PHP's Region(s);
 - b) Language proficiencies;
 - c) Types of disabilities;
 - d) Literacy levels;
 - e) Cultural needs of the Member population;
 - f) Age and age-specific or other targeted learning skills or capabilities; and
 - g) Ability to access and use technology.
 - iv. The PHP shall be permitted to provide information required to be communicated to Members and potential Members in the following manner:
 - a) Mailing a printed copy of the information to the Member's mailing address is the default absent an explicit preference stated by the Members or their authorized representative;
 - b) Emailing the information, after receiving the Member's or potential Member's express consent to receive information via email and obtaining a valid, up to date email address;
 - c) Posting the information on the PHP's website and advising the Member or potential Member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a Member may request communication accommodations; and
 - d) Providing the information by any other method that can reasonably be expected to result in the Member receiving the information. 42 C.F.R. § 438.10(g)(3).
 - v. The PHP shall not construe requirement herein to limit or alleviate the PHP's obligation to communicate directly with the Member, a Member's authorized representative, parent or guardian, or potential Member as required under the Contract or under federal or state law or regulation.
 - vi. The PHP shall provide information in the Member's preferred format upon request at no cost (e.g., a Member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
 - vii. The PHP shall consult with and comply with practices of the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.
- h. Written and Oral Member Materials
 - i. The PHP shall provide Member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which addresses information requirements related to written and oral information provided to Members.
 - ii. The PHP shall provide all written materials to Members and potential Members consistent with the following:

- a) Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).
- b) Use a san serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.
- c) Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Members or potential Members with disabilities or limited English proficiency.
- d) Include a large print (i.e., font size no smaller than 18 point) tagline and information on how to request auxiliary aids and services, including materials in alternative formats. 42 C.F.R. § 438.10(d)(6)(iii).
- e) Written in accordance with Associated Press Style and Department-specific style guide.
- f) Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
- g) Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the PHP's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:
 - 1. Spanish,
 - 2. Chinese,
 - 3. Vietnamese,
 - 4. Korean,
 - 5. French,
 - 6. Arabic,
 - 7. Hmong,
 - 8. Russian,
 - 9. Tagalog,
 - 10. Gujarati,
 - 11. Mon-Khmer (Cambodia),
 - 12. German,
 - 13. Hindi,
 - 14. Laotian, and
 - 15. Japanese.
- iii. The PHP shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to Members in their original format.
- iv. The PHP shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
- v. The PHP shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on user agents, such as mobile devices.
- i. Mailing Materials to Members
 - i. The PHP shall verify addresses against a United States Postal Service approved product or service on all Members enrolled in the PHP prior to mailing materials, at no additional cost to the Department or the Member.

- a) The PHP shall make all reasonable attempts to identify the correct mailing address and mail information to the Member within applicable timeframes, as required under the Contract.
- b) The PHP shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
- c) The PHP shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
- ii. The PHP shall notify the Department, or the local DSS office as directed by the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.
- iii. If the PHP identifies a new, updated address, the PHP shall resend only Member specific information at no additional cost to the Department or the Member.
- iv. All materials mailed to potential Members, Members, and, when applicable, authorized representatives, shall be sent via first class mail.
- v. The PHP shall consider cost-effective methods for controlling postage costs when producing Member materials for mailing.
- vi. The PHP shall develop a Member Mailing Policy, subject to Department review and approval. The PHP shall submit to the Department ninety (90) days after Contract Award.
- j. Translation and Interpretation Services
 - i. The PHP shall make interpretation services available to all potential Members and Members. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).
 - ii. The PHP shall notify its Members of the availability of interpretation services and inform them of how to access such services, including providing the following information:
 - a) That oral information is available for any language and written translation is available in prevalent languages free of charge to each Member. 42 C.F.R. § 438.10(d)(4); and
 - b) That auxiliary aids and services are available upon request and at no cost for Members with disabilities. 42 C.F.R. § 438.10(d)(5).
 - iii. The PHP shall offer qualified interpreter services available for oral contacts with Members and authorized representatives whose primary language is not English.
 - iv. The PHP shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.
 - v. The PHP shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with Member audiences.
 - vi. The PHP shall make interpretation services available free of charge to each Member. 42 C.F.R. § 438.10(d)(4).
 - vii. The PHP shall staff Member facing Service Lines with fluent Spanish speakers to converse with Members who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the Member or the Department. Oral interpretations must be available in all languages as required by regulation or determined by the Department.
 - viii. Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:

- a) Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
 - b) Translation of materials into Spanish and up to three additional languages, as required by the Department.
 - ix. The PHP shall notify the Department in writing within five (5) business days each time the PHP or its subcontractor charges a Member, potential Member, authorized representative or guardian for interpreter or translation services.
 - x. The PHP shall notify the Department of any change in the language preference for Members in an electronic format and frequency as defined by the Department.
- k. Member Welcome Packet
 - i. The PHP shall send a Welcome Packet to the Member within seven (7) calendar days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment.
 - a) For Members who participate in the crossover open enrollment period, the PHP shall send the Welcome Packet within seven (7) calendar days of the close of open enrollment.
 - b) For all new Members enrolled after the open enrollment period, the PHP shall send the Welcome Packet within seven (7) calendar days of receipt of a Member enrollment information.
 - ii. The PHP shall include the following in the initial Member Welcome Packet and upon Redetermination:
 - a) A welcome letter that notifies the Member of their enrollment in the PHP and provides:
 - 1. The effective date from which the PHP shall assume health coverage for the Member;
 - 2. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
 - 3. Information on how to change a PHP;
 - 4. The toll-free service line numbers which a Member may call for the Member Services Line, Behavioral Health Crisis Line, and Nurse Line;
 - 5. Information on how to inquire about accessing care management services;
 - 6. The role of an AMH/PCP in Medicaid Managed Care;
 - i. How to select or change an AMH/PCP;
 - ii. Why a Member might be auto-assigned an AMH/PCP;
 - 7. How to arrange for non-emergency transportation; and
 - 8. An offer of assistance in arranging initial visit to his or her AMH/PCP.
 - b) Member identification card; and
 - c) A current Member Handbook.
 - iii. Initially and annually thereafter, the PHP shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within ninety (90) calendar days of Contract Award.
- l. Member Identification Cards
 - i. The PHP is required to generate an identification card for each Member enrolled in the PHP with the following printed information:
 - a) The Member's North Carolina Medicaid or NC Health Choice identification number
 - 1. The Member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and

2. The Member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the PHP.
 - b) The PHP's name, mailing address and Member Portal.
 - c) The Member's AMH/PCP name, physical address and phone number.
 - d) The toll-free help line numbers for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
 - e) The North Carolina Department of Justice Medicaid Investigations Division (MID), fraud, waste and abuse hotline with the following language:
 1. *If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call (919) 881-2320.*
 - f) Information regarding Medicaid Managed Care carved-out services.
 - ii. The PHP shall provide the Member identification card with the Welcome Packet. A replacement identification cards shall be provided upon request by the Member or the Member's authorized representative or upon AMH/PCP change, at no charge to the Member.
 - iii. The PHP shall submit the Member identification card to the Department for review and approval ninety (90) days after Contract Award, after direction by the Department or when changes are made to the card layout or content.
- m. Member Handbook
- i. The PHP shall ensure that each Member receives a Member Handbook, which serves as a summary of benefits and coverage, within seven (7) calendar days after the PHP receives notice of the Member's enrollment in the PHP. 42 C.F.R. § 438.10(g)(1).
 - ii. The PHP shall use the Department's model Member Handbook as guidance in the development of the PHP's Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii).
 - iii. The PHP shall ensure that all Member Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, cultural competency and literacy standards.
 - iv. In accordance with 42 C.F.R. § 438.10(g) and N.C. Gen. Stat. §§ 58-3-190(f), 58-51-38(b), and 58-67-88(j), the PHP shall ensure that the Member Handbook includes sufficient information that enables the Member to understand how to effectively use Medicaid Managed Care. This information shall include at a minimum:
 - a) Covered benefits provided by the PHP.
 - b) Member enrollment and disenrollment policy, including Information on the Member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract.
 - c) How and where to access any benefits provided by the Department, including carved out services, cost sharing, and how non-emergency transportation is provided.
 - d) List of counseling or referral services that the PHP does not cover because of moral or religious objection, instructions for how the Member can obtain information from the Department about how to access those services, and notification that the PHP's failure to cover a service based on moral or religious objection is a with cause reason for Member disenrollment.
 - e) The amount, duration, and scope of benefits available under the PHP in sufficient detail to ensure that Members understand the benefits to which they are entitled.
 - f) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's AMH/PCP.

- g) Information on the EPSDT benefits, for Medicaid Managed Care Members, including:
 - 1. The benefits of preventive health care;
 - 2. Services available under the EPSDT program and where and how to obtain those services;
 - 3. That EPSDT services are not subject to cost-sharing; and
 - 4. That PHP will provide scheduling and transportation assistance for EPSDT services upon request by the Member.
- h) The extent to which, and how, after-hours and emergency coverage are provided, including:
 - 1. What constitutes an Emergency Medical Condition and emergency services;
 - 2. The fact that prior authorization is not required for emergency services; and
 - 3. The fact that, subject to 42 C.F.R. § 438.10, the Member has a right to use any hospital or other setting for emergency care.
- i) Any restrictions on the Member's freedom of choice among in-network providers and out-of-network providers.
- j) The extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the PHP cannot and shall not require a Member to obtain a referral before choosing a family planning provider.
- k) Cost sharing, if any, imposed on North Carolina Medicaid or NC Health Choice beneficiaries.
- l) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract.
- m) The process of selecting and changing the Member's AMH/PCP, including, but not limited to:
 - 1. The number and frequency limitations of AMH/PCP changes;
 - 2. Information on the two (2) annual without cause AMH/PCP changes; and
 - 3. The with cause reasons for switches beyond the two (2) without cause changes.
- n) Grievance, appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
 - 1. The right to file grievances and appeals;
 - 2. The requirements and timeframes for filing a grievance or appeal or State Fair Hearing;
 - 3. The availability of assistance in the filing process;
 - 4. The right to request a State Fair Hearing after the PHP makes a decision on the Member's appeal which is adverse to the Member; and
 - 5. The fact that, when requested by the Member, benefits that the PHP seeks to reduce or terminate will continue if the Member files a request within the timeframes specified for filing and that the Member may be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the Member.
- o) How to exercise an advance directive, as set forth in 42 C.F.R. § 438.3(j).
- p) An overview of its continuation of benefits policy and define when, why and how a Member or a Member's authorized representative may file for a continuation of benefits.
- q) How to access auxiliary aids and services, including additional information in alternative formats or languages.

- r) The toll-free help line numbers for the Member Services Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
 - s) Information on how to report suspected fraud, waste or abuse.
 - t) Information about Opioid Misuse Prevention Program.
 - u) Information on the PHP Transition of Care Policy.
 - v) Information about the PHP's prevention and population health programs.
 - v. The PHP shall make the Member Handbook available for review by the Department, upon request.
 - vi. The PHP shall provide the Department for review any changes to the Member Handbook forty-five (45) calendar days prior to the intended effective date of the change.
 - vii. The PHP shall notify each Member, using Department-developed templates, of any significant change to the Member Handbook at least thirty (30) calendar days before the intended effective date of the change.
- n. Member Education and Outreach
 - i. The PHP shall provide education and outreach to Members and potential Members including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department, the Enrollment Broker, Ombudsman Program and/or local health departments may be present.
 - ii. The PHP shall develop educational materials to be used by the Enrollment Broker to support PHP and AMH/PCP selection. The materials are subject to review and approval by the Department at least ninety (90) calendar days prior to use with Members, potential Members, and/or authorized representatives.
 - iii. The PHP shall provide information regarding its planned Member education efforts to the Department for review and approval sixty (60) days after Contract Award and annually thereafter.
 - iv. Any outreach or education related to the proposed Member Incentive Program must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater Member engagement will not be approved.
- o. Engagement with Consumers
 - i. The PHP must have a strong understanding of and capability to meet the needs of its Members. To that end, the PHP shall establish a Member Advisory Committee to garner Member and stakeholder input and advice regarding the PHP's programs and policies.
 - ii. The Member Advisory Committee shall reflect the geographic, racial, and cultural diversity of each Region covered by the PHP or their representatives, and include a majority (51%) of Member, consumer and family representatives. Topics for discussion shall include but should not be limited to:
 - a) Medical, pharmacy, and behavioral health benefits
 - b) Opportunities for Health priority domains
 - c) Care management
 - d) Enhanced Case Management Pilots (if applicable)
 - iii. The PHP shall consult with the Member Advisory Committee at least on a quarterly basis.
- p. Engagement with Beneficiaries Utilizing Long Term Services and Supports
 - i. The PHP must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. To that end, the PHP shall establish a LTSS Member Advisory Committee that garners stakeholder input and advice regarding

the LTSS covered under the PHP contract, and meets all provisions noted in 42 C.F.R. § 438.110.

- ii. The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the PHP or their representatives and include:
 - a) Members accessing LTSS;
 - b) Representatives of LTSS Members;
 - c) LTSS providers; and
 - d) PHP staff involved in the authorization of LTSS and/or care management of LTSS users.
 - iii. The PHP shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.
- q. Health Education and Promotion Programs
- i. The PHP shall develop Member health education and promotion programs that addresses prevention, wellness, and early intervention of illness and disease.
 - ii. The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.
 - iii. The PHP shall make the health education and promotion programs available to Members through various communication mediums including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
 - iv. The Department may select specific educational and health promotion topics for the PHP to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- r. Member Incentive Program
- i. The PHP may offer healthy behavior incentive programs to Members, provided that the following criteria is met:
 - a) The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy.
 - b) The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
 - c) The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed \$75.00.
 - ii. Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
 - iii. Prior to implementation, the PHP shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the QAPI.
 - iv. The PHP shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (1) the program meets the requirements of 1112(a)(5) of the Social Security Act; and (2) the program meets the criteria determined by the Department.

4. Marketing

- a. The Department views PHP marketing activities as a method to help publicize Medicaid Managed Care and educate potential Members about health plan options, while ensuring the protection of Members from coercive or misleading practices.
- b. The PHP shall comply with all marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the PHP to ensure that Members receive accurate oral and written information to make an informed decision on whether to enroll or reenroll in the PHP.
- c. The PHP shall not market nor distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i).
- d. The PHP shall ensure that marketing materials are accurate and does not mislead, confuse, or defraud Members or the Department. 42 C.F.R. § 438.104(b)(2).
- e. The PHP shall establish and maintain, a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented shall be the responsibility of the PHP.
- f. If the PHP chooses to market, the PHP shall distribute marketing materials to the entire region served by the PHP. 42 C.F.R. 438.104(b)(1)(ii).
- g. The PHP shall ensure that all marketing materials comply with the language, accessibility, and cultural competency requirements and the Member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- h. The PHP shall ensure that all marketing materials and marketing strategies shall abide by the PHP's Non-discrimination Policy. In addition, the PHP shall not discriminate against Members or potential Members who may:
 - i. Live or receive health care in rural or underserved areas; or
 - ii. Experience income disparities.
- i. The PHP shall assign a unique marketing code to all marketing materials distributed Members.
- j. Marketing Materials and Activities
 - i. Permissible Marketing Activities
 - a) The PHP may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health Fairs, and Public Libraries and other state-approved community-based marketing events or locations.
 - b) The PHP may participate in community-based marketing events or activities (e.g., health fairs, community events).
 - c) The PHP may sponsor outreach activities and events, including as a financial sponsor.
 - d) The PHP may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
 - e) The PHP may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
 - ii. Prohibited Statements, Claims, and Activities (Written or Oral)
 - a) The PHP shall not claim that a Member must enroll in the PHP to obtain benefits or to not lose benefits. 42 C.F.R. § 438.104(b)(2)(i).

- b) The PHP shall not claim that the PHP is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).
 - c) The PHP shall not use the Department or State logo in marketing materials.
 - d) The PHP shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
 - e) The PHP shall not reference competing PHPs or other contractors of the Department, list or reference providers who are not part of the plan network, or include negative information about the Department or other PHPs in any of its marketing materials.
 - f) The PHP shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).
 - g) The PHP shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.
 - h) The PHP shall not market materials or activities that are discriminatory or that target potential Members based on health status, geographic residence, location of the provision of possible services or income.
 - i) The PHP shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
 - j) The PHP shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
 - k) The PHP shall not engage in activities that seek to target Members currently enrolled in other PHPs.
 - l) The PHP shall not offer choice counseling or seek to enroll potential Members in the PHP. This is the sole responsibility of the Department and the Enrollment Broker.
 - m) The PHP shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
 - n) The PHP shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
- iii. References to Studies and Statistics
- a) The PHP shall not use irrelevant facts or inaccurate statistical information in any marketing materials, and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
 - b) If references to a study or statistics are included in any marketing material, the PHP shall provide reference information (e.g., publication, date, page number) and information about the PHP's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.
- iv. Nominal Gifts
- a) The PHP may conduct giveaways and distribute nominal gifts to Members and potential Members.
 - b) The PHP shall ensure the following for nominal gifts offered by the PHP:
 1. The gifts do not exceed ten dollars (\$10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance

- may be used, but must be based on venue size, response rate, or advertisement circulation.
 - 2. The gifts are made available to the public and are not in any way connected to enrollment.
 - 3. The gifts are distributed via in-person contacts only (e.g., community events).
 - v. Marketing of Multiple Lines of Business
 - a) The PHP shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.
 - b) The PHP shall be permitted to co-market QHPs and Medicaid products, to the extent the PHP is participating in both markets in the State.
 - c) The PHP shall be permitted to provide information about a QHP to potential Members who could enroll in such a plan as an alternative to Medicaid Managed Care due to a loss of Medicaid eligibility.
 - k. Department Approval of Marketing Materials
 - i. The PHP shall submit marketing materials to the Department for review at least ninety (90) calendar days before the proposed use of the material.
 - ii. If the PHP makes a significant change to marketing materials that have been previously approved by the Department, the PHP must resubmit the materials, in accordance with this section, for Department review and approval.
 - l. The PHP may engage in marketing activities beginning eight (8) weeks prior to the start of open enrollment for Phase 1 of Medicaid Managed Care and shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the PHP's marketing activities in accordance with *Section VI. Contract Performance*.

5. Member Rights and Responsibilities

- a. The Department expects the PHP to treat Members with dignity and respect, to protect Members' rights, to inform Members of their responsibilities as Members of the plan, and ensure each Member is not subject to any unlawful discrimination in the course of obtaining or receiving services from the PHP or any network provider of the PHP.
- b. The PHP shall establish and maintain written policies and procedures that are designed to protect the rights of Members and describe the responsibilities of each Member. The PHP shall develop and submit to the Department for review a Member Rights and Responsibilities Policy ninety (90) calendar days after Contract Award.
- c. The PHP shall include a written description of the rights and responsibilities of Members in the Member Welcome Packet provided to new Members and in Member Handbook.
- d. The PHP shall provide a copy of its Member Rights and Responsibilities Policy to all PHP employees and network providers.
- e. In accordance with 42 C.F.R. § 438.100(b), the PHP shall ensure its written policies and procedures, at a minimum, afford Members the right to:
 - i. Receive information in accordance with 42 C.F.R. § 438.10;
 - ii. Be treated with respect and with due consideration for his or her dignity and privacy;
 - iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand;
 - iv. Participate in decisions regarding his or her health care, including the right to refuse treatment;

- v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - vi. If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
 - vii. Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.
- f. The PHP shall not attempt to influence, limit, or otherwise interfere with the Member's decision to exercise his or her rights as provided in this Contract.
 - g. The PHP shall ensure that Members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the PHP or its network providers treat the Member. 42 C.F.R. § 438.100(c).
 - h. The PHP shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against Members in the course of obtaining or receiving services from the PHP or any network provider of the PHP. 42 C.F.R. § 438.100(d).

6. Member Grievances and Appeals

- a. The Department is committed to ensuring that Members understand and can freely exercise their appeal and grievance rights and resolve issues efficiently with minimal burden to the Member or their authorized representative. The PHP shall educate the Member on their rights and provide reasonable assistance with understanding and navigating the appeals and grievances processes.
- b. Member Grievances and Appeals General Requirements
 - i. The PHP shall establish and maintain a grievance and appeals system for reviewing and resolving Member grievances and appeals. Components of the system shall include a grievance process, a plan level appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F.
 - ii. The PHP shall, while adhering to the required Utilization Management Program, employ strategies to resolve grievance and appeals at lowest level of escalation that meets a Member's needs and in a manner that does not discourage Member's from exercising their rights.
 - iii. The PHP shall provide Members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section V.F.3. Integration with other Department Partners*.
 - iv. The PHP shall provide Members reasonable assistance in completing forms and taking other procedural steps related to a plan grievance or appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a).
 - v. The PHP shall ensure that the individuals making decisions on grievances and appeals:
 - a) Acknowledge receipt of each grievance and appeal (including oral appeals), unless the Member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
 - b) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).
 - c) If deciding an appeal of a denial is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal that

involves clinical issues, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).

- d) Take into account all comments, documents, records, and other information submitted by the Member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).
 - vi. The PHP shall allow an authorized representative (including providers) or legal guardian, with the Member's written consent, to request an appeal or file a grievance on behalf of a Member. 42 C.F.R. § 438.402(c)(ii).
 - 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).
 - viii. The PHP shall define an appeal, adverse benefit determination, and grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400.
 - ix. The PHP shall provide the information specified in 42 C.F.R. §§ 438.10(g)(xi) on its grievance, appeals, and State Fair Hearing procedures to all providers and applicable subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.
- c. Member Grievance Process
- i. The PHP shall develop and maintain a Member Grievance Policy subject to Department review and approval.
 - ii. The PHP shall allow a Member or authorized representative to file a grievance with the PHP, orally or in writing, at any time. 42 C.F.R. §§ 438.402(c)(2)(i)(ii), 438.408; 438.402(c)(2)(i), and 438.402(c)(3)(i).
 - iii. The PHP's Member grievance process shall include acknowledgement, in writing, within five (5) calendar days of receipt of each grievance. 42 C.F.R. § 438.406(b)(1).
 - iv. If a grievance relates to the denial of an expedited appeal request, the PHP shall acknowledge receipt of the grievance, in writing via trackable mail, within twenty-four (24) hours of receipt the grievance.
 - v. The PHP shall use the Department-defined Notice of Acknowledgement of Receipt of Grievance to notify the Member of receipt of the grievance.
 - vi. The PHP shall provide written notice of resolution of the grievance to the Member and, as applicable, the Member's authorized representative within thirty (30) calendar days from the date the PHP receives the grievance. 42 C.F.R. § 438.408(b)(1).
 - vii. If a grievance relates to the denial of an expedited appeal request, the PHP shall resolve the grievance and provide notice to the Member and, as applicable, the Member's authorized representative within five (5) calendar days from the date the PHP receives the grievance. 42 C.F.R. § 438.408(b)(1).
 - viii. Consistent with 42 C.F.R. § 438.408(c)(1)(i) - (ii), the PHP may extend the timeframes for resolution of a grievance by up to fourteen (14) calendar days if:
 - a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest.
 - b) If the timeframe is extended other than at the Member's request, the PHP shall do the following:
 - 1. Make reasonable efforts to give the Member oral notice of the delay;

2. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
 3. Resolve the grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
- c) The PHP shall notify Members of their opportunity to submit a complaint with the Department if the Member is dissatisfied with the PHP's resolution of a grievance.
- d. Notice of Adverse Benefit Determination
- i. The PHP shall give the Member and provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.404.
 - ii. Each notice of adverse action shall conform with 42 C.F.R. § 431.210, contain and explain:
 - a) The action the PHP has taken or intends to take. 42 C.F.R. § 438.404(b)(1);
 - b) The reasons for the action, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);
 - c) The Member's right to file an appeal, including information on exhausting the PHP's one (1) level of appeal and the right to request a State Fair Hearing if the adverse action is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);
 - d) Procedures for exercising Member's rights to file a grievance or appeal. 42 C.F.R. § 438.404(b)(4);
 - e) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
 - f) The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).
 - iii. The PHP shall use the Department-defined template for the Notice of Adverse Benefit Determination.
 - iv. The PHP shall provide the Member with a Department-developed appeal request form in conjunction with the Notice of Adverse Benefit Determination.
 - v. Timing of the Notice of Adverse Benefit Determination.
 - a) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PHP shall give written notice to the Member, and when applicable, an authorized representative at least ten (10) calendar days before the date of the adverse benefit determination is to take effect, except as provided in this Section. C.F.R. § 438.404(c)(1).
 - b) For termination, suspension, or reduction of previously authorized Medicaid-covered services the PHP shall provide written notice as expeditiously as possible and no later than five (5) calendar days before the date of the action if:
 1. The PHP has facts indicating that action should be taken because of probable fraud by the Member; and
 2. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).
 - c) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the PHP shall provide written notice no later than by the date of the action when any of the following occurs:

1. The PHP has factual information confirming the death of the Member;
 2. The PHP receives a signed, written statement from the Member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
 3. The Member is admitted to an institution where he or she is ineligible under the plan for further services;
 4. The Member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
 5. The PHP establishes the fact that the Member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
 6. A change in the level of medical care is prescribed by the Member's physician. 42 C.F.R. §§ 431.213 and 438.404(c).
- d) For denial of payment, the PHP shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 C.F.R. § 438.404(c)(2).
 - e) For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the PHP shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).
 - f) The PHP shall have a contingency plan to notify the Member of an adverse benefit determination notification to a Member or legally responsible person regarding termination or reduction of previously authorized Medicaid-covered services no later than the date of the benefit determination if the Member's address is unknown and mail directed to him/her has no forwarding address.
- vi. Internal Plan Appeals
- a) The PHP shall have an established internal Member appeal process for standard and expedited resolution of appeals requests.
 - b) The PHP shall have only one level of appeal for Members. 42 C.F.R. § 438.402(b).
 - c) The PHP shall include the Member and his or her representative or the legal representative of a deceased Member's estate as parties to the appeal. 42 C.F.R. § 438.406(b)(6).
 - d) The PHP shall provide Members a reasonable opportunity, by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the appeal. For requests for expedited resolution, the PHP shall inform the Member of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)
 - e) The PHP shall provide Members and his or her authorized representative the Member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the PHP (or at the direction of the PHP) in connection with the appeal. The PHP shall provide the information to the Member free of charge and sufficiently in advance of the appeal resolution timeframe. 42 C.F.R. § 438.406(b)(5).
 - f) The PHP shall consider all comments, documents, records, and other information submitted by the Member or, his or her authorized representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
 - g) The PHP shall require Members to exhaust the plan appeal process before requesting a State Fair Hearing. However, if the PHP fails to adhere to the notice and

timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, Members will be deemed to have exhausted the PHP's internal appeal process and can request a State Fair Hearing. 42 C.F.R. § 438.402(c)(1).

h) Request for Plan Appeals

1. The PHP shall allow Members, or an authorized representative, sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination to file a request, orally or in writing, for an appeal with the PHP. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).
2. The PHP shall do the following if the Member makes an oral request for appeal:
 - i. Require the Member to provide a written, signed appeal on the Appeal Request Form following an oral appeal request within sixty (60) days of the date on the notice of adverse benefit determination, unless the Member requests an expedited resolution.
 - ii. Constitute the date of the oral filing as the date of receipt of the appeal. The PHP shall not be required to proceed with evaluating the appeal request until a written signed appeal is received by the PHP from the Member.
 - iii. If an oral appeal request is made but no written request is submitted within fourteen (14) calendar days following the request, the PHP shall mail the Member an Appeal Request Form.
3. The PHP shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard appeal request, whether received orally or in writing, within five (5) calendar days of receipt of the request. 42 C.F.R. § 438.406(b)(1).
4. Standard resolution of appeals
 - i. The PHP shall provide written notice of resolution of the appeal to the Member and/or authorized representative as expeditiously as the Member's health condition requires and within thirty (30) calendar days of receipt of a standard appeal request. 42 C.F.R. § 438.408(b)(2).
 - ii. The PHP shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing appeal request form consistent with. 42 C.F.R. § 438.408(e).
5. Extension of standard resolution of appeal
 - i. The PHP may extend the timeframes for standard resolution of an appeal request by up to fourteen (14) calendar days if
 - a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
 - i. If the timeframe is extended other than at the Member's request, the PHP shall do the following:
 - a. Make reasonable efforts to give the Member oral notice of the delay;
 - b. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
 - c. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).

- ii. The PHP shall use a Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution. The Notice shall include:
 - a) The timeframe for extension;
 - b) The reason for extension;
 - c) A statement on the Member's right to file a grievance if he or she disagrees with the extension; and
 - d) A statement regarding the availability of assistance with the appeals process and the ability to call the PHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
 - iii. The PHP shall provide written notice of the resolution of the appeal, which shall include the date completed and reasons for the determination in easily, understood language. The PHP shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting Member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).
- vii. Expedited Resolution of Plan Appeals
 - a) The PHP shall establish, maintain and communicate to Members an expedited appeal resolution process for plan appeals for use when there is an immediate need for health services because a standard appeal could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).
 - b) The PHP shall allow Members or an authorized representative to file an expedited appeal resolution request either orally or in writing within sixty (60) calendar days of the date on the adverse benefit determination notice.
 - c) The PHP shall not require any additional written follow-up for oral requests for expedited appeal resolution requests. 42 C.F.R. § 438.406(b)(3).
 - d) For expedited appeal requests made by providers on behalf of Members, the PHP shall presume an expedited appeal resolution is necessary and grant the request for expedited resolution. The PHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(a)-(b).
 - e) The PHP shall acknowledge, in writing, receipt of each expedited appeal request within twenty-four (24) hours of receipt. 42 C.F.R. § 438.406.
 - f) The PHP shall use a Department-developed template for the written Notice of Acknowledgement of Receipt of an expedited appeal resolution request and adhere to timelines for sending the notice to Members.
 - g) If the PHP denies the request for an expedited plan appeal, it shall immediately transfer the appeal to the timeframes for standard resolution timeframe and provide written notice to the Member, and when applicable, an authorized representative, of the denial of the expedited resolution request. 42 C.F.R. 438.410(c).
 - h) For expedited resolution of appeals, the PHP shall make a determination as expeditiously as the Member's health condition requires but shall provide written notice, and make reasonable effort to provide oral notice, of resolution no later than seventy-two (72) hours of receipt of the expedited appeal request. 42 C.F.R. §§ 438.408(b)(2) and 431.230(b).

- i) PHP shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing appeal request form.
 - j) Extension of expedited appeal resolution
 - i. The PHP may extend the timeframes for expedited resolution of an appeal request by up to fourteen (14) calendar days if:
 - a) The Member requests the extension, or the PHP determines that there is a need for additional information and the delay is in the Member's interest.
 - b) If the timeframe is extended other than at the Member's request, the PHP shall do the following:
 - i. Make reasonable efforts to give the Member oral notice of the delay;
 - ii. Within two (2) calendar days, provide written notice and inform the Member of the right to file a grievance if he or she disagrees with that decision; and
 - iii. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
 - ii. The PHP shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
 - a) The timeframe for extension;
 - b) The reason for extension;
 - c) A statement on the Member's right to file a grievance if he or she disagrees with the extension; and
 - d) A statement on the availability of assistance with the appeals process and the ability to call the PHP with questions. 42 C.F.R. § 438.10(c)(4)(ii).
- e. Continuation of Benefits
- i. Timely Request for Continuation of Benefits: The PHP shall continue and pay for the Member's benefits during the pendency of the plan appeal and State Fair Hearing if all of the following occur:
 - a) The Member, or the Member's authorized representative, files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(2)(ii);
 - b) The plan appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - c) The services were ordered by an authorized provider;
 - d) The period covered by the original authorization has not expired; and
 - e) The Member files for continuation of benefits within ten (10) calendar days of the PHP sending the notice of the adverse benefit determination (or before), or on the intended effective date of the PHP's proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(b).
 - ii. Notwithstanding the Timely Request for Continuation of Benefits process, the PHP shall reinstate the Member's benefits during the pendency of the plan appeal and State Fair Hearing if all of the following occur:
 - a) The Member, or the Member's authorized representative, files the request for an appeal timely in accordance with 42 C.F.R. § 438.402(c)(2)(ii);
 - b) The Member files for continuation of benefits after the Timely Request for Continuation of Benefits period, but within thirty (30) calendar days of the date

- on the notice of the adverse benefit determination or the notice of resolution issued by the PHP;
 - c) The appeal involves the termination, suspension or reduction of previously authorized services; and
 - d) The services were ordered by an authorized provider.
- iii. If the PHP continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one (1) of the following occurs:
 - a) The Member withdraws the appeal, in writing;
 - b) The Member does not request a State Fair Hearing within ten (10) calendar days from when the PHP mails an adverse PHP decision regarding the Member's PHP appeal;
 - c) A State Fair Hearing decision adverse to the Member is made; or
 - d) The authorization expires or authorization service limits are met. 42 C.F.R. §§ 438.420(c)(1)-(3) and 438.408(d)(2).
- iv. The PHP shall not allow a provider to request continuation of benefits on behalf of a Member. 42 C.F.R. § 438.402(c)(ii).
- v. Following a request for continuation of benefits, the PHP shall notify the Department within twenty-four (24) hours of the decision to approve or deny the request.
- vi. Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
 - a) The PHP shall be permitted to recover the cost of services furnished to the Member during the pendency of the plan appeal and the contested case hearing if:
 - i. The PHP notified the Member of the potential for recovery;
 - ii. The PHP furnished benefits to the Member solely because of the requirement for continuation of benefits; and
 - iii. The final resolution of the plan appeal or the contested case hearing is adverse to the Member (i.e., upholds the PHP's adverse benefit determination). 42 C.F.R. § 438.420(d).
 - b) If the PHP chooses to seek to recover the cost of services provided to Members during the pendency of the plan appeal or the fair hearing, the PHP shall do the following:
 - i. Develop a Member hardship exemption process; and
 - ii. Obtain prior approval from the Department for each instance in which the PHP seeks to recover the costs of benefits provided to Members under this Section which includes an explanation of the services provided to the Member, the amount the PHP is seeking to recover and a detailed explanation for why the PHP is seeking recovery.
- f. State Fair Hearing Process
 - i. PHP shall comply with Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
 - ii. The PHP shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.
 - iii. The PHP shall allow Members or, an authorized representative, one hundred and twenty (120) calendar days from the date on the Notice of Resolution issued by the PHP upholding, in whole or in part, the adverse benefit determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f).

- iv. The parties to the State Fair Hearing shall include the PHP and the Member or, when applicable, the Member's authorized representative. 42 C.F.R. § 438.408(f)(3).
- v. The PHP shall designate a mailing and email address with the OAH for all fair-hearing-related communications from OAH and any party to the State Fair Hearing.
- vi. Mediation
 - a) The PHP shall notify Members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
 - b) The PHP shall inform Members that mediation is voluntary and that the Member is not required to request a mediation to receive a State Fair Hearing with OAH.
 - c) The PHP shall inform Members that if the Member voluntarily elects to participate in mediation and fails to attend without good cause, OAH will dismiss his or her case.
 - d) The PHP shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
- vii. Effectuation of Reversed Appeal Resolutions
 - a) If the PHP, during the plan appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PHP shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).
 - b) If the PHP, during the plan appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the Member received the disputed services while the appeal was pending, the PHP shall pay for those services in accordance with the terms of the Contract. 42 C.F.R. § 438.424(b).
- g. Appellate Responsibilities
 - i. The PHP shall notify the Department within five (5) calendar days of being served notice of a Member's request for judicial review, or other appeal, following an adverse ruling in a State Fair Hearing.
 - ii. The PHP is responsible for responding to the request for judicial review, or other appeal, as well as PHP's attorney's fees and costs.
 - iii. If Department is also a party, the Department is responsible for its response to the request for judicial review. The PHP will cooperate fully with Department in its response and defense. To the extent no conflict of interest exists or arises, the PHP and Department may agree to joint defense.
 - iv. The PHP is responsible for satisfying any judgement, including, payment of benefits, that result from a Court's ruling or order in favor of the Member and against the PHP. The Department will seek indemnification in accordance with the terms of this Contract for any ruling against the Department.
- h. NC Health Choice Member Grievances and Appeals
 - i. The PHP shall allow Members who are NC Health Choice beneficiaries enrolled in the PHP to file grievances in the same manner as Members who are North Carolina Medicaid beneficiaries as specified in this Contract. 42 C.F.R. § 457.1260.
 - ii. In accordance with 42 C.F.R. §§ 457.1260 and 457.1130(b), the PHP shall allow NC Health Choice Members enrolled in the plan to file appeals in the same manner as Members who

are North Carolina Medicaid beneficiaries as specified in this Contract, except that the PHP shall not provide continuation of benefits to NC Health Choice Members during the pendency of an appeal. 42 C.F.R. § 457.1260.

iii. Notwithstanding requirements within this Section, if the sole basis for the PHP's decision to delay, deny, reduce, suspend, or terminate health services, in whole or in part, is a provision in the NC Health Choice State Plan or in federal or North Carolina law requiring an automatic change in coverage under the health benefits package that affects all Members or a group of Members without regard to their individual circumstances, the PHP shall not be required to provide the Member with an opportunity for review of the matter. 42 C.F.R. § 457.1130(c).

i. Appeals and Grievances Recordkeeping and Reporting

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

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

- a) The name of the person for whom the appeal or grievance was filed;
- b) A general description of the reason for the appeal or grievance;
- c) The date received;
- d) The date of each review or, if applicable, review meeting;
- e) Resolution at each level of the appeal or grievance, if applicable;
- f) Date of resolution at each level, if applicable;
- g) Date of appeal decision and mail date of appeal decision;
- h) Whether the appeal was an expedited request, if applicable;
- i) Who conducted the review of the appeal or grievance and made the determination; and
- j) Whether an extension of appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b).

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

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

v. Medicaid Appeals and Grievance Clearinghouse

a) The PHP shall conduct daily uploads of each adverse benefit determination issued to Members and each grievance received from Members to the Medicaid Clearinghouse.

b) The PHP shall include each of the following data points for each adverse benefit determination in the submission, at minimum:

- i. DMA Form Type (2001, 2001A, 2001E, etc.);
- ii. Member identifiers (Medicaid ID, First/Last Name);
- iii. Date of adverse decision (mailing date to Member);
- iv. City and official county code of Member's residence;
- v. Date service request received;
- vi. Service code(s) (i.e., CPT / HCPCS);
- vii. Initial or concurrent authorization;

- viii. Current authorization end date (if concurrent authorization); and
- ix. Waiver type, if applicable.
- c) The PHP shall include, at minimum, each of the following data points for each grievance in the submission:
 - i. Member Identifiers (Medicaid or NC Health Choice ID, First/Last Name);
 - ii. A general description of the reason for the grievance;
 - iii. The date grievance was received;
 - iv. The date of each review or, if applicable, review meeting;
 - v. Resolution of the grievance; and
 - vi. Mail date for resolution notice.

C. Benefits and Care Management

1. Medical and Behavioral Health Benefits Package

- a. Throughout the term of this Contract, the PHP shall promptly provide, arrange, purchase or otherwise make available all medically necessary services required under this Contract to all its Members. Services shall be delivered within the standard of care and meet Department quality standards and expectations.
- b. The PHP shall:
 - i. Cover all services in the North Carolina Medicaid and NC Health Choice State Plans with the exception of services carved out of Medicaid Managed Care under Section 4.(4) of Session Law 2015-245, as amended;⁷ as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract.
 - ii. Use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;
 - iii. Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the Member's diagnosis, type of illness or condition;
 - iv. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. (42 C.F.R. § 438.210(a)(2));
 - v. Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i).
 - vi. Develop a comprehensive Utilization Management Program inclusive of a subset of Medicaid Fee-for-Service clinical coverage policies as defined in this Contract; and
 - vii. Implement and adhere to all Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) policies and protocols as defined in *Section V.C.2. Early and Periodic Screening, diagnosis and Treatment (EPSDT)*.
- c. Covered services:
 - i. The PHP shall cover all services as defined in the Medicaid and NC Health Care State Plans with the exception of services carved out under Section 4.(4) of Session Law 2015-245, as amended;⁸ as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid and NC Health Choice State Plan covered services are described in *Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services* (this

⁷ Section 4.(4) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186, and Session Law 2018-48.

⁸ Ibid.

table is not meant to be exhaustive and is only a summary of the services included in the Medicaid and NC Health Care State Plan);

- ii. The PHP shall not be responsible for providing carved out services to Members as defined in *Section V.C. Table 2: Services Carved Out of Medicaid Managed Care*;
- iii. Consistent with Session Law 2015-245, as amended,⁹ the PHP shall be responsible for covering behavioral health services that are defined as *Section V.C. Table 3: Behavioral Health Services for Standard Plans*.
- iv. The PHP shall implement changes to covered or carved-out services within thirty (30) calendar days after notification by the Department, unless otherwise indicated.

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Inpatient hospital services	<p>Services that –</p> <ul style="list-style-type: none"> 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 - <ul style="list-style-type: none"> (i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) Meets the requirements for participation in Medicare as a hospital; and (iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. <p>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</p>	<p>SSA, Title XIX, Section 1905(a)(1)</p> <p>42 C.F.R. § 440.10</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>North Carolina Medicaid State Plan, Att. 3.1-E</p> <p>NC Health Choice State Plan, Section 6.2.1</p> <p>NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services</p> <p>NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services</p> <p>NC Clinical Coverage Policy 2A-3, Out of State Services</p>	YES	YES

⁹ Ibid.

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R. § 482.66.</p> <p>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).</p> <p>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</p>			

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>requirements listed in 42 C.F.R. § 485.58.</p> <p>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.</p> <p>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.</p> <p>Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval.</p> <p>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</p>			
Outpatient hospital services	<p>Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that—</p> <ul style="list-style-type: none"> Are furnished to outpatients; Are furnished by or under the direction of a physician or dentist; and Are furnished by an institution that— <ul style="list-style-type: none"> (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 	<p>SSA, Title XIX, Section 1905(a)(2)</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan, Section 6.2.2</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>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.</p> <p>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</p>			
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].	<p>SSA, Title XIX, Section 1905(a)(4)(B)</p> <p>42 U.S.C. 1396(d)(r)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p> <p>NC Clinical Coverage EPSDT Policy Instructions</p> <p><i>Section V.C.2.: Early and periodic screening, diagnostic and treatment services (EPSDT) of the Contract</i></p>	YES	NO
Nursing facility services	<p>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.</p> <p>A nursing facility provides daily licensed nursing care and on-site physician</p>	<p>SSA, Title XIX, Section 1905(a)(4)(A)</p> <p>42 C.F.R. § 440.40</p> <p>42 C.F.R. § 440.140</p> <p>42 C.F.R. § 440.155</p> <p>NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9</p> <p>NC Clinical Coverage Policy 2B-1, Nursing Facility Services</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility	NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities		
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 3A	YES	YES
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician—	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.50	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>Within the scope of practice of medicine or osteopathy as defined by State law; and</p> <p>By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.</p> <p>All medical services performed must be medically necessary and may not be experimental in nature.</p> <p>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.</p> <p>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.</p> <p>Injections are excluded when oral drugs may be used in lieu of injections.</p> <p>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.</p>	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h</p> <p>NC Health Choice State Plan, Section 6.2.3</p> <p>NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment</p> <p>NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry</p> <p>NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants</p> <p>NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children</p> <p>NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation</p> <p>NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services</p> <p>NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy</p> <p>NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair)</p> <p>NC Clinical Coverage Policy 1A-11,</p>		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		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-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services		
		NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education		
		NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation		
		NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation		
		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		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-41, Office- Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1B-1, Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc) NC Clinical Coverage Policy 1B-2, Rituximab (Rituxan) NC Clinical Coverage Policy 1B-3, Intravenous Iron Therapy		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Rural health clinic services	<p>Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for “physician services” and “physician-directed services” whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. Child health assistance in RHCs is authorized for NC Health Choice beneficiaries in 42 U.S.C. 1397jj(a)(5).</p> <p>The specific health care encounters that constitute a core service include the following face to face encounters:</p> <ul style="list-style-type: none"> 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. 	<p>SSA, Title XIX, Section 1905(a)(9)</p> <p>42 C.F.R. § 405.2411</p> <p>42 C.F.R. § 405.2463</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p> <p>NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>	YES	YES
Federally qualified health center services	<p>Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally</p>	<p>SSA, Title XIX, Section 1905(a)(9)</p> <p>42 C.F.R. § 405.2411</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>Qualified Health Center (FQHC) services to the Medicaid program. Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in U.S.C. 1397jj(a)(5).</p> <p>The specific health care encounters that constitute a core service include the following face to face encounters:</p> <ul style="list-style-type: none"> 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. 	<p>42 C.F.R. § 405.2463</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p> <p>NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>		
Telemedicine	<p>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.</p>	<p>42 C.F.R. § 410.78</p> <p>NC Clinical Coverage Policy 1-H, Telemedicine and Telepsychiatry</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Health Choice State Plan, Section 6.2.8 NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		Approval for Imaging Services		
Family planning services	Regular Medicaid Family Planning (Medicaid FP) and NCHC services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and 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 Health Choice State Plan Section 6.2.9 NC Clinical Coverage Policy 1E-7, Family Planning Services	YES	YES
Certified pediatric and family nurse practitioner services	<p>(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.</p> <p>If the State specifies qualifications for pediatric nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> 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. <p>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 -</p> <ul style="list-style-type: none"> i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and 	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.</p> <p>(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.</p> <p>If the State specifies qualifications for family nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> Be currently licensed to practice in the State as a registered professional nurse; and Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. <p>If the State does not specify, by specialty, qualifications for family nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must -</p> <ul style="list-style-type: none"> Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and Have a family nurse practice limited to providing primary health care to individuals and families. 			
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid and NC Health Choice provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 NC NEMT Policy	YES	NO
Ambulance Services	Ambulance services provide medically necessary treatment for NC Medicaid Program or NC Health Choice beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary. Ambulance services include only emergency transport via ground and air medical ambulance for a NCHC beneficiary.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15	YES	YES
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2	YES	NO
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Health Choice State Plan, Sections 6.2.6, 6.2.7	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters <i>Section V.C.3. Pharmacy Benefits of the Contract</i>		
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	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:</p> <p>(a) Services furnished at the clinic by or under the direction of a physician or dentist.</p> <p>(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.</p> <p>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</p>	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4</p> <p>NC Health Choice State Plan Section 6.2.5</p>		
Physical therapy	<p>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</p>	<p>SSA, Title XIX, Section 1905(a)(11)</p> <p>42 C.F.R. § 440.110</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 5A, Durable Medical Equipment</p> <p>NC Clinical Coverage Policy 5A-1, Physical</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	supervision of a licensed Physical Therapist.	Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)		
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 devices. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
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	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	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.	NC Clinical Coverage Policy 10B, Independent Practitioners (IP)		
Limited inpatient and outpatient behavioral health services defined in required clinical coverage policy	<p>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.</p> <p>Please refer to NC Clinical Coverage Policies and services listed.</p>	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35</p> <p>NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19</p> <p>NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed):</p> <p>Mobile Crisis Management</p> <p>Diagnostic Assessment</p> <p>Partial Hospitalization</p> <p>Professional Treatment Services in Facility-based Crisis</p> <p>Ambulatory Detoxification</p> <p>Non-hospital Medical Detoxification</p> <p>Medically Supervised or ADATC Detox Crisis Stabilization</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers		
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	<p>SSA, Title XIX, Section 1905(a)(28)</p> <p>SSA, Title XIX, Section 102(e)(9)(A)</p> <p>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</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services</p>	YES	YES
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	<p>SSA, Title XIX, Section 1905(a)(13)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 5</p>	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>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;</p> <p>(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;</p> <p>(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</p>			
Podiatry services	<p>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</p>	<p>SSA, Title XIX, Section 1905(a)(5)</p> <p>42 C.F.R. § 440.60</p> <p>G.S. § 90-202.2</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	of clubfoot of an infant two years of age or less.”	NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care		
Optometry services	Medicaid and NCHC shall cover the following optical services when provided by ophthalmologists and optometrists: a. routine eye exams, including the determination of refractive errors; b. prescribing corrective lenses; and c. dispensing approved visual aids. Opticians may dispense approved visual aids.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a NC Health Choice State Plan Section 6.2.12 G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21	YES	YES
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
Private duty nursing services	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>SSA, Title XIX, Section 1905(a)(8)</p> <p>42 C.F.R. § 440.80</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b</p> <p>NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older</p> <p>NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age</p>	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	A member of the patient’s immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.			
Personal care	<p>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.</p> <p>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.</p> <p>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,</p>	<p>SSA, Title XIX, Section 1905(a)(24)</p> <p>42 C.F.R. § 440.167</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29</p> <p>NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)</p>	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.			
Hospice	<p>The North Carolina Medicaid (Medicaid) and NC Health Choice (NCHC) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care.</p> <p>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.</p> <p>Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General</p>	<p>SSA, Title XIX, Section 1905(a)(18)</p> <p>42 C.F.R. §418</p> <p>North Carolina Medicaid State Plan 3.1-A, Page 7</p> <p>NC Health Choice State Plan Section 6.2.14</p> <p>NC Clinical Coverage Policy 3D, Hospice Services</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>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).</p> <p>A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.</p>			
Durable medical equipment	<p>Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home:</p> <ol style="list-style-type: none"> 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 	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3</p> <p>NC Health Choice State Plan Section 6.2.12, 6.2.13</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5B, Orthotics & Prosthetics</p>	YES	YES
Prosthetics, orthotics and supplies	<p>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.</p> <p>Only items determined to be medically necessary, effective and efficient are covered.</p> <p>A qualified orthotic and prosthetic device provider must be approved by the</p>	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 440.120</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	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) or NC Health Choice (NCHC) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: <ul style="list-style-type: none"> a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy 	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES	YES
Services for individuals age 65 or older in an institution for mental disease (IMD)	Provides hospital treatment in a hospital setting twenty-four (24) hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for beneficiaries with acute psychiatric or substance use problems.	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services	YES	NO
Services in an intermediate care facility for individuals with Intellectual Disability	An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (42 C.F.R. § 435.1009) is an institution, or distinct part thereof, that: <ul style="list-style-type: none"> a. Functions primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or persons with a related condition; and 	SSA, Title XIX, Section 1905(a)(15) 42 C.F.R. § 435.1009 42 C.F.R. § 440.150 42 C.F.R. § 483.440 North Carolina Medicaid State Plan, Att. 3.1-A,	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>b. Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability.</p> <p>Active treatment is a continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services described in 42 C.F.R. § 483.440.</p>	Pages 6, 7; Att. 3.1-A.1, Page 16-17		
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.	<p>SSA, Title XIX, Section 1905(a)(16)</p> <p>42 C.F.R. § 440.160</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17</p> <p>NC Health Choice State Plan Section 6.2.10</p> <p>NC Clinical Coverage Policy 8B, Inpatient Behavioral Health Services</p>	YES	YES
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.	<p>North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9</p> <p>NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)</p> <p>NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>and Bone Marrow Transplant for Acute Myeloid Leukemia</p> <p>NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia</p> <p>NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias</p> <p>NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors</p> <p>NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma</p> <p>NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis</p> <p>NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone</p>		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms</p> <p>NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma</p> <p>NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin’s Lymphoma</p> <p>NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells</p> <p>NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood</p> <p>NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL)</p>		

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		NC Clinical Coverage Policy 11B-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	YES	YES
Allergies	Provides testing for allergies. The term “allergy” indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances	NC Clinical Coverage Policy 1N-1, Allergy Testing	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	<p>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.</p> <p>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.</p>	NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy		
Anesthesia	<p>Refers to practice of medicine dealing with, but not limited to:</p> <p>a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures.</p> <p>b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations.</p> <p>c. The clinical management of the patient unconscious from whatever cause.</p> <p>d. The evaluation and management of acute or chronic pain.</p> <p>e. The management of problems in cardiac and respiratory resuscitation.</p> <p>f. The application of specific methods of respiratory therapy.</p> <p>g. The clinical management of various fluid, electrolyte, and metabolic disturbances</p>	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4;</p> <p>NC Clinical Coverage Policy 1L-1, Anesthesia Services</p> <p>NC Clinical Coverage Policy 1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)</p>	YES	YES
Auditory Implant External Parts	<p>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</p>	<p>NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair</p> <p>NC Clinical Coverage Policy 13B, Soft Band and</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
	communication for individuals with profound hearing impairment.	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	YES	YES
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound	YES	YES
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease-related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services	YES	YES
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services	YES	YES
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1)	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>NC Clinical Coverage Policy 1M-2, Childbirth Education</p> <p>NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention</p> <p>NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment</p> <p>NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care</p> <p>NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit</p>		
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)</p> <p>NC Clinical Coverage Policy 1E-1, Hysterectomy</p> <p>NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions</p> <p>NC Clinical Coverage Policy 1E-3, Sterilization Procedures</p> <p>NC Clinical Coverage Policy 1E-4, Fetal Surveillance</p>	YES	NO

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		<p>NC Clinical Coverage Policy 1E-5, Obstetrics</p> <p>NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home</p>		
Ophthalmologic Services	<p>General ophthalmologic services include</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>NC Clinical Coverage Policy 1T-1, General Ophthalmological Services</p> <p>NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services</p>	YES	YES
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	<p>North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h</p> <p>NC Clinical Coverage Policy 9, Outpatient Pharmacy Program</p> <p>NC Clinical Coverage Policy 9A, Over-the-Counter-Products</p> <p>NC Clinical Coverage Policy 9B, Hemophilia</p>	YES	YES

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

SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administration Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older		
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	YES	YES
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	YES	YES

Section V.C. Table 1: Summary of Medicaid and NC Health Choice Covered Services				
SERVICE	DESCRIPTION	KEY REFERENCES	COVERED BY	
			MEDICAID	NCHC
		Exam and visual Aids for Recipients Under Age 21		

Section V.C. Table 2: Services Carved Out of Medicaid Managed Care ¹⁰
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Section V.C. Table 3: Behavioral Care Services Covered in Standard Plans ¹¹			
Inpatient behavioral health services	Mobile crisis management services	Outpatient behavioral health emergency room services	Outpatient behavioral health services provided by direct-enrolled providers

¹⁰ Section 4.(4) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186, and Session Law 2018-48.

¹¹ Section 4.(4)a. of Session Law 2015-245, as amended by Session Law 2018-48.

Section V.C. Table 3: Behavioral Care Services Covered in Standard Plans¹¹

Facility- based crisis services for children and adolescents,	Professional treatment services in a facility- based crisis program	Outpatient opioid treatment services,	Ambulatory detoxification services
Nonhospital medical detoxification services, partial hospitalization	Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization	Research- based intensive behavioral health treatment	Early and Periodic Screening, Diagnostic and Treatment services
Diagnostic assessment services			

- v. The PHP shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.
- vi. The PHP shall, in accordance with the federal Women’s Health and Cancer Rights Act of 1998 (WHCRA), provide protections to patients who choose to have breast reconstruction relating to a mastectomy, including coverage of:
 - a) All stages of reconstruction of the breast on which the mastectomy has been performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.
- vii. The PHP shall provide long term services and supports in a setting that complies with 42 C.F.R. § 441.301(c)(4) requirements for home and community based settings. 42 C.F.R. § 438.3(o).
- viii. The PHP shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a Member enrolling in the PHP.
- ix. The PHP shall encourage primary care providers, who serve Members under age 19, to participate in the Vaccines for Children (VFC) program, that allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
 - a) The PHP shall require that primary care providers administer vaccines consistent with the AAP/Bright Future periodicity schedule.
 - b) The PHP shall only pay for the vaccine administration fee for VFC eligible children.
 - c) Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
 - d) Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. The PHP shall reimburse the provider for both the vaccine and administration fee for NC Health Choice Members.
 - e) The PHP shall adhere to additional VFC requirements as defined in *Section V.C.7. Prevention and Population Management Health Programs*.

- x. Pursuant to 42 C.F.R. § 457.410(b)(1), the PHP shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
 - a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents” including:
 - 1. Screening for developmental delay at each visit through the 5th year;
 - 2. Screening for Autistic Spectrum Disorders per AAP guidelines;
 - b) Comprehensive, unclothed physical examination;
 - c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
 - d) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
 - e) Health education and anticipatory guidance for both the child and caregiver.
 - xi. Changes to Covered Benefits
 - a) The PHP shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans, except to the extent the service is carved out of Medicaid Managed Care or may only be covered by a BH I/DD Tailored Plan in accordance with North Carolina law.
 - b) In accordance with Section 11H.13.(c) of Session Law 2018-5, as amended by Section 3.13 of Session Law 2018-97, the Department is seeking approval from CMS to amend the Medicaid State Plan to add optical coverage for adults, effective January 1, 2019. The PHP shall be responsible for providing optical coverage to Members consistent with this Contract and any approved State Plan Amendments (SPA), except to the extent that services covered under the SPA are carved out of Medicaid Managed Care pursuant to Section 4.(4) of Session Law 2015-245, as amended.
- d. Medical Necessity
- i. For North Carolina Medicaid and NC Health Choice Members, the PHP shall cover all medically necessary services in accordance with *Section V.C. Benefits and Care Management*.
 - ii. The PHP shall provide medically necessary services to all Medicaid Managed Care Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or behavioral health, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.
 - iii. The PHP may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.C.1.e. Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.
 - iv. The PHP shall work with providers to ensure that providers identify an appropriate new level of care for a Member who no longer meets the medical necessity criteria for an existing service.
 - v. The PHP shall determine whether a service is medically necessary on a case by case basis.
- e. Utilization Management
- i. The PHP shall develop a utilization management (UM) program for medical, behavioral health, and pharmacy services that is based on nationally-recognized evidence-based

clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.

- ii. The Clinical Practice Guidelines shall:
 - a) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
 - b) Consider the needs of Members;
 - c) Be adopted in consultation with contracting health professionals;
 - d) Be reviewed and updated periodically as appropriate; and
 - e) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. §§ 438.236(b).
- iii. The PHP shall use a standardized prior authorization request form developed by the Department.
- iv. Subject to Department review and approval, the Utilization Management (UM) Program, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
 - a) Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
 - b) Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
 - c) Authorize LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
 - d) Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
 - e) Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
 - f) Protecting Members from discouragement, coercion, or misinformation about the amounts of Services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a Service.
 - g) Mechanisms for detecting instances of overutilization, underutilization, and misutilization;
 - h) Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the PHP;
 - i) Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act.
 - j) Dissemination of guidelines to all affected providers and, upon request, to Members and potential Members; and
 - k) Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member.
- v. The PHP shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or Member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.

- a) Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (score for neonatal acute physiology) for neonatal acute physiology) score or other clinical assessment.
 - b) Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH appeals is prohibited.
 - c) The care management process shall not be used to improperly influence, change or prevent a request for a prior approval.
 - d) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.
- vi. The PHP shall not retract a service authorization after the services, supplies, or other items have been provided, except as provided in N.C. Gen. Stat. § 58-3-200(c).
 - vii. The PHP shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).
 - viii. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).
 - ix. The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §§ 438.3(e)(1)(ii) and 438.910(b)-(d).
 - a) Annually, the PHP shall submit a completed standardized parity analysis workbook, developed by the Department, to demonstrate compliance.
 - x. The PHP shall have the option of using the Department's Medicaid Fee-for-Service clinical coverage policies as the basis for the UM program or developing its own.
 - a) A chart of all North Carolina Medicaid and NC Health Choice clinical coverage policies is found in *Attachment B. Clinical Coverage Policy List*.
 - xi. For a limited number of services, the PHP shall incorporate existing North Carolina Medicaid and NC Health Choice Fee-for-Service clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.C. Table 4: Required Clinical Coverage Policies*.
 - a) The Department reserves the right to require the PHP to follow additional Fee-for-Service clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	SCOPE
Behavioral Health and Intellectual/ Developmental Disability	8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): <ul style="list-style-type: none"> i. Mobile Crisis Management ii. Diagnostic Assessment iii. Partial Hospitalization iv. Professional Treatment Services in Facility-based Crisis

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	SCOPE
	v. Ambulatory Detoxification vi. Non-hospital Medical Detoxification vii. Medically Supervised or ADATC Detox Crisis Stabilization viii. Outpatient Opioid Treatment 8A-2: Facility-based Crisis Services for Children and Adolescents 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers 8Q [DRAFT]: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder
Obstetrics and Gynecology	1E-7: Family Planning Services
Physician	1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment 1A-23: Physician Fluoride Varnish Services 1A-36: Implantable Bone Conduction Hearing Aids (BAHA) 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair 13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	As defined in <i>Section V.C.3. Pharmacy Benefits</i>

- xii. The Department will allow “proprietary” utilization management policies under limited circumstances, with prior approval by the Department.
- xiii. As part of the UM program, the PHP shall adhere to the following Prior Authorization requirements.
 - a) To effectively manage the care of its Members, the PHP shall establish and maintain a referral and prior authorization process with the Member-selected or PHP-assigned AMH/PCP at its center.
 - b) The PHP shall conduct prior authorization reviews using current clinical documentation, and must consider the individual clinical condition and health needs of the Member.
 - c) The PHP may require a referral for any medical services not provided by the AMH/PCP except where specifically provided in the Department-PHP contract and in federal and state statute and regulations.
 - d) The PHP must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice programs for the first ninety (90) days after implementation to ensure the continuity of care for Members.

- e) The PHP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial.
- f) Consistent with 42 C.F.R. § 438.206, the PHP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
 - 1. Emergency services
 - i. In accordance with 42 C.F.R. § 438.114, the PHP shall not require Members to obtain a referral or prior authorization before receiving emergency services.
 - ii. The PHP shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
 - iii. The PHP shall not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the Member's AMH/PCP or PHP of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services.
 - iv. The PHP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the PHP's network.
 - v. The PHP shall not hold a Member with an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - vi. The PHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the PHP to seek emergency services.
 - 2. Family planning services
 - i. The PHP shall not require Members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 C.F.R. 438.206(b)(3).
 - ii. The PHP shall not restrict the Member's free choice of family planning services and supplies providers. 42 C.F.R. § 431.51(b)(2).
 - iii. The PHP shall not hold Members liable for payment for family planning services or supplies that are not in the PHP's network.
 - iv. Services provided by women's health specialists in accordance with 42 C.F.R. § 438.206(b)(2) and N.C. Gen. Stat. § 58-51-38.
 - v. The PHP shall not require female Members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.
 - vi. The PHP shall allow female Members direct access to a women's health specialist in addition to the Member's designated source of primary care if that source is not a women's health specialist.
 - vii. The PHP shall not require providers to obtain prior approval for any obstetrical ultrasound.
 - viii. Women's routine and preventive health care services may include but are not limited to: initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for

services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases.

3. Children's screening services
 - i. The PHP shall not require Members to obtain a referral or prior authorization for children's screening services.
 - ii. The PHP shall not require Members to obtain a referral or prior authorization for Local Health Department services.
 4. Behavioral Health services
 - i. The PHP shall not require Members to obtain a referral or prior authorization for the first mental health or substance dependence assessment completed in a twelve (12) month period.
 - ii. The PHP shall make available to all Members a complete listing of its participating mental health and substance use disorder providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.
- g) The PHP shall ensure Members have and are aware of having direct access to services for which the Department does not allow the PHP to require referral or prior authorization, as defined in this Section.
- xiv. For behavioral health services, the PHP shall require providers to use the following behavioral health screening tools at part of the PHP's UM Program:
- a) The PHP shall use the American Society for Addiction Medicine (ASAM) for substance abuse services for medical necessity reviews for all populations except children ages zero (0) through six (6). The PHP shall use EPSDT criteria when evaluation requests for service for children;
 - b) The PHP shall use the Level of Care Utilization System (LOCUS) scores for mental health services for medical necessity reviews for Members eighteen (18) and older;
 - c) The PHP shall use the Child and Adolescent Level of Care Utilization System (CALOCUS) scores for mental health services for medical necessity reviews for children and adolescents six (6) through seventeen (17) years old.
 - d) The PHP shall use either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers to determine medical necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.
 - e) The PHP shall use the Supports Intensity Scale (SIS) for I/DD services for medical necessity reviews for Members five (5) years old and older.
 1. The SIS Children's version shall be used for Members from the ages of five (5) through sixteen (16).
 2. The SIS Adult version shall be used for Members ages seventeen (17) and up.
- xv. UM Program Policy:
- a) The PHP shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review ninety (90) calendar after Contract Award,
 - b) The PHP shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) calendar days before such changes go into effect.
 - c) The PHP shall post the UM Program Policy on their publicly available website for providers and Members, or in other forms as requested by the provider or Member,

at no cost. The PHP shall include a prominent reference to the web address of the UM Program Policy in both its provider and Member Handbooks.

- d) The PHP shall conduct training and education with providers and prescribers on changes to the UM program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.D.2. Provider Relations and Engagement*.
- xvi. The PHP shall make the CMO or designee available to discuss and report on the Utilization Management Program, as requested by the Department.
- f. Telemedicine
 - i. The PHP shall provide services via telemedicine to Medicaid and NC Health Choice Members as an alternative service delivery model in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

The services provided via telemedicine shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. 42 C.F.R. § 438.210(a)(2).
 - ii. The PHP may use telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the PHP's network.
 - iii. The PHP shall not require a Member to seek the services through telemedicine and must allow the Member to access a face-to-face service through an out-of-network provider, if the Member requests.
 - iv. As part of the UM Program Policy, the PHP shall develop and submit a Telemedicine Coverage Policy to the Department.
 - a) The Telemedicine Coverage Policy shall include:
 - 1. Eligible providers who may perform telemedicine;
 - 2. Telemedicine modalities covered by the PHP;
 - 3. Telemedicine modalities not covered by the PHP;
 - 4. Requirements for and limitations on coverage;
 - 5. Description of each covered modality, including:
 - i. Evidence base;
 - ii. Compliance with local, state and federal laws, including HIPAA; and
 - iii. Process to ensure security of protected health information.
 - 2. Reimbursement mechanism (i.e. flow of funds from PHP to all relevant providers and facilities) for each covered modality; and
 - 3. Billing guidance for providers. PHP shall submit a revised Telemedicine Policy to the Department whenever there is a material change to the Policy.
 - v. The PHP shall pay at least the in-person rate for the same service delivered via telemedicine (i.e. payment parity).
 - vi. For all consultations that include two-way, real-time interactive audio and video communication, the PHP shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.
 - vii. The PHP shall pilot new approaches to telemedicine and value-based payment, and shall support providers in optimizing the use of telemedicine in their practices.

For purposes of any telemedicine pilot, the PHP may propose, for the Department's review and approval, a waiver of telemedicine payment parity requirements.

- g. In Lieu of Services
 - i. The PHP may use In Lieu of Services (ILOS), services or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plans, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)-iv.
 - ii. The PHP shall submit the ILOS Service Request Form, in a format to be defined by the Department, prior to implementation to the Department for approval.
 - a) In no instance shall the PHP reduce or remove ILOS service without approval by the Department concurrent within a contract year.
 - b) If changes, reduction, or removal of ILOS services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.
 - c) The PHP shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.
 - iii. The PHP shall post ILOS policies on its publicly available Member and provider websites.
 - iv. The PHP shall monitor the cost-effectiveness of each approved In Lieu of Service by tracking utilization and expenditures (see *Attachment J. Reporting Requirements* for more detailed requirements).
 - v. The PHP shall offer the following In Lieu Of Service:
 - a) Institute for Mental Disease (IMD) In Lieu of Services: The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care and SUD services in other covered settings for no more than fifteen (15) calendar days within a calendar month. 42 CFR 438.6(e)] 438.6(e).
 - b) Upon approval of the pending CMS SUD/IMD waiver:
 - 1. The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for SUD services as defined and otherwise approved CMS; and
 - 2. Institute for Mental Disease (IMD) In Lieu of Services: The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered settings for no more than fifteen (15) calendar days within a calendar month.
 - vi. The PHP shall not require the Member to utilize an ILOS.
 - vii. For In Lieu of Services that have been authorized for other PHPs or otherwise approved by the Department, the PHP is not required to submit an In Lieu of Services request form, but the PHP shall:
 - a) Submit projected cost and utilization data to demonstrate cost effectiveness, as specified by the Department;
 - b) Notify the Department of ILOS coverage start date; and
 - c) Post the Policy on its publicly available website.
 - viii. ILOS previously approved by the Department are outlined in *Attachment C. Approved Behavioral Health In Lieu of Services*.
- h. Value-Added Services
 - i. The PHP may offer Value-Added services as approved by the Department.
 - ii. For each Value-Added service, the PHP shall submit to the Department for approval, in a format defined by the Department, the following information:

- a) Definition and description of the Value-added Service, including if prior authorization is required;
 - b) Definition of the criteria to be eligible for proposed Value-Added service;
 - c) Types of providers eligible to provide the Value-Added services;
 - d) Description of how and when providers and Members will be notified about the availability of the proposed Value-Added service;
 - e) Duration for which Value-Added services will be provided; and
 - f) Description of if, and how, the services will be identified in encounter data.
 - iii. The PHP shall submit to the Department for approval any changes to Value-Added services.
 - a) In no instance may the PHP reduce or remove value added service without approval by the Department during a contract year.
 - b) If changes, reduction, or removal of Value-Added services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.
 - iv. Value-Added services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).
- i. Cost Sharing
- i. The PHP shall impose the same cost-sharing amounts as specified in North Carolina's Medicaid and NC Health Choice State Plans.
 - ii. The PHP shall not require Members to pay for any covered services other than the co-payment amounts required under the State Plans.
 - iii. The PHP shall not hold Member's responsible for any of the following:
 - a) PHP's debts in the event of PHP insolvency;
 - b) Covered services provided to the Member for which:
 - 1. The Department does not pay the PHP, or
 - 2. The Department, or PHP, does not pay the individual or health care provider that furnished the services under a contractual referral or other arrangement;
 - c) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the PHP covered the services directly. 42 C.F.R. § 438.106.
 - iv. The PHP shall track cost-sharing obligations of each Member and provide to the Department in a format and frequency to be defined by the Department.
 - v. Exceptions for cost sharing:
 - a) Pursuant to 42 C.F.R. § 457.505(d)(1), all NC Health Choice Member receive well-child visits and age-appropriate immunizations at no cost to their families.
 - b) Consistent with 42 C.F.R. § 447.56, Medicaid cost-sharing does not apply to subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
 - c) Consistent with 42 C.F.R. Part 457, Subpart E, NC Health Choice cost-sharing does not apply to members of federally-recognized American Indian tribes/Alaska Natives.

Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	ANNUAL ENROLLMENT FEE	SERVICE	COPAY
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency Visit in Hospital ER	\$3/visit \$3/visit \$3/visit \$3/script \$2/visit \$2/visit \$3/visit \$3/visit
North Carolina Health Choice (NCHC)			
NCHC beneficiaries with family income is < 159% FPL	None	Office visits Generic Prescription Brand Prescription when no generic available Brand prescription when generic available Over-the-counter medications Non-emergency emergency room visits	\$0/visit \$1/script \$1/script \$3/script \$1/script \$10/visit
NCHC beneficiaries with family income > 159% and < 211% FPL	\$50 per child or \$100 maximum for two or more children	Office visit Outpatient hospital Generic Prescription copay Brand Prescription (when no generic available) Brand prescription (when generic available) Over-the-counter medications Non-emergency emergency room visits	\$5/visit \$5/visit \$1/script \$1/script \$10/script \$1/script \$25/visit

- j. Noticing Requirements
 - i. The PHP shall provide written notice, using the Department-developed template, to Members on decisions related to authorization of services. The written notice shall include the following:
 - a) The bases for such decisions; and
 - b) Sufficient details that inform Members of the decision, which will provide them with information necessary to determine if they wish to appeal.
 - ii. The PHP shall provide written notice to Members of any Department-initiated changes to the Medicaid or NC Health Choice benefits package or cost sharing requirements.

Notification to Members shall be provided at least thirty (30) calendar days in advance of the effective date of such change.

- iii. The Department shall provide written notice to Members of the aggregate family limit on cost sharing.

The Department shall provide written notice to the PHP and Members when a Member incurs out-of-pocket expenses up to the aggregate household limit and individual household Members are no longer subject to cost sharing for the remainder of the quarter.

- iv. For standard authorization decisions, the PHP shall provide notice as expeditiously as the Member's condition requires and no later than fourteen (14) calendar days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).
- v. The PHP may receive a possible extension of up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.

If the PHP extends the timeframe beyond fourteen (14) days, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.

- vi. For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the PHP shall provide notice no later than seventy-two (72) hours after receipt of the request for service.
 - a) The PHP may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.
 - b) If the PHP extends the timeframe beyond seventy-two (72) hours, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.

k. Electronic Verification System

- i. The PHP must utilize an Electronic Visit Verification (EVV) system to verify personal care services prior to releasing payment.
- ii. The PHP must utilize an EVV system to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:
 - a) Type of service performed;
 - b) Individual receiving the service;
 - c) Date of the service;
 - d) Time that the service begins;
 - e) Location of service delivery;
 - f) Individual providing the service; and
 - g) Time that the service ends.
- iii. If the PHP utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.
- iv. The PHP shall ensure that utilization of an EVV system for Personal Care Services (as part of the State Plan) is in effect at Medicaid Managed Care launch and by January 1, 2023 for Home Health Care Services.

- I. Moral and Religious Objection
 - i. The PHP is not required to provide, reimburse for, or provide coverage of, a counseling or referral services if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R 438.102(b) have been met.
 - ii. If the PHP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PHP shall furnish information about the services it does not cover to the Department whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).

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

- a. The PHP shall cover services, products, or procedures for a Medicaid Member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).
- b. The PHP shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under Fee-for-Service and as defined in the Department's EPSDT policies.
- c. The PHP shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.
- d. The PHP shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for Medicaid Members under twenty-one (21) years of age.
- e. The PHP shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child.
- f. Upon conclusion of an individualized review of medically necessary services, the PHP shall cover medical necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The PHP shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the PHP responsible for delivery of the referred service, product, or treatment.
- g. The PHP may provide medically necessary services in the most economic mode possible, if
 - i. The treatment made available is similarly efficacious to the service requested by the Member's physician, therapist, or other licensed practitioner,
 - ii. The determination process does not delay the delivery of the needed service, or
 - iii. The determination does not limit the Member's right to a free choice of providers within the PHP's network.
- h. Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, utilization management policies, service definitions, or billing codes do not apply to Medicaid Members less than twenty-one (21) years of age when those services are determined to be

medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians.

Note that visits to dentists shall not be billed to the PHP but shall be billed to the Medicaid Fee-for-Service program.

- i. The PHP shall:
 - i. Require all in-network primary care providers to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule.
 - ii. Require all in-network primary care providers to refer infant Medicaid Members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.
 - iii. Require that participating primary care providers include all of the following components in each medical screening.
 - a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents".
 1. Screening for developmental delay at each visit through the 5th year; and
 2. Screening for Autistic Spectrum Disorders per AAP guidelines.
 - b) Comprehensive, unclothed physical examination.
 - c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
 - d) Laboratory testing (including blood lead screening appropriate for age and risk factors).
 - e) Health education and anticipatory guidance for both the child and caregiver.
- j. The PHP shall ensure and verify that network BH providers coordinate with primary care providers and specialists conducting EPSDT screenings.
- k. The PHP shall not require prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age. The PHP may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.
- l. The PHP shall comply with the Department's standards for the timely provision of EPSDT services.
- m. The PHP shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or Member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.
- n. The PHP shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:
 - i. Regular preventive care, and

- ii. Scope of services, products and treatments available when medically necessary to correct or ameliorate a health condition or problem.
- o. The PHP shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) calendar days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in *Section V.B.3. Member Engagement*.
- p. The PHP shall perform outreach to Members who are due or overdue for an EPSDT screening service monthly.
- q. The PHP shall effectively inform Members and/or their parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the *Section V.B.3. Member Engagement*.
- r. The PHP shall not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per EPSDT criteria.
- s. While an EPSDT request is under review, the PHP may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as the PHP makes clear that the Member has the right to request authorization of the services he or she wants to request.
 - i. The PHP shall not request that providers or Members withdraw or modify a request for EPSDT services to accept a less number of hours, or less intensive type of service, or to modify a SNAP (score for neonatal acute physiology) or other clinical assessment.
 - ii. Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH appeals is prohibited.
 - iii. Nothing in this Section should be construed to prevent clinical or treatment discussions.
- s. The PHP shall offer assistance with scheduling appointments for EPSDT services, upon a Member's request.
- t. The PHP shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services) for referrals. The PHP shall also make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.
- u. The PHP shall develop and maintain a EPSDT Policy. The PHP shall submit the EPSDT Policy to the Department for review ninety (90) days after Contract Award and annually thereafter.
- v. Educational and Training Materials
 - i. The PHP shall develop written and oral educational materials on EPSDT, including educational materials for Members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
 - a) The PHP shall submit the materials to the Department for review and approval as defined in *Section V.B.3. Member Engagement*.
 - b) The PHP may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.
 - ii. As part of the Provider Training Plan defined in *Section V.D.2. Provider Relations and Engagement*, the PHP shall provide training to all network providers where EPSDT is

relevant to the providers' area of practice on an annual basis. Training must include information related to:

- a) EPSDT benefits;
- b) EPSDT medical necessity review per federal criteria: standards and processes;
- c) AAP/Bright Futures Periodicity Schedule;
- d) Immunizations;
- e) Required components of an EPSDT screening service;
- f) Providing or arranging for all required lab screenings;
- g) Medical transportation services available to Members;
- h) Outreach activities related to EPSDT provided by the PHP;
- i) Necessary documentation required for reimbursement of EPSDT services; and
- j) Into the Mouths of Babes/Physician Fluoride Varnish Program.

Section V.C. Table 2: Services Carved Out of Medicaid Managed Care¹²
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program.
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Section V.C. Table 3: Behavioral Care Services Covered in Standard Plans¹³			
Inpatient behavioral health services	Mobile crisis management services	Outpatient behavioral health emergency room services	Outpatient behavioral health services provided by direct-enrolled providers
Facility-based crisis services for children and adolescents,	Professional treatment services in a facility-based crisis program	Outpatient opioid treatment services,	Ambulatory detoxification services
Nonhospital medical detoxification services, partial hospitalization	Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization	Research-based intensive behavioral health treatment	Early and Periodic Screening, Diagnosis, and Treatment services
Diagnostic assessment services			

¹² Section 4.(4) of Session Law 2015-245, as amended by Section 2.(b) of Session Law 2016-121, 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186, and Session Law 2018-48.

¹³ Section 4.(4)a. of Session Law 2015-245, as amended by Session Law 2018-48.

- iii. The PHP shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.
- iv. The PHP shall, in accordance with the federal Women’s Health and Cancer Rights Act of 1998 (WHCRA), provide protections to patients who choose to have breast reconstruction relating to a mastectomy, including coverage of:
 - a) All stages of reconstruction of the breast on which the mastectomy has been performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.
- v. The PHP shall provide long term services and supports in a setting that complies with 42 C.F.R. § 441.301(c)(4) requirements for home and community based settings. 42 C.F.R. § 438.3(o).
- vi. The PHP shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a Member enrolling in the PHP.
- vii. The PHP shall encourage primary care providers, who serve Members under age 19, to participate in the Vaccines for Children (VFC) program, that allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
 - a) The PHP shall require that primary care providers administer vaccines consistent with the AAP/Bright Future periodicity schedule.
 - b) The PHP shall only pay for the vaccine administration fee for VFC eligible children.
 - c) Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
 - d) Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. The PHP shall reimburse the provider for both the vaccine and administration fee for NC Health Choice Members.
 - e) The PHP shall adhere to additional VFC requirements as defined in *Section V.C.7. Prevention and Population Health Programs*.
- viii. Pursuant to 42 C.F.R. § 457.410(b)(1), the PHP shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
 - a) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents” including:
 1. Screening for developmental delay at each visit through the 5th year;
 2. Screening for Autistic Spectrum Disorders per AAP guidelines;
 - b) Comprehensive, unclothed physical examination;
 - c) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
 - d) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
 - e) Health education and anticipatory guidance for both the child and caregiver.
- ix. Changes to Covered Benefits
 - a) The PHP shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans, except to

the extent the service is carved out of Medicaid Managed Care or may only be covered by a BH I/DD Tailored Plan in accordance with North Carolina law.

- b) In accordance with Section 11H.13.(c) of Session Law 2018-5, as amended by Section 3.13 of Session Law 2018-97, the Department is seeking approval from CMS to amend the Medicaid State Plan to add optical coverage for adults, effective January 1, 2019. The PHP shall be responsible for providing optical coverage to Members consistent with this Contract and any approved State Plan Amendments (SPA), except to the extent that services covered under the SPA are carved out of Medicaid Managed Care pursuant to Section 4.(4) of Session Law 2015-245, as amended.

m. Medical Necessity

- i. For North Carolina Medicaid and NC Health Choice Members, the PHP shall cover all medically necessary services in accordance with *Section V.C. Benefits and Care Management*.
- ii. The PHP shall provide medically necessary services to all Medicaid Managed Care Members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or behavioral health, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.
- iii. The PHP may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.C.1.e. Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.
- iv. The PHP shall work with providers to ensure that providers identify an appropriate new level of care for a Member who no longer meets the medical necessity criteria for an existing service.
- v. The PHP shall determine whether a service is medically necessary on a case by case basis.

n. Utilization Management

- i. The PHP shall develop a utilization management (UM) program for medical, behavioral health, and pharmacy services that is based on nationally-recognized evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies.
- ii. The Clinical Practice Guidelines shall:
 - a) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
 - b) Consider the needs of Members;
 - c) Be adopted in consultation with contracting health professionals;
 - d) Be reviewed and updated periodically as appropriate; and
 - e) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. §§ 438.236(b).
- iii. The PHP shall use a standardized prior authorization request form developed by the Department.
- iv. Subject to Department review and approval, the Utilization Management (UM) Program, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:

- a) Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
 - b) Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
 - c) Authorize LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
 - d) Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
 - e) Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
 - f) Protecting Members from discouragement, coercion, or misinformation about the amounts of Services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a Service.
 - g) Mechanisms for detecting instances of overutilization, underutilization, and misutilization;
 - h) Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the PHP;
 - i) Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act.
 - j) Dissemination of guidelines to all affected providers and, upon request, to Members and potential Members; and
 - k) Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any Member.
- v. The PHP shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or Member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.
- a) Providers and Members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (score for neonatal acute physiology) for neonatal acute physiology) score or other clinical assessment.
 - b) Material misinformation to or intimidation of providers or Members that has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH appeals is prohibited.
 - c) The care management process shall not be used to improperly influence, change or prevent a request for a prior approval.
 - d) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.
- vi. The PHP shall not retract a service authorization after the services, supplies, or other items have been provided, except as provided in N.C. Gen. Stat. § 58-3-200(c).
- vii. The PHP shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).
- viii. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has

- appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).
- ix. The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §§ 438.3(e)(1)(ii) and 438.910(b)-(d).
 - a) Annually, the PHP shall submit a completed standardized parity analysis workbook, developed by the Department, to demonstrate compliance.
 - x. The PHP shall have the option of using the Department's Medicaid Fee-for-Service clinical coverage policies as the basis for the UM program or developing its own.
 - a) A chart of all North Carolina Medicaid and NC Health Choice clinical coverage policies is found in *Attachment B. Clinical Coverage Policy List*.
 - xi. For a limited number of services, the PHP shall incorporate existing North Carolina Medicaid and NC Health Choice Fee-for-Service clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.C. Table 4: Required Clinical Coverage Policies*.
 - a) The Department reserves the right to require the PHP to follow additional Fee-for-Service clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	SCOPE
Behavioral Health and Intellectual/ Developmental Disability	8A: Enhanced Mental Health and Substance Abuse Services (limited to services listed): <ul style="list-style-type: none"> ix. Mobile Crisis Management x. Diagnostic Assessment xi. Partial Hospitalization xii. Professional Treatment Services in Facility-based Crisis xiii. Ambulatory Detoxification xiv. Non-hospital Medical Detoxification xv. Medically Supervised or ADATC Detox Crisis Stabilization xvi. Outpatient Opioid Treatment 8A-2: Facility-based Crisis Services for Children and Adolescents 8B: Inpatient Behavioral Health Services 8C: Outpatient Behavioral Health Services Provided by Direct-enrolled Providers 8Q [DRAFT]: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder
Obstetrics and Gynecology	1E-7: Family Planning Services

Section V.C. Table 4: Required Clinical Coverage Policies	
CLINICAL SUBJECT	SCOPE
Physician	1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment 1A-23: Physician Fluoride Varnish Services 1A-36: Implantable Bone Conduction Hearing Aids (BAHA) 1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions
Auditory Implant External Parts	13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair 13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair
Pharmacy	As defined in <i>Section V.C.3. Pharmacy Benefits</i>

- xii. The Department will allow “proprietary” utilization management policies under limited circumstances, with prior approval by the Department.
- xiii. As part of the UM program, the PHP shall adhere to the following Prior Authorization requirements.
 - h) To effectively manage the care of its Members, the PHP shall establish and maintain a referral and prior authorization process with the Member-selected or PHP-assigned AMH/PCP at its center.
 - i) The PHP shall conduct prior authorization reviews using current clinical documentation, and must consider the individual clinical condition and health needs of the Member.
 - j) The PHP may require a referral for any medical services not provided by the AMH/PCP except where specifically provided in the Department-PHP contract and in federal and State statute and regulations.
 - k) The PHP must honor existing and active prior authorizations on file with the North Carolina Medicaid or NC Health Choice programs for the first ninety (90) days after implementation to ensure the continuity of care for Members.
 - l) The PHP shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial.
 - m) Consistent with 42 C.F.R. § 438.206, the PHP shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
 - 1. Emergency services
 - i. In accordance with 42 C.F.R. § 438.114, the PHP shall not require Members to obtain a referral or prior authorization before receiving emergency services.
 - ii. The PHP shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
 - iii. The PHP shall not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the Member’s AMH/PCP or PHP of the Member’s screening and treatment within ten (10) calendar days of presentation for emergency services.

- iv. The PHP shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the PHP's network.
 - v. The PHP shall not hold a Member with an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - vi. The PHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the PHP to seek emergency services.
2. Family planning services
- vii. The PHP shall not require Members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 C.F.R. 438.206(b)(3).
 - viii. The PHP shall not restrict the Member's free choice of family planning services and supplies providers. 42 C.F.R. § 431.51(b)(2).
 - ix. The PHP shall not hold Members liable for payment for family planning services or supplies that are not in the PHP's network.
3. Services provided by women's health specialists in accordance with 42 C.F.R. § 438.206(b)(2) and N.C. Gen. Stat. § 58-51-38.
- i. The PHP shall not require female Members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.
 - ii. The PHP shall allow female Members direct access to a women's health specialist in addition to the Member's designated source of primary care if that source is not a women's health specialist.
 - iii. The PHP shall not require providers to obtain prior approval for any obstetrical ultrasound.
 - iv. Women's routine and preventive health care services may include but are not limited to: initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted diseases.
4. Children's screening services
- i. The PHP shall not require Members to obtain a referral or prior authorization for children's screening services.
 - ii. The PHP shall not require Members to obtain a referral or prior authorization for Local Health Department services.
5. Behavioral Health services
- i. The PHP shall not require Members to obtain a referral or prior authorization for the first mental health or substance dependence assessment completed in a twelve (12) month period.
 - ii. The PHP shall make available to all Members a complete listing of its participating mental health and substance use disorder providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.
- n) The PHP shall ensure Members have and are aware of having direct access to services for which the Department does not allow the PHP to require referral or prior authorization, as defined in this Section.

- xiv. For behavioral health services, the PHP shall require providers to use the following behavioral health screening tools at part of the PHP's UM Program:
 - a) The PHP shall use the American Society for Addiction Medicine (ASAM) for substance abuse services for medical necessity reviews for all populations except children ages zero (0) through six (6). The PHP shall use EPSDT criteria when evaluation requests for service for children;
 - b) The PHP shall use the Level of Care Utilization System (LOCUS) scores for mental health services for medical necessity reviews for Members eighteen (18) and older;
 - c) The PHP shall use the Child and Adolescent Level of Care Utilization System (CALOCUS) scores for mental health services for medical necessity reviews for children and adolescents six (6) through seventeen (17) years old.
 - d) The PHP shall use either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers to determine medical necessity for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.
 - e) The PHP shall use the Supports Intensity Scale (SIS) for I/DD services for medical necessity reviews for Members five (5) years old and older.
 - 1. The SIS Children's version shall be used for Members from the ages of five (5) through sixteen (16).
 - 2. The SIS Adult version shall be used for Members ages seventeen (17) and up.
- xv. UM Program Policy:
 - e) The PHP shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review ninety (90) calendar after Contract Award,
 - f) The PHP shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) calendar days before such changes go into effect.
 - g) The PHP shall post the UM Program Policy on their publicly available website for providers and Members, or in other forms as requested by the provider or Member, at no cost. The PHP shall include a prominent reference to the web address of the UM Program Policy in both its provider and Member Handbooks.
 - h) The PHP shall conduct training and education with providers and prescribers on changes to the UM program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.D.2. Provider Relations and Engagement*.
- xvi. The PHP shall make the CMO or designee available to discuss and report on the Utilization Management Program, as requested by the Department.
- o. Telemedicine
 - i. The PHP shall provide services via telemedicine to Medicaid and NC Health Choice Members as an alternative service delivery model in compliance with all state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.
 - a) The services provided via telemedicine shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. 42 C.F.R. § 438.210(a)(2).

- ii. The PHP may use telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the PHP's network.
 - iii. The PHP shall not require a Member to seek the services through telemedicine and must allow the Member to access a face-to-face service through an out-of-network provider, if the Member requests.
 - iv. As part of the UM Program Policy, the PHP shall develop and submit a Telemedicine Coverage Policy to the Department.
 - a) The Telemedicine Coverage Policy shall include:
 - 6. Eligible providers who may perform telemedicine;
 - 7. Telemedicine modalities covered by the PHP;
 - 8. Telemedicine modalities not covered by the PHP;
 - 9. Requirements for and limitations on coverage;
 - 10. Description of each covered modality, including:
 - i. Evidence base;
 - ii. Compliance with local, state and federal laws, including HIPAA; and
 - iii. Process to ensure security of protected health information.
 - 2. Reimbursement mechanism (i.e. flow of funds from PHP to all relevant providers and facilities) for each covered modality; and
 - 3. Billing guidance for providers.
 - 1. The PHP shall submit a revised telemedicine policy to the Department whenever there is a material change to the policy.
 - v. The PHP shall pay at least the in-person rate for the same service delivered via telemedicine (i.e. payment parity).
 - vi. For all consultations that include two-way, real-time interactive audio and video communication, the PHP shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.
 - vii. The PHP shall pilot new approaches to telemedicine and value-based payment, and shall support providers in optimizing the use of telemedicine in their practices.
 - a) For purposes of any telemedicine pilot, the PHP may propose, for the Department's review and approval, a waiver of telemedicine payment parity requirements.
- p. In Lieu of Services
- i. The PHP may use In Lieu of Services (ILOS), services or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plans, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)-iv.
 - ii. The PHP shall submit the ILOS Service Request Form, in a format to be defined by the Department, prior to implementation to the Department for approval.
 - a) In no instance shall the PHP reduce or remove ILOS service without approval by the Department concurrent within a contract year.
 - b) If changes, reduction, or removal of ILOS services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.
 - c) The PHP shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.
 - iii. The PHP shall post ILOS policies on its publicly available Member and provider websites.

- iv. The PHP shall monitor the cost-effectiveness of each approved In Lieu of Services by tracking utilization and expenditures (see *Attachment J. Reporting Requirements* for more detailed requirements).
- v. The PHP shall offer the following In Lieu Of Service:
 - a) Institute for Mental Disease (IMD) In Lieu of Services: The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care and SUD services in other covered settings for no more than fifteen (15) calendar days within a calendar month. 42 CFR 438.6(e)] 438.6(e).
 - b) Upon approval of the pending CMS SUD/IMD waiver:
 - 3. The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for SUD services as defined and otherwise approved CMS; and
 - 4. Institute for Mental Disease (IMD) In Lieu of Services: The PHP must contract and pay for services for Members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in other covered settings for no more than fifteen (15) calendar days within a calendar month.
- vi. The PHP shall not require the Member to utilize an ILOS.
- vii. For In Lieu of Services that have been authorized for other PHPs or otherwise approved by the Department, the PHP is not required to submit an In Lieu of Services request form, but the PHP shall:
 - a) Submit projected cost and utilization data to demonstrate cost effectiveness, as specified by the Department;
 - b) Notify the Department of ILOS coverage start date; and
 - c) Post the policy on its publicly available website.
- ix. ILOS previously approved by the Department are outlined in *Attachment C. Approved Behavioral Health In Lieu of Services*.
- q. Value-Added Services
 - i. The PHP may offer Value-Added services as approved by the Department.
 - ii. For each Value-Added service, the PHP shall submit to the Department for approval, in a format defined by the Department, the following information:
 - a) Definition and description of the Value-added Service, including if prior authorization is required;
 - b) Definition of the criteria to be eligible for proposed Value-Added service;
 - c) Types of providers eligible to provide the Value-Added services;
 - d) Description of how and when providers and Members will be notified about the availability of the proposed Value-Added service;
 - e) Duration for which Value-Added services will be provided; and
 - f) Description of if, and how, the services will be identified in encounter data.
 - iii. The PHP shall submit to the Department for approval any changes to Value-Added services.
 - a) In no instance may the PHP reduce or remove value added service without approval by the Department during a contract year.
 - b) If changes, reduction, or removal of Value-Added services is approved, the PHP shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change within thirty (30) calendar days of approval.
 - iv. Value-Added services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).

- r. Cost Sharing
 - i. The PHP shall impose the same cost-sharing amounts as specified in North Carolina's Medicaid and NC Health Choice State Plans.
 - ii. The PHP shall not require Members to pay for any covered services other than the co-payment amounts required under the State Plans.
 - iii. The PHP shall not hold Member's responsible for any of the following:
 - a) PHP's debts in the event of PHP insolvency;
 - b) Covered services provided to the Member for which:
 - 1. The Department does not pay the PHP, or
 - 2. The Department, or PHP, does not pay the individual or health care provider that furnished the services under a contractual referral or other arrangement;
 - c) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the PHP covered the services directly. 42 C.F.R. § 438.106.
 - iv. The PHP shall track cost-sharing obligations of each Member and provide to the Department in a format and frequency to be defined by the Department.
 - v. Exceptions for cost sharing:
 - a) Pursuant to 42 C.F.R. § 457.505(d)(1), all NC Health Choice Member receive well-child visits and age-appropriate immunizations at no cost to their families.
 - b) Consistent with 42 C.F.R. § 447.56, Medicaid cost-sharing does not apply to subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
 - c) Consistent with 42 C.F.R. Part 457, Subpart E, NC Health Choice cost-sharing does not apply to members of federally-recognized American Indian tribes/Alaska Natives.

Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	ANNUAL ENROLLMENT FEE	SERVICE	COPAY
Medicaid			
All Medicaid beneficiaries	None	Physicians Outpatient services Podiatrists Generic and Brand Prescriptions Chiropractic Optical Services/Supplies Optometrists Non-Emergency Visit in Hospital ER	\$3/visit \$3/visit \$3/visit \$3/script \$2/visit \$2/visit \$3/visit \$3/visit
North Carolina Health Choice (NCHC)			

Section V.C. Table 5: Medicaid Managed Care Cost Sharing			
INCOME LEVEL	ANNUAL ENROLLMENT FEE	SERVICE	COPAY
NCHC beneficiaries with family income is < 159% FPL	None	Office visits Generic Prescription Brand Prescription when no generic available Brand prescription when generic available Over-the-counter medications Non-emergency emergency room visits	\$0/visit \$1/script \$1/script \$3/script \$1/script \$10/visit
NCHC beneficiaries with family income > 159% and < 211% FPL	\$50 per child or \$100 maximum for two or more children	Office visit Outpatient hospital Generic Prescription copay Brand Prescription (when no generic available) Brand prescription (when generic available) Over-the-counter medications Non-emergency emergency room visits	\$5/visit \$5/visit \$1/script \$1/script \$10/script \$1/script \$25/visit

s. Noticing Requirements

- i. The PHP shall provide written notice, using the Department-developed template, to Members on decisions related to authorization of services. The written notice shall include the following:
 - a) The bases for such decisions; and
 - b) Sufficient details that inform Members of the decision, which will provide them with information necessary to determine if they wish to appeal.
- ii. The PHP shall provide written notice to Members of any Department-initiated changes to the Medicaid or NC Health Choice benefits package or cost sharing requirements.
 - a) Notification to Members shall be provided at least thirty (30) calendar days in advance of the effective date of such change.
- iii. The Department shall provide written notice to Members of the aggregate family limit on cost sharing.
 - a) The Department shall provide written notice to the PHP and Members when a Member incurs out-of-pocket expenses up to the aggregate household limit and individual household Members are no longer subject to cost sharing for the remainder of the quarter.
- iv. For standard authorization decisions, the PHP shall provide notice as expeditiously as the Member's condition requires and no later than fourteen (14) calendar days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).
- v. The PHP may receive a possible extension of up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.

- a) If the PHP extends the timeframe beyond fourteen (14) days, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.
 - vi. For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the PHP shall provide notice no later than seventy-two (72) hours after receipt of the request for service.
 - a) The PHP may extend the seventy-two (72) hour time period by up to fourteen (14) days if the Member requests the extension or the PHP justifies a need for additional information and how the extension is in the Member's interest.
 - b) If the PHP extends the timeframe beyond seventy-two (72) hours, the PHP shall provide the Member and provider with a written notice of the reason for the decision to extend the timeline and inform the Member of the right to file a grievance if he or she disagrees with that decision.
- t. Electronic Verification System
 - i. The PHP must utilize an Electronic Visit Verification (EVV) system to verify personal care services prior to releasing payment.
 - ii. The PHP must utilize an EVV system to collect the following data as required by the Federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:
 - a) Type of service performed;
 - b) Individual receiving the service;
 - c) Date of the service;
 - d) Time that the service begins;
 - e) Location of service delivery;
 - f) Individual providing the service; and
 - g) Time that the service ends.
 - iii. If the PHP utilizes an existing EVV system, usage may continue provided that the system is compliant with State and Federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.
 - iv. The PHP shall ensure that utilization of an EVV system for Personal Care Services (as part of the State Plan) is in effect at Medicaid Managed Care launch and by January 1, 2023 for Home Health Care Services.
- u. Moral and Religious Objection
 - i. The PHP is not required to provide, reimburse for, or provide coverage of, a counseling or referral services if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R 438.102(b) have been met.
 - ii. If the PHP elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the PHP shall furnish information about the services it does not cover to the Department whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).

3. Pharmacy Benefits

- a. Prescription drugs play a significant and increasing role in maintaining health and treating illnesses, giving Members the opportunity to become healthier and improve their quality of life. Through current pharmacy program management strategies, the PHP shall implement a

pharmacy benefit which ensures Members and providers access to therapeutically needed medications that will provide the best overall value to Members, providers and the Department.

- b. The PHP shall:
 - i. Cover all covered outpatient drugs for which the manufacturer has a Centers for Medicare and Medicaid Services (CMS) rebate agreement and for which the Department provides coverage. 42 C.F.R. § 438.3(s)(1);
 - ii. Adhere to the Department's defined preferred drug list (PDL); and
 - iii. Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program. 42 C.F.R. § 438.210(a)(2).
- c. Drug Formulary and Preferred Drug List
 - i. The PHP shall not be allowed to maintain a closed formulary as defined in N.C. Gen. Stat. § 58-3-221(c)(1).
 - ii. In accordance with Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, the PHP shall use the same drug formulary established by the Department.
 - iii. The drug formulary shall, at minimum, include:
 - a) All drugs included the North Carolina Medicaid and NC Health Choice Preferred Drug List (PDL) as posted on the Department's website. The PHP shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid and NC Health Choice PDL.
 - b) All other covered drugs in drug classes not listed on the Department's PDL; and
 - c) Outpatient drugs that are not excluded through state or federal policy, as defined in 42 C.F.R. § 438.3(s)(1).
 - iv. The PHP may substitute a brand drug with a generic drug when the drug is considered bio-equivalent and clinically efficacious unless the brand drug is preferred on the Department's PDL.
 - v. Beginning in Contract Year Two (2), the PHP may submit additional information or requests for the inclusion of additional drug classes in the Department's PDL for the Department's review and approval.
 - a) The PHP will adhere to the Department defined uniform review and approval process for requests for the inclusion of additional drug classes in the Department PDL.
 - b) The PHP shall use the same drug formulary established by the Department, until provided written approval by the Department.
 - vi. In accordance with 42 C.F.R. § 438.10(h)(4)(i), the PHP shall make available to Members and providers in a machine-readable electronic file and paper format, the following information about the drug formulary:
 - a) List of all covered drugs (including over the counter, brand name, and generic prescription drugs); and
 - b) Each covered drug's tier (i.e. PDL preferred, PDL non-preferred, and non-PDL).
 - vii. Drug formulary updates:
 - a) The PHP will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid and NC Health Choice PDL. The PHP shall update their pharmacy claim system within one (1) calendar day of file receipt of the PDL file from Department's PDL vendor.

- b) The PHP shall implement routine PDL changes within thirty (30) calendar days of notification of changes to the PDL by the Department (i.e. annual or quarterly updates based on the Department’s routine PDL review).
 - c) The PHP shall, at the direction of the Department, perform off-cycle PDL file updates within one (1) calendar day of file receipt of the PDL file from Department’s PDL vendor.
- d. Utilization management:
- i. As defined herein, the PHP shall develop a Utilization Management (UM) program, inclusive of pharmacy benefits.
 - ii. For pharmacy services, the PHP shall follow the existing Medicaid and NC Health Choice Fee-for-Service clinical coverage policies and prior authorization (PA) criteria into the UM Program as described in:
 - a) Clinical Coverage Policies: *Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies* below.
 - b) PA Criteria: Drugs and/or drug classes requiring prior approval are available at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html>.

Section V.C. Table 6: Required Pharmacy Clinical Coverage Policies
9: Outpatient Pharmacy
9A: Over-the-counter products
9B: Hemophilia Specialty Pharmacy Program
9D: Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17
9E: Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
1B: Physician Drug Program

- iii. Consistent with N.C. Gen. Stat. § 108-68.1, the PHP shall not require PA for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.
- iv. The UM program shall include prior authorization (PA) processes, as defined within Section 1927(d)(5) of the Social Security Act and 42 C.F.R. § 438.3(s)(6), including but not limited to:
 - a) The PHP shall process pharmacy PA requests within twenty-four (24) hours from when the request is received.
 - b) The PHP shall notify the prescriber of the decision by electronic means within twenty-four (24) hours from when the request was received, unless it is necessary for the PA request to be pended to obtain additional information (in which case, the PHP shall have twenty-four (24) additional hours from the receipt of additional information).
 - c) The PHP shall allow a Member direct access to a drug requiring prior authorization if the physician certifies that the Member has previously used an alternative drug not requiring prior authorization and/or the alternative drug has been determined detrimental to the Member’s health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the Member’s health or ineffective in treating the condition again. The PHP shall

- not void or refuse to renew a provider contract because the provider has provided a certification for a medically necessary drug.
- d) The PHP shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement and the prescriber cannot be reached, the pharmacist may dispense a seventy-two (72)-hour emergency supply of the prescription.
 - e) The PHP shall not require a pharmacy to dispense a seventy-two (72)-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the Member's health or safety, and he or she has made good faith efforts to contact the prescriber.
 - f) The PHP shall allow the pharmacy to bill consecutive seventy-two (72) hour supplies if the prescriber remains unavailable.
 - g) The PHP shall reimburse the pharmacy for dispensing the temporary supply of medication and the pharmacy shall only receive one dispensing fee per month for each medication dispensed.
 - h) The PHP shall develop and maintain an Emergency Preparedness Protocol, consistent with Clinical Coverage Policy 9: Outpatient Pharmacy, to prevent a significant disruption in medication access during a state of emergency or disaster.
 - i) The PHP shall align prior authorization requirements as defined in the Opioid Misuse Prevention Program.
- v. The PHP shall implement prior authorization policies and procedures and pharmacy point of service edits process consistent with the A+KIDS program as part of its UM program to prevent overprescribing and inappropriate prescribing of antipsychotics in Members under the age of eighteen (18).
 - vi. As new drugs are approved to the market, the PHP may require PA for those drugs based on the drug's FDA approved indication(s) and use(s) until the Department determines the need for and establishes clinical coverage and PA criteria.
 - vii. Beginning in Contract Year Two (2), the PHP, after consultation with its, or its vendor/subcontractor's, P&T committee consistent with N.C. Gen. Stat. § 58-3-221(a)(1), may submit alternative pharmacy clinical coverage and PA criteria to the Department for review and approval. The PHP shall:
 - a) Adhere to the Department defined uniform review and approval process to request alternative clinical coverage and PA criteria.
 - b) Seek the Department's approval of alternative prior authorization criteria prior to implementing the criteria.
 - viii. Pharmacy Prior Authorization Process
 - a) The PHP shall develop web-based PA processes, which provides an electronic review system accessible to providers and the Department's staff.
 - b) The PHP shall utilize a common PA request form(s), developed by the Department, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.
 - c) The PHP's pharmacy claim processing system shall have the ability to integrate Member pharmacy claims and diagnosis history to automate the adjudication of pharmacy claims requiring PA based on criteria requiring the existence of diagnosis or prior pharmacy claims history.
- e. Pharmacy services website
 - i. The PHP shall maintain its own pharmacy services web page available to providers and Members with information regarding the drug formulary and Utilization Management Policy.
 - ii. The PHP shall post to their pharmacy services web page, at a minimum:

- a) The drug formulary,
 - b) Utilization Management Policy, including pharmacy clinical coverage and PA criteria; and
 - c) PA request form(s).
 - iii. All additions or changes to the drug formulary, UM Policy and PA request form shall be posted thirty (30) calendar days prior to the effective date of the requirement or revision.
 - iv. If the PHP utilizes a Pharmacy Benefits Manager (PBM), the PHP's pharmacy services web page may direct providers and Members to their PBM's pharmacy services web page which shall adhere to all the same requirements outlined in this Section.
- f. Pharmacy Benefit Managers
- i. The PHP may contract with a pharmacy benefits manager (PBM) to administer the pharmacy benefit.
 - ii. If the PHP utilizes a PBM, the PHP shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor pharmacy benefit manager performance, and ensure the confidentiality of Member information and the Department information that is not public.
 - iii. The PHP shall report all financial arrangements between the PHP/subcontractors and all drug-related companies to the Department on an annual basis. Drug-related companies include manufacturers, labelers, compounders, and benefit managers in a manner to be specified by the Department.
 - iv. If the PBM is owned wholly or in part by a retail pharmacy participating provider, chain drug store or pharmaceutical manufacturer, the PHP shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of Member and the Department proprietary information.
 - v. The PBM shall provide a liaison with whom the Department will communicate with directly. The PBM liaison shall be available for direct communication with pharmacy providers to resolve issues, and to work with the Department to resolve rebate issues resulting from the PHP's encounter and drug utilization files.
- g. Pharmacy Programs:
- i. The PHP shall develop and maintain the following pharmacy programs.
 - a) Drug Utilization Review
 - 1. As required by 42 C.F.R. § 438.3(s)(4), the PHP shall operate a drug utilization review (DUR) program that includes Prospective DUR, Retrospective DUR, and an educational program for prescribers and pharmacists and complies with 42 C.F.R. part 456, subpart K and Section 1927(g) of the Social Security Act.
 - 2. The Prospective DUR program shall:
 - i. Operate at pharmacy point of sale.
 - ii. Include, but not be limited to the following:
 - a) Screening for potential drug therapy problems due to therapeutic duplication,
 - b) Drug-disease contraindications,
 - c) Drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs),
 - d) Incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and

- e) Clinical abuse or misuse; and
 - f) Include other parameters as appropriate.
3. The Retrospective DUR program shall, at a minimum:
- i. Address the following:
 - a) Therapeutic appropriateness,
 - b) Over- and under-utilization,
 - c) Appropriate use of generic products,
 - d) Therapeutic duplication, drug-disease contraindication,
 - e) Drug-drug interaction,
 - f) Incorrect drug dosage,
 - g) Incorrect duration of drug treatment, and
 - h) Clinical abuse or misuse;
 - ii. At least a quarterly review of paid drug pharmacy and medical claims utilization data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and Members; and
 - iii. Address other programs and initiatives as directed by the Department.
4. The Educational Program within the DUR for prescribers and pharmacists that includes, at a minimum, the following:
- i. Written, oral, or electronic reminders containing patient-specific or drug utilization review-specific information (or both) and suggested changes in prescribing or dispensing practices;
 - ii. Face-to-face discussions, with follow up discussions when necessary, between health care professionals who are experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices;
 - iii. Intensified review or monitoring of selected prescribers or pharmacists; and
 - iv. Other educational activities as appropriate. 42 C.F.R. 456 subpart K.
5. The PHP shall implement DUR programs to address opioid misuse. The Department reserves the right to require the PHP to develop DUR programs for other targeted populations, drug classes and/or disease states.
6. The PHP shall provide a detailed description of its DUR program activities to the Department on an annual basis. 42 C.F.R. § 438.3(s)(5).
7. The PHP shall report DUR program data to the Department in a format consistent with the Department' reporting format for the CMS annual report no later than ninety (90) calendar days prior to the CMS due date.
- b) Opioid Misuse Prevention Program is defined in *Section V.C.7. Prevention and Population Health Management Programs*.

h. Pharmacy Reimbursement

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 pharmacy dispensing fee shall be the same rate as the Medicaid and NC Health Choice Fee-for-Service dispensing fee as determined by a 2015 cost of dispensing (COD) study. The COD study determined the pharmacy dispensing fee to be \$10.24.

- 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.
 - ii. Ingredient Costs
 - a) The PHP shall reimburse pharmacies ingredient costs at the same rate at the Medicaid and NC Health Choice Fee-for-Service rate.
 - b) The Fee-for-Service rates include, but are not limited to, the Wholesale Acquisition Cost, National Average Drug Acquisition Cost (NADAC), the State Maximum Allowable Cost (SMAC) list, and other financial arrangements established by the Department.
 - c) Based on lesser of logic methodology, such that the pharmacy is reimbursed the U&C if it is less than the allowed amount.
 - iii. The PHP may elect to reimburse pharmacies using a flat dispensing fee or use a tiered dispensing fee based upon a pharmacy's generic dispensing rate.
 - iv. The PHP shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.
 - v. Subject to Department review and approval, in Contract Year Two (2), the PHP may develop its own pharmacy contracting for ingredient reimbursement if the PHP can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the PHP must also submit a pharmacy network access monitoring plan.
 - vi. The PHP shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the PHP.
 - vii. Reimbursement Inquiries. The PHP shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.
- i. Drug Rebates
 - i. The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid and NC Health Choice Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid or NC Health Choice Program to a PHP. The PHP or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid and NC Health Choice program. If the PHP or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid and NC Health Choice covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.
 - ii. The PHP shall submit outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims encounter data to the Department or its Encounter Data Processing vendor on a weekly basis, no later than seven (7) calendar days following the date on which the PHP or its Subcontractor adjudicated the claims for drug rebate invoicing as defined in *Section V.H.2 Encounters*.
 - iii. The PHP shall submit all pharmacy and medical drug encounter data for rebate invoicing in a format determined by the Department or its Drug Rebate vendor. At a minimum, the data should be at claims level and include the total number of units by strength by National Drug Code (NDC) of each covered outpatient pharmacy drug, outpatient hospital drug and physician administered drug paid for by the PHP or its Subcontractor. 42 C.F.R. § 438.3(s)(2)
 - iv. The PHP shall submit drug encounters using a HCPCS/CPT code with the following:
 - a) An NDC that is appropriate for the HCPCS/CPT code based on the drug description, strength and date of service.

- b) HCPCS/CPT units and NDC units reported represent a medically appropriate dosing and package size.
 - c) Date of service that is not past the termination date of the drug.
 - d) An NDC that is from a rebate-eligible manufacturer on the date of service of the claim. 42 C.F.R. § 438.3(s)(2)
- v. 340B covered entities:
- a) The PHP pharmacy provider contracts shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program.
 - b) The PHP pharmacy provider contracts shall require 340B covered entities to identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3).
 - c) The PHP pharmacy provider contracts shall require that 340B covered entities' written agreements with contracted pharmacies specify that contract pharmacies comply with the point of sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3).
 - d) The PHP pharmacy provider contracts shall require contract pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).
 - e) The PHP shall report to the Department the commencement, conclusion and final results of all HRSA audits.
 - f) The PHP shall review 340B covered entities' HRSA audits and coordinate with the Department to ensure the prevention of duplicate discounts.
- vi. The PHP shall disclose to the Department all financial terms and arrangements for remuneration of any kind that apply between the PHP and other entities identified in the PHP Operating Plan and any drug manufacturer, labeler or pharmacy benefit manager (PBM) including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.
- a) The Department shall maintain the confidentiality of information disclosed by the PHP pursuant to this Section, to the extent that the information is confidential under North Carolina or federal law.
 - b) The Department may audit financial terms and arrangements for remuneration of any kind that apply between the PHP and any drug manufacturer or labeler.
- vii. The PHP shall support the Department with drug rebate dispute resolution processes within the timeframe requested by the Department.
- a) The PHP or its Subcontractor shall assign a single point of contact to research any encounters that are denied on submission to the Department or identified as a dispute by the drug manufacturers and within thirty (30) calendar days shall resolve.
 - b) The PHP or its Subcontractor shall provide an explanation of such disputes to the Department at the encounter claim level in a spreadsheet.
 - c) If the encounter claim information is found to be in error, the encounter shall be voided within five (5) business days of the determination.

4. Transition of Care

- a. The PHP shall develop policies, processes and procedures to support Members transitioning between PHPs or between delivery systems.
- b. Immediately following the Department's notification to the PHP to proceed with contract services, the PHP shall provide the Department with a contact person for transition of care coordination on behalf of the PHP.
- c. Regarding transition of care for newly enrolled Members transitioning to the PHP from Medicaid Fee-for-Service or another PHP and for Members transitioning out of a PHP to another PHP, the PHP shall follow the Department's Transition of Care Policy and, at a minimum, carry out the following responsibilities:
 - i. The PHP shall identify newly enrolled Members, as defined in the Managed Care Enrollment Policy, who are transitioning from another PHP or from Medicaid Fee-for-Service/LME/MCO.
 - ii. Provide for the transfer of relevant Member information, including medical records, care management records, open service authorizations, prescheduled appointments (including NEMT) and other pertinent materials, to another PHP, LME/MCO or Fee-for-Service program upon notification of establishment of care such that the transition of care shall be with minimal disruption to Members' established relationships with providers and existing care treatment plans.
 - a) If a Member enrolls with the PHP from another PHP, the PHP shall, within five (5) business days from the date of the Department's notification to the PHP of the Member's anticipated enrollment date, contact the Member to determine the name of the other PHP to request relevant Member information from the other PHP.
 - b) If the PHP is contacted by a Member's new PHP requesting relevant Member information, the PHP shall provide such data to the PHP within five (5) business days of receiving the request.
 - c) If the PHP becomes aware that a Member will transfer to another PHP, the PHP shall contact the other PHP within five (5) business days of becoming aware of the Member's transfer and shall share relevant Member information and respond to questions regarding the Member's care needs and services.
 - d) If the PHP receives new Members who were previously Members in the Fee-for-Service program, the PHP must contact the Member's AMH/PCP or the Department's designated Fee-for-Services Care Management vendor within five (5) business days of the Department's notification to the PHP of the Member's anticipated enrollment date, to request the necessary medical records and information.
 - iii. Ensure that any Member entering the PHP is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.
 - iv. The PHP shall allow a Member to complete an existing authorization period established by their previous PHP, LME/MCO or Medicaid Fee-for-Service. The PHP shall assist the Member in transitioning to an in-network provider at the end of the authorization period.
 - v. The PHP shall, in instances in which a Member transitions into a PHP from Medicaid Fee-for-Service, another PHP, or another type of health insurance coverage and the Member is in Ongoing Course of Treatment or has an ongoing special condition permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g).

- vi. Allow pregnant Members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.
 - vii. The PHP shall continue to bear the financial responsibility of an enrolled Member who is admitted to an inpatient facility while covered by the PHP through the date of discharge from such facility. Post discharge care may be coordinated prior to discharge.
 - viii. The PHP shall establish a written PHP Transition of Care Policy.
 - a) The PHP Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and processes and procedures for:
 1. Coordination of care for Members who have an ongoing special condition;
 2. Coordination of Members transitioning from Medicaid Fee-for-Service into Medicaid Managed Care;
 3. Coordination of Members transitioning from Local Management Entity/Managed Care Organization (LME/MCOs) into Standard Plans;
 4. Coordination of Members transitioning from Medicaid Managed Care into Medicaid Fee-for-Service;
 5. Coordination of Members transitioning from the PHP to another PHP, including the Tribal Option or other types of PHPs established by the Department;
 6. Coordination for Members in the Management of Inborn Errors of Metabolism (IEM) Program, as defined in *Section V.C.7. Prevention and Population Health Management Programs*;
 7. Coordination of services delivered under other sources of coverage, including Medicaid Fee-for-Service; and
 8. Other requirements as defined in this Section.
 - b) The PHP shall submit the PHP Transition of Care Policy to the Department for review and approval ninety (90) calendar days after the Contract Award.
- d. Transition of Care with Change of Providers
- i. The PHP shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated from the PHP's network.
 - a) Provider Termination, Expiration or Nonrenewal of the Contract. In instances in which a provider leaves the PHP's network for expiration or nonrenewal of the contract and the Member is in Ongoing Course of Treatment or has an ongoing special condition, the PHP shall permit the Member to continue seeing his/her provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).
 - b) Provider Termination for Reasons Related to Quality of Care or Program Integrity. In instances in which a provider leaves the PHP's network for reasons related to quality of care or program integrity, the PHP shall notify the Member in accordance with this Section and assist the Member in transitioning to an appropriate in-network provider that can meet the Member's needs.
 - ii. Member Notification of Provider Termination
 - a) The PHP shall provide written notice of termination of a network provider to all Members who have received services from the terminated provider within the sixty (60) calendar day period immediately preceding the date of notice of termination. 42 C.F.R. § 438.10(f)(1).

- b) The PHP shall provide the written notice of termination of a network provider to Members within fifteen (15) calendar days of the provider termination, except if a terminated provider is an AMH/PCP for a Member. 42 C.F.R. § 438.10(f)(1).
 - c) If a terminated provider is an AMH/PCP for a Member, the PHP shall notify the Member within seven (7) calendar days of the following:
 - 1. Procedures for selecting an alternative AMH/PCP.
 - 2. That the Member will be assigned to an AMH/PCP if they do not actively select one within thirty (30) calendar days.
 - d) If a terminated provider is an AMH/PCP for a Member, the PHP shall validate that the Member selects or is assigned to a new AMH/PCP within thirty (30) calendar days of the date of notice to the Member and notifies the Member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.
 - e) The PHP shall use a Member notice consistent with the Department-developed model Member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).
- iii. The PHP shall hold the Member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
 - iv. The PHP shall establish a Provider Transition of Care Policy.
 - a) The Provider Transition of Care Policy shall include processes and procedures for:
 - 1. Coordination of care for Members who have an ongoing special condition;
 - 2. Coordination for Members discharged from a high level clinical setting;
 - 3. Coordination for Members seeing a provider that leaves the PHP's network;
 - 4. Coordination for Members needing to select a new AMH/PCP after a provider termination; and
 - 5. Other requirements as defined in this Section.
 - b) The PHP shall submit the Provider Transition of Care Policy to the Department for review and approval ninety (90) calendar days after the Contract Award.

5. Non-Emergency Medical Transportation

- a. The PHP shall provide non-emergency medical transportation (NEMT) services to ensure that Members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid and NC Health Choice-enrolled providers.
- b. The PHP shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program.
- c. The PHP shall provide non-emergency medical transportation (NEMT) services for all enrolled Members:
 - i. By the least expensive mode available and appropriate for the Member;
 - ii. To the nearest appropriate medical providers; and
 - iii. For a Medicaid-covered service, including services carved out of Medicaid Managed Care, provided by a NC-enrolled Medicaid provider.
- d. When providing NEMT services, the PHP shall use the most appropriate form of transportation to meet the needs of the Member.
- e. The PHP shall provide travel-related expenses, including:
 - i. Lodging,

- ii. Food,
 - iii. Parking fees/tolls,
 - iv. Transportation vouchers (i.e. taxis, ride sharing services, public transit); and
 - v. Mileage.
- f. The PHP shall guarantee the following rights to Members:
- i. To be informed of the availability of Medicaid non-emergency medical transportation;
 - ii. To be informed that there is no cost to the Member;
 - iii. To be informed of who may accompany a Member without cost;
 - iv. To be informed that a Member under the age of eighteen (18) does not have to ride alone;
 - v. To have the PHP’s NEMT Policy, as defined below, explained including:
 - a) How to request or cancel a trip;
 - b) Limitations on transportation;
 - c) Advanced notice requirements; and
 - d) Expected Member conduct and procedures for no-shows.
 - vi. To be transported to medical appointments if unable to arrange or pay for transportation and by means appropriate to circumstances;
 - vii. To arrive at provider in time for the scheduled appointment; and
 - viii. To request an appeal, as defined in the Contract, if the request for transportation assistance is denied.
- g. The PHP shall not require Members to make transportation requests more than two (2) days in advance.
- h. The PHP shall ensure that an attendant is present with:
- i. Members under the age of eighteen (18), unless emancipated, at no additional cost to the Member or attendant. The attendant may or may not be the parent.
 - ii. Members with special medical, physical or mental impediments, at no additional cost to the Member or attendant. The attendant may or may not be the parent.
- i. The individuals included in *Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the PHP.

Section V.C. Table 7: Individuals Not Eligible to Receive NEMT Services	
North Carolina Health Choice Members	Not a covered benefit (unless offered by the PHP as a Value-Added benefit)
Members in a nursing home	The facility is responsible for providing transportation to their patients.

- j. The PHP shall develop a network of NEMT providers sufficient to fulfill the requirements as outlined in this Section.
- k. The PHP shall provide copies of its contract(s) with subcontractor(s) providing NEMT services upon Contract Award or within fourteen (14) calendar days of signing any new agreement or modification with the PHP’s NEMT subcontractor(s).
- l. The PHP shall develop, submit and maintain a NEMT Policy. The PHP shall submit the Policy ninety (90) days after Contract Award and annually thereafter, for use with Members.
- i. The Policy shall include, at a minimum, the following:
 - a) Transportation options available to Members;

- b) Methods and process by which to request transportation;
 - c) Driver and vehicle requirements;
 - d) Process for transportation assessment;
 - e) Member rights and responsibilities; and
 - f) Hours of operation.
- ii. The Policy shall adhere to the following:
 - a) Transportation shall be scheduled so that the Member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one (1) hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;
 - b) Members cannot be required to make transportation requests in person;
 - c) Urgent transportation services are exempt from any advance notice requirement;
 - d) The Department's requirements for written materials; and
 - e) All other requirements defined in this Section.

6. Care Management

- a. Care Management and Care Coordination
 - i. The Department seeks a PHP to provide access to appropriate care management and coordination support across multiple settings of care, including a strong basis in primary care and connections to specialty care, pharmacies, and community-based resources. Members with high medical, behavioral or social needs should have access to a program of care management that includes the involvement of a multidisciplinary care team and the development of a written care plan. The PHP shall ensure that it operates a care coordination and care management program that meets the requirements of this Section and helps to improve patient care and health outcomes while reducing inappropriate hospitalization and other unnecessary costs.
 - ii. The PHP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision for care management, including the capability to analyze data to identify patients who would benefit from care management; the capabilities to share data with practices through data transmission and a data portal; a care management IT platform that enables care managers to access all Member clinical data in support of care management activities and to store care management assessments and care plans.
 - iii. Care Coordination for All Members
 - a) The PHP shall ensure that each Member has an ongoing source of care appropriate to his or her needs. The PHP shall establish policies and procedures to deliver care to, and coordinate services for, all Members, regardless of risk or need, including meeting all provisions noted in 42 C.F.R. § 438.208.
 - b) The PHP shall ensure that each provider furnishing services to Members maintains and shares, as appropriate, a Member health record in accordance with professional standards and state and federal law.
 - c) The PHP shall establish policies and procedures for coordination between physical and behavioral health providers and between mental health and substance use providers.
 - d) The PHP shall establish policies and procedures to coordinate with services provided by community and social support providers, and to provide linkages with community resources. 42 C.F.R. § 438.208(b)(2)(iv).
 - e) For Members with identified unmet health-related resource needs, the PHP shall, as part of care coordination:

1. Coordinate services provided by community and social support providers to address Members' unmet health-related resource needs;
 2. Link Members to local community resources and social supports; and
 3. Modify their approaches based on tracking of outcomes, as needed.
- iv. Identification of High-Need Members Needing Care Management
- a) Care Needs Screening
 1. The PHP shall undertake best efforts to conduct a Care Needs Screening of every Member within ninety (90) calendar days of the effective date of enrollment. 42 C.F.R. § 438.208(b)(3).
 - i. The purpose of the Care Needs Screening shall be to provide the PHP with general information about Members' health and to identify Members with unmet health-related resource needs who may require a Comprehensive Assessment, as defined by the Contract, for care management.
 - ii. The Department defines "best efforts" as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful. The PHP shall develop processes and procedures to maximize rate of response on the screening.
 2. Each PHP shall establish an evidence-based or evidenced-supported tool to conduct the Care Needs Screening. At a minimum, the tool shall identify:
 - i. Chronic or acute conditions;
 - ii. Chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
 - iii. Behavioral health needs, including opioid usage and other substance use disorders;
 - iv. Medications—prescribed and taken; and
 - v. Other factors or conditions (e.g., pregnancy) about which the PHP would need to be aware to arrange available interventions for the Member.
 3. The PHP shall include standardized unmet health-related resource need questions to be provided by the Department for use in all Care Needs Screenings, covering four (4) priority domains:
 - i. Housing;
 - ii. Food;
 - iii. Transportation; and
 - iv. Interpersonal Safety.
 4. The PHP shall verify that any Care Needs Screenings conducted by designated care management entities are completed in a timely manner and results of the screenings are routed back to the PHP.
 5. The PHP shall share the results of the Care Needs Screening with each Member's assigned AMH/PCP within seven (7) calendar days of screening, or within seven (7) calendar days of assignment of a new AMH/PCP, whichever is earlier.
 6. The PHP shall share with any other Designated Care Management Entity who may be serving the Member the results of the Care Needs Screening within seven (7) calendar days of screening.
 7. If a Member's eligibility is reinstated to Medicaid and it has been more than ninety (90) days from the Member's previous eligibility, the PHP shall conduct the Care Needs Screening again within ninety (90) days.

8. In the event that the Care Needs Screening identifies a Member as part of a priority population for care management, a Comprehensive Assessment shall be conducted to determine that Member's care management needs.
 9. The PHP must attempt a Care Needs Screening at least annually for individuals not engaged in care management.
- b) Identification of Priority Populations through Risk Scoring and Stratification
1. The PHP shall use risk scoring and stratification to identify Members who are part of priority populations for care management and should receive a Comprehensive Assessment to determine their care management needs.
 2. The Department defines "priority populations" as populations likely to have care management needs and benefit from care management, including the following:
 - i. Individuals with Long Term Services and Supports (LTSS) needs;
 - ii. Adults and children with Special Health Care Needs;
 - iii. Individuals identified by the PHP as at Rising Risk;
 - iv. Individuals with high unmet health-related resource needs, as defined at a minimum to include:
 - a) Members who are homeless, according to the U.S. Department of Housing and Urban Development definition of homelessness;
 - b) Members experiencing or witnessing domestic violence or lack of personal safety; and
 - c) Members showing unmet health-related needs in three or more Opportunities for Health domains on the Care Needs Screening;
 - v. At-Risk Children (age 0-5);
 - vi. High-Risk Pregnant Women; and
 - vii. Other priority populations as determined by the PHP (i.e. Members with complex conditions like HIV, Hepatitis C, or Sickle Cell).
 3. Each PHP's risk scoring methodology and stratification methodology shall take into account, at a minimum, the following information:
 - i. Care Needs Screening results, including the content of the screening assessing unmet health-related resource needs;
 - ii. Claims history;
 - iii. Claims analysis;
 - iv. Pharmacy data;
 - v. Immunizations;
 - vi. Lab results;
 - vii. Admission, Discharge, Transfer (ADT) feed information;
 - viii. Provider referrals;
 - ix. Referrals from social services
 - x. Member's zip code
 - xi. Member's race and ethnicity; and
 - xii. Member or caretaker self-referral.
 4. In the event that the PHP identifies a Member as part of a priority population for care management, the PHP shall conduct a Comprehensive Assessment to determine that Member's care management needs.
- c) Comprehensive Assessment to Identify High-Need Members
1. The PHP shall perform a Comprehensive Assessment for every Member who is:
 - i. Identified through Care Needs Screening and/or PHP risk stratification as being within a priority population; and/or

- ii. Referred to the PHP for care management by a provider, Member (self-referral), family member, or other person or entity, including social services.
2. The Comprehensive Assessment shall identify ongoing special conditions that require a course of treatment or regular care monitoring
3. The Comprehensive Assessment shall be a person-centered assessment of a Member's health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform whether the Member will receive care management and will inform the Member's ongoing care plan and treatment.
4. The PHP shall develop and deploy Comprehensive Assessments tailored to Members that include, at a minimum, the following content
 - i. Member's immediate care needs;
 - ii. Member's current services;
 - iii. Other state or local services currently used;
 - iv. Physical health conditions, including dental conditions;
 - v. Current and past mental health and substance use status and/or disorders;
 - vi. Physical, intellectual, or developmental disabilities;
 - vii. Medications – prescribed and taken;
 - viii. Available informal, caregiver, or social supports, including peer support
 - ix. Current and past mental health and substance use status and/or disorders;
 - x. Four priority unmet health-related resource domains;
 - xi. Any other ongoing special conditions that require a course of treatment or regular care monitoring; and
 - xii. At the PHP's option, for adults only exposure to adverse childhood experiences (ACEs) or other trauma.
5. The PHP shall develop methodologies and tools for conducting the Comprehensive Assessment, as appropriate for differing Member demographics and needs.
6. The PHP shall undertake best efforts to complete the Comprehensive Assessment within thirty (30) calendar days of identifying a Member as being part of one or more priority populations or having received a referral for care management.
7. The PHP shall conduct the Comprehensive Assessment in a location that meets the Member's needs.
8. The PHP shall not withhold necessary services for Members while awaiting completion of the Comprehensive Assessment.
9. The PHP shall ensure that a Comprehensive Assessment is completed or re-completed for all Members, including re-assessment for Members already assigned to care management:
 - i. At least annually;
 - ii. When the Member's circumstances or needs change significantly; and/or
 - iii. At the Member's request.
10. The PHP shall share the results of the Comprehensive Assessment with the Member, Member's AMH/PCP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law.

11. In situations where the AMH/PCP develops the Comprehensive Assessment, the AMH/PCP shall share the results of the Comprehensive Assessment with the Member's PHP within fourteen (14) days of completion of the assessment to inform care planning and treatment planning, with Member consent to the extent required by law
 12. If the Comprehensive Assessment determines that the Member does not require care management, the PHP shall document that determination and will not be required to develop a Care Plan.
- d) Treatment of Members needing LTSS: All Members identified as needing LTSS shall be categorized as high-need Members and shall therefore receive care management.
- v. Provision of Care Management for High-Need Members
- a) Development of Care Plan
 1. Using the findings of the Comprehensive Assessment, the PHP shall develop a Care Plan for each high-needs Member. 42 C.F.R. § 438.208(c)(3).
 2. The PHP shall ensure that each Care Plan is individualized and person-centered, using a collaborative approach including Member and family participation where appropriate.
 3. The PHP shall undertake best efforts to complete each Care Plan within thirty (30) calendar days of completion of the Comprehensive Assessment and in accordance with any applicable state quality assurance and utilization review standards.
 4. The PHP shall ensure that development of the Care Plan does not delay the provision of needed services to a Member in a timely manner, even if that Member is waiting for a Care Plan to be developed.
 5. The PHP shall ensure that each Care Plan incorporates findings of the Care Needs Screening (including unmet health-related resource need questions), claims analysis and risk scoring, the Comprehensive Assessment, any available medical records, and other sources as needed.
 6. Each Care Plan shall contain, at a minimum:
 - i. Measurable goals;
 - ii. Medical needs including any behavioral health or dental needs;
 - iii. Interventions including addressing medication management, including adherence;
 - iv. Intended outcomes;
 - v. Social, educational, and other services needed by the Member.
 7. The PHP shall ensure that the Care Plan is regularly updated to address gaps in care, incorporating input from care team Members and Member, as part of care management; and that the Care Plan will be comprehensively updated:
 - i. At minimum every twelve (12) months;
 - ii. When a Member's circumstances or needs change significantly;
 - iii. At the Member's request; and/or
 - iv. When a re-assessment occurs
 8. The PHP shall ensure that each Care Plan is documented and stored and made available to the Member and care team members, including the Member's AMH/PCP.
 - b) Care Management Services

1. The PHP shall provide care management, according to the Care Plan developed, to each high-need Member or through a contracted AMH, consistent with local care management requirements.
2. The PHP shall ensure that care management includes:
 - i. Coordination of physical, behavioral health and social services;
 - ii. Medication management, including regular medication reconciliation and support of medication adherence;
 - iii. Progress tracking through routine care team reviews;
 - iv. Referral follow up;
 - v. Peer support;
 - vi. Training on self-management, as relevant; and
 - vii. Transitional care management (as described below), as needed.
3. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum:
 - i. Use the “NC Resource Platform” to identify community-based resources and connect Members to such resources, to the extent the “NC Resource Platform” is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1.
 - a) The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources.
 - b) The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.
 - ii. Provide in-person assistance securing health-related services that can improve health and family well-being, including assistance filling out and submitting applications, at a minimum to:
 - a) Food and Nutrition Services;
 - b) Temporary Assistance for Needy Families;
 - c) Child Care Subsidy; and
 - d) Low Income Energy Assistance Program.
 - iii. Have a housing specialist on staff or on contract who can assist individuals who are homeless in securing housing; and
 - iv. Provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.
4. The PHP shall provide every high-need Member with a designated care manager.
5. The PHP shall establish a multi-disciplinary care team for each high-need Member that consists of, where applicable depending on Member needs:
 - i. The Member;
 - ii. Caretaker(s)/legal guardians;
 - iii. AMH/PCP;
 - iv. Behavioral health provider(s);

- v. Specialists;
 - vi. Nutritionists; and
 - vii. Pharmacists and Pharmacy Techs.
6. The PHP shall ensure timely communication across the care team.
 7. The PHP shall ensure that each high-need Member is informed of:
 - i. The nature of the care management relationship;
 - ii. Circumstances under which information will be disclosed to third parties;
 - iii. The availability of the grievance and appeals process as described in *Section V.B.6. Member Grievances and Appeals*; and
 - iv. The rationale for implementing care management services.
 8. The PHP shall develop policies and procedures to close out the Care Plan process, should the care team determine that the Member no longer requires an ongoing Care Plan. Policies and procedures for closeout shall include Member notification processes.
- c) Transitional Care Management
1. The PHP shall manage transitions of care for all Members moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes. 42 C.F.R. § 438.208(b)(2)(i).
 2. The PHP shall develop policies and procedures for transitional care management.
 3. The PHP shall develop a methodology for identifying Members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:
 - i. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;
 - ii. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
 - iii. NICU discharges; and
 - iv. Identification of patients by severity of condition, medications, risk score, healthy opportunities, and other factors the PHP may prioritize.
 4. As part of transitional care management, the PHP shall:
 - i. Outreach to the Member's AMH/PCP and all other medical providers;
 - ii. Facilitate clinical handoffs;
 - iii. Obtain a copy of the discharge plan and verify that the care manager of the Member receives and reviews the discharge plan with the Member and the facility;
 - iv. Ensure that a follow up outpatient and/or home visit is scheduled within a clinically appropriate time window;
 - v. Conduct medication management, including reconciliation, and support medication adherence;
 - vi. Ensure that a care manager is assigned to manage the transition;
 - vii. Ensure that the assigned care manager rapidly follows up with the Member following discharge; and
 - viii. Develop a protocol for determining the appropriate timing and format of such outreach.

5. The PHP shall have access to an ADT data source that correctly identifies when Members are admitted, discharged or transferred to/from an emergency department or hospital in real time or near real time.
 6. As part of transitional care management, the PHP shall implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:
 - i. Real time (minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
 - ii. Same-day or next-day outreach for designated high-risk subsets of the population, such as children with special health care needs admitted to the hospital;
 - iii. Additional outreach within several day days after the alert to address outpatient needs or prevent future problems for other 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) HIV Case Management Providers
1. The PHP may contract with existing HIV Case Management providers, at their discretion.
 2. The PHP shall coordinate with local Ryan White HIV case management programs and providers.
- e) Care Management for Individuals Receiving Long Term Services and Support (LTSS)
1. The PHP shall meet all general care management requirements for Members with LTSS needs, and shall meet additional requirements for Members with LTSS needs as described in this subsection and in accordance with 42 C.F.R. § 438.208.
 2. The PHP shall conduct a Comprehensive Assessment for all Members identified as needing LTSS. The PHP shall use a Comprehensive Assessment tool to conduct such assessments that meets all requirements for Comprehensive Assessments given above.
 3. The PHP shall ensure that the care manager may elect to put an interim plan in place to ensure that the Member's needs are met while the Care Plan is developed.
 4. The PHP shall provide transitional care management for Members with LTSS from a nursing facility or other institution that includes outreach to a Member's prior care managers, Member's PCP and all other medical providers. The PHP shall define transition out of an institution as a change in Member circumstance and cause for re-assessment.
 5. The PHP's transitional housing specialist shall ensure that Members using LTSS transitioning from nursing facilities to the community are connected to appropriate housing options as needed.
 6. The PHP shall re-assess Member needs for Members with LTSS needs, and review and revise a Member's care accordingly, at least every twelve (12) months, at the request of the Member, or when the Member's circumstances change. A change in Member circumstances could include an increased need for care, decreased need for care, transition into or out of an institution, loss of a family/friend caretaker, or any other circumstance the plan deems to be a change in circumstance.

- vi. Care Manager Qualifications and Training
 - a) The PHP shall ensure that the clinician leading the care team has the minimum credentials of RN or LCSW.
 - b) The PHP shall engage appropriate staff on the care team to meet the needs of the Members including medical and behavioral health specialists, pharmacists and pharmacy technicians, peer specialists, navigators, and community health workers.
 - c) The PHP shall require that care management staff show competency in areas including:
 - 1. Person-centered needs assessments and care planning;
 - 2. Motivational interviewing;
 - 3. Self-management;
 - 4. Trauma informed care;
 - 5. Cultural competency;
 - 6. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level; and
 - 7. Understanding and addressing Adverse Childhood Experiences (ACEs) and trauma.
 - d) Qualifications for care managers for Members with LTSS needs shall meet the minimum requirements defined within this Contract for all other care managers herein and shall additionally include, at a minimum:
 - 1. Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience;
 - 2. Prior experience with social work, geriatrics, gerontology, pediatrics, or human services.
 - e) The PHP shall ensure that care manager training include at a minimum:
 - 1. Self-management, including medication adherence strategies;
 - 2. Motivational interviewing or comparable training;
 - 3. Person-centered needs assessments and care planning;
 - 4. Integrated and coordinated physical and behavioral health care;
 - 5. Execution of Comprehensive Assessments of Members;
 - 6. Services available only through BH I/DD TPs and BH I/DD TP eligibility criteria;
 - 7. BH crisis response (for care managers with assigned Members with BH needs);
 - 8. Transitional care management;
 - 9. Cultural competency, including considerations for Tribal population for PHPs that enroll Tribal members;
 - 10. Understanding and addressing ACEs, Trauma, and Trauma Informed Care; and
 - 11. Understanding and addressing unmet health-related resource needs, including expertise in identifying and utilizing available social supports and resources at Members' local level.
 - f) The PHP shall train care managers for Members with LTSS needs in the training listed herein and additionally in LTSS care management including:
 - 1. Person-centered needs assessment and care planning related to populations with LTSS needs;
 - 2. Cultural competency for populations with LTSS needs; and
 - 3. Independent living.
 - g) The PHP shall ensure that care managers remain conflict-free, which shall be defined as not being related by blood or marriage to a Member, financially responsible for a

Member, or with any legal power to make financial or health related decisions for a Member.

b. Local Care Management and Related Programs

- i. The Department seeks a Contractor that has the ability to provide a robust system of local care management—care management that is performed at the site of care, in the home or in the community where face-to-face interaction is possible. Local care management is the preferred approach to care management. The PHP shall have an established system of care management through Advanced Medical Home (AMH), and defined in *Attachment M. 2. Advanced Medical Home Program Policy*, and Local Health Departments that will provide high quality care to Members. The Department’s AMH framework, is intended to be a minimum initial framework laying out basic requirements on top of which PHPs and AMHs are encouraged to innovate around payment and delivery models according to their strategies, capabilities, and preferences – and, most importantly, the needs and preferences of Medicaid beneficiaries. Aspects of the Department’s AMH model, including further definition around AMH Tier 4, will evolve over time based on experiences in the market and input from stakeholders.
- ii. General Requirements for Local Care Management
 - a) The PHP shall ensure that the majority of its high-need Members in each Region receive care management services through local care management, which includes care management provided by AMHs or LHDs as well as care management provided by the PHP that is delivered locally.
 - b) To facilitate the implementation of local care management, the PHP shall designate care management responsibility to AMH Tier 3 practices, as defined in *Attachment M. 2. Advanced Medical Home Program Policy*, and Local Health Departments.
 - c) The PHP shall remain responsible for care management delivered through local care management and shall be responsible for oversight of AMH Tier 3 practices and Local Health Departments.
 - d) The PHP shall ensure that any care management and care coordination requirements that apply to the PHP will also apply to the PHP’s AMH Tier 3 practices, as applicable. Specific program requirements for Care Management for High Risk Pregnancy and Care Management for At-Risk Children are found in *Attachment M. 4. Care Management for High-Risk Pregnancy Policy* and *Attachment M. 5. Care Management for At-Risk Children Policy*.
 - e) For At-Risk Children (age 0-5) with complex medical needs, the PHP shall coordinate with the Member’s assigned AMH to lead the provision of care management for that Member. The PHP may also involve the LHD for support for unmet health-related resource or care coordination needs identified in the Care Plan.
 - f) The PHP shall ensure that the elements of care management described below are conducted by a consistent entity and care manager/care team, to the maximum extent possible.
 - g) In the event that a Member is receiving care management from more than one entity, the PHP shall ensure that the Member’s care plan(s) document respective roles and responsibilities between the PHP, AMH Tier 3 practices and/or Local Health Departments.
 - h) The PHP shall develop and implement policies and procedures, within parameters established by the Department, to verify that AMH Tier 3 practices and Local Health Departments meet all federal and state requirements related to their designated services.

- iii. Local Care Management Provided by AMH Tier 3 Practices
 - a) The PHP shall contract with at least eighty percent (80%) of all AMH Tier 3 practices located in each PHP Region.
 - b) The PHP shall designate each AMH Tier 3 practice as holding primary responsibility for conducting the comprehensive assessment, providing care management, and providing transitional care management for such practice's high-needs Members.
 - c) The PHP shall permit the AMH Tier 3 to take on additional care management functions, subject to AMH Tier 3 and PHP mutual agreement.
 - d) The PHP shall coordinate with, and provide support to, the AMH Tier 3 practice in performance of care management responsibilities and any additional, mutually agreed upon AMH Tier 3 care management functions.
- iv. Advanced Medical Home Contracting
 - a) General Requirements
 - 1. The PHP shall only contract with a PCP as an AMH provider if the PCP has been certified as an AMH by the Department.
 - 2. PHPs shall not be required to contract with any particular entity to meet Advanced Medical Home requirements.
 - 3. The PHP shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices, as applicable based on if a practice is AMH Tier 1, 2 or 3, and as noted in *Attachment M. 2. Advanced Medical Home Program Policy*.
 - 4. The PHP shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the AMH practice and the PHP.
 - 5. The PHP shall be required to participate in Department-led meetings involving the AMH program, including providing appropriate clinical and operational leadership in meetings.
 - 6. The PHP shall be required to track all Department-led AMH programmatic changes, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP operations and AMH contracts, as applicable, and within Department-specified timelines.
 - 7. Nothing in this Section shall be interpreted to preclude the PHP from developing additional relationships or agreements related to care management.
 - b) Advanced Medical Home Quality Metrics
 - 1. Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for PHPs, the PHP shall compile and calculate each of the AMH quality metrics for each AMH practice and share them with the Department.
 - 2. The PHP shall provide feedback on quality scoring results to each AMH practice.
 - i. The Department will provide the PHP with AMH measure set and reporting schedule at award.
 - 3. The PHP shall develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics.
 - c) Advanced Medical Home Data and Information Sharing
 - 1. In cases where the Department establishes a standard file format for data sharing reports, the PHP shall utilize the file format as specified by the Department.
 - i. In order to support care management activities, the PHP shall provide the following information to all AMH practices, at a minimum:

- ii. Member Assignment Files to include:
 - a) Point-in-time assignment information on at least a monthly basis.
 - b) Projected assignment information for the following month (to the extent information is available).
 - c) Information about newly-assigned Members to the PHP, within seven (7) business days of enrollment (more rapid notification may be required for assignment of newborns).
 - d) Notifications of any ad-hoc changes in assignment as they occur, within seven (7) business days of each change.
 - iii. Risk Stratification information
 - a) The PHP shall share PHP-furnished risk scoring results with all AMH practices (regardless of tier), including (where possible and relevant) Member-level information about cost and utilization outliers.
 - b) The PHP shall notify AMHs when Members fall into required Department priority population categories (i.e. "Special Health Care Needs").
 - c) The PHP is encouraged to share types or categories of risk stratification model inputs (i.e. frequent hospital utilization) that can inform specific actions by the AMH.
 - iv. Initial Care Needs Screening information
 - a) The PHP shall share the results of all available Initial Care Needs Screenings with primary care providers in all AMH tiers within seven (7) days of screening, or within seven (7) days of assignment of a new PCP or AMH, whichever is earlier.
 - b) The PHP shall identify Members they have not been able to contact for Initial Care Needs Screenings to primary care providers in all AMH tiers within seven (7) days of the end of the screening window.
 - v. Quality measure performance information at the practice level
 - a) The PHP shall provide feedback annually on quality scoring results to each AMH practice on both an annual and an interim basis as specified by the Department, and in a format to be defined by the Department.
 - vi. Encounter and Other Data
 - a) The PHP shall provide encounter data directly to AMH Tier 3 and 4 practices or to their designated CINs or third-party partners, as appropriate, using the same specifications that the PHP will use to share encounter data with the Department.
 - b) Data flows from the PHP to AMHs, CINs or delegated partners of AMH Tier 3 and 4 practices shall only include attributed Member assigned to the receiving (or delegating) practices or groups of practices.
 - c) The PHP shall provide encounter, provider and Member data at least monthly, or more frequently as requested by the Department.
 - d) The PHP shall deliver pharmacy data at least weekly, or more frequently as requested by the Department.
2. The PHP shall participate in a Department-led Advisory Committee around AMH data sharing.
 3. The PHP shall adopt standardized data sharing formats and protocols as they are developed by the Advisory Committee.

4. The PHP shall develop a strategy to share data with beneficiaries, in a format that is secure, takes into account varying levels of health literacy, and promotes Member engagement in care.
- d) Advanced Medical Home Oversight
1. The PHP shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms.
 2. In the event of underperformance by an AMH practice, the PHP shall send a notice of underperformance to the AMH practice and copy the Department.
 3. In the event of continued underperformance (i.e. non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the PHP to stop paying the Care Management Fee and/or Medical Home Payment (as applicable based on Tier status) and downgrade the Tier status of the AMH for that PHP, only.
 4. In the event that the PHP notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Payments that would otherwise be required by the Department, the PHP shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification.
 5. In the event a practice is downgraded from Tier 3 to Tier 2, the PHP shall ensure that there are no gaps in care management functions for Members assigned to the practice.
 6. The requirements of this subsection shall apply to all tiers of AMH practices, including Tier 3 AMHs providing Local Care Management and Tier 1 and Tier 2 AMHs that do not provide Local Care Management, unless otherwise specified.
- v. Local Care Management Provided by Local Health Departments
- a) General Requirements
1. In Contract Years 1-3, 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.
 2. The PHP shall use standard contract language provided by the Department to contract with LHDs for the provision of care management services to High Risk Pregnant Women and At-Risk Children.
 - i. The PHP shall incorporate all Department-defined care management practice standards for High Risk Pregnant Women and At-Risk Children into each of its contracts with LHDs, as noted in *Attachment M. 4. Care Management for High-Risk Pregnancy Policy* and *Attachment M. 5. Care Management for At-Risk Children Policy*.
 - ii. The PHP shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the LHD and the PHP.
 3. If an LHD in the PHP's Region(s) chooses not to provide care management services for High Risk Pregnant Women and/or At-Risk Children, then:
 - i. The PHP shall be responsible for ensuring that those services are provided locally, either by another Local Health Department or in accordance with guidelines set by the Department; and
 - ii. The PHP shall notify the Department and adhere to Department guidelines in securing coverage for the applicable county(ies).

4. In the event of underperformance by an LHD, the PHP shall follow standard procedures specified by the Department. In the event of continued underperformance by an LHD that is not corrected, the PHP shall be permitted to terminate the contract with that LHD with provider appeal rights to the PHP. The PHP shall notify the Department of underperformance or contract termination. The Department reserves the right to specify the timing and format of this notification.
 5. The PHP shall be required to participate in Department-led meetings involving the High Risk Pregnant Women and Care Management for At-Risk Children program, including providing appropriate clinical and operational leadership in meetings.
 6. The PHP shall be required to track all Department-led changes for the Care Management for High Risk Pregnant Women and the Care Management for At-Risk Children programs, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP operations and LHD contracts, as applicable, and within Department-specified timelines.
- b) Specific Requirements for Care Management for High Risk Pregnant Women
1. Through contracting with LHDs using standard terms and conditions as described above, the PHP shall ensure that the functions of the Care Management for High Risk Pregnant Women that were in place prior to Medicaid Managed Care are performed for pregnant Members, including (but not limited to):
 - i. Outreach;
 - ii. Motivational interviewing;
 - iii. Development of patient-centered care plans;
 - iv. Identification of community resources available to meet the specific needs of the population; and
 - v. Referrals to childbirth education, oral health, behavioral health or other needed services reimbursed by Medicaid.
 2. The PHP shall be permitted to add its own high-risk pregnancy care management functions and approaches in addition to the required Care Management for High Risk Pregnant Women program.
 3. The PHP shall identify high-risk pregnancies for referral to LHD Care Management and other high-risk pregnancy services that are available, through one or more of the following mechanisms:
 - i. Standardized Risk Screening Tool conducted by providers;
 - ii. Risk stratification by the PHP; and
 - iii. Direct referral by providers, Members or families.
- c) Specific Requirements for Care Management for At-Risk Children
1. Through contracting with LHDs using standard terms and conditions as described above, the PHP shall be required to ensure that the following functions are available to at-risk Members aged 0-5. These functions include, but are not limited to:
 - i. Addressing unmet health-related resource needs;
 - ii. Addressing family social needs; and
 - iii. Forging and strengthening linkages with pediatric medical homes.
 2. The PHP shall be responsible for maintaining criteria already established for referrals for the following children:

- i. Children with Special Health Care Needs;
 - ii. Children exposed to severe stress in early childhood, including:
 - a) Extreme poverty in conjunction with continuous family chaos;
 - b) Recurrent physical or emotional abuse;
 - c) Chronic neglect;
 - d) Severe and enduring maternal depression;
 - e) Persistent parental substance abuse;
 - f) Repeated exposure to violence in the community or within the family; and
 - g) Children in neonatal intensive care needing help transitioning to community/Medical Home care.
 - 3. The PHP shall identify at-risk children for referral to Local Health Departments, by the following methods:
 - i. Provider referrals;
 - ii. Social service agency referrals (e.g. Care Management for High Risk Pregnant Women program, WIC, DSS);
 - iii. Direct referral by Members or families; and
 - iv. Risk stratification or other identification by the PHP.
 - 4. When an at-risk child is identified for Care Management for At-Risk Children by an entity outside the PHP (e.g. pediatric practice), the PHP shall make the referral to a Local Health Department and inform that entity that the referral has been made.
- d) Pregnancy Management Program in Coordination with Care Management for High Risk Pregnant Women
- 1. The PHP shall be required to participate in Department-led meetings involving the PMP program, including providing appropriate clinical and operational leadership in meetings.
 - 2. The PHP shall be required to track all Department-led PMP programmatic changes, including incorporating new guidance, policy, operational manuals and other program-specific requirements into PHP operations and PMP contracts, as applicable, and within Department-specified timelines.
 - 3. The PHP shall adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by the Department.
 - 4. The PHP shall be responsible for receiving standardized screening tool results from PMP providers and for arranging intake into the Care Management for High Risk Pregnant Women program based on referrals by PMP providers.
 - 5. When a high-risk pregnancy is referred to the PHP by a PMP provider, Member, family or other entity, the PHP is responsible for arranging intake of the Member into the Care Management for High Risk Pregnant Women program and shall inform the Member's PMP provider that the Member has entered the program.
- c. AMH/PCP Choice and Assignment
- i. Consistent with 42 C.F.R. § 438.3(l), the PHP shall ensure that each Member has a choice of AMH/PCP.
 - 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.
 - iii. The PHP's methodology for assigning Members to an AMH/PCP shall include the following components, in this order, to the extent that such information is available.

- a) Prior AMH/PCP assignment;
 - b) Member claims history;
 - c) Family member's AMH/PCP assignment;
 - d) Family member's claims history;
 - e) Geographic proximity;
 - f) Special medical needs; and
 - g) Language/cultural preference
- iv. In Contract Year 2 (or another date identified by the Department), the Department may direct the methodology to include AMH tier 3 status.
- v. The Department reserves the right to adjust the AMH/PCP methodology for assigning Members to AMH/PCP as defined in this Contract and to audit the PHP's AMH/PCP auto-assignment logic upon request.
- vi. When applicable, the PHP shall notify Members when they have been assigned to an AMH/PCP.
- vii. Members can change their AMH/PCP without cause twice per year. Members shall be given thirty (30) days from receipt of notification of their AMH assignment to change their AMH/PCP without cause (1st instance) and shall be allowed to change their AMH/PCP without cause up to one time per year thereafter (2nd instance).
- viii. In addition, Members shall be allowed to change their AMH/PCP with cause at any time.
- ix. The Department shall consider the following as appropriate "cause" for Member AMH/PCP changes:
- a) The provider has failed to furnish accessible and appropriate medical care, services or supplies to which the Member is entitled under the terms of the contract under which the PHP has agreed to provide services. This includes, but is not limited to, the failure to:
 1. Provide primary care services;
 2. Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
 3. Arrange for consultation appointments;
 4. Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
 5. Arrange for services with qualified licensed or certified providers;
 6. Coordinate the Member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;
 - b) The Member disagrees with a treatment plan;
 - c) The Member and provider are not able to communicate due to a language barrier or other impediment to communication;
 - d) The provider is not able to reasonably accommodate the Member's special needs;
 - e) There is a change in the provider's practice, including but not limited to the following:
 1. The provider moves to a location that is not convenient for the Member;
 2. There is a significant change in the hours the provider is available and the Member cannot reasonably make appointments during the new hours;
 3. The provider no longer has hospital privileges;
 - f) The Member and the provider agree that a change would be in the best interest of the Member; or
 - g) The provider leaves the PHP's network.

- x. The PHP shall allow PCPs to request removal of a Member from his/her panel and must submit to the Department their process for reviewing and approving such removal requests.
 - xi. The PHP shall allow Members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such Members direct access to a specialist as appropriate to the Member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).
- d. The PHP shall develop a comprehensive Care Management Policy that outlines the PHP's approach to meet the requirements of this Section. The PHP shall submit the Policy for review and approval by the Department ninety (90) days after Contract Award and annually thereafter.
- i. The Care Management Policy shall include the PHP's policies and process for:
 - a) Conducting Care Needs Screenings, including but not limited to:
 - 1. Care Needs Tool(s) Question used;
 - 2. Method for screening, including any tailoring for specific populations (including LTSS);
 - 3. Strategies to increase completion rates;
 - 4. Processes and timelines for reassessment based on PHP analytics or other best practices; and
 - 5. Strategies to use over time to screen Members for unmet health-related resource needs routinely, in addition to at initial enrollment.
 - b) Other Member need identification methods including:
 - 1. Regular claims analysis and risk scoring;
 - 2. Provider referral (including communication to providers for how they may refer into care management); and
 - 3. Member self-referral (including communication to Members for how they may refer into care management).
 - c) Risk scoring and stratification:
 - 1. Information and data to be utilized;
 - 2. Description of the methodology;
 - 3. Methodology for identifying members of priority populations;
 - 4. Number of risk strata;
 - 5. Criteria for each risk stratum (i.e. risking, high, low, medium risk);
 - 6. Approximate expected population and penetration rate in each stratum by priority population.
 - d) Comprehensive Care Needs Assessment, including but not limited to:
 - 1. Assessment Tools/Questions used;
 - 2. Variation in Care Needs Assessment based on population (including LTSS);
 - 3. Expected volume of Care Needs Assessment by priority population monthly and annually;
 - 4. Method of conducting the Care Needs Assessment based on Member needs or other factors; and
 - 5. Approach to determining when high-need Members will receive face-to-face care management.
 - e) Care plan development with Members including:
 - 1. Approach to identification of the threshold for high-need care management / care plans;
 - 2. Approach for involving multi-disciplinary care team;

3. Approach for ensuring that care plans are individualized and person-centered and the Member and the Member's family, advocates, caregivers, and/or legal guardians are actively involved; and
 4. Process for and frequency of Care Plan updates.
- f) Training and Qualification of care managers and other multidisciplinary team members including timing/frequency of training and ongoing continuing education;
 - g) Care coordination, including assigning ongoing source of care, coordination across settings of care, and coordination during Member transitions (including transitions from a Standard Plan to a BH I/DD TP, from Medicaid Fee-for-Service into Medicaid Managed Care, among managed care organizations, among payers, and between community and social support providers);
 - h) Linkages with community resources for all Members as needed, including for those identified as having unmet health-related resource needs;
 - i) Providing information and navigation regarding community providers of social services and tracking effectiveness of these interventions;
 - j) Transitional care management, including the approach to working with Members with LTSS needs;
 - k) Written Local Care Management Plan, including the approach to:
 1. Providing care management through local care management;
 2. Determining when care management should be conducted face to face;
 3. Working with LHDs;
 4. Contracting with at least eighty percent (80%) of Tier 3 AMH practices; and
 5. Working with AMH practices generally.
 6. Include the names and proposed service area of Designated Care Management Entity(s).
 - l) Requisite health IT infrastructure technologies and data privacy security policies.
 - m) Planned methodology and schedule for sharing patient data with AMH practices.
 - n) Methodology for AMH quality measurement incentive payments.
- ii. The PHP shall modify Care Management Policy based on EQRO review, Department review, or care management improvement activities as part of the QAPI.

7. Prevention and Population Health Management Programs

- a. The Department expects the PHP to use innovative methods to promote better health outcomes, such as rewarding Members and providers for improved outcomes and partnering with other agencies and organizations to work toward the aims of the Department's public health goals and Quality Strategy. The PHP must take a population-based approach to improving the overall health of Medicaid Members and work collaboratively with community partners on targeted public health initiatives (e.g. opioid crisis, infant mortality).
- b. The PHP shall establish prevention and population health programs aligned with the Department's larger public health goals and Quality Strategy. The Department will provide population-level measures to the PHP, such as measures related to infant and maternal mortality, that are intended to inform the PHP about regional trends and assist the PHP in performance improvement efforts.
- c. The Department's selected population health priorities as defined in the Quality Strategy, include:
 - i. Diabetes;
 - ii. Asthma;
 - iii. Obesity;

- iv. Hypertension;
 - v. Tobacco cessation;
 - vi. Infant mortality;
 - vii. Low birth weight;
 - viii. Early childhood health and development; and
 - ix. Additional prevention and population health management programs to encourage improved health and wellness among Members.
- d. The PHP shall identify individuals for prevention and population health programs through several mechanisms, including but not limited to:
- i. Care Needs Screenings;
 - ii. Claims analysis and risk scoring;
 - iii. Provider referral; and,
 - iv. Member self-referral.
- e. The PHP shall ensure that prevention and population health programs are available to all Members.
- f. The PHP will be expected to engage as active partners in Healthy NC 2020 and 2030 planning, including thorough review and discussion of PHP-level data and quality performance consistent with *Section V.E.1. Quality Management and Quality Improvement*. The PHP should incorporate information from LHD Community Health Assessment in the development of their Population Health programs.
- g. Tobacco Cessation Services
- i. The PHP shall contract with the Department's Quitline vendor at a minimum benefit level defined by the Department that promotes evidenced base standard of care for tobacco cessation.
 - ii. The PHP shall ensure that Members are given complete information about the coverage of tobacco cessation items and services.
 - iii. The PHP shall partner with the Department to, at a minimum:
 - a) Promote the full Tobacco Cessation Benefit to Members;
 - b) Partner with Department and the Department's Quitline vendor on outreach;
 - c) Submit marketing and educational materials for review and approval consistent with the requirements pursuant to the Contract.
- h. Opioid Misuse Prevention Program
- i. The PHP shall implement:
 - a) A comprehensive Opioid Misuse Prevention Program.
 - b) A Member Lock-In program.
 - c) A cumulative maximum Morphine Milligram Equivalent (MME) dosage limit not subject to utilization management prior approval, as established by the Department in opioid clinical coverage criteria.
 - d) Diagnosis codes, which may be established by the Department, exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM Program.
 - ii. Opioid Misuse Prevention Program
 - a) The Program shall:
 - 1. Align with the North Carolina Opioid Action Plan, including recommendations from NC Payers Council.

2. Promote appropriate utilization of health care resources by monitoring potential abuse or inappropriate utilization of targeted medications, and
 3. Contain interventions that support and promote safer prescribing of opioids, management of chronic pain with opioid sparing pharmacologic and non-pharmacologic modalities, early detection of opioid misuse and intervention, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and increased access to Naloxone and substance use disorder treatment, including Medication Assisted Therapy.
- b) The Program shall incorporate requirements in the Strengthen Opioid Misuse Prevention (STOP) Act¹⁴ including quantity limits, mandatory electronic prescribing, utilization of the Controlled Substances Reporting System, and reporting.
 - c) The Program shall describe goals and metrics as specified by the Department to report progress to goals on at least a bi-annual basis.
 - d) The PHP shall develop an Opioid Misuse Prevention Program Policy and submit to the Department for review and approval ninety (90) days after the Contract Award. The Policy shall be made available on a publicly available website and in the Provider Manual.
 - e) Member Lock-in Program
 1. The PHP's Lock-In Program criteria shall comply with the Department Lock-In Program criteria as defined in N.C. Gen. Stat. § 108A-68.2.¹⁵
 2. The PHP shall not require Members to be enrolled in the lock-in period for no more than two (2) years without reassessing for continued eligibility in the program.
 3. The PHP shall provide care coordination for Members in the Lock-In Program in conjunction with the Member's AMH/PCP as described in *Section V.C.6. Care Management*.
 4. The PHP shall report Lock-In program outcomes including, but not limited to, reduced emergency room visits and reduced opioid misuse in a format to be developed by the Department.
 5. The PHP shall accept and enroll all individuals enrolled in the Fee-for-Service or another PHP lock-in program into the PHP's lock-in program for the remaining duration of the lock-in period.
- i. Additional Prevention and Population Health Management Programs
 - i. The PHP shall actively participate and support the Department's public health initiatives and to coordinate with all existing public health and human services programs, including reporting, education, and care management activities. That includes coordination with the following:
 - a) Women Infant Children (WIC) Program
 1. The PHP shall make referrals to the WIC program based on the following criteria:
 - i. Pregnant women;
 - ii. Women up to six (6) months postpartum;
 - iii. Breastfeeding women up to one (1) year postpartum;
 - iv. Infants; and

¹⁴ The STOP Act, Session Law 2017-74, <https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf> was enacted by the NC General Assembly on June 29, 2017.

¹⁵ See Section 3.(a) of Session Law 2018-49.

- v. Children under age five (5).
 - 2. The PHP shall establish relationships with the WIC entities.
 - 3. The PHP shall collaborate with the Office of the State WIC director to establish a plan to coordinate these activities and share data as needed to accomplish joint program goals.
- b) Newborn Screening Programs
- 1. Consistent with N.C. Gen. Stat. §§ 130A-125 and 130A-130.2, the PHP shall comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and shall assure that all lab testing for samples drawn for Newborn Screening under this statute be sent to the NC State Lab for processing.
 - 2. The PHP shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Attachment M. 7. Management of Inborn Errors of Metabolism Policy*.
 - 3. The PHP shall establish a joint plan with the Department to implement reporting, education, and care management activities regarding children who screen positive for Hereditary and Congenital Disorders, including sickle cell, during Contract Year 1 or time otherwise defined by the Department.
- c) Hearing Screening Program
- 1. Consistent with N.C. Gen. Stat. § 130A-125 and 10A NCAC 43F, the PHP shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program including reporting to the Early Hearing Detection and Intervention (EHDI) Program at <https://wcs.ncpublichealth.com>.
 - 2. The PHP shall establish a joint plan with the Department to implement the requirement of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or time otherwise defined by the Department.
- d) Vaccines for Children (VFC) Program and NC Immunization Registry
- 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 VCF program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.
 - 2. The PHP shall educate providers on the use of the NC Immunization Registry.
- e) NCDPH Early Intervention Program
- 1. The PHP shall coordinate with the Department's Early Intervention Program specifically around services provided by the Children's Developmental Service Agencies (CDSAs).
 - 2. The PHP shall collaborate with local CDSAs to ensure smooth coordination and transition of care between children receiving service coordination through the CDSA and other services in the child's ISP (individualized service Plan) provided by the PHP network providers (i.e. CBRS, OT/PT, SL).
 - 3. The PHP shall coordinate with CDSA in each Region that it operates.
 - 4. The PHP shall detail the plan to ensure referral and coordination for all children who receive service coordination through the CDSA during Contract Year 1, or time otherwise defined by the Department, and annually thereafter.

- j. Informing and Educating Members and Providers
 - i. Members:
 - a) The PHP shall inform all Members through the Member Handbook and separately of the availability and accessibility of Prevention and Population Health Programs, including the use of program services.
 - b) The PHP shall provide Members with information regarding their participation eligibility, how to self-refer, and how to either accordingly “opt in” or “opt out” of a program.
 - c) The PHP shall give Members the option to have the PHP notify their PCP of the Member’s participation in a Prevention and Population Health Program.
 - ii. Providers:
 - a) As part of the Provider Training Plan, the PHP is responsible for educating providers regarding the operation and objectives of all Prevention and Population Health programs. The PHP shall give providers instructions on how to access specific services and benefits.
 - b) For those Members receiving Prevention and Population Health Program support, the PHP will notify their AMH/PCP by letter, email, fax, or via a secure web portal of their patient’s involvement, unless the Member notified the PHP not to inform their PCP as described above.

8. Opportunities for Health

- a. The Department is committed to providing the opportunity for health for North Carolinians, while improving health outcomes and reducing health care costs, and addressing the conditions in which people live that directly impact health.
- b. Working collaboratively with its PHPs, the Department envisions establishing North Carolina as a national leader in optimizing the health and well-being for all by effectively stewarding resources that bridge our communities and our health care system to address all factors that impact health.
- c. The Department has identified four priority domains for Opportunities for Health and health-related resource needs: housing, food, transportation and interpersonal safety.
- d. The PHP shall address these domains to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:
 - i. **Care Management:** The PHP shall establish care management competencies, workforce and procedures that enable the care team to comprehensively address unmet health-related needs, including screening for and addressing such needs through trauma informed care, navigation support and other strategies. For full Care Management requirements, see *Section V.C. Benefits and Care Management*.
 - ii. **Quality:** The PHP will focus on health outcomes and not only health care process measures. The PHP shall report on rates of completed screenings for unmet health-related resource needs. For full Quality requirements, see *Section V.E.1. Quality Management and Quality Improvement*.
 - iii. **Value-Based Payment:** The PHP shall submit a written plan to the Department that indicates how it will incorporate addressing Opportunities for Health into its value-based payment strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full Value Based Payment requirements, see *Section V.E.2. Value-Based Payments/Alternative Payments*.

- iv. **In Lieu of Services:** The PHP is encouraged to use In Lieu of Services to finance services that improve health through connecting Members with resources, social services and other supports upon receipt of the Department approval. For full In Lieu of Services requirements, see *Section V.C.1. Medical and Behavioral Health Package*.
 - v. **Contributions to Health-Related Resources:** The PHP is encouraged to make contributions to health-related resources that help to address Members' and communities' unmet health-related needs.
 - vi. **Enhanced Case Management Pilots:** The PHP shall participate in Enhanced Case Management Pilots operating in its region, as described below.
- e. The PHP shall use North Carolina-developed tools to address the four priority domains for Opportunities for Health including:
- i. **Standardized Screening Questions:** As part of care management, the PHP shall undertake best efforts to conduct a Care Needs Screening of every Member as defined in the Contract. The Screening shall include standardized screening questions, to be developed by the Department, to identify Members with unmet health-related resource needs who required a Comprehensive Assessment for care management.
 - ii. **North Carolina Resource Platform:** The NC Resource Platform will be a telephonic, online, and interfaced IT platform providing: (a) a robust statewide resource database of community-based organizations and social service agencies, and b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, community members, and others to eventually refer and connect Members directly to community resources and track the connections and outcomes through "closed loop referral" capacity. The platform is being developed under the authority of the Foundation for Health Leadership and Innovation. The PHP shall ensure that the care management approach includes help for Members in addressing unmet resource needs. The PHP shall, at a minimum:
 - a) Use the "NC Resource Platform" to identify community-based resources and connect high-need Members to such resources, to the extent the "NC Resource Platform" is available to support such a connection. The Department anticipates this functionality will be ready for PHP use by Contract Year 1.
 - 1. The PHP shall use the NC Resource Platform for its community-based organization and social service agency database/directory to identify local community-based resources.
 - 2. The PHP shall use the NC Resource Platform for referring Members to the community-based organizations and social service agencies available on the NC Resource Platform and for tracking closed loop referrals once such functionality is ready for PHP use. The PHP may use existing platforms for this capability until the NC Resource Platform is certified as fully functional and ready for statewide PHP adoption.
 - iii. **North Carolina "Hot Spot" Map:** The NC "Hot Spot" Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. PHPs are encouraged to use this tool to strategically guide contributions to health-related resources in the regions and communities it serves (Available at: <http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b>)

- f. PHP Contributions to Health-Related Resources
 - i. The PHP is encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves.
 - ii. The PHP that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V. I. 2. Medical Loss Ratio*.
 - iii. A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a Region to health-related resources may be awarded a preference in auto-assignment to promote enrollment in each Region in which the PHP contributes, contingent on the Department determining that the contribution meets the Department's Quality Strategy standards. The auto-assignment increase will take effect the next Contract Year, or at a date determined by the Department, after the contribution is made.
 - iv. The PHP is encouraged to identify opportunities to contribute to health-related resources in the Quality Assurance and Performance Improvement (QAPI) plan. See *Section V. E. 1. Quality Management and Quality Improvement*.
- g. Enhanced Case Management Pilots to Address Unmet Health-Related Needs
 - i. Through Enhanced Case Management Pilots, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) priority domains (housing, food, transportation, and interpersonal safety) can be delivered effectively to Medicaid Members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the pilots is to learn which evidence based interventions and processes are best matched for a specific population to improve health, lower health care costs, and to inform health care delivery statewide.
 - ii. Through a competitive procurement process, the Department will establish Enhanced Case Management pilots in up to four (4) areas of the State to provide a subset of high-need, high-risk, and emerging-risk Medicaid Members with information, services and benefits targeted to measurably improve health and lower costs. The pilots will employ evidence-based interventions addressing Members' needs in housing, food, transportation, and interpersonal safety. The PHP shall play a key role in executing the pilots in accordance with the roles and responsibilities enumerated below.
 - iii. A pilot Region is defined as at least three (3) counties, with a mix of urban and rural communities. A pilot region will not need to include all counties within a PHP Region, but cannot cross PHP Region boundaries.
 - iv. Each pilot will have a Lead Pilot Entity (LPE). The LPE's role is to develop, contract with and manage a network of pilot service providers (e.g., community based organizations) that can deliver the evidence-based interventions across each of the four (4) priority domains.
 - v. The PHP shall contract with any LPE operating within the PHP's Region(s).
 - vi. The PHP shall utilize care managers—employed by or under contract with the PHP or in a Tier 3 Advanced Medical Home (AMH)—to execute key pilot functions.
 - vii. The PHP shall ensure that the care manager screens Members using a forthcoming Department-developed "Pilot Qualification Screening Tool" to assess whether they meet pilot eligibility criteria.
 - viii. The PHP shall ensure that the care manager, in consultation with the LPE, develops a care plan and identifies the pilot services that a Member is eligible to receive based on Member need, the pilot services available in the Member's pilot region, and forthcoming DHHS-developed guidance.

- ix. The PHP shall ensure that the care manager obtains Members' consent to enroll in the pilot based on forthcoming DHHS-developed guidance.
- x. The PHP shall authorize enrollment into the pilot and the delivery of pilot services based on forthcoming Department guidelines, to be developed in collaboration with PHPs and LPEs prior to launching the pilots.
- xi. The PHP shall ensure that the care managers communicate approved pilot service authorization to pilot enrolled Members
- xii. The PHP shall ensure that the care manager connects Members approved for pilot enrollment to pilot providers in the LPE's network for approved pilot services, in partnership with the LPE.
- xiii. The PHP shall ensure that the care manager conducts a reassessment for the mix of pilot services no less frequently than every three (3) months and for the eligibility for services no less frequently than every six (6) months.
- xiv. The PHP shall ensure that the care manager is responsible for identifying information and data on pilot Members in accordance with forthcoming Department guidelines that support the State's oversight and evaluation efforts, including:
 - a) Pilot enrollment and referral source;
 - b) The identified needed pilot services in an individual's care plan;
 - c) Approved pilot services;
 - d) Denied pilot services; and
 - e) Number of reassessments and associated findings.
- xv. The PHP will receive payments from the Department up to a PHP-specific capped allotment to fund pilot services based on the cost and volume of specified services authorized for the PHP's Members.
- xvi. The PHP shall make payments to the Lead Pilot Entity to manage the delivery of pilot services.
- xvii. The PHP shall manage total pilot funding against allocations for eligible populations, covered services, and Opportunities for Health domains, as developed by the LPE and approved by the Department.
 - a) Eligible populations include those that qualify for pilot services under Department determined health and resource need based risk eligibility criteria.
 - b) Covered services include those authorized by the PHP and that follow Department guidelines.
- xviii. The PHP shall support the Department's efforts to evaluate the effectiveness of the pilots by reporting quarterly on a range of metrics, including:
 - a) Pilot enrollment;
 - b) Pilot service utilization;
 - c) Pilot expenditures;
 - d) Member health outcomes; and
 - e) Member cost and utilization metrics.

D. Providers

1. Provider Network

- a. Providers are the backbone of North Carolina's Medicaid and NC Health Choice Program and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks PHPs which share and support that tradition.
- b. The Department seeks a PHP with a robust Provider Network to meet the medical, behavioral health and pharmacy needs of all Members within its Region(s) including those with limited English proficiency, physical, or mental disabilities. The PHP shall demonstrate that its Network will meet Department's availability, access, and quality goals and requirements as well as the willingness of the PHP to act to continuously improve its delivery of health care services to Members.
- c. Availability of Services (42 C.F.R. § 438.206)
 - i. The PHP shall establish and maintain a Medicaid Managed Care Provider Network (Network), supported by written agreements with providers, that is sufficient to ensure that all services covered under the Contract are available and accessible to all Members in a timely manner, including those Members with limited English proficiency or physical or mental disabilities.
 - ii. The PHP shall meet all federal and state provisions for availability, including:
 - a) Providing for a second opinion from a Network Provider, or arrange for the Member to obtain one outside the network at no cost to the Member if requested by the Member and subject to the Utilization Management Program requirements if applicable. PHP shall clearly state its procedure for obtaining a second opinion in its Member Handbook.
 - b) Adequately and timely covering services out-of-network for a Member if the PHP's Network is unable to provide the covered service on a timely basis, taking into account the urgency of the need for services. PHP shall cover the Member's out-of-network services for the duration of the Network's inability to provide them in network.
 - c) Coordinating out-of-network providers for payment of services and ensure the cost to the Member is not greater than it would be if the services were furnished within the network.
 - d) Sufficient family planning providers to ensure timely access to covered services.
 - e) Providing female Members with direct access to a women's health specialist within the provider network for covered care necessary to provider women's routine and preventive health care services; this shall be in addition to the Member's designated source of primary care if that source is not a women's health specialist.
 - iii. Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)
 - a) The PHP shall make good faith efforts to contract with IHCPs and demonstrate that sufficient number of IHCPs are participating in their networks to ensure timely access to contracted services for the tribal population.
 - b) The PHP shall allow any Tribal member eligible to receive services from an Indian Health Care Provider (IHCP) to choose the IHCP as the Tribal member's PCP, if the IHCP has the capacity to provide PCP services at all times. The PHP shall consider any referral from such IHCP acting as the Member's PCP to a network provider as satisfying any coordination of care or referral requirement of the Contract.

- c) The PHP shall provide Tribal members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
- d) The PHP shall permit Tribal members to obtain services from out-of-network IHCPs from whom the Member is otherwise eligible to receive such services.
- e) If the PHP cannot provide timely access to necessary services in state and/or in-network for Tribal members, the PHP must provide access to out-of-state and/or out-of-network IHCPs.
- f) The PHP must refer Tribal members to IHCPs and other sources of culturally competent care as determined by the Department. The PHP enrolling Tribal populations shall additionally provide training for culturally competent care among contracted providers.
- g) The PHP shall permit out of network IHCPs to make referrals to contracted providers for any Tribal members without prior authorization or a referral from a contracted provider.
- h) The PHP shall permit IHCPs to refer a Tribal member to any provider within the IHCP PRC network, even if the provider is not a contracted provider, without having to obtain prior authorization or a referral from a contracted provider
- i) The PHP shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any Tribal member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contract health services.

iv. Pharmacy Services

- a) The PHP shall ensure its pharmacy network meets the time and distance standards defined in *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards*, as amended by the Department from time to time.
- b) The PHP shall maintain a Pharmacy Provider Network Audit Program. The PHP shall submit the program to Department for approval ninety (90) days after Contract Award and annually thereafter.
- c) The PHP shall not require Members to accept mail order pharmacy services unless mail order is the only dispensing channel for a drug. The PHP may allow Members to choose to receive prescribed drugs through mail order pharmacy services.
- d) The PHP shall submit its Mail Order Program Policy including a sample of all Member mail order-related correspondence to the Department for approval ninety (90) days after Contract Award and annually thereafter. The PHP shall specifically identify any pharmacy service where mail order is the only dispensing channel for the drug.
 - 1. The request for approval must be submitted in accordance with the Implementation Plan.
 - 2. The PHP must submit any significant changes to its mail order program to Department for approval at least ninety (90) calendar days before implementation target date.
- e) The PHP may contract with a limited specialty pharmacy network if the PHP demonstrates that:
 - 1. A specialty drug is only available through a limited network of pharmacies; and
 - 2. The specialty pharmacy has clinical and care coordination programs that improve medication adherence and drug therapy outcomes.
- f) PHP may contract with 340B covered entities. Drugs purchased through the 340B program shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus dispensing fee as defined in *Section V. C.3. Pharmacy Benefits*.

- v. Telemedicine Services:
 - a) The PHP may use telemedicine as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the PHP's network and in accordance with the PHP Telemedicine Coverage Policy.
 - b) PHPs shall be permitted to leverage telemedicine in their Request for Exception to the Department's network adequacy standards, as appropriate.
 - c) PHP shall not require an Member to seek the services through telemedicine and must allow the Member to access a face-to-face service through an out-of-network provider, if the Member requests.
 - d) Access to telemedicine providers does not count toward meeting network adequacy standards, unless approved as part of an exception to Network requirements.
- d. Furnishing of Services (42 C.F.R. § 438.206(c))
 - i. The PHP shall meet the Network time and travel distance, and appointment wait time standards established by the Department as described in *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards*, unless otherwise approved by the Department in accordance with the requirements herein.
 - a) The Department is studying the application of provider-patient ratios and may implement ratios by Region and hold the PHP accountable to those ratios upon one hundred twenty (120) calendar days prior notice.
 - b) The Department may amend the Network time and travel distance, appointment wait time, or other adequacy standards from time-to-time. PHP shall comply with the new standards as directed, but with no less than a ninety (90)-day prior notice.
 - ii. The PHP shall meet and require its network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services.
 - iii. The PHP shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial Members or comparable to Medicaid Fee-for-Service, if the provider serves only Medicaid or NC Health Choice.
 - a) The Department encourages after hours and weekend hours to address the needs of the Member.
 - iv. The PHP shall make covered services available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
 - v. The PHP shall establish mechanisms to ensure that its Network providers comply with the timely access requirements.
 - a) The PHP shall monitor Network providers regularly to determine compliance with the timely access requirements.
 - b) The PHP shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
 - vi. The PHP shall ensure that Network Providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Members with physical or mental disabilities.
 - vii. The PHP shall promote the delivery of services by Network providers in a culturally competent manner to all Medicaid Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
 - a) The PHP shall support providers with these requirements including educating providers on the availability of the resource, accessing the resource and creating sufficient interpreter capacity.

- viii. To furnish services to meet Members' accessibility needs, the PHP is encouraged to contract with providers outside of the PHP's Region(s).
 - a) An individual Member's accessibility and PHP's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.
- e. Essential Providers (SL 2015-245, Section 5)
 - i. The PHP shall include all Essential Providers located in the PHP's Region(s) in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.
 - a) Except for a Veterans Home, a PHP must submit a request for an alternative arrangement relating to any Essential Provider that fails the PHP's Quality Determination process.
 - ii. At such time the PHP is notified by the Department that a Member is determined eligible for and transferred for treatment to a DMVA-operated Veterans Home, the PHP shall include the Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) in its Network as an Essential Provider and shall reimburse the veterans home at the rates established by the Department until such time as the Member is disenrolled as provided in the Contract.
- f. Exceptions to Network Requirements
 - i. Network adequacy measures, in part, the PHP's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, and all health care services included under the terms of the contract. Recognizing that there are conditions in the field which cannot be remedied by the PHP's alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to network requirements. However, the Department will partner with PHPs which understand the health needs of North Carolina and which find innovative ways to develop or foster provider capacity or otherwise meet the requirements of Medicaid Managed Care. Therefore, the Department will grant exceptions based on the evidence presented by the PHPs and exceptions granted will generally be time-limited.
 - ii. The PHP may request approval for an alternative arrangement for an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision. An alternative arrangement request must:
 - a) Be made for each Essential Provider that the PHP is proposing to not contract with;
 - b) Describe efforts to negotiate in good faith;
 - c) Include justification for the alternative arrangement with a description of how the alternative arrangement will meet Medicaid Member needs; and
 - d) Include the PHP's plan to address Member needs and remedy the need for the alternative arrangement including a suggested time line for implementation.
 - iii. In accordance with 42 C.F.R. § 438.68(d)(1), the PHP may request Department approval for an exception to meeting the Department's Network Adequacy Standards in a specific Region for a specific provider type. Requests must:
 - a) Be made in writing;
 - b) Describe efforts to negotiate in good faith;
 - c) Include justification for the exception and a description of how Medicaid Member needs for the specific Region and provider type will be met; and

- d) Include the PHP's plan to address Member needs and remedy the network deficiency, including an estimated time line to close the network gap.
 - iv. The Department's approval of an exception request to the Network Adequacy Standards or an Essential Provider alternative arrangement will include a specific time frame for the approval. Forty-five (45) calendar days before an exception/alternative arrangement is set to expire, the PHP shall submit a new request for the exception/alternative arrangement or inform the Department the exception/alternative arrangement is no longer needed.
 - v. The Department is not required to approve a request for an alternative arrangement with an Essential Provider or exception to meeting the Department's Network Adequacy Standards and may deem a PHP to be out of compliance.
- g. Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)
 - i. The PHP shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's Network Adequacy Standards (as found *Attachment F. North Carolina Medicaid Managed Care Network Adequacy Standards*), state and federal law, and the terms of this Contract.
 - a) The PHP's Network Access Plan must:
 - 1. Demonstrate compliance, or, for submissions prior to Phase 1 of Medicaid Managed Care, plans for compliance, with all the following:
 - i. Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of Members for the Region.
 - ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medicaid Members in the Region.
 - iii. Include procedures to address the following:
 - a) Referrals;
 - b) Disclosures and notices to Members of PHP services and features;
 - c) Coordination and continuity of care; and
 - d) Transition of care that complies with Department requirements set forth in *Section V. C. 4. Transition of Care*.
 - 2. Demonstrate the PHP's efforts to:
 - i. Address the needs of all Members, including those with limited English proficiency or illiteracy;
 - ii. Ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities; and
 - iii. Support and sustain providers, including hospitals, in rural and other traditionally underserved areas.
 - 3. Include the PHP's:
 - i. Efforts to establish a network that meets the Department's Network Adequacy Standards.
 - ii. Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all Members on an ongoing basis.
 - iii. Factors used to build the Network, including a description of the Network and criteria used to select providers, i.e. objective quality standards.

- iv. Process and methodology to understand the distribution of Member health care needs against available providers and provider capacity to serve those needs.
 - v. Plan to provide in-network access, compliant with the Department's Network Adequacy Standards, to children to the full range of age-appropriate health care providers, subspecialists and facilities, including:
 - a) Method for ensuring children's physical and behavioral health needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in pediatrics or in child health and development, and
 - b) Approach to assure children's access to child psychologists and psychiatrists, pediatric occupational, physical and speech therapists, pediatric neurologists, and pediatric surgeons.
 - vi. Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
 - vii. Geographical location of providers in the Provider Network in relationship to where Members.
- b) The Network Access Plan must be provided as follows:
 - 1. Thirty (30) days after Contract Award;
 - 2. As specified by the Department;
 - 3. Annually; and
 - 4. Within thirty (30) days of a significant change.
 - c) The demonstration that the PHP has the capacity to serve the expected enrollment shall be on a regional basis. For a statewide PHP, this means demonstration shall be for each Region 1 through 6.
- ii. The PHP and its network providers shall comply and cooperate with EQRO network adequacy validations and activities including:
 - a) Annual validation of PHP's Network adequacy and compliance with state and federal network requirements.; and
 - b) Telephone surveys of Network providers to verify accuracy of reported data or other aspects of program requirements or performance.
 - iii. The PHP shall provide the Department with Network data files quarterly and anytime there is significant change that impacts Network adequacy and the ability to provide services. The Department will prescribe the standardized file format. The standardized detailed file layout must include the following data elements:
 - a) Provider names (first, middle, last);
 - b) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - c) Street address(as) of service location(s);
 - d) County(ies) of service location(s);
 - e) Telephone number(s) at each location;
 - f) Website URL(s);
 - g) Provider specialty;
 - h) Provider NPI or API;
 - i) NPI type (individual or organization/facility providers);
 - j) Taxonomy(ies);
 - k) Whether provider is accepting new Members and the conditions if applicable;
 - l) Identification as an IHCP

- m) Identification as an Essential Provider
- n) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
- o) Whether provider has completed cultural competency training; and
- p) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.

2. Provider Network Management

- a. The PHP shall manage its Network to meet availability, accessibility, and quality goals and requirements. In developing its Network, Department expects PHP to negotiate with any willing provider in good faith regardless of provider or PHP affiliation. The PHP shall have a strong monitoring program to ensure providers are meeting Member needs and program requirements.
- b. To help recognize the Department's aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency. Until the Department fully implements a PDM/CVO, the Department will engage a Provider Data Contractor, who is certified by the NCQA, to supplement the current enrollment and credentialing process. The period before the PDM/CVO has achieved full Implementation will be considered the Provider Credentialing Transition Period. The information gathered by the Department's vendors will be shared with the PHP who will use that information to make Quality Determinations for network contracting purposes.
- c. Provider Contracting
 - i. The PHP contracts with Providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses identified in *Attachment G. Required Standard Provisions of PHP and Provider Contracts*.
 - ii. The PHP shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) calendar days after the Contract Award.
 - a. The PHP may utilize proposed contract templates submitted as part of the Offeror's Proposal and Response prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
 - b. Upon approval by the Department, the PHP shall discontinue use of previously submitted contract templates.
 - c. The PHP shall re-submit contract templates to Department for approval at least ninety (90) calendar days before use with providers when significant changes are proposed.
 - iii. The PHP shall not include any provider (ordering, prescribing, or referring) in its Medicaid Managed Care Provider Network that is not enrolled in North Carolina Medicaid.
 - a. The PHP shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract.
 - b. This validation should be done monthly thereafter.

- iv. The PHP shall not employ or contract with any provider excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).
- v. In accordance with Section 5.(6)d. of Session Law 2015-245, except as otherwise allowed under the Contract, the PHP shall not exclude eligible providers from its network except under the following circumstances:
 - a. When a provider fails to meet Objective Quality Standards; or
 - b. Refuses to accept network rates (which shall not be lower than any applicable rate floors).
- vi. The PHP shall not deny a pharmacy the opportunity to participate in its network as required by N.C. Gen. Stat. § 58-51-37(c)(2). Nothing in this subsection shall require the PHP to contract with a pharmacy when the pharmacy fails to meet Objective Quality Standards.
- vii. The PHP shall offer to contract with a provider in writing.
 - a. All offers shall include the standard provisions for provider contracts found in *Attachment G. Required Standard Provisions of PHP and Provider Contracts*, including the prescribed provisions located therein.
 - b. If within thirty (30) calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, the PHP may consider the request for inclusion in the Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the PHP shall not consider the request rejected.
 - c. The PHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the PHP for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-complete provisions in contracts with providers, including non-medical service providers (e.g. non-emergency medical transportation drivers), require a provider to participate in the governance of a PLE, or otherwise prohibit a provider from providing services for or contracting with any other PHP.
- viii. The PHP shall not require individual practitioners, as a condition of contracting with PHP, to agree to participate or accept other products offered by the PHP nor shall the PHP automatically enroll the provider in any other product offered by PHP. This requirement shall not apply to facility providers.
- ix. The PHP shall give written notice to any provider with whom it declines to contract within ten (10) business days after the PHP's final decision. The notice shall include the reason for the PHP's decision, the Provider's right to appeal that decision, and how to request an appeal. 42 C.F.R. § 438.12(a)(1)].
- x. The PHP shall, with regard to payment to any provider or subcontractor that is "related to" the PHP, comply with the requirements in *Section V. A. 4. PHPs and Related Providers* and *Section V. I. 2. Medical Loss Ratio*.
- xi. The PHP shall include a provision regarding Provider's right to file a grievance or appeal in its contracts with providers. PHP shall include a notice in all provider contracts that internal appeal processes with the PHP must be completed before seeking other legal or administrative remedies under state or federal law.
- xii. The PHP shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:
 - a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - b. Any information the Member needs to decide among all relevant treatment options.

- c. The risks, benefits, and consequences of treatment or non-treatment.
 - d. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 C.F.R. § 438.102(a)(1)(i)-(iv).
- xiii. The PHP shall include a provision that requires all in-network primary care providers (PCPs) to perform EPSDT screenings for Members less than twenty-one (21) years of age in accordance with *Section V. C. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*.
 - xiv. The PHP shall include a provision that requires providers notify the PHP when a Member in a high level clinical setting is being discharged.
 - xv. The PHP shall not utilize evergreen contracts with Medicaid Managed Care providers.
 - xvi. The PHP shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.
 - xvii. In contracting with providers, the PHP shall comply with all applicable Chapter 58 statutes in accordance with *Attachment G. Required Standard Provisions of PHP and Provider Contracts*.
 - xviii. The PHP shall include in Provider contracts that Participating Providers shall not submit claim or encounter data for services covered by Medicaid Managed Care and PHPs directly to the Department.
 - xix. In Contract Years 1-3, the PHP shall contract with each LHD in its Region(s) to provide Care Management for At-Risk Children and Care Management for High Risk Pregnant Women, to the extent that each LHD chooses to provide these services.
 - xx. The PHP shall contract with, and using a Department-developed contract template, the following State-operated facilities for alcohol treatment, drug treatment, and psychiatric care:
 - a. Julian F Keith ADATC,
 - b. R.J. Blackley ADATC,
 - c. Walter B. Jones ADATC,
 - d. Cherry Hospital,
 - e. Broughton Hospital, and
 - f. Central Regional Hospital.
- d. Provider Preventable Conditions
 - i. The PHP shall comply with 42 C.F.R. § 438.3(g) which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. The PHP shall submit all identified Provider Preventable Conditions in a form or frequency as described in *Attachment J. Reporting Requirements*.
 - ii. The PHP shall include a provision in all provider contracts that requires the provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the PHP.
 - e. Indian Health Care Providers
 - i. The PHP shall use the Medicaid Managed Care Addendum for Indian Health Care Providers when contracting with Indian Health Care Providers as described in *Attachment H. Medicaid Managed Care Addendum for Indian Health Care Providers*.
 - ii. The PHP shall not include any additional special terms and conditions to the Medicaid Managed Care Addendum when contracting directly with IHCPs without mutual consent

of both PHP and the IHCP. For any mutually agreed upon additional special terms and conditions, the PHP shall:

- a. Within thirty (30) calendar days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.
 - b. Recognize that the IHCP addendum provisions supersedes any conflicting terms of the contract between PHP and IHCP.
 - iii. The PHP must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148.
- f. Program Integrity
- i. The PHP shall develop policies and procedures to perform monitoring and auditing of provider payment. The PHP shall provide those policies and procedures to the Department upon request for review.
 - ii. The PHP shall require network providers and subcontractors to have compliance plans that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
 - iii. The PHP shall require network providers and non-contract providers to have policies and procedures that recognize and accept Medicaid as “the payer of last resort”.
 - iv. The PHP shall prohibit providers and referral providers from billing Members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2).
 - v. The PHP shall not impose a monetary advantage or penalty that would affect a Member’s choice of pharmacy in accordance with N.C. Gen. Stat. § 58-51-37(c)(4) or any other provider.
- g. Credentialing and Re-credentialing Process
- i. The PHP shall develop a Credentialing and Re-credentialing Policy consistent with the Department requirements and its associated policies and subject to Department approval.
 - a. The PHP shall develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.
 - ii. The PHP shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department’s written prior approval. PHP is not prohibited from collecting other information from providers necessary for the PHP’s contracting process but that information should not be used for making contracting Quality Determinations.
 - a. The PHP shall make timely referrals to the Provider Network Participation Committee, as defined in *Attachment M. 6. Uniform Credentialing and Re-credentialing Policy*, of providers who have been identified as potential network providers. The referral shall include all credentialing and verified information pertaining to the provider as provided by the Department.
 - iii. The PHP shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.D. Providers*.

- iv. The PHP is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.
 - v. Re-credentialing:
 - a. During the Provider Credentialing Transition Period, the PHP shall apply Objective Quality Standards to contracted providers no less frequently than every five (5) years consistent with the Department policy and procedure.
 - b. After the Provider Credentialing Transition Period, the PHP shall apply Objective Quality Standards to contracted providers every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
 - vi. During the Provider Credentialing Transition Period, the PHP shall apply the Objective Quality Standards most recently approved by the Department, or designated Department vendor, to contracted providers as the provider is re-enrolled in Medicaid.
 - vii. Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all PHP network providers as Medicaid providers. 42 C.F.R. § 438.602(b)(1).
 - a. The PHP may execute network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected Members. 42 C.F.R. § 438.602(b)(2).
 - viii. The PHP shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.
- h. Network Provider System Requirements
- i. The PHP shall accurately and timely load into the PHP's claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.
 - ii. Unless otherwise written in the contract, the PHP shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:
 - a. Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
 - b. Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
 - c. Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
 - d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
 - e. Change in existing contract terms within ten (10) business days of the effective date after the change; and
 - f. Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after the PHP receives updated provider information.
 - iii. Payment should be made on the next payment cycle following the requirement outlined above.

- iv. In no case shall a provider be used as a PCP or loaded into the provider directory during a timeframe in which the provider cannot receive payment on the health plan's current payment cycle.
- 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 develop and maintain a Network Provider Credentialing and Re-credentialing Policy as defined in *Attachment M. 6. Uniform Credentialing and Re-credentialing Policy*
 - ii. The PHP shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) days after the Contract Award. The Policy must be approved by the Department at least sixty (60) days prior to executing contracts with providers.
 - a. The PHP may utilize the draft Policy submitted as part of the Offeror's Proposal and Response prior to approval by the Department with notification to the provider that the Policy is subject to amendment based upon Department review and approval.
 - iii. PHP shall submit any significant policy changes to Objective Quality Standards to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes.
 - iv. Provider Network Participation Committee
 - a. PHP shall establish and maintain a Provider Network Participation Committee to make Quality Determinations in accordance with PHP's Credentialing and Re-credentialing Policy.
 - b. PHP's Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.
 - c. PHP shall make Quality Determinations within the following timeframes:
 - 1. For ninety percent (90%) of providers within thirty (30) calendar days of the Committee's receipt of complete credentialing and verified information for consideration; and
 - 2. For one hundred percent (100%) of providers within forty-five (45) calendar days of the Committee's receipt of complete credentialing and verified information for consideration. days of the Provider Network Participation Committee's determination.
 - d. The PHP shall provide written notice of Quality Determinations to providers within five (5) business days of the Provider Network Participation Committee's determination.
- j. Provider Disenrollment and Termination
 - 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 re-credentialing documentation to the Department or otherwise fail to meet Department requirements.
 - 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 Network Provider Credentialing and Re-credentialing Policy.
 - ii. Termination as a Medicaid Provider by the Department:
 - a. The PHP shall remove any provider from the PHP network, claims payment system, and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) business day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.
 - b. If the PHP suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the PHP shall release applicable claims and deny payment.
 - iii. PHP Provider Termination
 - a. The PHP may terminate a provider from its network with cause. Any decision to terminate must comply with the requirements of the Contract.
 - b. The PHP shall comply with the Program Integrity Provider Termination Requirements outlined in *Section V. J. 2. Program Integrity*.
 - c. The PHP must provide written notice to the provider of the decision to terminate to the provider. The notice, at a minimum, must include:
 - 1. The reason for the PHP's decision;
 - 2. The effective date of termination;
 - 3. The Provider's right to appeal the decision; and
 - 4. How to request an appeal.
 - d. The PHP shall notify the Department in writing of any decision to terminate a network provider. Notice must be provided concurrent with notification to the Provider and shall, at a minimum, include:
 - 1. The reason for the PHP's decision; and
 - 2. The effective date of termination.
- k. Member Notice of Provider Disenrollment/Termination
 - i. The PHP shall notify each Member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the Network. PHP shall:
 - a. Make a good faith effort to provide written notice within fifteen (15) calendar days after receipt of a notice of termination by the Department or issuance of termination notice to the Provider by the PHP. 42 C.F.R. 438.10(f)(1).
 - b. Include in the notice information about selecting or being auto-assigned a new AMH/PCP.
 - c. Describe the PHP's efforts to support transition of care for the Member to the new provider.
 - d. If the terminated provider was a specialist, assist impacted Members with transition of care.
- l. Provider Directory
 - i. The PHP shall develop a consumer-facing provider directory of all Network providers including the required information for all contracted providers.

- ii. The directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by Department.
- iii. The PHP shall ensure that the consumer-facing 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.
- iv. In accordance with 42 C.F.R. § 438.10(h)(3):
 - a. The PHP shall update the paper directory at least monthly and clearly identify the date of the update.
 - b. The PHP shall update the electronic version of the consumer-facing directory no later than ten (10) business days after the PHP receives updated provider information and clearly identify the date of the update.
- v. The PHP shall provide Department with a copy of both the electronic and paper versions of the provider directly as follows:
 - a. At the request of the Department during the readiness review;
 - b. Annually; and
 - c. Any time there has been a significant change in PHP operations that impacts the content of the directory.
- vi. All provider directories must include the following information as required by 42 C.F.R. § 438.10(h)(1):
 - a. Provider names (first, middle, last);
 - b. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - c. Street address(es) of service location(s);
 - d. County(ies) of service location(s);
 - e. Telephone number(s) at each location;
 - f. Website URL(s);
 - g. Provider specialty;
 - h. Whether provider is accepting new beneficiaries;
 - i. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
 - j. Whether provider has completed cultural competency training;
 - k. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment; and
 - l. A telephone number a Member can call to confirm the information in the directory.
- vii. In no case shall a provider be loaded into the provider directory which cannot receive payment on the PHP's current payment cycle.
- viii. The PHP shall provide the provider directory to the Enrolment Broker as described in *Section V. K. Technical Specifications*.

3. Provider Relations and Engagement

- a. Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to Members. Department seeks a Contractor that will engage and support providers through a call center and online provider portal as well as provide training and education on the Medicaid program and their rights within the program.
- b. Provider Relations: Service Line; Provider Portal; Welcome Packet
 - i. The PHP shall operate a Provider Relations function, that includes a Support Service Line consistent with the applicable standards found in *Section V. G. Program Operations*.
 - ii. Be staffed with personnel specifically trained on the requirements, policies and procedures of the PHP operating in the North Carolina market and are able to respond to all areas within the provider manual including resolving claims payment inquires, in “one-touch”.
 - iii. The PHP shall provide and maintain a provider web portal that provides access to program and provider specific information including the Provider Manual, as defined by the Contract.
 - iv. The PHP shall send a Welcome Packet and enrollment notice to providers within five (5) days of executing a contract with the Provider for participation within its Medicaid Managed Care Network. The Welcome Packet must include orientation information and instructions on how to access the PHP’s Provider Manual.
 - v. The PHP shall develop and maintain a Provider Support Plan as described in *Section V. E. 1. Quality Management and Quality Improvement* and make it available to Department upon request.
- c. Provider Education and Training
 - i. The PHP shall provide education, specific to the Medicaid Managed Care requirements, policies and procedures, training and technical assistance on all PHP-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.
 - ii. The PHP shall communicate with Network providers, or include in its training and technical assistance, information as requested by Department.
 - iii. The PHP shall provide training to Network providers within thirty (30) days of provider joining the Network. Additional training will be provided as determined by the PHP and as requested by Department.
 - iv. The PHP shall make training materials available on the Provider Online Portal as determined appropriate by the PHP and upon request by Network providers or Department.
 - 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; and
 - c) Into the Mouth of Babies (IMB) program training (required before being permitted to receive reimbursement for IMB program).
 - vi. The PHP shall submit the Provider Training Plan to the Department as follows:
 - a) Upon award of the Contract;
 - b) When material changes are made to the Training Plan; and
 - c) Annually.

d. Provider Manual

- i. The PHP shall develop, maintain, and distribute a provider manual that offers information and education to providers about the PHP and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:
 - a) Clinical practice standards and Utilization Management Program;
 - b) Covered Services, Additional Benefits and Carved-out Services;
 - c) Provider responsibilities;
 - d) Primary care provider responsibilities;
 - e) Network requirements, including nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
 - f) Telemedicine;
 - g) Network adequacy and access standards;
 - h) Billing, claim editing, SNIP editing and clearinghouse requirements;
 - i) Cultural competency and accessibility requirements;
 - j) Authorization, utilization review, and care management requirements;
 - k) Care coordination and discharge planning requirements;
 - l) Department-required documentation requirements;
 - m) Provider appeals and grievance process;
 - n) Complaint or Grievance investigation and resolution procedures;
 - o) Notification of the availability of the Department's provider ombudsman service where a provider may submit a complaint about a PHP. The manual shall include instructions on how to submit the complaint;
 - p) Performance improvement procedures including Member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
 - q) Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
 - r) Interest and penalty provisions for late or under-payment by the PHP;
 - s) North Carolina Medicaid payer of last resort requirements;
 - t) Member rights and responsibilities;
 - u) Member cost sharing requirements; and
 - v) Provider program integrity requirements that address how to report suspected fraud, waste and abuse, and other federal and state requirements.
- ii. The PHP shall also include in the Provider Manual providers' obligations to:
 - a) Monitor and audit Provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
 - b) Monitor and report on provider preventable conditions;
 - c) Retain patient records for the mandated period;
 - d) Ensure that all documentation regarding services provided is timely, accurate, and complete;
 - e) Ensure PHP is the payer of last resort; and
 - f) To report and promptly return overpayments within sixty (60) days of identifying the overpayment.
- iii. The PHP shall include standardized language in the Provider Manual as requested by the Department.

- iv. The PHP shall submit provider manual to Department for approval thirty (30) days after Contract Award. The PHP shall not use or distribute the Provider Manual prior to approval by Department.
 - v. The PHP shall regularly review and update the provider manual to reflect changes to applicable federal and state laws, rules and regulations, Department or PHP policies, procedures, bulletins, guidelines or manuals, or PHP business processes as necessary.
 - vi. The PHP shall submit the provider manual to Department for approval within fifteen (15) days of making substantive updates or revisions.
 - vii. The PHP shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) days of notification or request by Department. Corrections or revisions to the printed version must be included in the next printing.
- e. Provider Survey
- i. The PHP shall conduct ongoing quality assurance of its Provider Relations staff via provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - a) Provider surveys shall be made available after each web, call center or in-person interaction;
 - b) Surveys and internal audits are intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness.
 - c) Reports, including the results of provider surveys and PHP's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.

4. Provider Payments

- a. Provider payment requirements are established to comply with state law, encourage continued provider participation in the Medicaid program to ensure Member access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of PHP steerage to other providers.
- b. The PHP shall assist the Department to comply with all federal laws, state laws, State Plans, Waivers, program integrity or audit requirements, investigations, findings or corrective action plans related to provider payments.
- c. The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.
- d. Physician and Physician Extender Payments
 - i. The PHP shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of the Medicaid Fee-for-Service rate for the service or bundle (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

- ii. The PHP shall reimburse all in-network physicians and physician extenders no less than one hundred percent (100%) of the Medicaid Fee-for-Service rate for obstetrics services, which includes an enhanced rate on all vaginal deliveries (equal to the Medicaid Fee-for-Service rate for caesarian deliveries) unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.
 - a) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.
 - iii. The PHP shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department as described pursuant to the contract.
 - iv. The PHP shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with N.C. Gen. Stat. § 58-50-26.
- e. Hospital Payments (Excluding Behavioral Health Claims)
- i. The PHP shall reimburse all in-network hospitals no less than the applicable Medicaid Fee-for-Service rate ("rate floor") for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(ii)(A)) and utilize the applicable Fee-for-Service payment methodology, unless the PHP and hospital have mutually agreed to an alternative reimbursement amount or methodology.
 - ii. The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee-for-Service reimbursement rate using the Medicaid Fee-for-Service case weights and outlier methodology.
 - iii. The applicable rate floor and methodology for outpatient hospital services, including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.
 - iv. The hospital rate floors shall apply for the following defined time periods, after which the PHP will have flexibility to negotiate reimbursement arrangements with the hospitals:
 - a) The first five (5) contract years for critical access hospitals and hospitals in economically depressed counties as defined by the Department.
 - b) The first three (3) contract years for all other hospitals.
 - v. The PHP shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in the Contract.
 - vi. The Department shall reimburse hospitals directly for any graduate medical education payments due under the State Plan (as allowed under 42 C.F.R. § 438.60).
 - vii. The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments.
- f. Hospital Payments for Behavioral Health Claims
- i. The PHP shall negotiate inpatient and outpatient hospital rates with hospitals for behavioral health claims to be defined by the Department.
- g. Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments
- i. The PHP shall reimburse FQHCs and RHCs for covered services at negotiated rates that are no less than rates to be defined by the Department and no less than rates paid to other providers for similar services in accordance with 1903(m)(2)(A)(ix) of the Social Security Act.
 - ii. The PHP shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs on a schedule to be defined by the Department. Data shall be separated between Medicaid and NC Health Choice beneficiaries.

- h. Indian Health Care Provider (IHCP) Payments
 - i. In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the PHP shall reimburse IHCPs as follows:
 - a) Those that are not enrolled as an FQHC, regardless of whether they participate in the PHP's network:
 - 1. The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - 2. The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.
 - b) Those that are enrolled as FQHCs, but do not participate in the PHP's network, an amount equal to the amount the PHP would pay a network FQHC that is not an IHCP.
 - ii. The PHP shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
- i. Local Health Department (LHD) Payments
 - i. The PHP shall reimburse in-network local health departments' enhanced role registered nurses providing EPSDT well child exams, STD exams, low-risk family planning, and obstetrical services according to the enhanced local health department Medicaid fee schedule (as allowed under 42 C.F.R. § 438.6(c)).
 - ii. For Contract Years 1-3, 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 as allowed under 42 C.F.R. § 438.6(c) or to change the methodology in Contract Year 2 or Contract Year 3.
 - iii. For Contract Years 1-3, 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 Year 2 or Contract Year 3.
 - iv. The PHP shall negotiate base reimbursement amounts to in-network LHDs that are no lower than rates paid to non-public providers for similar services.
 - v. In addition to base reimbursements, the PHP shall make additional, utilization-based, directed payments to in-network LHDs as defined by the Department and as outlined below in *9. Additional Directed Payments for Certain Providers*.
- j. Public Ambulance Provider Payments
 - i. The PHP shall negotiate base reimbursement amounts to in-network public ambulance providers no lower than rates paid to non-public providers for similar services.
 - ii. In addition to base reimbursements, the PHP shall make additional utilization-based payments to in-network public ambulance providers for Medicaid Members, only, (not NC Health Choice Members) as defined by the Department and as outlined below in *9. Additional Directed Payments for Certain Providers*.
 - iii. The PHP shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full, for NC Health Choice.

- k. State Owned and Operated Facilities Payments
 - i. The PHP shall reimburse facilities that are state-owned and operated by the Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).
 - ii. At such time that the PHP is required to cover services provided by Veterans Homes operated by the Department of Military and Veterans Affairs (DMVA), the PHP shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).
- l. Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))
 - i. The PHP shall make additional directed payments as determined by the Department, to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center.
 - ii. Additional directed payments will be prescribed by the Department and approved by CMS. Types of payments may include, but may not be limited to payment based on utilization of certain services multiplied by a Department-defined specific dollar amount or a percentage of the base payment.
 - iii. The PHP shall include the Department defined additional directed payments in its contracts with applicable providers.
 - iv. The PHP shall determine a due date for providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.
 - v. The PHP shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) calendar days of receiving the payment from the State.
 - vi. The PHP shall submit the data to substantiate additional directed payments to the Department and each applicable provider quarterly in a format to be defined by the Department.
 - vii. The Department shall reconcile the data to the PHP's encounter submissions. The PHP shall support the reconciliation process upon request from the Department.
 - viii. The PHP shall adhere to the directed payment service unit encounter requirements as described in *Section V. H. 2. Encounters*.
- m. Nursing Facility Payments
 - i. For a period of time to be defined by the Department, the PHP shall reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee-for-Service rate in effect six (6) months prior to the start of the capitation rating year (e.g., January 1 prior to a July 1 rating year), unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.
- n. Hospice Payments
 - i. The PHP shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:
 - a) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY)).
 - b) For hospice services provided to Members residing in nursing facilities, the PHP shall reimburse the hospice provider:
 - 1. Hospice rate, and

2. Ninety-five percent (95%) of the Medicaid nursing home Fee-for-Service room and board rate in effect at the time of service.
- o. Pharmacy Payments
 - i. The PHP shall adhere to the pharmacy claims payments requirements as described in *Section V. C. 3 Pharmacy Benefits*.
 - p. Advanced Medical Home Payments
 - i. In addition to the payment for services provided, the PHP shall pay AMH practices each of the following components:
 - a) Medical Home Fee (all Tiers);
 - b) Care Management Fee (Tiers 3 and 4 only); and
 - c) Performance Incentive Payments (required only for Tier 3 until such time the Department expands the required payment to other tiers).
 - ii. The PHP shall pay Medical Home Fees to AMH Tiers 1 – 3 practices no less than the following amounts (as allowed under 42 C.F.R. § 438.6(c)) for the first two contract years:
 - a) \$1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee-for-Service program);
 - b) \$2.50 PMPM for Members not in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program); and
 - c) \$5.00 PMPM for Members in the aged, blind and disabled eligibility category for Tier 2 and 3 practices (consistent with Carolina ACCESS II in the Medicaid Fee-for-Service program).
 - iii. The PHP shall pay Care Management Fees to Tier 3 practices that are negotiated between the PHP and Tier 3 practice and that adequately compensate Tier 3 practices for the additional care management responsibility assumed. The PHP shall not be required to contract with any particular entity as an Advanced Medical Home
 - iv. In Contract Years 1 and 2, the PHP shall pay Performance Incentive Payments to Tier 3 AMH practices, with the following requirements:
 - a) The PHP shall design Tier 3 Performance Incentive Payments to be in addition to Medical Home Fees (i.e., the PHP shall not place all or part of the Medical Home Fees at risk based on performance).
 - b) The PHP shall use the HCP LAN Levels 2 through 4 as a framework for the design of the Performance Incentive Payments for AMH Tier 3.
 - c) The PHP shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set, once finalized.
 - v. The PHP shall have flexibility to develop its own payments within AMH Tier 4.
 - q. Payment Limitations
 - i. The PHP shall not pay more for similar services rendered by any provider or subcontractor that is “related to” the PHP than the PHP pays to providers and subcontractors that are not related to the PHP.
 - a) For purposes of this subsection, “related to” means providers or subcontractors that have an indirect ownership interest or ownership or control interest in the PHP, an affiliate of the PHP, or the PHP’s management company/corporate parent as well as providers or subcontractors that the PHP, an affiliate of the PHP or the PHP’s management company/corporate parent has an indirect ownership interest, ownership or controlling interest in.

- b) The standards and criteria for determining indirect ownership interest, an ownership interest or a controlling interest are set out at 42 C.F.R. part 455, subpart B.
 - ii. Upon request by the Department, the PHP shall submit information on payments to related providers and subcontractors and provide a demonstration of how payment levels for related providers and subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are value-based payment arrangements in place.
- r. Out of Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)
 - i. With the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, the PHP shall be prohibited from reimbursing an out of network provider more than ninety percent (90%) of the Medicaid Fee-for-Service rate if:
 - a) The PHP has made a good faith effort to contract with a provider but the provider has refused that contract, or
 - b) The provider was excluded from the PHP's network for failure to meet Objective Quality Standards.
 - ii. The PHP shall develop Good Faith Provider Contracting Policy that includes a description of how the PHP will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions. The PHP shall submit the policy to the Department for review ninety (90) days after Contract Award.
 - a) The PHP shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.
 - b) The PHP should provide for a process so a provider may "cure" the issue identified in the Quality Determination. Upon cure, the parties may initiate a new "good faith" contracting effort.
 - iii. The PHP shall reimburse an out-of-network provider who is providing services to a Member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee-for-Service rate.
 - iv. The PHP shall reimburse an out-of-network provider who is not excluded for quality reasons or refused a "good faith" contract at one hundred percent (100%) of the Medicaid Fee-for-Service rate if an agreement is not negotiated.
 - v. The PHP shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee-for-Service rates specified in State Plan Amendments 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:
 - a) Are more reasonably available than can be provided by an enrolled in-state provider; or
 - b) The care and services are provided in any one of the following situations:
 1. In response to an Emergency Medical Condition;
 2. The health of the Member would be endangered if the care and services were postponed until the Member returns to North Carolina; or
 3. The health of the Member would be endangered if travel were undertaken to return to North Carolina.
 - vi. In accordance with 42 C.F.R. § 438.206(b)(5), the PHP shall coordinate payment with the out-of-network provider to ensure that the cost to the Member is no greater than it would be if services were provided within the network.

- s. Out of Network Emergency Services and Post-Stabilization Services Payments
 - i. In accordance with 42 C.F.R. § 438.114, the PHP shall be subject to the following requirements:
 - a) The PHP shall cover and pay for emergency services without regard to prior authorization or whether the provider that furnishes the service has a contract with the PHP.
 - b) The PHP shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the Member having been instructed by a representative of the PHP to seek emergency services.
 - c) Likewise, the PHP shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - d) The PHP shall provide coverage and payment of services until the attending emergency physician, or the provider actually treating the Member, determines that the Member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the Member, of when the Member is sufficiently stabilized for transfer or discharge is binding on the PHP.
 - ii. In accordance with SSA 1932(b)(2)(D), the PHP shall pay out-of-network providers who provide emergency services or post-stabilization services to a Member no more than the applicable Medicaid Fee-for-Service rates.
 - iii. The PHP shall reimburse out of state hospitals that are also out of network for emergency and post-stabilization care services according to the applicable Medicaid Fee-for-Service rates.
 - iv. In accordance with 42 C.F.R. § 422.113(c), the PHP shall be subject to following requirements:
 - a) The PHP shall be required to reimburse for out of network post-stabilization care services that are pre-approved by a PHP representative.
 - b) The PHP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain the Member's stabilized condition within one (1) hour of a request to the PHP for pre-approval of further post-stabilization care services.
 - c) Additionally, the PHP shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the Member's stabilized condition in the following instances:
 - 1. If the PHP cannot be contacted;
 - 2. If the PHP does not respond to request for pre-approval within one (1) hour;
 - 3. If the PHP representative and the treating physician cannot reach an agreement concerning the Member's care and a PHP physician is not available for consultation.
 - 4. If the PHP representative and treating physician cannot reach an agreement concerning the Member's care and a PHP physician is not available for consultation, the PHP shall give the treating physician the opportunity to consult with a PHP physician and the treating physician may continue with the care of the Member until the PHP physician is reached or one of the other post-stabilization care services criteria is met.
 - d) The PHP shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:
 - 1. Once a network physician with privileges at the treating hospital assumes responsibility for the Member's care;

2. Once a network physician assumes responsibility for the Member's care through transfer;
 3. Once a PHP representative and the treating physician reach an agreement regarding the Member's care; and
 4. Once the Member is discharged.
- e) The PHP shall limit charges to Members for post-stabilization care services to an amount no greater than what the PHP would charge the Member if he or she obtained the services through the PHP.
- t. Payments under Locum Tenens Arrangements
- i. The PHP shall recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 45 C.F.R. § 455.410(b).
 - ii. The PHP shall establish and maintain a Locum Tenens Policy to comply with the requirements of N.C. Gen. Stat. § 58-3-231(b) and (c) and shall submit the Policy to the Department for review ninety (90) days after Contract Award.
- u. The PHP shall develop and maintain a Reimbursement Policy consistent with N.C. Gen. Stat. § 58-3-227(a)(5). The PHP shall provide the Policy to the Department upon request, for review.

5. Provider Grievances and Appeals

- a. The PHP shall handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The PHP shall have in place a provider appeals and grievance system, distinct from that offered to Members, that includes a grievance process for providers to bring issues to the PHP, an appeals process for providers to challenge certain PHP decisions, and information regarding access to a state level review through the Office of Administrative hearings. The PHP shall be transparent with providers regarding its appeals and grievance processes and procedures.
- b. The PHP shall submit the PHP Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) days after Contract Award. The PHP shall submit any significant policy changes to the Department for review at least sixty (60) calendar days before implementing the changes.
- c. The PHP shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends, review existing operational or clinical opportunities to improve the provider experience.
- d. Grievances
 - i. The PHP shall have a process in place to receive and resolve complaints or disputes with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
 - ii. The PHP shall accept and resolve provider grievances regarding the PHP referred from the Department.
 - iii. The PHP shall have a method of allowing providers to submit grievances through the PHP provider portal.
 - iv. The PHP shall provide information regarding provider grievances to Department as outlined in *Attachment J. Reporting Requirements* and upon request.

- e. Appeals
 - i. The PHP shall offer providers appeal rights as described in *Attachment I. Provider Appeals*.
 - ii. The PHP shall provide written notice of provider's right to appeal with the notice of decision giving rise to the provider's right to appeal.
 - iii. The PHP shall have a method of allowing providers to submit appeals through the PHP provider portal.
 - iv. The PHP shall accept a written request for an appeal from the provider within thirty (30) calendar days on which:
 - a) Provider receives written notice from the PHP of the decision giving rise to the right to appeal; or
 - b) PHP should have taken a required action and failed to take such actions.
 - v. The PHP shall acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request.
 - vi. The PHP shall extend the timeframe by thirty (30) calendar days for providers to request an appeal for good-cause shown as determined by the PHP.
 - a) PHP shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an appeal request.
 - b) PHP shall include voluminous nature of required evidence/supporting documentation, and appeal of an adverse quality decision as good-cause reasons to extend the timeframe.
 - vii. The PHP shall provide information regarding provider appeals to Department upon request.
 - viii. The PHP Grievances and Appeals Policy shall provide that a provider must exhaust the PHP internal appeals process before seeking recourse under any other process permitted by contract or law.
- f. Resolution of Appeal
 - i. The PHP shall establish a committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal. The committee must include an external peer reviewer when the issue on appeal involves whether the provider met Objective Quality Standards.
 - ii. The PHP shall provide written notice of decision of the appeal within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the PHP. Notice shall include information regarding further appeal rights, if any.
 - iii. The PHP shall allow providers to be represented by an attorney during the appeals process.
- g. Appeals of Suspension or Withhold of Provider Payment
 - i. The PHP shall limit the issue on appeal in cases of suspension or withhold or provider payment to whether the PHP had good-cause to commence the withhold or suspension of provider payment. PHP shall not address whether the provider has or has not committed fraud or abuse.
 - ii. The PHP shall notify the Department within ten (10) business days of a suspension or withhold of provider payment.
 - iii. The PHP shall offer the provider an in person or telephone hearing when provider is appealing whether PHP has good cause to withhold or suspend payment to the provider.
 - iv. The PHP shall schedule the hearing and issue a written decision regarding whether PHP had good cause to suspend or withhold payment within fifteen (15) business days of

receiving the provider's appeal. Upon a finding that PHP did not have good-cause to suspend or withhold payment, PHP shall reinstate any payments that were withheld or suspended within five (5) business days.

- v. The PHP shall pay interest and penalties for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.
- h. Notice to Department
 - i. The PHP shall provide notice to the Department of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by PHP, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) business days of the appeal.
 - ii. The PHP shall notify Department if a provider has sued PHP in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) business days of being served.

E. Quality and Value

1. Quality Management and Quality Improvement

- a. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health.
- b. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department.
- c. As North Carolina transitions to Medicaid Managed Care, the Department will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes.
- d. The PHP shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations.
- e. The PHP shall have a robust Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan.
 - i. The Quality Management and Improvement Program Plan shall include the following elements:
 - a) Mechanisms to conduct and assess performance improvement projects (PIPs) specified by the Department;
 - b) Mechanisms to assess the quality and appropriateness of care for Members with special health care needs;
 - c) Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between

- settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;
- d) Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, and by key population group (e.g., LTSS);
 - e) Mechanisms to incorporate population health programs targeted to improve outcomes measures;
 - f) Mechanisms for collection and submission of all quality performance measurement data required by the Department;
 - g) Mechanisms to detect both underutilization and overutilization of services;
 - h) Mechanisms for participation in efforts by the Department to prevent, detect, and remediate critical incidents including those required for home and community-based waiver programs;
 - i) Mechanisms to assess and address health disparities at a statewide and regional level, including findings from the disparity report that PHPs are required to develop;
 - j) A Provider Support Plan (see additional details below in Section 11); and
 - k) The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy.
- ii. Quality Assessment and Performance Improvement Plan (QAPI) (42 C.F.R. § 438.330)
- a) The PHP shall submit an annual QAPI plan, delineating PHP's plans for performance improvement programs and other quality improvement efforts as part of the Quality Management and Improvement Program plan.
 - b) The PHP shall address any Department concerns regarding performance against quality measures directly through the QAPI plan, and, as applicable, build specific programs to improve quality performance into the QAPI plan.
 - c) The QAPI plan must include the following elements:
 1. Completion of performance improvement projects (PIPs) specified by the Department;
 2. Collection and submission of all quality performance measurement data required by the Department;
 3. Mechanisms to detect both underutilization and overutilization of services;
 4. Mechanisms to assess the quality and appropriateness of care for Members with special health care needs;
 5. Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan;
 6. Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS);
 7. Mechanisms to incorporate population health programs targeted to improve outcomes measures;
 8. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS services and programs;
 9. Mechanisms to assess and address health disparities, including findings from the disparity report that PHPs are required to develop; and
 10. The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy.

- f. The PHP shall participate in monthly PHP Quality Director Meetings.
- g. The PHP shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.
- h. The PHP shall modify their proposed process to evaluate the impact and effectiveness of its Quality Assessment and Performance Improvement program as part of each PHP's overall Quality Assessment and Performance Improvement program design as directed by the Department.
- i. Quality Measures
 - i. The PHP shall report, and will be held accountable for performance against, measures aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence.
 - ii. The PHP shall report a set of quality and administrative measures listed in *Attachment E. Required PHP Quality Metrics* that are meant to provide the Department with a complete picture of the PHP's processes and performance.
 - a) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the PHPs prior to launch and annually thereafter.
 - b) The PHP shall submit to the Department all data necessary for the Department to calculate the PHP's performance.
 - iii. The PHP shall incorporate Department identified "Priority Set" into the PHP's QAPI and quality improvement activities. Priority measures are indicated in *Attachment E. Required PHP Quality Metrics*. The "Priority Set" is a subset of the total measure set which will be finalized for PHP by Department prior to go-live. The Department reserves the right to change the priority measure indication.
 - iv. Beginning in Contract Year 3, the Department may implement withhold measures based on quality measures used to administer a PHP quality withhold/incentive program. A subset of the Priority Set may be included in the Withhold/Incentive Program. Priority measures that may be subject to future withholds are indicated **for reference only** in *Attachment E. Required PHP Quality Metrics*. The Department reserves the right to change priority measures that may be subject to future withholds.
 - v. The Department shall monitor for CMS development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.
- j. Disparities Reporting and Tracking
 - i. The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
 - a) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the PHP after Contract Award and annually thereafter.
 - ii. The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures.
 - a) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.

- k. Public Health Measure Reporting and Tracking
 - i. The PHP shall work with the Department to target areas of collaboration and develop programs as part of Quality Improvement efforts that can:
 - a) Remove barriers (e.g., benefit coverage, implementation challenges, Member education);
 - b) Align incentives by targeting withholds for measures that will affect public health priorities; and
 - c) Require select quality initiatives to be embedded in QAPIs, including PIPs and contributions to health-related resources.
 - ii. The PHP shall be an active partner in Healthy NC 2020 goals and 2030 <https://publichealth.nc.gov/hnc2020/> planning by participating at a minimum as follows:
 - a) Joining planning meetings;
 - b) Designating a senior level clinical staff person to engage in public health issue discussions; and
 - c) Aligning QI activities to support Health NC 2020 and 2030 goals.
- l. Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)
 - i. The PHP shall include no less than three (3) performance improvement projects as part of the annual Quality Assessment and Performance Improvement program. The PHP's PIPs must be approved by the Department annually as part of the PHP's QAPI program.
 - ii. The PHP shall develop a Performance Improvement Project (PIP) that is:
 - a) Designed to achieve significant improvement in health outcomes as part of the annual PHP Quality Assessment and Performance Improvement program review; and
 - b) Includes measurement of performance using quality indicators as part of the annual PHP Quality Assessment and Performance Improvement program review.
 - iii. Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
 - iv. The PHP shall conduct at least one (1) non-clinical Performance Improvement Project (PIP) on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
 - v. The PHP shall be required to develop and execute two (2) clinical performance improvement projects annually that must be related to the following areas:
 - a) Pregnancy Intendedness;
 - b) Tobacco Cessation;
 - c) Diabetes Prevention;
 - d) Birth outcomes;
 - e) Early childhood health and development;
 - f) Hypertension; and
 - g) Behavioral Health Integration.
 - vi. If the PHP performs below seventy-five percent (75%) for overall CMS 416 rates, the PHP shall submit one Performance Improvement Project on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical Performance Improvement Projects annually.
- m. External Quality Review (42 C.F.R. § 438.3(s)(1))
 - i. The PHP shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and communicated by the Department.

- ii. The PHP shall participate in the annual the Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS) and Provider Survey conducted by the EQRO.
- n. Quality Improvement - Provider Supports
- i. The PHP shall provide support to providers tailored to advance state interventions and ensure providers' ability to achieve the goals outlined in the Quality Strategy. The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.
 - ii. The PHP shall develop and maintain a PHP Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the PHP Provider Support Plan.
 - iii. The Provider Support Plan shall be developed as a component part of the QAPI and provider support activities should relate to improvement in specific health outcomes.
 - iv. The PHP Provider Support Plan shall include an overview of which metrics the PHP will use to evaluate its provider engagement progress over time based.
 - v. The PHP Provider Support Plan shall include:
 - a) The list of provider supports;
 - b) How the PHP will provide in-person, online, and regional collaborative support opportunities;
 - c) A detailed overview of how it will assess which stakeholders will be engaged for participation in Regional Forums (see below);
 - d) All planned technical support activities;
 - e) An overview of which metrics the PHP will use to evaluate its provider support progress over time; and
 - f) Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy.
 - vi. The PHP shall develop and distribute targeted toolkits to all network providers. The PHP shall be responsible for distributing toolkits related to quality improvement activities, population health management, and specific Department-led transformation initiatives for all network providers.
 - vii. The PHP shall provide access to online resources to all network providers.
 - viii. The PHP shall provide quality improvement support to network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
 - a) The opioid strategy interventions;
 - b) The Healthy Opportunity interventions;
 - c) The Advanced Medical Home program;
 - d) Behavioral Health integration;
 - e) Value-Based Payment;
 - f) Pregnancy management/Pregnancy Management Program;
 - g) Activities to support at-risk children; and
 - h) The CDC 6|18 initiative.
 - ix. The PHP shall meet with clinical leadership at the regional level at least quarterly to discuss implementation of quality improvement activities aligned with the Quality Strategy (e.g., disease management protocols, maternal and infant health, child health and wellness activities) and implementation of Department-led transformation initiatives (e.g., clinical protocols for high-risk pregnancy management). Clinical leadership should include active

- network providers (see list below), the PHP CMO and PHP Quality Director. The Department's quality staff and medical leadership should be invited participants.
- x. The PHP shall conduct at least one (1) in-person Regional Forum per year. The PHP shall work with the Department to coordinate forums with other PHPs in the Region.
 - a) The PHP shall deliver all Regional Forum services and Technical Assistance support activities at a regional level regardless of the number of Regions the PHP offers services in.
 - xi. The PHP shall provide the space for in person events and all technology necessary to conduct Regional Forums, including conference call and webinar technology.
 - xii. Invitees shall include:
 - a) Advanced Medical Homes/Primary Care Physicians;
 - b) Obstetric/Gynecological Providers;
 - c) Behavioral Health providers;
 - d) Local health Departments;
 - e) School-based health centers;
 - f) Hospitals;
 - g) Long-term services and support agencies;
 - h) Clinical Integrated Networks;
 - i) Local Department of Social Service (DSS); and
 - j) Other relevant stakeholders based on the agenda and goals of the Forum.
 - xiii. The PHP shall also provide an opportunity for providers (in-person, online, routine/ad-hoc) to raise local challenges and exchange best practices related to Quality and Population Health outcomes as outlined in the Quality Strategy and other Department transformation initiatives as part of Regional Forums.
 - xiv. The PHP shall communicate with the Department-designated primary contact in order to raise regional issues related to Quality and Population Health Outcomes as outlined in the Quality Strategy and as otherwise specified by the Department.

2. Value-Based Payments/Alternative Payment Models

- a. To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value, the Department is encouraging accelerated adoption of value-based payment (VBP) 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.
- b. The Department defines VBP arrangements as payment arrangements between PHPs and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>.
- c. The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures.
- d. PHPs shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision in moving toward value-based payment, including having systems that can support alternative payment arrangement models which require shared savings and/or risk-

sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.

- e. The PHP shall complete an APM assessment based on the categories developed by HCP-LAN within three (3) months of Contract Award. The Department will provide specifications on the assessment methodology upon Contract Award.
 - i. The Department shall use the APM assessment to demonstrate the “baseline” amount of payment arrangements with providers in HCP-LAN Levels 1 through 4 and compare documented progress to the PHP’s final APM Strategy on an annual basis.
 - ii. The PHP shall report the results of their APM assessment within six (6) months of Contract Award.
- f. To ensure the PHP’s response aligns with the Department’s strategy and goals, the PHP shall provide a description of the PHP’s Value Based Purchasing/Alternative Strategy over the initial three (3) year period and its alignment to the Department’s short- and long-term goals to shift from a fee-for-service system to VBP. The VBP/APM Strategy must be submitted within six (6) months Contract Award.
 - i. The PHP VBP/APM Strategy shall incorporate required incentive programs for AMHs. The PHP may develop additional Physician Incentive Plans provided that any such Physician Incentive Plans are related to the aims and goals set forth in the Department’s Quality Strategy and in compliance with the requirements set forth in 42 C.F.R. § 422.208 and 422.210.
- g. The Strategy shall also contain the following elements:
 - i. The results of the HCP-LAN APM assessment.
 - ii. The PHP’s goals, strategies and interventions for moving providers through higher levels of the HCP-LAN framework.
 - iii. The PHP’s strategy to align Medicaid Managed Care payment models with the PHP’s other payor contracts.
 - iv. The PHP’s annual targets for amount of funding in VBP/APM arrangements by year, including a description of the payment model(s), their HCP-LAN classification, and targets across different models and provider types.
 - v. The PHP’s plan for measurement of outcomes and ROI related to VBP/APM by year.
 - vi. Specific program(s) that will be offered to AMH Tier 3 practices, which must align to HCP-LAN Categories 2 through 4 and meet any other criteria specified within AMH program requirements.
 - vii. Specific program(s) that will be offered to other AMH providers and/or specialties.
 - viii. The PHP’s expected percent of total premium flowing to providers through shared savings and other incentive arrangements.
 - ix. A description of the PHP’s IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the PHPs VBP/APM programs. Specific functionalities to address include:
 - a) Risk adjustment;
 - b) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
 - c) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;

- d) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - e) Reporting capabilities; and
 - f) Payment functions.
- h. The PHP shall submit an updated VBP/APM Strategy to the Department on an annual basis that includes the following updates:
 - i. Updates to the HCP-LAN APM assessment;
 - ii. Progress towards the PHPs goals, strategies and interventions for moving providers through higher levels of the LAN framework;
 - iii. The PHP's progression over time, if applicable, in advancing providers through higher levels of the LAN framework.
 - iv. Progress toward the PHP's annual targets for amount of funding in VBP/APM arrangements by year;
 - v. Updates against all Physician Incentive Plans (as applicable); and
 - vi. Results of the PHP's outcome measurements and analysis of the ROI by year and to-date.
 - vii. Changes or improvements in the PHP's IT capabilities necessary for the successful implementation of the targeted VBP/APM arrangements.
- i. Additionally, the PHP shall participate in any VBP/APM stakeholder meeting process initiated by the Department. The PHP will be responsible for meeting any requirements outlined by a Departmental VBP/APM stakeholder group for future contract years.
- j. Starting in Contract Year 3, the Department may use PHP-submitted HCP-LAN assessments to implement withholds associated with VBP penetration.
- k. Physician Incentive Plans
 - i. The PHP is permitted to develop Physician Incentive Plans outside of the VBP and Pregnancy Management Program requirements and put forth by the Department, provided that any such physician incentive plans are related to the aims and goals set forth in the Quality Strategy.
 - ii. The PHP shall submit all Physician Incentive Plans as part of the PHP VBP/APM Strategy to the Department for review and approval prior to PHP implementation of such incentives.
 - iii. Any Physician Incentive Plans developed by PHPs shall be in compliance with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210, in which references to 'MA organization', 'CMS', and 'Medicare beneficiaries' must be read as references to 'PHP', 'the Department', and 'Medicaid beneficiaries', respectively.
 - iv. The PHP shall submit to the Department annual reports as part of the annual update to the VBP/APM strategy containing a detailed overview of any implemented (and previously approved) Physician Incentive Plans, or, if no such arrangement is in place, attest to that fact. Annual Physician Incentive Plan reports must provide assurance satisfactory to the Department that the requirements of 42 C.F.R. § 422.208 are met.
 - v. The PHP shall provide the following information to any Medicaid Member who requests it:
 - a) Whether the PHP uses a Physician Incentive Plan that affects the use of referral services;
 - b) The type of incentive arrangement; and
 - c) Whether stop-loss protection is provided.

F. Stakeholder Engagement

1. Engagement with Federally Recognized Tribes

- a. The PHP must have a strong understanding of and capability to meet the needs of federally recognized tribal members, including North Carolina's federally recognized tribe – the Eastern Band of Cherokee Indians (EBCI).
- b. As specified in Section 4. (5)e. of Session Law 2015-245, as amended by Session Law 2016-121, members of federally recognized tribes are exempt from mandatory enrollment in Medicaid Managed Care enabling them to choose enrollment in the Medicaid Fee-for-Service or Medicaid Managed Care at any time.
- c. The Department is collaborating with the EBCI to develop a Tribal Option that considers and addresses the unique cultural, behavioral health and medical needs of federally recognized tribal members.
- d. The PHP shall establish an ongoing partnership with the EBCI and other tribal populations that supports Members who are tribal members.
- e. For federally recognized tribal members that enroll in a PHP, the PHP will implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health care for the individual, family, or community members of federally recognized tribes. The Strategy should adapt individual engagement interventions, programs, and policies, demonstrate cultural humility, cultural awareness, respect and honor and fit the historical and cultural context of the individual, family, or community members of federally recognized tribes.
- f. The Tribal Engagement Strategy shall include:
 - i. A proposal of an administrative, clinical and operating model intended to meet the needs of federally recognized tribes and specifically in western NC;
 - ii. Culturally appropriate, proactive, innovative methods for engaging and communicating with EBCI tribal members and EBCI leadership;
 - iii. A proposal and strategy to improve communication through the utilization of a health information exchange in order to improve coordination of care and health outcomes for tribal members;
 - iv. A description of how the PHP's care management and quality strategies take into consideration the needs of tribal members;
 - v. Seamless integration with the ECBI, its local Public Health and Human Services (PHHS) staff, members of other federally recognized tribes residing in NC and other tribal populations native to North Carolina;
 - vi. Medicaid Managed Care education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may create barriers to health care, provider access and service delivery; and
 - vii. Approaches the PHP will take to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities.
- g. The Tribal Engagement Strategy shall be submitted to the Department for review and approval within ninety (90) days of Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.
- h. The PHP shall consult with the Indian Tribes and Tribal Organizations quarterly regarding implementation of the North Carolina Amended Section 1115 Demonstration Waiver initiatives impacting tribal populations.

- i. The PHP shall collaborate with the EBCI to facilitate, at least semi-annually, meetings and forums with the EBCI and IHCPs that serve tribal members.
- j. When requested, the PHP shall make member education and training material available to licensed and unlicensed physical and behavioral health personnel who work with federally recognized tribal members or their families.
- k. The PHP shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.
 - i. The PHP shall provide and maintain a point of contact for IHCP billing issues to the Department.
- l. The PHP shall ensure its staff, materials, and resources adhere to the requirements described in *Section V. B. 3. Member Engagement*.
- m. Annually, the PHP shall train their staff regarding the PHP's Tribal Engagement Strategy and in providing cultural sensitive and consumer-specific supports to the tribal population as referenced in *Section V. G. 2. Staff Training*.

2. Engagement with Community and County Organizations

- a. The PHP must have a strong understanding of and capability to meet the needs of North Carolina's local communities, including County Agencies (e.g., local health departments, local Department of Social Services, Area Agency on Aging, Local Education Agencies, housing authorities, county commissioners, county managers, etc.) and County and Community Based Organizations (e.g. faith-based organizations, food pantries) that deliver services to Members and their families.
- b. The PHP shall engage with County Agencies and County and Community Based Organizations (CBOs) to understand the potentially unique resources and needs of each community and to integrate its model of care with the local community it serves.
- c. The PHP shall establish an ongoing partnership with North Carolina County Agencies and CBOs that support North Carolina Medicaid and NC Health Choice Members, in the Region(s) that the PHP is contracted to cover.
- d. The PHP shall develop and implement a Local Community Collaboration Strategy that supports continued engagement with county and community organizations and build partnerships at the local level to improve health of their Members.
- e. The Local Community Collaboration Strategy shall address how the PHP will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, Member engagement, and local continuums of care.
 - i. The strategy shall include:
 - a) Approach to understand the unique needs of the counties and communities the PHP is serving;
 - b) Methods of collaborative outreach with county agencies, CBOs, community partners;
 - c) Measures of successful engagement and collaboration; and
 - d) Reporting of outcomes to county agencies, CBOs, and community partners.
- f. The Local Community Collaboration Strategy shall be submitted to the Department for review and approval within ninety (90) days of Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.

- g. The PHP shall consult with the county agencies, county executives and/or the county commissioners' association quarterly regarding implementation of the North Carolina Amended Section 1115 Demonstration Waiver initiatives impacting counties and community organizations.
- h. The PHP shall collaborate with the county agencies, county executives and/or the county associations to facilitate, at least semi-annually, meetings and forums with the county agencies, county executives and/or the county associations.

3. Integration with Other Department Partners

- a. The Department seeks a PHP with the ability to seamlessly integrate with key Medicaid Managed Care partners, including the Enrollment Broker, Ombudsman Program and local county DSS offices to support beneficiaries through the transition to and on-going implementation of Medicaid Managed Care. To achieve this goal, the PHP shall be required to do the following:
 - i. Engage in joint community based education events and activities with the staff of the Enrollment Broker and Ombudsman Program as requested by the Department, including but not limited to health fairs and community events.
 - ii. Provide information to the Enrollment Broker such that those interested in enrolling have adequate, written descriptions of the PHP's rules, procedures, benefits, services, and other information necessary for Members to make an informed decision about enrollment.
 - iii. Provide educational materials described in *Section V. B. 3. Member Engagement* in hard copy and electronic format for distribution to local DSS offices and to Members that may utilize the Ombudsman Program for assistance.
 - iv. Collaborate with the Ombudsman Program to facilitate issue resolution for Members navigating the Medicaid Managed Care delivery system.
 - v. Coordinate efforts with the Department, the Enrollment Broker and the Ombudsman Program to improve the Member experience by incorporating Member feedback into the PHP education campaign strategy by modifying, updating, removing, changing, or adding materials, call center scripts, website content, education materials, presentations, or other administrative or operational processes.
 - vi. Collaborate with county DSS offices, PHHS offices, community based and advocacy organizations and the Ombudsman Program to understand and incorporate the needs of Member into the PHP's Member education strategy.

G. Program Operations

1. Service Lines

- a. All service lines shall be staffed with personnel specifically trained on the requirements, policies and procedures of the North Carolina market and can resolve an inquiry or issue in "one-touch".
- b. The PHP shall establish the following service lines as part of its call center:
 - i. **Member Service Line:** To enable Members to conveniently access information about benefits or claims, referral assistance and access to treatment or services.
 - ii. **Provider Support Service Line:** To assist providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries and complaints
 - iii. **Pharmacy Service Line:** To assist pharmacies and prescribers with point of sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.

- iv. **Nurse Line:** To provide Members with around-the-clock access to medical information and advice on where to access care.
 - v. **Behavioral Health Crisis Line:** To provide Members with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year through a confidential, toll free number with immediate access to trained, skilled, licensed behavioral health professionals who provide assistance for any type of behavioral health distress the Member may be experiencing, and offers assistance in linking Members to supportive available community resources.
- c. The PHP shall adhere to the Department’s hours of operations, location, and staffing and Member ID requirements for each service line:

Section V.G. Table 1: Member and Provider Support Call Center Operations			
Service Line Name	Hours of operation	Required to be located in North Carolina	Include on Member ID card
i. Member Service Line	<ol style="list-style-type: none"> 1. Non-emergency Member issues: Monday – Saturday: 7AM – 6PM ET for Member questions and additional hours as required by the Department during times of expected high volume (e.g. managed care launch) 2. Emergency Member issues: open twenty-four (24) hours per day / seven (7) days per week 3. Open all State holidays 	Yes	Yes
ii. Provider Support Service Line	<ol style="list-style-type: none"> 1. Monday – Saturday: 7AM – 6PM ET 2. Open all State holidays 	Yes	Yes
iii. Pharmacy Service Line	<ol style="list-style-type: none"> 1. Monday – Saturday: 7AM – 6PM ET 2. Prescriber prior authorization services available to meet 24-hour review requirements as defined in <i>Section V. C. 3. Pharmacy Benefits</i> 3. Open all State holidays 	Yes	Yes
iv. Nurse Line	<ol style="list-style-type: none"> 1. Twenty-four (24) hours per day / seven (7) days per week / 365 days per year 	No	Yes
v. Behavioral Health Crisis Line	<ol style="list-style-type: none"> 1. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year 	Yes	Yes

- d. The PHP service lines shall be accessible via a toll-free telephone line.
- e. The PHP services lines shall have capacity to handle:
 - i. All inbound and outbound telephone calls during the hours of operation as defined in this Section;
 - ii. Calls from Members and providers, with Limited English Proficiency, as well as Members and providers with communications impairments, including individuals with hearing and/or speech disabilities;

- iii. Technology needed to receive calls from deaf, hard of hearing and Deaf-Blind callers to include TTY, Captioned phones and amplified phones;
 - iv. After-hours calls, including:
 - a) Accepting, recording or providing instruction in response to incoming calls during non-business hours;
 - b) Allowing option to leave a message and request for call back;
 - c) If a request for a call back is made, the return phone call shall be made the following business day during normal hours of operations; and
 - d) Department approval of the after-hours message.
 - v. An Automated Voice Response System (AVRS) which:
 - a) Interacts with the Member through voice and/or numeric prompts and allows Members to perform self-service activities and resolve simple inquiries without the need to interact with a live person;
 - b) May prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the Member prior to the call being distributed to a call center representative;
 - 1. The AVRS must have the capability of allowing non-enrolled Members and providers to access service line staff.
 - c) Offers user-friendly options that are easily understood by Medicaid beneficiaries and authorized representatives (including a decision tree illustrating AVRS system);
 - d) Works in conjunction with an Automated Call Distributor (ACD) which intelligently routes and effectively manages all calls to appropriate and available staff:
 - 1. When a Member desires to speak with a live person; and
 - 2. Based on unique Member needs i.e. caller language needs.
 - vi. Ensure adequate staffing and capacity to meet the service line performance standards defined in the Contract.
- f. The PHP shall be permitted to use overflow or secondary call centers to meet capacity requirements as defined in this Section. All call centers shall be held to the same service line performance standards as defined within the Contract.
 - g. The PHP shall be permitted to provide educational messages or other messages which improve the customer experience (e.g., announcement of new program changes or reminders) while callers are on hold, as directed or approved by the Department.
 - h. All PHP services lines shall be able to transfer calls via warm transfer to the Department's Fee-for-Service Provider and Medicaid call centers, Enrollment Broker, Ombudsman, county DSS or EBCI PHHS offices, and all participating PHPs or LME/MCOs when appropriate and without impacting the capacity to handle in-bound calls simultaneously.
 - i. The warm transfer is required only during the operational hours of the entities listed above in *Section V.G. Table 1: Member and Provider Support Call Center Operations*.
 - ii. If the service line is attempting to connect a Member to another entity that is closed, the PHP shall provide the information on how the caller may contact the entity directly during their operating hours.
 - i. All PHP services lines shall be able to transfer calls via warm transfer to all other PHP service lines, when appropriate.
 - j. The PHP shall digitally record and store one hundred percent (100%) of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months.

- k. The PHP shall allow the Department real time remote access via secure internet connection to all call recordings, including video and audio, with the Department having ownership and control of these recordings.
- l. The PHP shall ensure the service lines are staffed with professionals who have sufficient training and knowledge on North Carolina Medicaid and NC Health Choice as defined within this Contract.
- m. The PHP shall acquire the necessary phone number(s) to support the requirements of this Section within sixty (60) calendar days of the Contract Award.
 - i. The PHP shall relinquish ownership of the toll-free number(s) upon contract termination or expiration, at which time the Department shall take title of these telephone numbers.
 - ii. All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the PHP and shall be paid prior to the Department taking title.
- n. The PHP shall develop service line scripts for use by PHP staff when talking with Members, authorized representatives, and providers.
 - i. All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies and procedures of the North Carolina market.
 - ii. The PHP shall submit to the Department for approval a listing of topics which scripts will address, and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
 - a) Member Medicaid Managed Care resources, education and assistance to understand Medicaid and NC Health Choice benefits;
 - b) Provider contracting;
 - c) AMH certification;
 - d) Provider claim submission and adjudication issues;
 - e) Service prior authorization process and status;
 - f) Member pharmacy lock-in program;
 - g) Information to contact the Enrollment broker;
 - h) Member grievance and appeal process, including information on Member supports available; and
 - i) Other topics as identified by the Department.
 - iii. All service line scripts shall be made available to the Department upon request, and all Member Service Line, Nurse Line, and Behavioral Health Crisis Line scripts shall be approved by the Department prior to use or when significant changes are made.
- o. The PHP shall track all call center interactions with Members, authorized representative and providers. The record of contact must include:
 - i. Member/potential Member's name;
 - ii. Medicaid or NC Health Choice identification number (preferred);
 - iii. Channel of interaction;
 - iv. Demographics, including, but not limited to
 - a) Phone number and
 - b) Emergency or alternative number if needed;
 - v. Notes summary of Member/potential Member interaction (e.g. summary of issue, if issue was resolved or addressed, what information was provided by the PHP's representative);
 - vi. Record of the time and date of interaction;
 - vii. Contact agent;
 - viii. Resolution and/or if additional follow-up is or was required; and
 - ix. Interpreter requests and the language requested;

- p. The PHP shall develop and maintain a Call Center and Service Line Policy that defines how the PHP will meet and maintain the requirements of the Contract. The Policy shall be made available to the Department, upon request.
 - i. The Policy shall include at a minimum:
 - a) Service line process flows and call-tree routing options;
 - b) Service line script topics;
 - c) Staffing and licensure requirements;
 - d) Quality assurance and monitoring approach;
 - e) Provider and Member issue tracking and resolution process; and
 - f) Incorporation of provider and Member issues into broader PHP quality improvement.
- q. Member Service Line:
 - i. Emergency Member issues shall be defined as a Member having an Emergency Medical Condition or in need of emergency services.
 - ii. The Member services line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined in *Section V. B. 3. Member Engagement*.
 - iii. The PHP Member Service Line must be able to connect to the PHP Behavioral Health Crisis Line via a warm transfer twenty-four (24) hours per day, seven (7) days per week.
- r. The Nurse Line shall integrate with the PHP's overall care management program.
 - i. Within forty-eight (48) hours of a Member call, the Nurse Line shall follow up with the Member's care manager to share relevant clinical and follow up information.
- s. Pharmacy Service line:
 - i. The Service Line Policy shall include standards to meet twenty-four (24) hour prior authorization requirement as defined in *Section V. C. 3. Pharmacy Benefits*.
- t. Behavioral Health Crisis Line:
 - i. The PHP Behavioral Health Crisis Line must be staffed with licensed BH professionals.
 - ii. The PHP Behavioral Health Crisis Line must immediately connect to the crisis response systems.
 - iii. The PHP Behavioral Health Crisis Line must have patch capabilities to 911 emergency services.
 - iv. The PHP Behavioral Health Crisis Line must not:
 - a) Allow Members to receive a busy signal in order to meet the minimum performance requirements;
 - b) Allow Member calls to be answered by an automated response;
 - c) Allow Members to leave messages and receive a call back;
 - d) Shift calls to an overflow system during high volume call times; or
 - e) Allow Maximum call duration limits.

2. Staff Training

- a. The PHP shall meet the Department's goals and objectives of providing support and services to meet Member and provider needs by training and educating PHP staff members and contractors on the requirements, policies and procedures of Medicaid Managed Care and the unique needs of Medicaid Managed Care Members.
- b. The PHP shall ensure that staff and contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under this

contract. Staff members having contact with Members or providers, or with the Department or the county Departments of Social Services staff shall receive training regarding the appropriate identification and handling of questions and concerns.

- c. The PHP shall train new staff to the North Carolina Medicaid Program within seven (7) calendar days of their start date.
- d. The training program shall include distinct training for:
 - i. Member services staff and contractors;
 - ii. Provider relations staff and contractors;
 - iii. Staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators; and
 - iv. Staff and contractors whose work integrates with the Department.
- e. The PHP shall be responsible for ensuring training directed toward Member Services staff and contractors include, but are not limited to:
 - i. Overall understanding of Medicaid Managed Care, including program eligibility, benefits, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
 - ii. Services which the PHP is required to make available to all Members;
 - iii. Awareness of all supports and services that enhance the Member experience;
 - iv. Awareness of stakeholders who may interact with Members;
 - v. Member rights and responsibilities;
 - vi. Member grievance and appeals process, including State Fair Hearing Process;
 - vii. The PHP's provider networks;
 - viii. Overcoming barriers to accessing medical care;
 - ix. Understanding the role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to Members' health and health care needs;
 - x. Awareness of other Medicaid Managed Care and Medicaid Fee-for-Service programs and services for distinct populations, including individuals with military service or who are pregnant;
 - xi. Linking Members to other state and local programs or assistance, including but not limited to social services, state-funding behavioral health services, law enforcement and the criminal justice system.
 - xii. Fraud, waste, and abuse detection, investigation, and prevention;
 - xiii. Process for offering suggestions to improve the Member or provider experience;
 - xiv. Awareness of and sensitivity to low-income families, individuals with disabilities, people who do not fluently speak or read English, or individuals with varying levels of reading comprehension or illiteracy;
 - xv. Ability to communicate appropriately with bilingual individuals or those with special needs. Use of bilingual interpreters, sign language interpreters both in person and through video remote interpreting, Relay Video Conference Captioning, video relay service, 711 relay services, TTY machines, or assistive communication devices;
 - xvi. Awareness of benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI;
 - xvii. Sensitivity to different cultures and beliefs;
 - xviii. Understanding of generational, experiential and other preferences to receiving information;

- h. The PHP shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the Department includes topics identified for all other training programs.
- i. Submission and Approval
 - i. No later than fifteen (15) calendar days after Contract Award, the PHP shall submit a training and evaluation program to the Department.
 - a) The training program shall comply with all state and federal provisions, and should utilize Department resources where available.
 - b) Each training program shall be approved by the Department before use with PHP staff and contractors.
 - c) The PHP shall initiate training within five (5) calendar of approval by the Department.
 - ii. Training materials include, but are not limited to:
 - a) Training Policies and Procedures;
 - b) Training Plan;
 - c) Training Curriculum; and
 - d) Evaluation Methodology.
 - iii. The PHP shall update the training materials and conduct training of its staff and contractors annually, as changes are made to Medicaid Managed Care, in response to improving the Member experience, improving the provider experience, improving staff and contractor performance, or as requested by the Department.
 - a) The PHP shall submit all updates and changes to the Department for review and approval before use with PHP staff and contractors.
- j. The PHP must collaborate with the Department on providing training to Department, county DSS staff, the EBCI, the Ombudsman program and Enrollment Broker.
 - i. Training must:
 - a) Be completed at least sixty (60) calendar days prior to the Managed Care Phase 1 open enrollment period;
 - b) Be hosted at multiple locations as defined by the Department;
 - c) Contain information on the role of the PHP;
 - d) Describe the relationship and integration of the PHP with the Department, Enrollment Broker, county DSS staff, the EBCI PHHS, and the Ombudsman program; and
 - e) Describe how to navigate the public facing websites.
 - ii. Materials for the training must be provided to the Department no later than thirty (30) days prior to scheduled events for review, if necessary.

3. Reporting

- a. The PHP shall comply with all the reporting requirements established by the Contract.
- b. The Department shall provide the PHP with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in *Attachment J. Reporting Requirements*.
- c. The Department may, at its discretion, change the content, format or frequency of reports or require the PHP to submit additional reports both ad hoc and recurring.
 - i. If the Department requests any revisions to the reports already submitted, the PHP shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.

- d. The PHP shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.
- e. The PHP shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.
- f. Except as otherwise specified, all reports shall be specific to each Region covered by this Contract.

4. PHP Policies

- a. The PHP shall develop policy documents outlining key business process, procedures and staffing requirements as required in this Contract.
- b. The policy document shall include:
 - i. Outline processes and procedures;
 - ii. Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
 - iii. Define required PHP and Department systems; and
 - iv. Describe PHP's continuous improvement approach to update policies.
- c. All required PHP policies are outlined in the Contract. The PHP shall submit policy documents to the Department for review and approval as defined in the Contract.
- d. After initial approval, the PHP shall submit any material modifications, additions, or deletions of all policies to the Department at least thirty (30) calendar days prior to implementation.

5. Business Continuity

- a. The PHP shall develop and maintain a Business Continuity Plan this is acceptable to the Department, and demonstrate the adequacy of the Plan at the Department's request. The PHP shall adhere to all applicable published Department Privacy and Security policies, (located at <https://it.nc.gov/documents/statewide-information-security-manual> and <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>) and all other requirements set forth in the Contract.
- b. Within thirty (30) calendar days of the Contract Award, the PHP shall submit a detailed description of its Business Continuity Plan for all requirements specified in the Contract. See *Attachment N. Business Continuity Management Program*. The PHP shall demonstrate how it will restore call center operations and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) calendar days following a natural or manmade disaster. The Plan shall meet recognized industry standards for security and disaster recovery requirements. The Plan shall identify disaster situations (e.g., fire, flood, terrorist event, hurricanes/tornadoes), which could result in a major failure. For each identified situation, the PHP shall explain in detail:
 - i. The preventive measures that would be instituted to minimize the likelihood of its occurrence;
 - ii. The back-up, off-site storage, and other pre-disaster safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
 - a) Descriptions of the controls for back-up processing, including how frequently back-ups occur;
 - b) Documented back-up procedures;
 - c) The location of data that has been backed up (off-site and on-site, as applicable);
 - d) Identification and description of what is being backed up as part of the back-up plan;

- e) Any change in back-up procedures in relation to the PHP's technology changes;
 - f) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and
 - g) The same safety and data security measures need to be in place as for normal operations.
- iii. Identify and review all federal or state disaster declarations made in North Carolina or affecting North Carolina in the last five (5) years as part of the PHP's business continuity planning;
 - iv. The tasks that would be involved, and identify by job description or title the PHP's staff and the Department's staff involvement;
 - v. The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans;
 - vi. The time-frame required to accomplish full recovery from the point of interruption;
 - vii. The procedures for coordinating with the Department in the event of a disaster; and
 - viii. The procedures for notifying the Department, Enrollment Broker, Members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.
- c. As part of the Business Continuity Plan, the PHP shall submit Business Continuity Plan(s) for any/all call center(s) for the Department's review and approval within thirty (30) calendar days of the Contract Award and be updated at least every six (6) months thereafter.
 - d. The PHP shall notify the Department each time the Business Continuity Plan is activated within two (2) hours of an event.
 - e. The Plan shall, at a minimum, include an overflow telephone system to operate in the event of line trouble or other problems so that access to the call center by telephone is not disrupted.
 - i. The overflow system must interface with the call tracking and recording standards and technology required in the Contract.
 - ii. All quality and performance standards required in this Contract shall apply to the overflow call center.

H. Claims and Encounter Management

1. Claims

- a. In order to incentivize successful Medicaid Managed Care and increase provider participation, the PHP shall pay all providers on a timely basis upon receipt of any clean medical and pharmacy claims for covered services rendered to covered Members who are enrolled with the PHP in accordance with state and federal statutes.
- b. Incorrect claim payment or inappropriate claim denial result in increased administrative costs to both the provider and the PHP and by extension, increase the program costs of Medicaid Managed Care. Therefore, the PHP shall develop, maintain and operate a claims payment, review and program integrity process which minimizes incorrect claim payments and inappropriate claim denials.
- c. Claims Processing and Reprocessing Standards
 - i. The PHP shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when the Department decisions are made that would

- warrant reprocessing (i.e. Member retrospective eligibility determinations or plan enrollment changes).
- ii. In addition to processing claims for all Medicaid Managed Care covered services, the PHP shall have the operational and administrative capability to process ILOS, Value-Added services, and qualifying EPSDT services which may be otherwise non-covered.
 - iii. The PHP shall process and reimburse providers in accordance with the Department's prompt payment standards, regardless of Provider contracting status.
 - a) Prior to paying a claim, the PHP shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of Provider contracting status.
 - b) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid and NC Health Choice programs, are subject to an out of state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.
 - iv. The PHP shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:
 - a) The PHP shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.
 - b) The PHP shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the contract, and be of sufficient capacity to expand as needed to accommodate Member enrollment or program changes.
 - c) The PHP shall capture and retain the IP address/location and the login/user name for all claims submitted.
 - v. In instances where a provider submits an adjustment to a previously adjudicated claim, the PHP shall adjudicate the adjusted claim within the same timeframes as required for the initial Clean Claim.
 - vi. The PHP shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.
- d. Prompt Payment Standards
- i. The PHP shall promptly pay Clean Claims, regardless of provider contracting status. The PHP shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.
 - a) Medical Claims
 1. The PHP shall, within eighteen (18) calendar days of receiving a Medical Claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.
 2. The PHP 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.
 - b) Pharmacy Claims
 1. The PHP shall within fourteen (14) calendar days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the claim.
 2. A Pharmacy Pended Claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.

- c) 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 PHP may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).
 - ii. The PHP shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
 - iii. Pursuant to N.C. Gen. Stat. § 58-3-225(f), the PHP may require that claims be submitted within one hundred eighty (180) calendar days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) calendar days after the date of the Member's discharge from the facility. However, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.
 - iv. Interest and Penalties
 - a) The PHP shall pay interest on late payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.
 - b) In addition to the interest on late payments required by this Section, the PHP shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.
 - c) The PHP shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).
 - v. The PHP shall maintain written or electronic records of its activities under this Section in accordance with N.C. Gen. Stat. § 58-3-225(i).
- e. The PHP shall comply with the Department's Tribal Payment Policy, to be provided by the Department upon Contract Award.
- f. Overpayment or Underpayment Recovery
 - i. The PHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the PHP for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. 42 C.F.R. § 438.608(a)(2).
 - ii. In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with N.C. Gen. Stat. § 58-3-225(h).
 - iii. The PHP shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
- g. System Standards
 - i. The PHP shall have a Claims Processing and Management Information System (MIS) capable of meeting Medicaid Managed Care requirements and maintaining compliance throughout the term of the Contract.
 - ii. The PHP shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a Member.

- h. Mass Adjustment
 - i. The PHP shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
 - ii. The PHP shall comply with the Department's policies and procedures on mass adjustment.

2. Encounters

- a. The Department collects and uses medical, behavioral health, and pharmacy service encounter data for many purposes including, but not limited to, Federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.
- b. The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with Medicaid Managed Care.
- c. Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, penalties paid or recovered, incentive payments paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated services, third party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the PHP, its delegees or subcontractors.
- d. Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPPA rejection and not a denied claim or claim line.
- e. Submission Standards and Frequency
 - i. The PHP shall ensure that all HIPAA transactions adhere to the Department Encounter Submission Companion Guide and Encounter Data Manual developed by the Department or its vendor(s) to be provided at Contract Award.
 - ii. The PHP shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
 - iii. The PHP shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Submission Companion Guide and Encounter Data Manual.
 - iv. Encounter data submissions must contain adjustments made by PHP due to payment errors and/or provider adjusted claims.
 - v. The PHP shall submit a monthly certification from the PHP Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
 - vi. The PHP is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
 - vii. Specifications
 - a) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Submission Companion Guide and Encounter Data Manual.

- b) Encounters are defined in two (2) groups:
 - 1. Medical, including ILOS, value added services and ECM pilot services
 - 2. Pharmacy, including outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.
 - c) The PHP shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
 - 1. The PHP shall have the capability to submit to the Department encounter data from:
 - i. Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
 - ii. Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
 - d) The PHP shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.
 - e) The PHP, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.
 - f) The PHP shall reference the same edit codes as the Department's system, which are defined in the Department Encounter Submission Companion Guide, and Encounter Data Manual.
- viii. The PHP shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the PHP submitted an encounter data file.
- ix. Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
- a) Timeliness
 - 1. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) calendar days from the claim adjudication date.
 - 2. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) calendar days from the claim adjudication date.
 - b) Completeness
 - 1. PHP encounter data submissions shall meet or exceed a monthly data acceptance rate of ninety-eight percent (98%).
 - 2. Encounter data completeness shall be measured as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
 - c) Accuracy
 - 1. PHP encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
 - 2. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.

- x. Initial Encounter Data at Medicaid Managed Care Launch
 - a) The PHP shall include encounter data for medical claims which have a date of service on or after the Medicaid Managed Care Launch date on which the PHP becomes responsible for the administration of services.
 - b) The PHP shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the PHP becomes responsible for the administration of services.
 - xi. To support the Department achieving efficient encounter data processing, the PHP shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.
 - xii. In the event the PHP enters into a sub-capitated or other Value Based Payment reimbursement arrangement with a provider, the PHP shall be responsible for submitting all encounters to the Department, containing all the required data fields.
 - xiii. The PHP shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding fifteen thousand (15,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.
 - xiv. The PHP shall work with the Department on ad hoc encounter submissions when needed.
- f. Encounter Data Resubmission Standards
- i. Following the Department's validation and processing of encounter data submissions, the PHP shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.
 - ii. The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial Date of Service.
 - a) The PHP shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
 - b) The Department will work with a PHP for any retroactive encounter denial longer than three (3) years after the initial Date of Service.
 - iii. Timeliness
 - a) The PHP will receive notification of medical encounter data errors requiring correction and resubmission within thirty (30) calendar days of the PHP's initial medical encounter data submission date.
 - 1. PHP shall, where the PHP submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) business days following the date that the negative 999 response is generated.
 - 2. PHP shall, where PHP submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) business days following the date that the negative 999 response is generated.
 - b) Within thirty (30) days after a pharmacy encounter fails NCPDP edits, X12 (EDI) edits or NC MMIS system edits, the PHP or its subcontractor shall correct and resubmit each pharmacy encounter for which errors can be remedied.
 - iv. Completeness
 - a) PHP shall address medical encounter data errors by remediating ninety percent (90%) of reported medical encounter errors within thirty (30) calendar days and

- remediating one hundred percent (100%) of reported medical encounter errors within ninety (90) calendar days from the initial encounter submission date.
- b) The PHP or its subcontractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP pharmacy encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.
- v. Accuracy. Unless otherwise directed by the Department, the PHP shall correct and successfully resubmit:
- a) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) calendar days from the date the 277 was generated;
 - b) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) calendar days from the date the 277 was generated;
 - c) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) calendar days from the date the 277 was generated.
- g. Data Validation and Processing
- i. The PHP shall have the capability to access sufficient enrollment information to perform Member and service provider matching on all claim and/or encounter transactions, if necessary.
 - ii. The Department shall utilize data validation protocols on encounter data files to assess PHP encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).
 - iii. The PHP shall perform testing with the Department prior to system changes when medical or pharmacy clinical policy changes that may impact operational transactions (i.e. encounter submissions) are identified by PHP or by Department. The PHP shall not implement any system changes until testing is approved by the Department.
 - iv. The PHP shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.
 - v. The PHP shall, in instances where the PHP is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) days prior to the date the modified file will be submitted to the Department production environment.
 - vi. The PHP shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.
 - vii. At the discretion of the Department, the PHP may be prohibited from submitting a specific encounter type to the Department's production Encounter Processing Systems if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the PHP. In addition, if the PHP loses its access to the Production encounter processing system, the PHP must actively test with the Department until such a time that the compliance or

critical errors are remediated. Successful testing that would allow Production access to be restored is expected to occur within thirty (30) calendar days. Any penalties incurred by the PHP because of the loss of production access are the responsibility of the PHP.

- h. Denied Claims Submitted as Encounters
 - i. The PHP shall submit denied claims as encounters to support denial trend analysis.
 - ii. PHP submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
 - iii. On denied claims submitted as encounters, the PHP shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
 - iv. Denied claims submitted as encounters must also include the same data content, including provider, Member and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
 - v. The PHP shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction or the Department designated pharmacy encounter format.
- i. Communication and Oversight
 - i. If the PHP experiences a technical issue preventing encounter data submission, the PHP shall notify the Department via the approved communication method within the predefined timeline.
 - ii. The PHP shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the PHP's system(s) or process(es) that prevents the PHP from submitting encounter data files as scheduled.
 - iii. The PHP shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
 - iv. The PHP shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.
- j. Testing
 - i. The PHP will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the PHP to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The PHP shall pass the testing phase for all encounter claim type submissions at a time specified by the Department
 - ii. The PHP shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Submission Companion Guide and Encounter Data Manual.
- k. In the event of Contract Termination or Non-renewal, the PHP shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) calendar days following the Contract Termination Effective Date for adjudicated claims with the Date of Service (DOS) on or before the Contract Termination or Non-renewal effective date.
- l. In instances where the Contract has been terminated for greater than ninety (90) calendar days from the contract termination effective date, the PHP shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

I. Financial Requirements

1. Capitation Payments

- a. Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of PHPs. Capitation payments include risk-adjusted Monthly Per Member Per Month payments, maternity event payments and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFP. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Draft Rate Book.
- b. The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates. More information on both rate setting and risk adjustment can be found in *Section IX. Draft Rate Book*. Further details will be provided after Contract Award.
- c. The Department shall set PHP capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.
- d. The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.
- e. The PHP shall supply, certify, and validate data to support rate setting, risk adjustment, and qualified directed payments based on schedules to be provided by the Department after Contract Award.
- f. The Department shall update the PHP risk adjustment factors applied to capitation rates based on changes in monthly enrollment for Contract Year 1. In subsequent years, the Department shall update the PHP risk adjustment factors on a frequency no more than monthly and no less than every six (6) months.
- g. The Department has established a separate maternity event payment. This payment will be made to the PHP after the PHP submits required documentation of a successful delivery event to the Department. The required documentation and process for submission will be finalized prior to Contract Year 1 effective date, and annually thereafter, and included in an Amendment.
- h. The Department will reimburse PHP for additional directed payments to providers as required under *Section V. D. 4. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The PHP is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The PHP shall provide the necessary data to support this process in a format and frequency to be defined by the Department.
- i. The Department will make capitation payments in accordance in with the Payment and Reimbursement term in *Section III. D. 32. PAYMENT AND REIMBURSEMENT*.

2. Medical Loss Ratio

- a. The Medical Loss Ratio standards are to ensure the PHP is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.
- b. The PHP shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two bases as follows:
 - i. The PHP shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8.
 - ii. The numerator of the PHP's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the PHP's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
 - iii. The denominator of the PHP's CMS-defined MLR for a MLR reporting year shall equal the PHP's adjusted premium revenue. The adjusted premium revenue shall be defined as the PHP's premium revenue minus the PHP's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
 - iv. The PHP shall calculate the Department-defined MLR experienced 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 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.
 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), 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 payments to providers shall be subtracted from the denominator along with any associated taxes and fees.
- c. The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
 - i. The PHP's classification of activities that improve health care quality shall be subject to Department review and approval.

- ii. The PHP shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
 - a) Interest or penalty payments to providers for failure to meet prompt payment standards;
 - b) Rebates paid to the Department if the PHP exceeds the minimum MLR threshold for a prior year;
 - c) Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the PHP exceeds the minimum MLR threshold for a prior year; and
 - 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.
 - iii. The PHP shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
 - iv. The PHP shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 Member months in a MLR reporting year.
 - v. Payments related to the Enhanced Case Management Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
 - vi. The PHP shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.
- d. If the PHP's Department-defined MLR is less than the minimum MLR threshold, the PHP shall do one of the following:
- i. Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
 - ii. Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V. 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. Allocate a portion of the total obligation to contributions to health-related resources and the remaining portion to a rebate to the Department, with amounts for each at the discretion of the PHP.
- e. The minimum MLR threshold in aggregate across all contracted PHPs shall be exactly eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49. To recognize MLR variability across rate cells, the minimum MLR threshold for the PHP shall be calculated based on the capitation revenue mix of the PHP, by taking the revenue weighted average of each of the Department-calculated factors below based on the total capitation payments made for the rating year for each payment category.
- f. The PHP must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports. 42 C.F.R. § 438.8(n).
- g. The PHP shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PHP within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the

PHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. 42 C.F.R. § 438.8(k)(3).

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

3. Financial Management

- a. The Department's financial management requirements were developed to monitor and promote program sustainability. The Department expects, and will rely upon, the PHP to be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve Member health. The Department will pay the PHP a capitation payment that is set in an actuarially sound manner. The PHP is expected to manage PHP expenditures within the capitation payments and have access to sufficient capital to cover any losses the PHP experiences.
- b. The PHP shall closely track and report their expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor PHP expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.
- c. Managing and Monitoring Cost Growth
 - i. The PHP shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
 - ii. Pursuant to Section 5.(6)a. of Session Law 2015-245, risk-adjusted cost growth for the PHP's Members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."
 - iii. The Department shall monitor annual cost growth of PHP expenditures by region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
 - iv. The PHP shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.
- d. Pharmacy Savings
 - i. Section 5.(6)b. of Session Law 2015-245, as amended by Session Law 2016-121, requires that PHP spending for prescribed drugs, net of rebates, ensures the Department realizes a net savings for the spending on prescription drugs. To ensure net savings, the Department shall monitor PHP compliance with the Department's Preferred Drug List and compliance with pharmacy claims encounter reporting.
 - ii. The PHP shall provide reports as requested, and in a format prescribed, by the Department to demonstrate net pharmacy savings.
- e. Reinsurance
 - i. The PHP shall have and maintain at all times an adequate plan for protection against insolvency pursuant to N.C. Gen. Stat. § 58-93-50. Any arrangement proposed by the PHP is subject to review and approval by NC DOI. The PHP shall provide the Department with

- the most currently approved plan, including amendments, upon request. The PHP shall inform the Department when a previously approved plan is revised.
- ii. The PHP shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify PHP of any required changes to the proposed reinsurance arrangement or alternative mechanism. The PHP shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.
 - iii. The PHP shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. This requirement may be met by providing copies of documentation submitted to the Commissioner of Insurance pursuant to N.C. Gen. Stat. §§ 58-93-50 and 58-93-55. The Department may require additional protections and documentation at any time.
 - iv. The Department reserves the right to revisit reinsurance requirements annually and to modify the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that such a change in the threshold is deemed warranted by the Department.
 - v. The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a PHP or its reinsurer within forty-five (45) calendar days of the request by the PHP.
 - vi. The PHP shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the PHP or the reinsurance carrier, the PHP shall be fully responsible for all pending and unpaid claims.
 - vii. Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include Medicaid Managed Care Members as a covered class.
 - viii. The PHP shall notify the Department when the PHP incurs a claim against the reinsurance policy.
- f. Financial Viability
- i. The PHP shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. (Current assets include any short-term investments that can be converted to cash within five (5) business days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%).
 - ii. The PHP shall maintain a Defensive Interval Ratio above thirty (30) calendar days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as Cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period measured in days.
 - iii. The PHP shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.
 - iv. The Department reserves the right to impose enrollment caps on the PHP based on the PHP's financial position.

J. Compliance

1. Compliance Program

- a. The PHP shall implement a comprehensive Compliance Program focused on ensuring the PHP is in compliance with all applicable federal and state laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.
- b. The PHP's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include:
 - i. Written policies, procedures, and standards of conduct that articulate the PHP's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:
 - a) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Medicaid Managed Care program, including termination of the provider agreement with the PHP. 42 C.F.R. § 438.608(a)(4)
 - b) Retention policies for the treatment of recoveries of all overpayments from the PHP to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i).
 - c) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the PHP is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii).
 - d) Reporting to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. 42 C.F.R. § 438.608(c)(3).
 - e) Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5).
 - f) Process for providers to report and promptly return overpayments within sixty (60) days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2).
 - ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors.
 - iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the PHP's Compliance Program and its compliance with the requirements under the Contract.
 - iv. A system for training and education for the Compliance Officer, the PHP's senior management, and the PHP's employees on the federal and state standards and requirements under the Contract.
 - v. Effective lines of communication between the Compliance Officer and the PHP's employees.
 - vi. Enforcement of standards through well-publicized disciplinary guidelines.
 - vii. Identification of potential and actual compliance risks.
 - viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as

identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

- c. The PHP shall develop a Compliance Plan which defines the PHP's Compliance Program.
 - i. The PHP shall provide the Compliance Plan to the Department:
 - a) As part of the Implementation Plan, during Readiness Review;
 - b) Annually thereafter; and
 - c) Upon request by the Department.
 - ii. The PHP shall revise the PHP's Compliance Plan as requested by the Department.
 - iii. The PHP shall submit any requested document within five (5) calendar days of the Department's request to review the PHP's Compliance Plan, and any other policy or procedures governing the PHP's compliance activities.
 - iv. Annually, the PHP shall develop monitoring and auditing work plan(s) for the upcoming year.
 - a) The PHP shall submit a Compliance Program report describing the workplans for the upcoming year.
 - b) In Contract Year 1, the report shall be submitted ninety (90) days prior to Phase 1 of Medicaid Managed Care.
 - c) Following Contract Year 1, the Compliance Program report shall include proposed workplan(s) for the upcoming year and summarize of the status of the previous year's work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.

2. Program Integrity

- a. To ensure the effective use and management of public resources in the delivery of services to Medicaid Managed Care Members, the PHP shall also increase awareness within its organization and across its provider network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the PHP shall comply with all applicable federal and state laws and regulations including, but not limited to Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.
- b. To promote Program Integrity, the PHP shall adhere to the following program standards, at a minimum:
 - i. Validation of Exclusion List Status
 - a) The PHP shall, prior to contracting, check the exclusion status of all contracted providers against the following lists (collectively, these lists are referred to as the "Exclusion Lists") to ensure that the PHP does not pay federal funds to excluded persons or entities:
 1. State Exclusion List;
 2. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
 3. The System of Award Management (SAM);
 4. The Social Security Administration Death Master File (SSADMF);
 5. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
 6. Office of Foreign Assets Control (OFAC).

- b) The PHP shall disclose to the Department within thirty (30) calendar days of PHP's knowledge any disciplinary actions that have been imposed on any licensed physician, physician assistant, nurse practitioner or psychologist or their governing body related to fraud, waste, or abuse as defined within the Contract.
 - c) The PHP shall check, at least every month, the exclusion status of persons with an ownership or controlling interest in the PHP, agents and managing employees of the PHP, network providers, delegated entities, and subcontractors against the Exclusion Lists to ensure that the PHP does not pay federal funds to excluded persons or entities. The PHP shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).
 - d) The PHP shall take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
 - e) The PHP shall report to the Department within two (2) business days of identification of an Excluded Person the following information:
 - 1. The name(s) of the Excluded Person(s);
 - 2. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
 - 3. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.
- ii. Prohibited Relationships
- a) In accordance with 42 C.F.R. § 438.610, the PHP shall not knowingly have a relationship with any of the following:
 - 1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
 - 2. An individual or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person.
 - 3. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
 - 4. For the purposes of this Section, a "relationship" means any of the following:
 - i. A director, officer, or partner of the PHP;
 - ii. A subcontractor of the PHP, as governed by 42 C.F.R. § 438.230;
 - iii. A person with beneficial ownership of five percent (5%) or more of the PHP's equity; or
 - iv. A network provider or person with an employment, consulting or other arrangement with the PHP for the provision of items and services that are significant and material to the PHP's obligations under this Contract.
 - b) If the Department learns that the PHP has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the PHP has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the PHP unless

the Secretary of HHS directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the PHP unless the Secretary of HHS provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

iii. Deficit Reduction Act Reporting

- a) The PHP shall have a policy and procedure which complies with the requirements of the Deficit Reduction Act (DRA) of 2005, which requires entities that make or receive annual Medicaid payments of five million (\$5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
- b) The PHP shall submit annually to the Department, in the format prescribed by the Department, policies and procedures in accordance with the Deficit Reduction Act.
- c) Providers and Subcontractors
 1. The PHP shall require network providers and subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the Deficit Reduction Act of 2005 requirements.
 2. The PHP shall provide its network providers and subcontractors with training materials regarding fraud, waste, and abuse prevention.
 3. The PHP shall annually certify that no payments are made for services or items provided to a provider, subcontractor, or financial institution located outside of the United States.
 4. In accordance with federal regulations, the PHP shall require network providers and non-contract providers to have and implement a policy recognizing Medicaid as the payer of last resort.

iv. Suspensions and Withholds for Payments to Providers for Program Integrity

- a) The PHP shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold.
- b) The PHP shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold.
- c) When the Department notifies the PHP that payments to a provider have been suspended or are being withheld, the PHP shall suspend payments to or withhold payments from the provider in accordance with the Department's instructions within one (1) business day of receipt of the notice or as otherwise instructed. The PHP shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
- d) The PHP shall commence a payment suspension or withhold in accordance with the Department's instructions and such suspension or withhold shall continue until the PHP receives notice from the Department to lift the suspension or withhold.
- e) The PHP shall lift the suspension or withhold within three (3) business days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
- f) The PHP shall obtain the Department's written approval of the suspension prior to suspending payments to any provider due to suspected fraud or abuse. The PHP

shall initiate such suspension within two (2) business days of receipt of the approval if the Department approve the suspension of payment.

- g) The PHP shall provide the following information to the Department to request a suspension or withhold of payment to a network provider or non-contract provider:
 - 1. Name of the network provider or non-contract provider and NPI;
 - 2. The nature of the suspected fraud;
 - 3. Basis for the suspension/withhold;
 - 4. Desired date for the suspension/withhold to begin;
 - 5. Proposed length of the suspension/withhold;
 - 6. Proposed percentage of the withhold, if applicable; and
 - 7. If applicable, the good cause rationale for imposing a partial payment suspension.
- h) The PHP shall be permitted to immediately stop payment to providers in the case of credible fraud, waste, or abuse.

v. Prohibited Payments

- a) The PHP shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
 - 1. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
 - 2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
 - 3. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
 - 4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
 - 5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.
- vi. The PHP shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services (U.S. DHHS), the Inspector General of the US DHHS, the Comptroller General, and Members a description of transactions between the PHP and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
 - a) Any sale or exchange, or leasing of any property between the PHP and such a party;
 - b) Any furnishing for consideration of goods, services (including management services), or facilities between the PHP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
 - c) Any lending of money or other extension of credit between the PHP and such a party. Section 1903(m)(4)(A) of the Social Security Act.

- c. Coordination of Provider Monitoring and Auditing
 - i. The PHP may conduct an audit of a provider or accept a self-disclosure from a provider even when the Department or MID conducted an audit of the same provider or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period with prior permission from the Department.
 - ii. The PHP shall comply with any Department directive not to conduct an audit of a provider.

3. Fraud, Waste, and Abuse Prevention

- a. To promote integrity in all PHP activities and combat fraud, waste, and abuse, the PHP shall:
 - i. Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (Members, providers, subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid Managed Care;
 - ii. Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits;
 - iii. Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
 - iv. Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
 - v. Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
 - vi. Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;
 - vii. Refer all credible allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department;
 - viii. Define the quality and data integrity standards maintained by the PHP to produce accurate clinical quality metrics and reporting to the Department; and
 - ix. Have an identified individual(s) testify to the potential financial loss due to fraud, waste, and abuse upon request by the Department.
- b. Fraud, Waste, and Abuse Investigation Staffing
 - i. The PHP shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the PHP in preventing and detecting fraud and abuse.
 - ii. The PHP shall establish a Special Investigations Unit (SIU) sixty (60) calendar days prior to Phase 1 of Medicaid Managed Care, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan. The PHP shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.
 - a) The SIU will consist of at least one (1) dedicated staff member who is located in North Carolina.
 - b) The PHP's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
 - c) The PHP shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics,

government/public administration, auditing, security management or pre-law, or have at least three (3) years of relevant experience.

- d) The PHP shall require that the members of its SIU, as well as its Chief Compliance Officer, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training.

c. Investigation Coordination

- i. The PHP shall refer credible allegations of fraud, including instances involving the PHP's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) days of making the credibility determination.
- ii. Once a credible allegation of fraud has been referred to the Department, until further written notice by the Department, the PHP shall not take any further action including the following:
 - a) Contacting the subject of the investigation about any matters related to the investigation;
 - b) Continuing the investigation into the matter;
 - c) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
 - d) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- iii. The PHP shall cooperate with all appropriate state and federal agencies, including MID and/or federal OIG, in investigating fraud and abuse.
- iv. The PHP shall provide data or information requested by the Department or MID in the standardized form within five (5) calendar days of receiving the request.
- v. The PHP shall cooperate with the Department and MID to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.
- vi. If the PHP is directed to complete the investigation into potential instances of fraud, then the PHP shall report to Department and MID, in a specified format, its finding within ten (10) calendar days of the conclusion of the investigation.
- vii. The PHP shall report new information related to a previously referred potential instance of fraud where PI and MID did not intervene in the investigation to the Department. The PHP shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) days of receiving or identifying the new information.
- viii. The PHP cannot take action, such as termination or suspension, or withhold of payment, related to potential findings of fraud, waste or abuse without approval of the Department and/or MID. Any such action taken after PHP has received approval by the Department must be reported to the Department within five (5) days of taking the action.
- ix. Action by the PHP shall not preclude the Department or MID from conducting an audit or accepting a self-disclosure from a provider even if the PHP has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.
- x. The PHP must participate in:
 - a) Monthly calls with the Department regarding fraud, waste, and abuse;
 - b) Quarterly in person meetings with the Department and MID regarding fraud and abuse; and
 - c) Ad hoc calls or meetings as requested by the Department and MID.

d. Whistleblower Protections

- i. The PHP shall develop and maintain a Whistleblower Policy related to whistleblower protections and submit to the Department for review ninety (90) days after Contract Award.
- ii. The PHP shall include fraud, waste, and abuse policies and procedure information in the PHP's employee handbook with reference to and description of the applicable federal and state fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the PHP's compliance policies and how to access those policies.

e. Fraud Prevention Plan

- i. The PHP shall develop and maintain a Fraud Prevention Plan subject to Department review and approval. The PHP shall submit the Plan to the Department:
 - a) Ninety (90) days after Contract Award;
 - b) Annually thereafter; and
 - c) Upon request by the Department.
- ii. The PHP shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the PHP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the PHP's Fraud Prevention Plan.
- iii. The Fraud Prevention Plan shall include the following:
 - a) The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2;
 - b) Name of the Chief Compliance Officer;
 1. The Chief Compliance Officer shall be responsible for making the decisions on which fraud, waste, or abuse cases to refer to the Department.
 - c) Description of the Special Investigations Unit (SIU), the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care;
 - d) Description of other staff assigned to fraud, waste, and abuse functions;
 - e) Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
 - f) Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
 - g) Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
 - h) Processes and procedures for in-network provider and PHP staff terminations related to suspected or confirmed fraud and abuse;
 - i) Processes and procedures by which the PHP avoids fraud, waste and abuse engaged in by out-of-network providers;
 - j) Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by Members;
 - k) Training procedures for directors, officers, employee, delegated entities, and subcontractor education on federal and state laws, as well as PHP practices for detection, identification, reporting and prevention of fraud, waste and abuse;
 - l) Processes and procedures for ensuring in and out of network providers and Members know and understand fraud, waste and abuse obligations;
 - m) Processes and procedures for putting a provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating

whether prepayment review continues to be appropriate. The Policy shall be included in the PHP's provider manual;

- n) Description of the PHP's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
 - 1. A list of automated pre-payment claims edits;
 - 2. A list of automated post-payment claims edits;
 - 3. A list of desk audits on post-processing review of claims planned;
 - 4. A list of reports on network provider and non-contract provider profiling used to aid program and payment integrity review;
 - 5. The methods the PHP will use to identify high-risk claims and the PHP's definition of "high-risk claims";
 - 6. Visit verification procedures and practices, including sample sizes and targeted providers types or locations;
 - 7. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
 - 8. Policies and procedures used by the PHP designed to prevent, detect, and report known or suspected fraud, waste and abuse;
 - 9. A list of references in provider and Member material regarding fraud and abuse referrals (e.g. on Member EOB);
 - 10. Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly; and
 - 11. The process by which the Special Investigations Unit (SIU) shall monitor the PHP's marketing representative activities to ensure that the PHP does not engage in inappropriate activities, such as provision of inducements.
- o) Assurance that the identities of individuals reporting violations by the PHP are protected and that there is no retaliation against such persons;
- p) Description of criminal background and exclusion screening processes for its owners, agents, delegated entities, employees, network providers and subcontractors; and
- q) Process and procedures for working and coordinating with the Department, including its state and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.

4. Third Party Liability (TPL)

- a. The PHP shall be responsible for actively seeking and identifying third party resources for the purposes of the following:
 - i. Cost avoidance;
 - ii. Credit balance;
 - iii. Commercial health insurance;
 - iv. Medicare disallowance;
 - v. Casualty insurance; and
 - vi. Liability insurance.
- b. Cost Avoidance
 - i. The PHP shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
 - a) Policy number;
 - b) Policyholder's name;

- c) Group Policy number;
 - d) Group Policy name;
 - e) Identification of whether the policyholder is the non-custodial parent;
 - f) Member Medicaid/NC Health Choice ID;
 - g) Member relationship to policy holder;
 - h) The begin date of insurance coverage; and
 - i) The end date of insurance coverage.
- c. The PHP shall engage in third party resource recovery and cost avoidance for all other types of recovery.
- d. The PHP shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the Member becoming Medicaid eligible or was enrolled with the PHP.
- e. The PHP shall report cost recovery and cost adjustments through the encounter process, including denials.
- f. The PHP shall make every reasonable effort to determine the liability of third parties to pay for services rendered to Members and to cost avoid and/or cost recover such liability from the third party.
- g. The PHP shall treat all funds recovered by the PHP from third party resources as income to the PHP.
- h. TPL Recovery
- i. The PHP shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
 - ii. The PHP shall open a new case upon receipt of a Third-Party Liability Accident Information Report form from the Member's attorney or other reliable leads that indicate third party recovery might be possible.
 - iii. The PHP shall be responsible for attorneys retained for tort action, through contact with the Members, participating providers, and the Department for seeking and identifying third party resources.
 - iv. The Department shall review the effectiveness of the PHP's TPL recovery programs annually and may revoke TPL activities from an PHP if the PHP's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the PHP's TPL Recovery programs may include:
 - a) A comparison to annual Fee-for-Service recovery averages to PHP recovery averages per beneficiary.
 - b) The percentage of recoveries over total spend.
 - c) The percentage of cost avoidance over total spend.
 - d) The average turnaround time from the remittance to recovery.
 - e) The average number of policy adds in comparison to historical Fee-for-Service Policy adds on a monthly basis.
 - f) Quarterly audits on PHP encounter data.
 - v. The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.
- i. Identification of Other Forms of Insurance
- i. The PHP shall notify the Department within five (5) calendar days if it has identified that a Member has another form of insurance.

- ii. The PHP shall load and submit to the Department updates and additions on other forms of insurance into its system within thirty (30) calendar days of matching and verification.
 - iii. The PHP shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been updated in the PHP's system or submitted by the PHP to the Department for Medicaid Managed Care Members.
 - iv. The PHP shall ensure that the information on other forms of insurance accurately tracked and maintained within the Member record. The PHP must correct all errors made in its submission of other forms of insurance to the Department within five (5) business days of notification by the Department and must provide proof of such corrections upon request from the Department.
 - v. The PHP shall review paid claims to determine which paid claims should have been paid by the Member's other forms of insurance instead of by the PHP.
 - vi. The PHP shall notify the Department of overpayments paid to the PHP from an insurance carrier for recovery claims billed by the PHP for Members with other forms of coverage.
 - vii. The PHP shall bill the applicable insurance carriers for Medicaid Managed Care Members' major medical, prescription drug and dental claims within thirty (30) calendar days of matching the claims to TPL segments pertaining to Members' active insurance policies for commercial insurance direct billing.
 - a) The PHP shall adhere to the billing requirements of each commercial insurance carrier.
 - b) In instances where the carrier will not accept the claim without supporting medical records, the PHP shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) calendar days of becoming aware of the need for medical records for commercial insurance direct billing.
 - viii. Within ten (10) business days after receipt of a direct claim billing denial or other types of denials, the PHP shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the PHP's IT system; and resubmit the claim to the appropriate insurance carrier.
- j. Subrogation Cases
- i. Pursuant to 42 C.F.R. § 438.608, the PHP agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
 - ii. The PHP lien in each subrogation case shall be equal to the payments made by the PHP.
 - iii. The PHP shall identify the PHP paid medical claims amounts for each subrogation case using data from the paid claims file.
 - iv. Relevant information in the subrogation case at the time of closure shall include:
 - a) Settlement sheet listing all providers with medical subrogation rights.
 - b) Original lien amount of each entity with subrogation right.
 - c) The PHP recovered amount.
 - d) The amount disbursed to each entity involved.
 - v. The PHP shall review the diagnosis code and Member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
 - vi. A subrogation case shall be closed with recovery after the PHP lien has been satisfied to the statutory limits, as referenced in N.C. Gen. Stat. § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery only after the PHP provides relevant and adequate documentation

supporting the reason for case closure without recovery. The PHP shall obtain and record all relevant information in the subrogation case at the time of closure.

- vii. In accordance with N.C. Gen. Stat. § 108A-57(a1), the PHP shall collect the amount of the PHP lien or up to one-third (1/3) of the amount of the Member's gross recovery in the personal injury or wrongful death case, whichever is less.
 - viii. The PHP shall coordinate collection of the settlement amount with the Member or the Member's attorney.
 - ix. The PHP shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the PHP's claim to any part of the proceeds of any settlement.
 - x. The PHP shall not compromise, waive or reduce the PHP's lien without written authorization from the Department or its designated legal counsel.
 - xi. The PHP shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.
 - xii. The PHP shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.
- k. The PHP shall develop and maintain a TPL Policy for review and approval by the Department.
- i. The TPL Policy shall include the following:
 - a) Cost avoidance activities;
 - b) Payment recovery activities;
 - c) Identification of other forms of insurance processes and procedures; and
 - d) Subrogation, including:
 - 1. The analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify beneficiaries with a legal liable third party; and
 - 2. Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
 - ii. The PHP shall submit the TPL Policy:
 - 1. Ninety (90) days after Contract Award;
 - 2. Annually thereafter; and
 - 3. Upon request by the Department.

5. Recipient Explanation of Medical Benefit (REOMB)

- a. The PHP shall create the REOMB using the previous month's claims for North Carolina Medicaid and the previous month's paid claims (i.e. February claims comprise March REOMB sample).
- b. The PHP shall include the following in the REOMB:
 - i. List of services provided and billed to the PHP;
 - ii. The name of the provider administering the service;
 - iii. The date on which the service was administered;
 - iv. The paid and unpaid services; and
 - v. The reason a service was not paid.
- c. The PHP shall exclude those claims that include sensitive procedure information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB as defined by the Department. Sensitive procedure information shall be defined as any procedures for allergies,

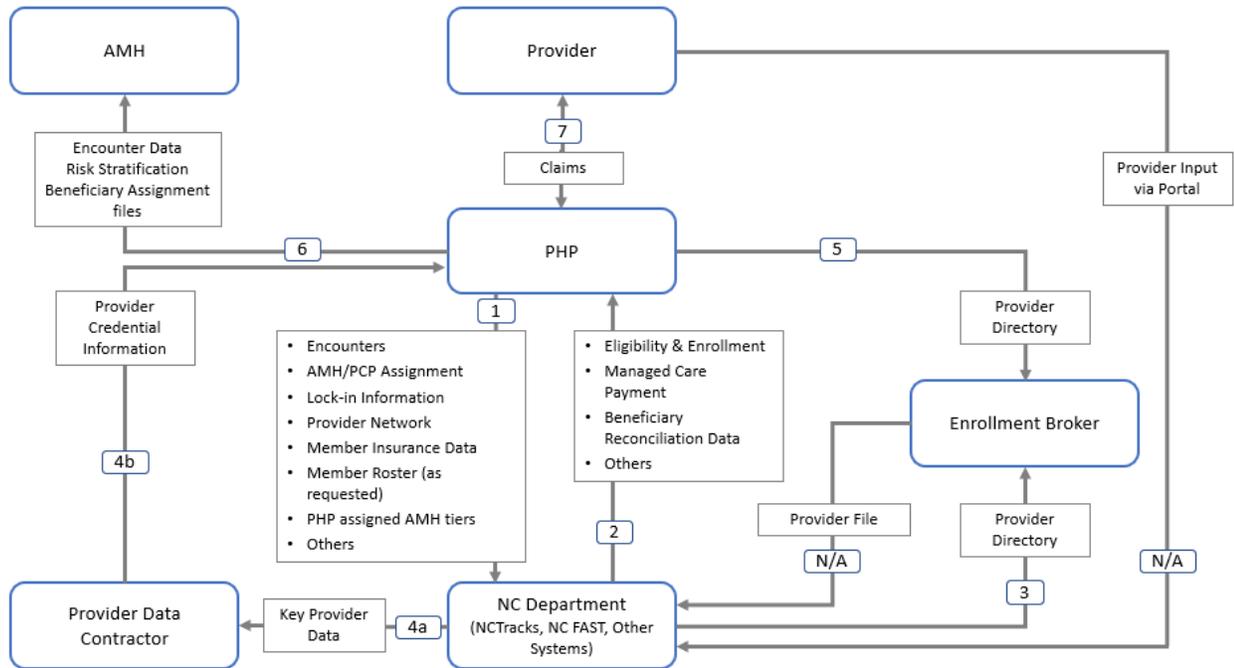
newborn treatment and care, and any treatment for a Member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, and sterilization.

- d. The PHP shall exclude sensitive procedure information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with NC Chapter 48A.
- e. The PHP shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month, whichever is less. (Excluded claims include those in referenced in this Section).
- f. The PHP shall send the REOMB via US mail to randomly selected Members that have been approved by the Department. The PHP shall collect responses from the REOMB mailing.
- g. The PHP shall use a Department approved sampling method to determine population for the REOMB and include it in the PHP's annual Fraud Prevention Plan.
- h. The PHP shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.
- i. The PHP shall provide ad hoc REOMB to a Member upon request.

K. Technical Specifications

1. Data Exchange Model

- a. The following diagram and accompanying matrix provides a point in time, high-level view of the primary data exchanges associated with the PHP, the Department, and Department Vendors. As the program evolves and technical designs are finalized the data exchanges depicted below will change. The PHP will be responsible for implementing the data exchanges as defined by the Department.
- b. The Department anticipates changes to its Information Technology Systems. The PHP will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file). The Department will provide test environments to allow adequate testing time.



No.	Data Exchange Description – For Informational Purposes
1.	<p>The PHP will send the Department or its Vendors the following data:</p> <ul style="list-style-type: none"> 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 e) Member Insurance Data f) Member Enrollment – On request the PHP will send the Department its current, complete roster of Medicaid Managed Care Members g) 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.	<p>The Department will send the PHP the following data:</p> <ul style="list-style-type: none"> 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
3.	<p>The Department will send the Enrollment Broker the following data:</p> <ul style="list-style-type: none"> a) Fee for Service Providers – The Department will send the Enrollment Broker its Fee-for-Service provider roster for inclusion in the Consolidated Provider Directory.

No.	Data Exchange Description – For Informational Purposes
4a.	The Department will send to its Provider Data Contractor (PDC) its roster of Managed Care Medicaid Providers on a daily basis. This will be a full file.
4b.	The PDC will add supplementary data to the Departments Provider data and make available to the PHP via a secure FTP site. This data is the Department’s Provider data to be used by the PHP for contracting and Provider reconciliation. This will be a full file.
5.	The PHP will send the Enrollment Broker the following data: a) All Contracted Medicaid Managed Care Providers – The PHP will send to the Enrollment Broker its directory of Medicaid Managed Care providers for inclusion in the Consolidated Provider Directory
6.	The PHP will send the following data to the AMH’s: a) Member Assignments b) Encounter / Claims Data c) Member Risk Stratification Data
7.	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. b) Payment Data – The PHP will send payments to the provider.

2. Electronic Data Submission

- a. Electronic Data Interchange (EDI) and Other Integrations
 - i. Integrations between the PHP, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.
 - ii. The PHP shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 142.308(d).
 - iii. If the PHP stores, transmits, or maintains data or information in an encrypted format, the PHP will, at the Department’s request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
 - iv. The PHP will work with the Department or its designated Vendor to establish and manage all integration.
 - v. Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the PHP’s ability to deliver Member services, it must be reported immediately. The PHP will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at

its discretion will track issues reported by the PHP and may require a more comprehensive corrective action plan if the Department identifies trends in the PHPs performance.

- b. Retransmissions
 - i. If the PHP receives an unintelligible transmission from the Department or Department vendor, the PHP will immediately notify the Department and the Department shall retransmit as soon as the errors are remediated.
 - ii. If the PHP is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the PHP shall retransmit as soon as the errors are remediated.
 - iii. For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.
- c. Test Data Transmission
 - i. The PHP will be required to test **all** data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for Member enrollment prior to Open Enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the PHP, or between the PHP and other Department vendors such as the Enrollment Broker or Provider Data Contractor. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.

3. Enrollment and Reconciliation

- a. Member Enrollment and Reconciliation
 - i. Enrollment:
 - a) The PHP shall accept an 834 eligibility file daily from the Department with new, modified, and terminated Member records.
 - b) The PHP shall add, modify, or terminate Members daily based on 834 eligibility file.
 - c) The PHP shall send a daily Pharmacy lock-in file to the Department, or entity designated by the Department.
 - ii. Reconciliation:
 - a) The Department will provide to the PHP a weekly 834 eligibility file, including all Members that were added, modified, and terminated for the period.
 - b) The PHP at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
 - c) At the Department's request, the PHP shall provide a full roster of Members currently enrolled in their PHP in the Department's preferred format within seventy-two (72) hours.
 - d) The PHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
 - e) The Department shall determine if corrections are needed to the enrollment data to address PHP discrepancies identified during reconciliation.
 - f) The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the PHP.

- g) The PHP shall add, modify, or terminate Members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
 - h) The PHP shall reconcile the monthly 820 payment file with the weekly 834 eligibility file.
 - i) The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
 - j) In addition to the reconciliation process defined above, the PHP shall be able to identify duplicate Members and report those findings to the Department in a format defined by the Department.
- b. Advanced Medical Home/Primary Care Physician Assignment and Reconciliation
- i. All AMH/PCP choices made by the Member at application will be transmitted to the PHP by the Department via an 834 transaction.
 - ii. If no choice is made by the Member, the PHP shall assign an AMH/PCP and transmit to the Department on a daily basis.
 - a) The file format and layout will be defined by the Department. It is anticipated this will be a daily batch transaction.
 - iii. The PHP shall reconcile AMH/PCP data with the Department at least monthly using the monthly 834 file described above.
 - iv. The PHP is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
 - v. The Department shall determine if corrections are needed to the AMH/PCP data to address PHP discrepancies identified during reconciliation.
 - vi. The PHP will provide to the Department any AMHs that the PHP moves to a Tier other than that attested to by the Provider and sent to the PHP by the Department.
- c. Provider Enrollment and Credentialing
- i. The Department or a designated vendor will provide to the PHP a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment and credentialing information.
 - a) During the Provider Credentialing Transition Period, the information will be provided on a daily basis, in a format and transmission protocol to be defined by the Department.
 - b) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the PHP a notice of change to the frequency and format not less than one-hundred and twenty (120) days prior to implementation.
 - ii. The PHP shall reconcile provider data with the Department, or designated vendor, at least monthly.
 - iii. The PHP is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
 - iv. The Department, or designated vendor, shall determine if corrections are needed to the provider data to address PHP discrepancies identified during reconciliation.

4. Provider Identification Numbers (NPIs, APIs)

- a. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the PHP must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the PHP.
- b. The Department produces a daily provider file that includes all active and terminated Medicaid Providers. The PHP is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.

5. Provider Directory

- a. The PHP shall develop a Provider Directory in accordance with *Section D. 2 Provider Network Management* and integrate provider directory information into the Enrollment Broker's Consolidated Provider Directory to support PHP choice counseling and selection.
- b. Consolidated Provider Directory Data Transmissions
 - i. The Department has included within the scope of its Enrollment Broker the creation of a Consolidated Provider Directory which will include all Managed Care and Medicaid Fee for Service providers.
 - ii. The PHP will, on all business days, create a full provider file including data (as defined in the Contract) on all contracted providers in their network. The PHP will deliver the file based on the Enrollment Brokers defined technical process.
 - iii. The final file format will be determined by the Enrollment Broker; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).
 - iv. The transport will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).
 - v. The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the selected Enrollment Broker.
 - vi. The PHP shall be provided with policies and process flows developed by the Enrollment Broker that defines the overall process.
 - vii. The Department has recommended that the Enrollment Broker leverage the open source tools developed by healthcare.gov in developing the Consolidated Provider Directory. The PHP should review this information as well as it will be the basis of the interface between the PHP and the Enrollment Broker. The documentation is available at <https://www.healthcare.gov/developers/>.

6. Technology Documents

- a. The PHP shall provide the following documents to the Department for review and approval thirty (30) calendar days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.
- b. Security Compliance Plan: The PHP shall provide a plan that details how the PHP will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the Plan shall be updated annually and resubmitted to the Department for review. The plan must include at a minimum:
 - i. Approach to customer and Member data protection including internal programs and policies;
 - ii. Approach to compliance with Federal, State, and Department standards including audit and oversight processes;

- iii. Approach to complying with HITECH and HIPAA;
 - iv. Approach to risk analysis and assessment associate with NIST;
 - v. Processes for monitoring for monitoring for security vulnerabilities including the use of external organization such as US CERT;
 - vi. Processes and plans for vulnerability and breach management including response processes; and
 - vii. Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).
- c. Encounter Implementation Approach. The PHP shall provide a plan that shows how the PHP will implement their encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
- i. Approach to meeting performance, accuracy, and timeliness requirements;
 - ii. Operating model including staffing and technology to process and submit encounters;
 - iii. Reference data management process including how the State’s reference data (if applicable) will be integrated into the encounter management process;
 - iv. Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
 - v. QA and Process improvement processes including how errors detected by the State’s Encounter Processing System are addressed by the Offeror, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Offeror’s processes; and
 - vi. The plan should include distinctions for medical and pharmacy encounter management.
- d. System Interface Design. The PHP shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
- i. Detailed design by interface showing the Offeror’s approach to meeting the requirements defined by the State;
 - ii. Approach to managing EDI transactions including technology;
 - iii. Technical integration architecture including the Offerors technical approach to integrating multiple internal systems with external partners;
 - iv. Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
 - v. Software and platform testing processes for new interfaces including the data management approach.

7. PHP Data Management and Health Information Systems

- a. The following Section contains high-level information on Health Information System and Member Data that will be established, maintained, analyzed, and reported by the PHP. Specific details on the data, analysis, and reporting will be provided upon Contract Award.
 - i. The PHP shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the PHP’s operations as well as satisfying the reporting requirements detailed in this RFP which may include but are not limited to

utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

- ii. The PHP shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act.
- iii. The PHP shall collect and maintain data on Member and Provider characteristics and interactions as specified by the state and on all services furnished to Members through a claims processing system or other methods as specified by the state.
- iv. All data, reports, and information submitted by the PHP on behalf of the Providers (including Providers within or outside of its networks) shall be validated by the PHP as accurate and complete prior to submission.
- v. The PHP shall collect data from Providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
- vi. The PHP shall make all collected data available to the Department and upon request to CMS.