Section VI. Contract Performance
Section VII. Attachments A.-R.
Section VIII. CFSP Data Book and Capitation Rate Methodology

VI. Contract Performance

A. Contract Compliance and Performance

1. The Contractor shall comply with all terms, conditions, requirements, performance standards, and applicable laws as set forth in the Contract or any amendments thereto, including any rules, policies, or procedures incorporated pursuant to the Contract.

2. The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity including but not limited to, remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the Contractor has violated any provision of the Contract, or if the Contractor does not comply with any other applicable North Carolina or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract, which shall include, but may not be limited to the following:
   a. Fails substantially to provide Medically Necessary covered services;
   b. Imposes on Members premiums or cost share that are in excess of the premiums or cost share permitted by the Department;
   c. Acts to discriminate among Members on the basis of their health status or need for health care services;[1]
   d. Misrepresents or falsifies information that it furnishes to CMS or to the State;
   e. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care provider;
   f. Fails to comply with the requirements for physician incentive plans as required by 42 C.F.R. §§ 422.208 and 422.210;
   g. Distributes directly, or indirectly through any agent or independent Contractor, Marketing Materials that have not been approved by the Department or that contain false or materially misleading information; or
   h. Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.

3. Risk Level Assignment
   a. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or any other noncompliance by the Contractor, the Department shall assign the violation into one of four risk levels:
      i. **Level 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or jeopardize the integrity of Medicaid Managed Care.
      ii. **Level 2:** Action(s) or inaction(s) that jeopardize the integrity of Medicaid Managed Care, but does not necessarily jeopardize Member(s) health, safety, and welfare or reduces access to care.
      iii. **Level 3:** Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid Managed Care.

[1] This includes termination of Enrollment or refusal to reenroll a Beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by Beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3).

iv. **Level 4:** Action(s) or inaction(s) that inhibit the efficient operation of Medicaid Managed Care.

b. The Department's decision to impose specific remedial action(s), intermediate sanction(s) and/or liquidated damages against the Contractor will include consideration of some or all of the following factors:
   i. Risk Level assignment;
   ii. The nature, severity, and duration of the violation;
   iii. The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, Program Integrity);
   iv. Whether the Violation resulted from negligent or willful conduct;
   v. Whether the violation (or one that is substantially similar) has previously occurred;
   vi. The timeliness in which the Contractor self-reports a violation;
   vii. The Contractor's history of compliance;
   viii. The good faith exercised by the Contractor in attempting to stay in compliance (including self-reporting by the Contractor); or
   ix. Any other factor the Department deems relevant based on the nature of the violation.
   x. The Department may impose additional remedial actions, intermediate sanctions, or liquidated damages and/or elevate the violation to a higher Risk Level if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.

c. Additional detail on risk level assignment is included in Section VII. Attachment J. Risk Level Matrix.

B. Notice of Deficiency

1. Except for the appointment of temporary management imposed pursuant to the Contract, prior to the imposition of any remedial action, intermediate sanction, or liquidated damages against the Contractor or termination of the Contract for cause, the Department shall provide the Contractor with written notice detailing the nature of the violation or noncompliance, the risk level assigned to the violation, any actions the Department seeks to impose against the Contractor, and, if applicable, the method and timeframes by which the Contractor may dispute the claim of noncompliance and the imposed actions.

2. Within three (3) Business Days of full remediation of the identified violation(s) in the Notice of Deficiency, or within another timeframe as requested by the Department, the Contractor shall provide the Department with written notice confirming the date that the noncompliant behavior was resolved and the actions the CFSP took to remediate the noncompliance.

C. Remedial Actions

1. **Remedial Actions**: Prior to the imposition of intermediate sanctions or liquidated damages or contemporaneously with, if the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may require the Contractor to take or to engage in the following actions to address identified violation(s) or other noncompliance:
   a. Immediate remediation of the violation or non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the violation or noncompliance;

b. Submission and implementation of a Corrective Action Plan; or
c. Participation in additional education or training.

2. Corrective Action Plans (CAPs):
   a. CAPs developed by the CFSP
      i. Following notification of the original violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the violation until an approved CAP is implemented.
      ii. Any CAP required to be submitted by the Contractor shall, at a minimum, identify the following:
         1) The finding resulting in a request for corrective action by the Department;
         2) A description of how the finding resulting in a request for corrective action will be remediated;
         3) The timeline for the implementation and completion of the corrective action(s); and
         4) The name of the responsible person(s) who will lead all corrective action activities.
      iii. Any CAP submitted by the Contractor shall be subject to approval by the Department.
      iv. The Contractor shall submit the CAP within fifteen (15) Calendar Days, or within a time determined by the Department depending on the nature of the violation, from the date on the written notice requesting the CAP.
      v. Upon receipt, the Department may accept the CAP as submitted, accept the CAP with specified modifications, or reject the CAP.
      vi. If the Department requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP within ten (10) Calendar Days, or within a time determined by the Department depending on the nature of the violation, that addresses the identified concerns identified.
      vii. The Contractor shall complete the corrective action(s) contained in the CAP within the time period approved by the Department.
      viii. The Contractor shall provide updates to the Department on the remediation of all findings resulting in a request for corrective action at the interval requested by the Department.
   b. CAPs defined by the Department
      i. The Contractor shall accept and implement a Department defined CAP.

3. Effective Date of Remedial Actions
   a. The notice effective date for any requirement imposed by the Department for the Contractor to engage in a remedial action is the date on the written Notice of Deficiency. Any time frames regarding Contractor action will be calculated from the date on the written notice.
   b. A remedial action is not contestable under the dispute resolution process described in this Section, and the Contractor shall be required to complete the remedial action within the timeframe provided in the Notice of Deficiency, except for a requirement to submit and implement a CAP that shall be completed in accordance with Contract requirements.

D. Intermediate Sanctions

1. If the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may impose the following intermediate sanctions against the Contractor:
   a. Civil monetary penalties in accordance with 42 C.F.R. § 438.704;
   b. Appointment of temporary management of the Contractor in accordance with 42 C.F.R. § 438.706(a);[2]
   c. Notification to Members of their right to terminate their Enrollment with the Contractor without cause;
   d. Suspension of all or part of new Enrollment, including default Enrollment, after the effective date of the sanction;
   e. Suspension of payment for Members enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 C.F.R. § 438.702(a)(5);
   f. Suspension of all or part of Marketing activities;
   g. Suspension of part of the Contract;
   h. Exclusion from participation in Medicaid Managed Care; or
   i. Any other additional sanctions allowed under North Carolina or federal law or regulation.
2. Effective Date of Intermediate Sanctions
   a. If the Contractor elects not to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next Calendar Day following the expiration of the period to Appeal included in the written Notice of Deficiency, or on the effective date provided by the Department in the written notice based on the nature of the violation and the sanction imposed.
   b. If the Contractor elects to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next Calendar Day of the date on the written final decision issued by the Department.
   c. The Department shall not be required to delay the appointment of temporary management to provide the Contractor the opportunity to dispute the imposition of the sanction before imposing temporary management. The Department shall not terminate temporary management until it determines that the Contractor can ensure that the noncompliant behavior resulting in the temporary management will not reoccur.

E. Liquidated Damages

1. If the Contractor is determined to be in violation with the terms, conditions, requirements, and/or performance standards of the Contract, it is presumed by the Contractor that the Department will be harmed, and the Department shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

[2] If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. Part 438, the Department will notify affected Members of their right to terminate Enrollment in the Contractor without cause.

2. The actual damage sustained by the Department as a result of the Contractor's failure to meet the requirements of this Contract will be extremely difficult or impossible to ascertain with precise accuracy. Therefore, the Department and the Contractor agree that if the Contractor is in violation of the terms, conditions, requirements and/or performance standards of the Contract, the Department may assess liquidated damages against the Contractor in accordance with the Contract.

3. Following receipt of a Notice of Deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract until such time as the Department, in its sole discretion, determines the Violation(s) has been cured.

4. The Department, in its sole discretion, reserves the right to assess a general liquidated damage of two hundred and fifty dollars ($250) per Calendar Day, per occurrence, as applicable, for any violation not specifically listed in this *Section VII. Attachment N. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages*.

5. Liquidated damages assessed by the Department do not affect the Contractor's rights or obligations with respect to any third-party including Beneficiaries or Providers.

F. Payment of Liquidated Damages and other Monetary Sanctions

1. If the Contractor elects not to appeal the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within thirty-five (35) Calendar Days of the date on the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.

2. If the Contractor elects to appeal the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages or other monetary sanctions shall be due and payable within ten (10) Calendar Days of the date on the written notice of the final decision issued by the Department upholding its original decision to impose the liquidated damages or other monetary sanctions (including a final decision modifying the amount owed).

3. If the Contractor fails to pay liquidated damages or other monetary sanctions by the applicable due date, the Contractor shall be subject to Interest and a late payment penalty in accordance with NCGS § 147-86.23 until the past due amount is paid.

4. The Department shall reserve the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount (including Interest and late payment penalties) from future capitation payments owed to the Contractor. Actions taken by the Department to withhold a portion of the capitation payment for assessed liquidated damages or other monetary sanctions shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a). The Department shall provide written notice to the Contractor prior to withholding a portion of the payment for assessed liquidated damages or other monetary sanctions.

G. Dispute Resolution

1. The Contractor shall exhaust the dispute resolution process as provided in the Contract to contest the imposition of intermediate sanctions, the assessment of liquidated damages, and/or for cause termination of the Contract pursuant to 42 C.F.R. § 438.708 by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.

2. The Contractor shall have the right to dispute certain Contract performance actions arising under this Contract including the imposition of intermediate sanctions, liquidated damages, or a withhold through the dispute resolution process, except that the Contractor shall not have the right to contest a requirement imposed by the Department to perform a remedial action.

3. Dispute Resolution Procedures
    a. To raise a dispute, the Contractor shall submit a written request for dispute resolution within fifteen (15) Calendar Days of the date of the written notice imposing the Department's intended action. The Department may extend the Contractor's deadline to request dispute resolution for good cause if the Contractor requests an extension within ten (10) Calendar Days of the date on the written notice.
    b. The Contractor shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
    c. The Contractor waives any dispute not raised within fifteen (15) Calendar Days of the date on the written notice imposing any proposed action by the Department (unless the Department grants an extension).
    d. The Contractor also waives any arguments it fails to raise in writing within fifteen (15) Calendar Days (unless the Department grants an extension) of the date of the written notice imposing the proposed action, and waives the right to use any materials, data, and information not contained in or accompanying the Contractor's written request for dispute resolution in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
    e. The Department shall review the dispute resolution request and submitted evidence and information and issue a written final decision within sixty-five (65) Calendar Days of the Contractor's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the Contractor of any extension and the reason for such extension.
    f. The final decision issued by the Department following dispute resolution shall not be subject to further review or Appeal within the Department.

4. Hearing Prior to Termination of Contract with Cause
    a. The Contractor shall only be entitled to a hearing prior to the Department seeking to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the Termination for Cause Section of the Contract.
    b. At least fifteen (15) Calendar Days prior to the hearing, the Contractor shall receive written notice of the hearing that includes the date, time, place, nature of the hearing. The hearing may be held in-person or by telephone.

c. The hearing may be conducted even if the Contractor fails to appear at the hearing after receiving proper notice.
d. At the hearing, the burden shall be on the Contractor to demonstrate that the Department's decision to terminate the Contract with cause pursuant to 42 C.F.R. § 438.708 should be reversed.
e. Following the hearing, the Contractor shall receive a written final decision within sixty-five (65) Calendar Days of the date of the scheduled hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, the Contractor shall be notified of the extension and the reason for such extension.
f. In a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to the Contractor, and give the Contractor's Members notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services after the contract is terminated.

5. Legal Representative: The Department and the Contractor may be represented by legal counsel throughout the dispute resolution process.

6. For a Contractor licensed by NC DOI, for any adverse action taken by NC DOI against the Contractor related to the licensure or solvency of the Contractor, the Contractor shall follow DOI's Appeals process, as described in the Prepaid Health Plan Licensing Act, Article 93 of Chapter 58 of the General Statutes[3], to dispute the adverse action. The Department, in its sole discretion, may take separate, additional action, in accordance with *Section VI. Contract Performance*, against the Contractor based on any adverse action taken by DOI.

H. Notice to External Agencies

1. The Department shall provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) Calendar Days after the Department imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.

2. The Department may provide written notice to DOI after the Department imposes or lifts any intermediate sanction(s), liquidated damages, or withholds against the Contractor that is licensed by NCDOI.

3. The Department shall provide notice as required by law to any other state or federal agency for violations of the terms, conditions, or requirements of this Contract or for any other violation of applicable laws or regulations by the Contractor.

I. Publication of Contract Compliance Issues

1. The Department may publish on its website on a quarterly basis a list of Contractors that were subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the risk level assigned to Violation(s), the type of actions imposed on the Contractor, and the basis for the actions taken by the Department.

[3] See Section 1 of Session Law 2018-49.

2. The Department shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by the Department.

J. Right to Waive or Modify

1. The Department, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor for any good cause as determined by the Department, which includes the right of the Department to suspend the imposition of a remedial action, liquidated damages, or an intermediate sanction while the Contractor works to resolve the underlying issue that resulted in the action taken by the Department.

K. Performance Standards and Service Level Agreements

1. The Department has established performance standards for the measures listed in *Tables 1-2 of Section VII. Attachment N. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* and corresponding liquidated damages for any performance standard that is not met.
2. The Contractor shall meet the requirements of the Contract, including the performance standards and service level agreements specified in *Section VII. Attachment N. Performance Metrics, Service Level Performance Metrics, Services Level Agreements (SLAs) and Liquidated Damages.*
3. If the Contractor fails to meet any performance standard, the Department may assess liquidated damages and impose any other remedial action or intermediate sanction, in accordance with *Section VI. Contract Performance*, for the period in which the deficiency occurs and until the Department, in its sole discretion, determines the deficiency has been cured.

L. Withholds

1. The CFSP shall participate in the Department's withhold program.
2. The withhold program will conform to 42 C.F.R. § 438.6.
3. The withhold program will be effective beginning Contract Year 2, or at a later date as determined by the Department.
4. Prior to implementing a withhold pursuant to this Section and *Section III.D.40.i. Other Managed Care Payment Terms and Conditions.*
5. The Department shall provide the CFSP with written notice detailing the applicable withhold(s) and the performance period for the associated performance target(s), the amount being withheld, and the effective date in which the Department will begin withholding funds.
6. Notice of Withhold Determination
    i. Following the end of the applicable withhold performance period, the Department shall issue a written Notice of Withhold Determination to the CFSP detailing the following:
        1) The Department's determination of whether the CFSP fully met, partially met, or did not meet the applicable withhold performance targets during the performance period; and

2) The method and timeframes by which the Contractor may dispute the Department's determination that the CFSP partially met or did not meet the withhold performance targets.

7. Payment of any withheld amounts for which the Department determines that the CFSP met the performance target(s) shall be made by the Department to the CFSP by no later than sixty (60) Calendar Days of the date on the written Notice of Withhold Determination.

8. Disputes of the Withhold Determination
   i. If the CFSP elects to dispute the Department's withhold determination, the CFSP shall follow the process specified in *Section VI.G. Dispute Resolution*.
   ii. If the Contractor elects to dispute the Department's withhold determination as provided in the Contract and the Department overturns its original decision, the Department shall pay the CFSP any withheld amounts owed to the CFSP by no later than sixty (60) Calendar Days of the date on the written notice of final decision. The CFSP shall not be entitled to any interest or penalties from the Department for any disputed withheld amounts that were not paid by the Department during the pendency of the dispute resolution process.

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VII. Attachments A. – R.

Attachment A: CFSP Organization Roles and Positions

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

Section VII. Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Care Management Supervisor	These individuals are responsible for overseeing assigned care managers and ensuring fidelity to the CFSP Care Management model. These individuals are responsible for reviewing all Care Plans and ISPs for quality control and providing guidance to care managers on how to address Members' complex health and social needs. These individuals are responsible for ensuring care managers provide Trauma-Informed Care and recognize the impact of ACEs on the CFSP population. These individuals must oversee coordination with a multidisciplinary care team collaborating with primary health care professionals, Behavioral Health care professionals, specialty providers and stakeholders unique to the children, youth and families served by the child welfare system (e.g., Parents with children in Foster Care) and Care Coordination across the child welfare system (e.g., awareness of juvenile justice system).	• Must reside in North Carolina. • Must be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN. • Must have three (3) years of experience providing care management, case management, or care coordination to individuals served by the child welfare system (either in North Carolina or another state). • Supervising care managers overseeing care managers that are conducting in-reach and transition shall also meet the following requirements: ○ Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
2. Care Managers	These individuals shall be responsible for providing integrated whole-person Care Management under the CFSP Care Management model, including coordinating across physical health, BH, I/DD, LTSS, pharmacy and Unmet Health-Related Resource Needs. These individuals shall be responsible for providing Trauma-Informed Care, recognizing	• Must reside in North Carolina. • Must hold a bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as an RN. • Two (2) years of experience working directly with individuals served by the child welfare system is preferred.

Section VII. Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	the role of ACEs in the CFSP population and coordinating cross-agency care to meet children's physical, behavioral, social, educational, and legal needs. These individuals shall be responsible for coordinating closely with each Member's assigned County Child Welfare Worker and ensuring alignment between the Member's health care needs and permanency planning goals. These individuals shall coordinate with a multidisciplinary care team collaborating with primary health care professionals, Behavioral Health care professionals, specialty providers and stakeholders unique to the children, youth and families served by the child welfare system (e.g., Parents of children in Foster Care) and Care Coordination across the child welfare system (e.g., awareness of juvenile justice system).	
3. Certified Family Peer Specialist	Responsibilities include, but are not limited to, serving as a care manager extender in accordance with *Section V.D.2.s.v. Care Manager Qualifications.*	• Must reside in North Carolina. • Must have National Certification for Family Peer Specialists.
4. System of Care Outreach Coordinators	These individuals support the System of Care Manager with comprehensive planning, implementation, coordination, and training related to the CFSP's core System of Care functions at the local level.	• Must reside in North Carolina. • Must hold bachelor's degree in a human services field. • Must have minimum of two (2) years of professional experience working in and across multiple child-serving systems (e.g., education, child welfare, Behavioral Health, juvenile justice or early childhood systems).
5. System of Care Manager	This individual is responsible for comprehensive planning, implementation, coordination, and training related to the CFSP's core System of Care functions.	• Must reside in North Carolina. • Must hold a master's degree in a human services field. • Must have a minimum of five (5) years of professional experience working in and across child public service systems (e.g., education, child welfare,

Section VII. Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		Behavioral Health, juvenile justice or early childhood systems).
6. Member Appeal Coordinator	This individual manages and adjudicates Member Appeals in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.
7. Member Complaint and Grievance Coordinator	This individual manages and adjudicates Member complaints and Grievances in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.
8. Full-Time Member Services and Service Line Staff	These individuals coordinate communication with Members. All call center employees must receive training related to the CFSP, and the roles and responsibilities of the CFSP and County DSS, and how these agencies will coordinate and collaborate, and ACEs of children, youth, and families served by the child welfare system.	• Must reside in North Carolina.
9. Provider Relations and Service Line Staff	These individuals coordinate communications between the CFSP and providers.	• Must reside in North Carolina.
10. Provider Complaint, Grievance, and Appeal Coordinator	This individual manages and adjudicates provider. complaints, Grievances and Appeals in a timely manner.	• Must reside in North Carolina. • Fully dedicated to North Carolina DHHS programs.
11. Pharmacy Director for the Pharmacy Service Line	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract. The Pharmacy Director shall lead the Plan's efforts implementing the Medication Reconciliation and management requirements in accordance with the contract.	• Must reside in North Carolina. • Must be a North Carolina registered pharmacist with a current NC pharmacist license. • Minimum of three (3) years of pharmacy benefits call center experience. • Demonstrated experience in Medication Reconciliation and management for high-risk children, including those who served by the child welfare system.
12. Full-Time Utilization Management Staff	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing.

Section VII. Attachment A. Table 1: CFSP Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
13. Tribal Provider Contracting Specialist	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must reside in North Carolina.
14. Liaison between the Department and the North Carolina Attorney General's MID	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must reside in North Carolina.
15. Regional Liaisons to County DSS	These individuals serve as the primary contact for with County DSS, including County Directors of Social Services and County Child Welfare Workers, to triage and escalate issues where County Child Welfare Workers are seeking to coordinate with CFSP care managers and Member specific and/or CFSP-related questions. The CFSP shall establish a minimum of (1) Regional Liaison to County DSS for each DSS Region.[4]	• Must reside in North Carolina. • Must have experience working with North Carolina County DSS staff and knowledge of North Carolina's child welfare system.
16. I/DD and TBI Clinical Director	This individual oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid services to Members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and BH benefits. This individual reports to the CMO.	• Must be licensed in North Carolina. • Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI. • Minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in I/DD care.

[4] DSS Regions: https://www.ncdhhs.gov/cws772022a1/download?attachment

Attachment B: Summary of Medicaid Services

Section VII. Attachment B. Table 1: Summary of Medicaid Services below documents the set of Medicaid services that will be covered by the CFSP. Full details on the Clinical Coverage Policies are available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Inpatient hospital services	Services that: ▪ Are ordinarily furnished in a hospital for the care and treatment of inpatients; ▪ Are furnished under the direction of a physician or dentist; and ▪ Are furnished in an institution that - ▪ Is maintained primarily for the care and treatment of patients with disorders other than mental diseases; ▪ Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; ▪ Meets the requirements for participation in Medicare as a hospital; and ▪ Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary. Inpatient hospital services include: ▪ Swing Bed Hospitals: a hospital or Critical Access Hospital (CAH) participating in Medicare that has Center for Medicare and Medicaid Services (CMS) approval to provide post-hospital skilled nursing facility care and meets the requirements set forth in 42 C.F.R.§ 482.66. ▪ Critical Access Hospitals: a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs shall be located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements may use beds for either inpatient acute care or swing beds in accordance with 42 C.F.R. § 485.620(a). ▪ Inpatient Rehabilitation Hospitals: a hospital that serves Medicaid and NCHC beneficiaries who have multiple diagnoses. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. § 440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	provide daily access to a rehabilitation physician and 24-hour nursing. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least five (5) days per week. In certain well- documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven (7)-consecutive day period, beginning with the date of admission to the IRF. In order for an IRF claim to be considered reasonable and necessary, there must be a reasonable expectation that the patient meets all of the requirements listed in 42 C.F.R. § 485.58. ▪ Specialty Hospitals: a hospital that is exclusively engaged in the care and treatment of beneficiaries who: a. have cardiac or orthopedic conditions; b. are receiving a surgical procedure; or c. need any other specialized category of services designated by CMS. ▪ Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for Long term care hospitals and have an average Medicare length of stay described in 42 C.F.R. § 412.23(e)(2). Refer to clinical coverage policy 2A-2, Long Term Care Hospital Services. ▪ Inpatient hospital services do not include Skilled Nursing Facility and Intermediate Care Facility services furnished by a hospital with a swing-bed approval. ▪ Inpatient hospital services which include services furnished under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
Outpatient hospital services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that: ▪ Are furnished to outpatients; ▪ Are furnished by or under the direction of a physician or dentist; and ▪ Are furnished by an institution that:	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and ▪ May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State. ▪ Outpatient hospital services which include preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	
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 42U.S.C. § 1396d(a) [1905(a) of the Social Security Act].	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)® North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions *Section V.C.2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* of the Contract

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Nursing facility services	A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the North Carolina Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services. A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care. Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. § 440.40 42 C.F.R. § 440.140 42 C.F.R. § 440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Home health services	Home Health Services include medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology, and occupational therapy), home health aide services, and medical supplies provided to beneficiaries in any setting in which normal life activities take place, other than a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities; except for home health services in an intermediate care facility for Individuals with Intellectual Disabilities that are not required to be provided by the facility under subpart I of part 483 or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound in accordance with 42 C.F.R. § 440.70.	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. § 440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.1, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A
Physician services	Whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician— Within the scope of practice of medicine or osteopathy as defined by State law; and By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.1, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	All medical services performed must be Medically Necessary and may not be experimental in nature. Experimental is defined as medical care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina. In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) medical literature research and 3) qualified medical experts. Therapeutic abortions are covered only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by physician, place the woman in danger of death unless an abortion is performed; therapeutic abortions are also covered in cases of rape or incest.	NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, 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

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA)

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		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
Rural health clinics	The specific health care encounters that constitute a core service include the following face to face encounters: a. Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. Services provided by physician assistants and incident services supplied; c. Nurse practitioners and incident services supplied; d. Nurse midwives and incident services supplied; e. Clinical psychologists and incident services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	supplied; and f. Clinical social workers and incident services supplied.	NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Federally qualified health center services	The specific health care encounters that constitute a core service include the following face to face encounters: a. Physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self-administered; b. Services provided by physician assistants and incident services supplied; c. Nurse practitioners and incident services supplied; d. Nurse midwives and incident services supplied; e. Clinical psychologists and incident services supplied; and f. Clinical social workers and incident services supplied.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Telemedicine	The use of two-way real-time interactive audio and video between places of lesser and greater medical or psychiatric capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via telemedicine or telepsychiatry.	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telemedicine and Telepsychiatry
Laboratory and X-ray services	All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1- A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Family planning services	Regular Medicaid Family Planning (Medicaid FP) services include consultation, examination, and treatment prescribed by a physician, nurse midwife, physician assistant, or nurse practitioner, or furnished by or under the physician's supervision, laboratory examinations and tests, and medically approved methods, supplies, and devices to prevent conception.	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Certified pediatric and family nurse practitioner services	a. Requirements for certified pediatric nurse practitioner. The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section. b. If the State specifies qualifications for pediatric nurse practitioners, the practitioner must: i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services.	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	c. If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must: i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age. d. 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. e. If the State specifies qualifications for family nurse practitioners, the practitioner must: i. Be currently licensed to practice in the State as a registered professional nurse; and ii. Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services. f. 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: i. Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and ii. Have a family nurse practice limited to providing primary health care to individuals and families.	
Freestanding birth center services (when licensed or otherwise recognized by the State)	Free standing Birth Centers can only bill for vaginal delivery. These centers are subject to all rules and limitations as specified in the Ambulatory Surgical Center section of the State Plan.	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Non-emergent transportation to medical care	Medicaid is required to assure transportation to medical appointments for all eligible individuals who need and request assistance with transportation. Transportation will be available if the recipient receives a Medicaid covered service provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider). Medicaid only pays for the least expensive means suitable to the recipient's needs.	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1 D, NC NEMT Policy
Ambulance services	Ambulance services provide Medically Necessary treatment for NC Medicaid Program beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary.	42 C.F.R. § 410.40 NC State Plan Att. 3.1-A.1, Page 18 NC Clinical Coverage Policy 15
Tobacco cessation counseling for pregnant women	Counseling and pharmacotherapy for cessation of tobacco use by pregnant women.	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Prescription drugs and medication management	The North Carolina Medicaid Pharmacy Program offers a comprehensive prescription drug benefit, ensuring that low-income North Carolinians have access to the medicine they need.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The-Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		North Carolina Medicaid Pharmacy Newsletters *Section V.C.3. Pharmacy Benefits* of the Contract
Clinical services	Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients: a. Services furnished at the clinic by or under the direction of a physician or dentist. b. Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients if furnished at the clinic by or under the direction of a dentist are carved out of Medicaid Managed Care and should be billed to the Medicaid Fee-for-Service program.	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4
Physical therapy	Services to address the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. These services must be provided by a Physical Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist.	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages7c, 7c.15 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Occupational therapy	Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devises. These services must be provided by an Occupational Therapist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Speech, hearing, and language disorder services	Services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation. These services must be provided by a Speech Pathologist as defined in 42 C.F.R. § 440.110 and be licensed pursuant to North Carolina State law or, a Speech/Language Pathology Assistant who works under the supervision of an enrolled licensed Speech Pathologist. A Speech/Language Pathology Assistant (SLPA) must hold an Associate's degree in Speech/Language Pathology or a Bachelor's Degree from an accredited institution with specialized coursework in Speech/Language Pathology. A SLPA must also pass a competency test by the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists.	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Behavioral health services	Except as noted in the relevant State Plan and clinical coverage policies, 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.	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services: • Mobile Crisis Management • Intensive-In-Home Services

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		• Multisystemic Therapy • Child and Adolescent Day Treatment • Partial Hospitalization • Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Substance Abuse Comprehensive Outpatient Treatment Program • Substance Abuse Intensive Outpatient Program • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Community Residential Treatment • Ambulatory Detoxification Services • Non-Hospital Medical Detoxification Services • Opioid Treatment Program NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-6: Community Support Team (CST) NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders NC Clinical Coverage Policy 8G – Peer Support Services

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		8H-3, 1915(i) Individual and Transitional Support (ITS) 8H-4, 1915(i) Respite 8H-6, 1915(i) Community Transition NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH) 8J. Children's Developmental Service Agencies (CDSAs) 8L, Mental Health/Substance Abuse Targeted Case Management 8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders
Office-based opioid treatment (OBOT)	Provides buprenorphine and buprenorphine-naloxone combination product serves as an alternative to methadone as an evidence-based treatment of beneficiaries with opioid use disorders in an office-based setting.	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone
Respiratory care services	Respiratory therapy services as defined in 1902(e)(9)(A) of the Social Security Act when provided by the respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act.	SSA, Title XIX, Section 1905(a)(28) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Other diagnostic, screening, preventative 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	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and ‘‘(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; b. With respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level; c. Any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.	
Podiatry services	Podiatry, as defined by G.S. § 90-202.2, “is the surgical, medical, or mechanical treatment of all ailments of the human foot and ankle, and their related soft tissue structure to the level of the myotendinous junction of the ankle. Excluded from the definition of podiatry is the amputation of the entire foot, the administration of an anesthetic other than a local, and the surgical correction of clubfoot of an infant two years of age or less.”	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Optometry services	Medicaid shall cover the following optical services when provided by ophthalmologists and optometrists: a. Routine eye exams, including the determination of refractive errors; b. Prescribing corrective lenses; and 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 G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Chiropractic services	Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 C.F.R. § 440.60(b); 10A NCAC25P.0403(a)(b) and (c)]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation. Chiropractic services include only services provided by a chiropractor who is licensed by the State. Chiropractic providers must meet the educational requirements as outlined in 42 C.F.R. § 410.21.	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services
Private duty nursing services	Medically Necessary private duty nursing (PDN) services are provided under the direction of the recipient's physician in accordance with 42 C.F.R. §440.80 and prior approval by the Division of Medical Assistance, or its designee. This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13bNC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	a basis for authorizing PDN services or expanding the hours needed for PDN services. Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services. Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing and employed by a licensed home care agency. A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.	
Personal care	Personal care services (PCS) include a range of human assistance provided to persons of all ages with disabilities and chronic conditions to enable them to accomplish tasks that they would ordinarily do for themselves if they were not disabled. These PCS are intended to provide person-to-person, hands-on assistance by a PCS direct care worker in the beneficiary's home or residential setting with common activities of daily living (ADLs) that, for this program are eating, dressing, bathing, toileting, and mobility. PCS also include: assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's plan of care.	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	PCS is provided by a direct care worker who is employed by a licensed home care agency, or by a residential facility licensed as an adult care home, family care home, supervised living facility, or combination home, and who meets the qualifications specified on Attachment 3.1-A.1, Pages 23-29, section c. In addition to the specified assistance with ADLs and IADLs, qualified PCS direct care workers may also provide Nurse Aide I and Nurse Aide II tasks as specified on Attachment 3.1-A.1, Pages 23-29, section c., pursuant to the North Carolina Board of Nursing as described in 21 NCAC 36.0403 and as specified in the beneficiary's approved plan of care.	
Hospice services	The North Carolina Medicaid (Medicaid) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG to deliver medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in their environment that best meets the care and comfort needs of the patient and unit of care. The hospice IDG achieves this by organizing and managing, a comprehensive care plan focused on coordinating care, services and resources to beneficiaries, caregivers, and families' necessary for the palliation and management of the terminal illness and related conditions. Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through NC Division of Health Service Regulation. Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C). A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.	
Durable medical equipment	Durable Medical Equipment (DME) refers to the following categories of equipment and related supplies for use in a beneficiary's home: a. Inexpensive or routinely purchased items b. Capped rental/purchased equipment c. Equipment requiring frequent and substantial servicing d. Oxygen and oxygen equipment e. Related medical supplies f. Service and repair g. Other individually priced items h. Enteral nutrition equipment	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Prosthetics, orthotics and supplies	Medically Necessary orthotic and prosthetic devices are covered by the Medicaid program when prescribed by a qualified licensed health care practitioner and supplied by a qualified provider. Only items determined to be Medically Necessary, effective and efficient are covered. A qualified orthotic and prosthetic device provider must be approved by the Division of Medical Assistance. The provider requirements are published in Medicaid Clinical Coverage Policies.	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Home infusion therapy	Covers self-administered infusion therapy and enteral supplies provided to a North Carolina Medicaid (Medicaid) beneficiary residing in a private residence or to a Medicaid beneficiary residing in an adult care home. Covered services include the following: a. Total parenteral nutrition (TPN) b. Enteral nutrition (EN) c. Intravenous chemotherapy d. Intravenous antibiotic therapy e. Pain management therapy, including subcutaneous, epidural, intrathecal, and	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	intravenous pain management therapy	
Transplants and Related Services	Provides stem-cell and solid organ transplants. Hematopoietic stem-cell transplantation (HSCT) refers to a procedure in which hematopoietic stem cells are infused to restore bone marrow function in cancer patients who receive bone marrow-toxic doses of cytotoxic drugs, with or without whole-body radiation therapy.	North Carolina Medicaid State Plan, Page 27, Att. 3.1- E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem- Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non-Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic lymphocytic leukemia (CLL) and Small lymphocytic lymphoma (SLL) NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multi-visceral Transplants
Ventricular Assist Device	Device surgically attached to one or both intact heart ventricles and used to assist or augment the ability of a damaged or weakened native heart to pump blood.	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		NC Clinical Coverage Policy 11C, Ventricular Assist Device
Allergies	Provides testing for allergies. The term "allergy" indicates an abnormally hypersensitive immune reaction in response to exposure to certain foreign substances. Allergy-producing substances are called "allergens. When an allergic individual comes in contact with an allergen, the immune system mounts a response through the immunoglobulin E (IgE) antibody. Allergy immunotherapy (a.k.a., desensitization, hyposensitization, allergy injection therapy, or "allergy shots"), is an effective treatment for allergic rhinitis, allergic asthma, and Hymenoptera sensitivity.	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Anesthesia	Refers to practice of medicine dealing with, but not limited to: a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures. b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations. c. The clinical management of the patient unconscious from whatever cause. d. The evaluation and management of acute or chronic pain. e. The management of problems in cardiac and respiratory resuscitation. f. The application of specific methods of respiratory therapy. g. The clinical management of various fluid, electrolyte, and metabolic disturbances.	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Auditory Implant External Parts	Replacement and repair of external components of a cochlear or auditory brainstem implant device that are necessary to maintain the device's ability to analyze and code sound, therefore providing an awareness and identification of sounds and facilitating communication for individuals with profound hearing impairment.	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Burn Treatment and Skin Substitutes	Provides treatment for burns.	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	Provides comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives.	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Dietary Evaluation and Counseling and Medical Lactation Services	Offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and treatment. Individualized care plans provide for disease- related dietary evaluation and counseling. Medical lactation services provide support and counseling, or behavioral interventions to improve breastfeeding outcomes.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c)NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Hearing Aids	Provides hearing aids, FM systems, hearing aid accessories and supplies, and dispensing fees when there is medical necessity.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	Assists in gaining access to needed medical assistance to facilitate the beneficiary's medical, social, and educational needs. HIV Case Management contains the following core service components: assessment, care planning, referral and linkage, monitoring and follow-up.	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Maternal Support Services	Provides childbirth, health, and behavioral interventions and home nursing benefits for mothers and newborns.	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
Obstetrics and Gynecology	Provides for obstetrical and gynecological care.	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non- therapeutic Abortions NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home
Ophthalmological Services	General ophthalmologic services include: a. Intermediate ophthalmological services: an evaluation a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. This service is used for an acute condition or for a chronic condition which is stable. b. Comprehensive ophthalmological services: a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but do not need to be performed at one session. c. Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given.	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Pharmacy Services	Provides offers a comprehensive prescription drug benefit.	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter- Products

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
		NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Reconstructive Surgery	Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level.	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision
Vision Services	Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and visual Aids for Recipients Under Age 21
Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services	Telehealth: Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations. Virtual Patient Communications: Virtual Patient Communications is the use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Covered Virtual Patient Communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation). Remote Patient Monitoring: Remote Patient Monitoring is the use of digital devices to measure and transmit personal health information from a beneficiary in one location to a provider in a different location. Remote patient	42 C.F.R. § 410.78 NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring

Section VII.B. Table 1: Summary of Medicaid Services		
Service	**Description**	**References**
	monitoring enables providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations. There are two types of remote patient monitoring: Self-Measured and Reported Monitoring and Remote Physiologic Monitoring. a. Self-Measured and Reported Monitoring: When a patient uses a digital device to measure and record their own vital signs, then transmits the data to a provider for evaluation. b. Remote Physiologic Monitoring: When a patient's physiologic data is wirelessly synced from a patient's digital device where it can be evaluated immediately or at a later time by a provider.	

Attachment C: Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of CFSP services beginning on December 1, 2024[5]. The Department may make adjustments after Contract Award.

Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
1.	Contract Award	The date the Department will award the CFSP Contract for CFSP	August 15, 2024
2.	Commencement of CFSP Implementation Planning	The date the CFSP Implementation Team must be ready to commence Implementation Planning activities	August 15, 2024
3.	Identification of additional resources for Implementation Team	The date the CFSP must identify any additional resources needed to support the implementation activities	Contract Award + thirty (30) days
4.	Submission of CFSP Operating Plan	The date the CFSP's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
5.	Submission of key technology deliverables	The date the CFSP submits to the Department: • System Security Plan • Encounter Implementation Approach • System Interface Design • SOC 2 Type 2 Report • Vendor Readiness Assessment (VRAR)	Contract Award + thirty (30) days
6.	Submission of Business Continuity Plan	The date the CFSP's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
7.	Submission of key provider materials	The date the CFSP submits to the Department: • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual	Contract Award + thirty (30) days
8.	Value-Added Services	The date the CFSP submits to the Department submit to the Department for approval, in the Department developed standardized template, required information as described in *Section V.C.1.h.Value-Added Services.*	Contract Award + thirty (30) days

[5] As defined in SL XYZ, CFSP will launch on December 1, 2024. Upon Contract award and based on the Offeror's responses, the Department will work with NCGA to establish an appropriate launch date.

Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
9.	ILOS Service Request Form	The date the CFSP submits to the Department the standardized ILOS Service Request Form for approval	Contract Award + thirty (30) days
10.	Draft Implementation Plan	The date the CFSP's Implementation Plan Draft must be submitted to the Department	Contract Award + forty-five (45) days
11.	Submission of Member education efforts	The date the CFSP submits its planned Member education efforts to the Department	Contract Award + sixty (60) days
12.	Acquisition of service line phone numbers	The date the CFSP must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days
13.	Submission of key Member materials	The date the CFSP submits to the Department: • Enrollment and Disenrollment Policy • Member ID Card • Welcome Packet • Mailing Policy • Rights and Responsibilities Policy	Contract Award + sixty (60) days
14.	Submission of Tobacco Cessation Plan	The date the CFSP must submit a Tobacco Cessation Plan to the Department	Contract Award + ninety (90) days
15.	Submission of Fraud Prevention Plan	The date the CFSP must submit a Fraud Prevention Plan to the Department for review and approval	Contract Award + ninety (90) days
16.	Establishment of CFSP Office and Call Center(s) in NC	The date the CFSP must begin implementing call center(s) and staff in North Carolina	Contract Award + ninety (90) days
17.	Submission of Locum Tenens Policy	The date the CFSP submits to the Department the Locum Tenens Policy	Contract Award + ninety (90) days
18.	Tribal Engagement Strategy	The date the CFSP's Tribal Engagement Strategy must be submitted to the Department for review	Contract Award + ninety (90) days
19.	Pharmacy Provider Network Audit Program	The date the CFSP's Pharmacy Provider Network Audit Program must be submitted to the Department	Contract Award + ninety (90) days
20.	Mail Order Program Policy	The date the CFSP's Mail Order Program Policy, including a sample of all Member mail order-related correspondence, must be submitted to the Department	Contract Award + ninety (90) days

Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
21.	Critical Incident Response Policy	The date the CFSP submits to the Critical Incident Response Policy	Contract Award + ninety (90) days
22.	Good Faith Provider Contracting Policy	The date the CFSP shall develop and submit Good Faith Provider Contracting Policy that includes a description of how the CFSP will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions	Contract Award + ninety (90) days
23.	Submission of Third Party Liability Policy	The date the CFSP submits to the Department the Third Party Liability Policy	Contract Award + ninety (90) days
24.	Whistleblower Policy	The date the CFSP shall develop and submit a Whistleblower Policy related to whistleblower protections	Contract Award + ninety (90) days
25.	Opioid Misuse Prevention and Treatment Program Policy	The date the CFSP shall develop and submit an Opioid Misuse Prevention Program Policy	Contract Award + ninety (90) days
26.	Submission of Training Program	The date the CFSP's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
27.	Submission of Transition of Care Policy	The date the CFSP shall submit the Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
28.	Provider Transition of Care Policy	The date the CFSP shall submit the Provider Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
29.	EPSDT Policy	The date the CFSP submits to the Department the EPSDT Policy	Contract Award + ninety (90) days
30.	NEMT Policy	The date the CFSP submits to the Department the NEMT Policy	Contract Award + ninety (90) days
31.	Submission of Local Community Collaboration Strategy	The date the CFSP must submit the Local Community Collaboration Strategy to the Department for review and approval	Contract Award + ninety (90) days
32.	Provider Hardship Payment Policy	The date the CFSP shall submit the Provider Hardship Payment Policy to the Department for review and approval	Contract Award + ninety (90) days
33.	Conflict of Interest Policy	The date the CFSP shall submit the Conflict of Interest Policy to the Department	Contract Award + ninety (90) days

Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
34.	Prevention and Population Health Management Plan	The date the CFSP shall submit the Prevention and Population Health Management Plan for review and approval	Contract Award + ninety (90) days
35.	Member Engagement and Marketing Plan for Historically Marginalized Populations	The date the CFSP shall submit Member Engagement and Marketing Plan for Historically Marginalized Populations goals and strategies for engaging with Historically Marginalized Populations, specific initiatives to address disparities, and expected outcomes of the plan.	Contract Award + one hundred twenty (120) days
36.	Key Personnel	The date the CFSP must fill all Key Personnel positions listed in *Section V.A.9. Table 1: CFSP Key Personnel Requirements*	Contract Award + one hundred twenty (120) days
37.	Member Grievance Policy	The date the CFSP must submit the Member Grievance Policy.	Contract Award + one hundred twenty (120) days
38.	Provider Grievances and Appeals Policies	The date the CFSP shall submit the CFSP Provider Grievances and Appeals Policies	Contract Award + one hundred twenty (120) days
39.	Submission of key clinical and Care Management materials	The date the CFSP must submit to the Department • Care Management Policies • UM Program Policies, including Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy • System of Care Policy • In-Reach and Transition Policy	Contract Award + one hundred twenty (120) days
40.	AMH Performance Incentive Payments Methodology	The date the CFSP must submit its AMH Performance Incentive Payments Methodology for review and approval	Contract Award + one hundred twenty (120) days
41.	Submission of VBP Assessment and VBP Strategy for Medicaid	The date the CFSP's first retrospective VBP Assessment and prospective VBP Strategy must be submitted to the Department	Contract Award + six (6) months
42.	Draft CFSP Marketing Materials	The date the CFSP's Marketing Materials must be submitted to the Department	Ninety (90) days before use of CFSP Marketing Materials
43.	Commencement of Marketing Activities	The date the CFSP is allowed to begin Marketing activities	Eight (8) weeks before Auto-Enrollment

Section VII. Attachment C. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
44.	PHP license	Deadline for CFSP to obtain a PHP license issued by the NCDOI, if applicable under Section V.A.2.b.ii	One hundred eighty (180) days before CFSP launch
45.	Contracting with AMHs/PCPs	The date the contracts must be finalized with providers to allow for PCP assignment	Ninety (90) days before CFSP launch
46.	Compliance Program report	The date the CFSP shall submit a Compliance Program report describing the workplans for the upcoming year.	Ninety (90) days before CFSP launch
47.	PCP Auto Assignment	The date that PCP auto assignment must be completed for Members enrolling in the CFSP at launch	Sixty (60) days before CFSP launch
48.	CFSP Care Management Member Enrollment Packets	The date the CFSP will send Members the CFSP Care Management Enrollment packet, with information on their Care Management assignment and options for changing their assignment	Thirty (30) days before CFSP launch
49.	CFSP Launch	The date the CFSP must begin delivering health care services to Members	December 1, 2024
50.	Funding of Risk Reserves	The CFSP must meet the capital requirements as outlined in *Section V.J.3.f. Financial Viability*	December 1, 2024
51.	System Test Plan	The date the CFSP shall submit the System Test Plan to the Department	Contract Award + ninety (90) days
52.	Marketing Plan	The date the CFSP shall submit its marketing plan to the Department for review and approval	Contract Award + sixty (60) days

Attachment D: Required CFSP Quality Metrics

Section VII. Attachment D. Required CFSP Quality Metrics is meant to provide the Department with a complete picture of the CFSP's processes and performance as described in *Section V.F. Quality and Value*. The measures below include a set of Medicaid Adult and Child Core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website, as necessary, to align with the annual January update.

The CFSP shall begin to track the updated measures when posted annually in January. The CFSP shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with Second Revised and Restated *Section VII. Attachment I. Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the CFSP would report the results in June 2024).

The CFSP will also be required to report the 1915(i) measures listed in *Section VII.D. Table 3: 1915(i) Service Performance Measures*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with CFSP around these performance measures.

Section VII.D. Table 1: Survey Measures and General Measures

CBE #	Measure Name	Reporting Responsibility	Steward
NA	Absolute Number of Providers Serving CFSP Members	TBD	NA
NA	Absolute Number of Providers Serving CFSP Members	TBD	NA
105	Antidepressant Medication Management (AMM)	CFSP	NCQA
32	Cervical Cancer Screening (CCS)	CFSP	NCQA
1516	Child and Adolescent Well-Care Visit (WCV)	CFSP	NCQA
38	Childhood Immunization Status (CIS) - Combination 10	CFSP	NCQA
33	Chlamydia Screening in Women (CHL)	CFSP	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	CFSP	PQA
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	CFSP	USC
18	Controlling High Blood Pressure (CBP)	CFSP	NCQA
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	CFSP	NCQA
TBD	EPSDT Screening Ratio	Department-calculated	CMS

Section VII.D. Table 1: Survey Measures and General Measures			
CBE #	**Measure Name**	**Reporting Responsibility**	**Steward**
3488	Follow-Up After Emergency Department Visit for Substance Use (FUA)	Department-calculated	NCQA
576	Follow-Up After Hospitalization for Mental Illness (FUH)	CFSP	NCQA
108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	CFSP	NCQA
0059	Glycemic Status Assessment for Patients with Diabetes (GSD)[6]	CFSP	NCQA
1407	Immunizations for Adolescents (IMA) - Combination 2	CFSP	NCQA
NA	Low Birth Weight	CFSP	NC DHHS
27	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	CFSP	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	CFSP	NCQA
1768	Plan All-Cause Readmissions (PCR) [Observed versus Expected Ratio]	CFSP	NCQA
1517	Prenatal and Postpartum Care (PPC)	CFSP	NCQA
NA	Rate of Screening for Health-Related Resource Needs (HRRN)	CFSP	DHHS
NA	Rate of Screening for Pregnancy Risk	CFSP	DHHS
0418/0418e	Screening for Depression and Follow-up Plan (CDF)[7]	CFSP	CMS
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	CFSP	NCQA
2940	Use of Opioids at High Dosage in Persons Without Cancer (OHD)	Department-calculated	PQA
2950	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	Department-calculated	PQA
1392	Well-Child Visits in the First 30 Months of Life (W30)	CFSP	NCQA

[6] Pending additional information regarding the collection of clinical data

[7] Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it is inappropriate.

Section VII.D. Table 2: Survey Measures and General Measures: Patient and Provider Satisfaction		
NQF #	**Measure Name**	**Steward**
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new CFSP Members who have an Independent Evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of CFSP Members who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
3.	Number of CFSP Members with SMI/SED who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
4.	Number of CFSP Members with SUD who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
5.	Number of CFSP members with I/DD who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
6.	Number of CFSP members with TBI who received an Independent Evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of independent re-evaluations completed at least annually for CFSP members using 1915(i) Services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
8.	Proportion of new Independent Evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Independent Evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
11.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to CFSP monitoring schedule	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) Services	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of non-certified 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of Person Centered Plans that are completed in accordance with DHB requirements	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
18.	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
19.	Proportion of Care Plan/ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
20.	Proportion of Care Plans/ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of individuals whose annual Care Plan/ISP was revised or updated	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
22.	Proportion of individuals for whom an annual Care Plan/ISP took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
23.	Number and percentage of CFSP Members using 1915(i) Services whose Care Plans/ISPs were revised, as applicable, by the care manager to address their changing needs	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
24.	Proportion of beneficiaries who are using 1915(i) Services in the type, scope, amount, and frequency as specified in the Care Plan/ISP	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
26.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
27.	Proportion of CFSP Members using 1915(i) Services reporting their care manager helps them to know what 1915(i) services are available	NC DHHS	Annually Fiscal Year	November 1
28.	Proportion of CFSP Members using 1915(i) Services reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
29.	Number and percentage of beneficiary deaths of CFSP members using 1915(i) Services where required CFSP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
30.	Number and percent of actions taken to protect the beneficiary using 1915(i) Services, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
31.	Percentage of CFSP Members using 1915(i) Services who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percentage of medication errors resulting in medical treatment for CFSP Members using 1915(i) Services	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 3 April 1 – June 30	February 1 May 1 August 1 November 1
34.	Percentage of CFSP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
35.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
36.	Number and percentage of level 2 or 3 incidents where required CFSP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
37.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
38.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
39.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	The proportion of claims paid by the CFSP for 1915(i) Services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1
42.	The percentage of continuously enrolled CFSP Members using 1915(i) Services (ages 3 and older) who also received a primary care or preventative health service	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII.D. Table 3: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
43.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled CFSP Members using 1915(i) Services ages twenty (20) and older who received a primary care or preventative health service during the measurement period	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Attachment E: CFSP Network Adequacy Standards

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

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

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

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

For purposes of Network Adequacy Standards for physical health providers/services, except as otherwise noted, adult services are those provided to a Member who is 21 years of age or older and pediatric (child/children) services are those provided to a Member who is less than 21 years of age.

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

The CFSP is required to use the definitions of service categories for BH time/distance standards found in *Distance Standards* for BH service types in *Section VII. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards*

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

Section VII. Attachment E. Table 1: CFSP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of Members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of Members
5	Obstetrics[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of Members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of Members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of Members
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of Members • *Research-based BH treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of Members • *Research-based BH treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8	Location-Based Services	• P*sychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program :* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members • *Child and Adolescent Day Treatment Services:* Not subject to standard	• *Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program:* ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members • *Child and Adolescent Day Treatment Services:* Not subject to standard
9	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: o 2+ facilities within each SP Region, or o 1 facility within each region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* Not subject to standard • *Non-Hospital Medical Detoxification:* ≥ 2 providers per SP Region	

[1] Measured on Members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Attachment E. Table 1: CFSP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:* ≥ At least 1 provider per SP Region *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
10	Inpatient BH Services	At least 1 provider per SP Region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of Members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of Members
12	Community/ Mobile Services	At least 2 providers per SP Region. Each county must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities and 1915(i) Services)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	
15	Residential Treatment Services	• *Residential Treatment Services*: Contract with 100% of providers statewide for each of the following service levels: ○ Level I /Level II Family Type ○ Level II Program Type ○ Level III ○ Level IV Secure • *Substance Abuse Medically Monitored Residential Treatment*: At least 1 provider per SP Region (refer to 10A NCAC 27G.3400) • *Substance Abuse Non-Medical Community Residential Treatment*: ○ *Adult:* Contract with 100% of providers statewide (refer to licensure requirements to be determined by the Department). *Standard does not apply until ninety (90) Calendar Days following the establishment of licensure requirements as determined by the Department* ○ *Adolescent:* Contract with all designated CASPs statewide ○ *Women & Children:* Contract with all designated CASPs statewide • *Substance Abuse Halfway House*: ○ *Adult:* At least 1 male program and 1 female program per SP Region (Refer to 10A NCAC 27G.5600E) ○ *Adolescent:* At least 1 provider per SP Region (Refer to 10A NCAC 27G.5600E)	

Section VII. Attachment E. Table 1: CFSP Time/Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Psychiatric Residential Treatment Facilities (PRTFs):* Contract with 100% PRTF providers statewide.	
16	Indian Health Care Providers	• Contract with 100% of IHCPs statewide.	
17	1915(i) Services	• Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD): ≥ 2 providers of each 1915(i) Service within each Standard Plan Region. • In-Home Respite: ≥ 2 providers within 45 minutes of the Member's residence. • Community Transition: Not subject to standard	

Section VII. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Opioid Treatment Program (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds

Section VII. Attachment E. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards		
Reference Number	**Service Type**	**Definition**
		Inpatient Hospital – Adolescent / Children • Acute care hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs)
7.	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment • Mobile Crisis
8.	1915(i) Services	• Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

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

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21	Care provided to prevent illness or injury; examples include, but are not	Within thirty (30) Calendar Days

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
	years of age and older	limited to, routine physical examinations, immunizations, mammograms and pap smears	
1a	Preventive Care Services – child, birth through 20 years of age[2]		Within fourteen (14) Calendar Days for Member less than six (6) months of age Within thirty (30) Calendar Days for Members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar Days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) Calendar Days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) Calendar Days
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

[2] Preventive care services appointment wait time standard does not impact the requirement to conduct an initial physical examination within seven (7) days of entering County DSS custody.

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
Behavioral Health Services			
9	Opioid Treatment Program (Adults Only)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Routine: Within forty-eight (48) hours Urgent: Within twenty-four (24) hours
10	Mobile Crisis Management Services	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within two (2) hours
11	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
12	Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
13	Residential Treatment Services (Levels I-IV)	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five (5) Business Days of the Member's level of care determination, or sooner based on a Member's condition or urgency of treatment need[3]

[3] SL 2021-132, SB693.

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
			• Admission within seventy-two (72) hours of the Member's level of care determination for Members without a therapeutic placement who are in County DSS custody
14	PRTFs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Admission within five (5) Business Days of the Member's level of care determination, or sooner based on a Member's condition or urgency of treatment need[4] • Admission within seventy-two (72) hours of the Member's level of care determination for Members without a therapeutic placement who are in County DSS custody
15	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Psychiatric Beds	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Urgent: Within twenty-four (24) hours • Emergency Services: available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
16	Acute Care Hospitals and Hospitals with Adult/Adolescent Inpatient Substance Use Beds	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Urgent: Within twenty-four (24) hours • Emergency Services: available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
17	Partial Hospitalization	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Available day/night for a minimum of 4 hours per day, 5 days per week, and 12 months per year
18	Outpatient Mental Health Services	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	• Routine: Within fourteen (14) Calendar Days • Urgent: Within twenty-four (24) hours

[4] SL 2021-132, SB693.

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
19	Post-Psychiatric Hospital Discharge Visit		• Within seven (7) Calendar Days with Providers listed as meeting numerator criteria in the technical specifications for the Healthcare Effectiveness Data and Information Set (HEDIS)® measure "Follow Up After Hospitalization for Mental Illness" (HEDIS is a registered trademark of NCQA)
20	Comprehensive Clinical Assessment (CCA)		• Within five (5) Business Days of request, or sooner based on a Member's condition or urgency of treatment need [5] • Within twenty-four (24) hours of the request for Members with a Behavioral Health need and without a level of care recommendation who are in County DSS custody or a Member who requires a CCA to begin services necessary to discharge from an emergency room or other emergency/urgent care setting to a community or residential setting
21	Emergency Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
22	Emergency Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
23	Urgent Care Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within twenty-four (24) hours
24	Urgent Care Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within twenty-four (24) hours

[5] SL 2021-132, SB693.

Section VII. Attachment E. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
25	Routine Services for Mental Health	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within fourteen (14) Calendar Days
26	Routine Services for SUDs	Refer to *Section VII.L.7. CFSP Behavioral Health Service Definition Policy*	Within forty-eight (48) hours

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

Section VII. Attachment E. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry (General)
20.	Psychiatry (Child and Adolescent) [6]
21.	Radiology

[6] Not subject to separate adult and pediatric provider standards.

Section VII. Attachment E. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
22.	Rheumatology
23.	Urology

Attachment F: Required Standard Provisions for CFSP and Provider Contracts

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

1. Contracts between the CFSP and providers, must, at a minimum, include provisions addressing the following:
    a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the CFSP utilizes the definition as found in *Section III.A. Definitions* of the CFSP Contract or include the definition verbatim from that section.
    c. Contract Term: The contract term shall not exceed the term of the CFSP Contract with the State.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. The CFSP shall specifically include a provision permitting the CFSP to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the CFSP or the Division.
    e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the CFSP's insolvency the contract must address:
            1) Transition of administrative duties and records; and
            2) Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the CFSP provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the CFSP's Network participation requirements as outlined in the CFSP's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the CFSP of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain Enrollment.
        ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
            1) During the provider Credentialing transition period, no less frequently than every five (5) years.
            2) During provider Credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
    g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the CFSP and to notify the CFSP of subsequent changes in status of professional liability insurance on a timely basis.

h. Member Billing: The contract must address the following:

   i. That the provider shall not bill any Member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and Member from agreeing to continue non-covered services at the Member's own expense, as long as the provider has notified the Member in advance that the CFSP may not cover or continue to cover specific services and the Member to receive the service; and

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

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

   i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid Beneficiaries;

   ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when Medically Necessary;

   iii. Prior to discharging a Member, make an effort connect the Member to an accepting provider who is best suited to meet their needs. Providers shall notify the CFSP of the Member's discharge within 24 hours of the discharge; and

   iv. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the CFSP and the provider.

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

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

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

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

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

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

m. Provider Network: The CFSP shall require network providers of services provided under Outpatient Commitment to a Member to notify the CFSP of the Outpatient Commitment order upon receipt.

n. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ+) Members who obtain covered services are not subject to treatment or bias that does not affirm their identity/orientation.

o. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be

consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the CFSP's web-based billing process.

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

   i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
   ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
   iii. Notification of changes in these requirements shall also be provided by the CFSP, allowing providers time to comply with such changes.

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

r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.

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

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

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

   i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the CFSP.
   ii. The CFSP shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

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

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

   i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member.

   ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

   iii. The provider shall report to the CFSP, in a format and frequency to be determined by the CFSP, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

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

y. AMHs: For all contracts with any provider who is an AMH, a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall

include a statement that the contracted provider agrees to comply with the Department's AMH Program.

z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out CMHRP, a provision that outlines the Care Management requirements consistent with the Department's CMHRP Policy. Each contract with a LHD who is carrying out CMHRP shall include a statement that the contracted provider agrees to comply with the Department's CMHRP Policy.

aa. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.

bb. Chapter 58 requirements: As codified in G.S. 108D-65(6)(f), the contract must include provisions that address the following statutes and subsections:

i. G. S. 58-3-200(c).

ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).

iii. G.S. 58-50-270(1), (2), and (3a).

iv. G.S. 58-50-275 (a) and (b).

v. G.S. 58-50-280 (a) through (d).

vi. G.S. 58-50-285 (a) and (b).

vii. G.S. 58-51-37 (d) and (e).

cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

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

ee. Coordination with County DSS: Contracts should include a provision requiring providers to coordinate and share information with a Member's County Child Welfare Worker, as required by law or as otherwise appropriate.

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

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

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

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

ii. For all applicable contracts with Designated Pilot Care Management Entities, provisions that indicate:

i. The Designated Pilot Care Management Entity shall:

1) Utilize NCCARE360 for functions outlined in CFSP Contract *Section V.d.9.f.viii.* and *Section V.D.9.f.xii.*

2) Provide care management to all Members enrolled in the Healthy Opportunities Pilot, as referenced in *Section V.D.9 Healthy Opportunities*.

3) Manage transitions of care for Healthy Opportunities Pilot-enrolled Members as outlined *Section V.D.2.n. Transitional Care Management* for Members that change health plans.

4) Perform Healthy Opportunities Pilot-related care management responsibilities as outlined in *Section V.D.9.f Healthy Opportunities Pilot to Address Unmet Health-Related Needs*, also known as Healthy Opportunities Pilot.

5) Abide by the Healthy Opportunities Pilot provider complaint process described in *Section V.E.5.k HSO Grievances related to the Healthy Opportunities Pilot.*

6) Adhere to the technology requirements described in *Section V.L. Technology Specifications.*

ii. The CFSP shall:

1) Make Healthy Opportunities Pilot care management payments to Designated Pilot Care Management Entities for Healthy Opportunities Pilot-enrolled members as outlined in *Section V.E.4.cc. Healthy Opportunities Pilot Payments*, as applicable.

2) Make the Healthy Opportunities Pilot eligibility criteria, the Healthy Opportunities Pilot Fee Schedule, CFSP timeframes for Pilot service authorization, and information on the Pilot Member complaint process available to the Designated Pilot Care Management Entity.

iii. The CFSP shall include Department-developed standard contract language included in the AMH Manual in its contracts with Designated Pilot Care Management Entities.

iv. Healthy Opportunities Network Leads: The CFSP must contract with any Healthy Opportunities Network Lead operating in the CFSP region, as noted in *Section V.D.9.e.*., using a Department-standardized CFSP-Network Lead model contract, to access the Network Lead's network of Healthy Opportunities Pilot providers, also referred to as Human Service Organizations (HSOs).

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

a. Section VII.L.2. CFSP Advanced Medical Home Program Policy

b. Section VII.L.3. CFSP Pregnancy Management Program Policy

c. Section VII.L.4. CFSP CMHRP Policy

d. Advanced Medical Home Manual

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

a. Compliance with state and federal laws

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

b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination: Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

The [Provider] agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. County DSS is designated with the administration and determination of eligibility for the two programs.

f. Access to provider records

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

i. The United States Department of Health and Human Services or its designee;

ii. The Comptroller General of the United States or its designee;

iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee

iv. The Office of Inspector General

v. North Carolina Department of Justice Medicaid Investigations Division

vi. Any independent verification and validation Contractor, audit firm, or quality assurance Contractor acting on behalf of NC DHHS;

vii. The North Carolina Office of State Auditor, or its designee

viii. A state or federal law enforcement agency.

ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

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

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

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

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

i. For Medical Claims (including BH):

1) The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
2) The [Company] shall pay or deny a clean Medical Claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
3) A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

ii. For Pharmacy Claims:

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

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

1) The [Company] shall Reprocess Medical Claims and Pharmacy Claims in a timely and accurate manner as described in this provision (including Interest and penalties if applicable).

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

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

vi. The [Company] shall pay the Interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to requests the Interest or the liquidated damages.

b. Contract Effective Date

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

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

c. Tobacco-free Policy

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

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

ii. Providers Subject to a Partial Tobacco-Free Policy

Starting April 1, 2024, contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities shall at a minimum include the following in relation to the implementation of a partial tobacco-free policy. In these settings, the following policies shall be required:

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

1. Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the provider's control as owner or lessee.

2. Outdoor areas of the property, under [PROVIDER'S] control as owner or lessee shall:

a) Ensure access to common outdoor space(s) free from exposure to tobacco use.

b) Prohibit staff/employees from using tobacco products anywhere on the property. Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based

Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

iii. Providers subject to Full Tobacco-Free Policy

Starting April 1, 2024, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.

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

Attachment G: Medicaid Managed Care Addendum for Indian Health Care Providers

The CFSP shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. **Purpose of Addendum; Supersession.**

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____(herein "Managed Care Plan") and _____(herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions. [14]

2. **Definitions.**

For purposes of this Addendum, the following terms and definitions shall apply:

a. "Indian" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

   i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

   ii. Is an Eskimo or Aleut or other Alaska Native;

   iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;

   iv. Is determined to be an Indian under regulations issued by the Secretary.

   The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

b. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any Subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid Managed Care contract.

[14] Please note that if the contract includes Medicaid and separate CHIP Beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

e. "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

f. "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

g. "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26)

h. "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. **Description of IHCP.**

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

□ *IHS.*

□ *An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.*

□ *A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 450 et seq.*

□ *A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).*

□ *An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.*

4. **Cost Sharing Exemption for Indians; No Reduction in Payments.**

The Managed Care Plan shall not impose any Enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any Enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. **Enrollee Option to Select the IHCP as Primary Health Care IHCP.**

The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14(b)(3) and 457.1209.

6. **Agreement to Pay IHCP.**

a. The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 C.F.R. §§ 438.14 and 457.1209.

b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the Plan pays and the amount the IHCP would have received under FFS or the applicable

Encounter rate published annually by the IHS if the amount the IHCP receives from the Plan is less than the amount they would have received under FFS or the applicable Encounter rate.

7. **Persons Eligible for Items and Services from IHCP.**

   a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

   b. No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. **Applicability of Federal Laws not Generally Applicable to other Providers.**

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

9. **Non-Taxable Entity.**

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. **Insurance and Indemnification.**

   a. **Indian Health Service.** The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

   b. **Indian Tribes and Tribal Organizations**. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including Contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including Contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services Contractor to perform any act outside the scope of his/her employment.

   c. **Urban Indian Organizations**. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement

or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. **Licensure and Accreditation.**

Pursuant to 25 USC §§ 1621t and 1647a, the Managed Care Organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the Managed Care Organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. **Dispute Resolution.**

In the event of any dispute arising under the Managed Care Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. **Governing Law.**

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. **Medical Quality Assurance Requirements.**

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675.)

15. **Claims Format.**

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. **Payment of Claims.**

The Managed Care Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act, ((42 U.S.C. §1396u-2(h))and 42 C.F.R. §§ 438.14(c)(2) and 457.1209, and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable Encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. **Hours and Days of Service.**

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. **Coordination of Care/Referral Requirements.**

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. **Sovereign Immunity.**

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. **Endorsement.**

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the Managed Care Plan.

APPROVALS

For the Managed Care Plan: **For the IHCP:**

*Date:*_____ *Date:* _____

_____ _____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS as an IHCP:

a. Anti-Deficiency Act, 31 U.S.C. § 1341;
b. ISDEAA, 25 U.S.C. § 450 et seq.;
c. Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
d. Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
e. Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
f. IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

a. ISDEAA, 25 U.S.C. § 450 et seq.;
b. IHCIA, 25 U.S.C. § 1601 et seq.;
c. FTCA, 28 U.S.C. §§ 2671-2680;
d. Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
e. Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
f. HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

a. IHCIA, 25 U.S.C. § 1601 et seq.
b. Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
c. HIPAA, 45 C.F.R. Parts 160 and 164.

Attachment H: Provider Appeals

The following are the reasons for which the CFSP must allow a provider to appeal an adverse decision made by the CFSP. The CFSP shall provide an Appeals process to providers in accordance with *Section V.E.5. Provider Grievances and Appeals.*

Section VII. Attachment H.1. Table 1: Provider Appeals	
Reference Number	**Appeal Criteria**
For Network Providers	
1	A Network Provider has the right to appeal certain actions taken by the CFSP. Appeals to the CFSP shall be available to a network provider for the following reasons: a) Program Integrity related findings or activities; b) Finding of fraud, waste, or abuse by the CFSP; c) Finding of or recovery of an overpayment by the CFSP; d) Withhold or suspension of a payment related to fraud, waste, or abuse concerns; e) Termination of, or determination not to renew, an existing contract for LHD care/case management services; and f) Violation of terms between the CFSP and provider.
For Out-of-Network Providers	
2	An OON Provider may appeal certain actions taken by the CFSP. Appeals to the CFSP shall be available to an OON Provider for the following reasons: a) An OON payment arrangement such as a single-case agreement; b) Finding of waste or abuse by the CFSP; and c) Finding of or recovery of an overpayment by the CFSP.

Attachment I: Reporting Requirements

The following tables detail the reports that the CFSP must submit to the Department. The Department will provide additional details on report format, fields and frequency after Contract Award. For select reporting requirements, the CFSP is expected to submit a report with metrics for Medicaid as identified in *Attachment I. Table 1: CFSP Reporting Requirements* and *Attachment I. Table 2: CFSP Data Extracts.*

The Department will provide additional details and on report format, fields and frequency after Contract Award.

1. Although the State has indicated the reports that are required, the CFSP may suggest additional reports.
2. As part of Readiness Review, the CFSP shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. The Department reserves the right to require additional reports beyond what is included in this document.
4. The CFSP shall submit complete and accurate data required by the Department for tracking information on Members obtaining Medicaid benefits in the CFSP and with providers contracted to provide those services.
    a. This information shall include information on consumer eligibility for services, shadow claims, demographics, adverse events and service outcomes for consumers served by the CFSP.
5. The CFSP shall submit all data on a schedule provided by the Department.
6. The CFSP shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to the Department.
7. The CFSP shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to the Department.

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Administration and Management		
CFSP Operating Report	Annual report of each entity identified under the CFSP Operating Report, providing evidence of CFSP oversight activities and entity performance (i.e. metrics, CAPs, sanctions).	Annually
Members		
Member Services Quality Assurance Report	Quarterly report of survey results which measures Member ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
Member Marketing and Educational Activities Report	Quarterly summary of Member Marketing and educational activities, including number/type of events hosted, event locations and number of Members reached.	Quarterly
Member Appeals and Grievances Report	Monthly report on the Appeals and Grievances received and processed by the CFSP including the total number of Appeal and Grievance requests filed with the CFSP, the basis for each Appeal or Grievance, the status of pending	Monthly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	requests, and the disposition of any requests that have been resolved.	
Children with Complex Needs Report	Monthly report containing the names and Member Medicaid ID numbers of Children with Complex Needs statewide.	Monthly
Quarterly Member Incentive Programs Report	Quarterly report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Quarterly
Annual Member Incentive Programs Report	Annual report of Member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
CFSP Enrollment Summary Report	Monthly summary report highlighting key Member Enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of Enrollment and disenrollment by Medicaid eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in Member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
Nursing Facility Admission Disenrollment Report	Ad-hoc report including the process for a Member's disenrollment from the CFSP due to a Nursing Facility stay longer than 90 days.	Ad hoc
Care Management		
System of Care Report	Quarterly report of System of Care activities, including, but not limited to, coordination with Community Collaboratives, care planning, and implementation of evidence-based practices in communities.	Quarterly
CMHRP Corrective Action Plan Report	Quarterly CMHRP report on corrective action plan and the associated decision reasoning.	Quarterly
Care Needs Screening Report	Quarterly report of Beneficiary screening results including SDOH and Care Needs Screening	Quarterly
Local Health Department (LHD) Contracting Report	Monthly report of LHD Care Management contracting.	Monthly
PCP Operational Monitoring Report	Report to gather data related to PCP assignment, provider panel and demographics, and ongoing assignment activities to facilitate the Department's monitoring efforts.	Bi-Weekly
Enhanced Case Management Pilot Report	Quarterly report of Members served, services used, total costs related to Enhanced Case Management pilots. Further guidance will be provided at a later date.	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Care Management (CM) Interaction Beneficiary Report	Monthly report of Care Management Interactions from the Designated Care Management Entities.	Monthly
AMH Contracting Report	Monthly report of paid AMH Medical Home Fees.	Monthly
Substance Abuse/Juvenile Justice Initiative Monthly Report	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
Nursing Facility Transitions Report	Quarterly report listing CFSP Members discharged from a nursing facility and to where they were discharged.	Quarterly
High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need Members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
Care Management Ineligibility Report	Quarterly report listing Members ineligible for Care Management provided by the CFSP (e.g., Members receiving High-Fidelity Wraparound, Members in ACT)	Quarterly
Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a Qualified Professional in Substance Abuse (QPSA).	Quarterly
High-Fidelity Wraparound Report	Quarterly report demonstrating • Fidelity to the High-Fidelity Wraparound model using the WFI-EZ • Members' length of stay in High-Fidelity Wraparound • Use of crisis services, including length of service • Residential placements (after initial return home, number of additional placements during High-Fidelity Wraparound, and length of stay in placements during High-Fidelity Wraparound) • Number of informal supports at the end of High-Fidelity Wraparound • Increase in self-efficacy and skills using the Transition Asset Tool	Quarterly
Local Department of Social Services (DSS) Office Boarding Report	Daily report of all children under age 18 who are boarding in a DSS office awaiting Medicaid-funded Medically Necessary treatment for twenty-four (24) hours or more, document detailed plans to ensure member receives medically necessary treatment and escalation to CFSP Chief Medical Officer or designee.	Daily
Daily Reporting on Supportive Housing Rental Subsidies and Leases	Data entry to document rental subsidy and leasing information and updates for individuals including, but not limited to, members with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) residing in or	Daily

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	at risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) platform or other systems determined by the State.	
1915(i) Service Care Management Report	Quarterly report providing the number of Members obtaining 1915(i) Services actively engaged in CFSP Care Management. In the event the CFSP delegates CFSP Care Management to care management agencies, report must also include the number of Members obtaining 1915(i) Services at each care management agency that is also a 1915(i) service provider.	Quarterly
Providers		
Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for Provider Contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the Members' residences that a Member must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).	Ad hoc
Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where Members live.	Annually
PHP NEMT Provider Contracting Report	Non-emergency provider contracting report at a detailed and summary level from the CFSP's	Twice per month
PCP CFSP Panel Capacity Limit Report	PCP CFSP Panel Capacity Limit Report.	Weekly until launch and then monthly
Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for Behavioral Health within specified timeframes by category.	Annually
Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for Behavioral Health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
Provider Grievances and Appeals Report	Monthly report of all Provider Appeals and Grievances and Provider Grievance and Appeal statistics, including number/type of Appeals, Appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
Provider Quality Assurance Report	Quarterly report of survey results which measures providers' ability to access needed services, ease of use of	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	
Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly
Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.	Annually
Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. Submit with Timely Access Physical Health Provider Appointment Wait Times Report.	Annually
Provider Preventable Conditions Log	Quarterly report of Provider Preventable Conditions.	Quarterly
Rate Ceiling Necessity Report	Report to identify provider types for which the CFSP recommends an establishment of a rate ceiling, to include information supporting the recommendation.	Ad hoc
Local Health Department Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: local health departments. The CFSPs will leverage the template to use their data to calculate the Directed Payment and submit it as an “invoice” to NC Medicaid for payment. The CFSPs will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the CFSP as an enclosure from NC Medicaid with formal instructions to pay each Local Health Department the amounts in accordance with the invoice summary.	Quarterly
Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: public ambulance providers. The CFSP will leverage the template to use their data to calculate the Directed Payment and submit it as an “invoice” to NC Medicaid for payment. The CFSP will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the CFSP as an enclosure from NC Medicaid with formal instructions to pay each Public Ambulance Provider the amounts in accordance with the invoice summary.	Quarterly
Out-of-Network (OON) Services Request Reports	Monthly report on all requests for OON services, including status of requests of each request, determination, and basis for determination	Monthly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Summary UNC_ECU Physician Claims Report	Quarterly report. The CFSP will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. The CFSP will include records of Members where no payment was received from the State or payment received differed from the amount expected. The CFSP will only include Member records with discrepancies on this report to the State. The CFSP Capitation Reconciliation Report will be submitted on a monthly cadence. The CFSP will indicate expected values and values observed on ASC x12 834 monthly file for Members.	Monthly
Emergency Department Boarding for Children in Medicaid	Daily report of all children under age 18 who are boarding in an Emergency Department awaiting Medically Necessary treatment for Behavioral Health, I/DD, or TBI. For any child in the ED for twenty-four (24) hours or more , document escalation to CFSP Chief Medical Officer or designee.	Daily
Quality and Value		
QAPI Progress Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
Service Utilization	Quarterly update on underutilization/overutilization and timely utilization of services, including joint reporting by DHB and DSS.	Quarterly
VBP Assessment	A report listing the VBP contracts and payments made under VBP arrangements during the relevant reporting period.	Annually
VBP Strategy Report	Numerical tables quantifying the CFSP's projected VBP contracts in the coming year, and the amount of payments the CFSP anticipates will fall under these contracts.	Annually
VBP Strategy Narrative Report	Annual narrative report accompanying VBP Strategy Report.	Annually
Quality Measures Report	Annual CFSP performance on quality measures.	Annually
Eligible Mothers for Low Birth Weight Measure	Eligible mothers of all live singleton deliveries within measurement period for low birth weight measure (DHB-0094)	Quarterly
Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators since 20061. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its	Quarterly Quality Measures Report

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.	
Stakeholder Engagement		
Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by the CFSP to collaborate with county organizations to address issues by county.	Monthly
Tribal Engagement Report (as indicated)	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
TCL Gaps and Needs Assessment Report	Gaps and needs analysis for community-based housing, IPS- Supported Employment, Community-based MH services. Includes implementation plan to address these gaps.	Annually
TCL Gaps and Needs Assessment Progress Report	Quarterly update on concrete steps taking to implement TCL Gaps and Needs Assessment implementation plan.	Quarterly
Program Administration		
Service Line Report	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
Service Line Issue Summary Report	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
Compliance		
Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the CFSP, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by Members, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
Other Member Complaints Report	Monthly report detailing a cumulative listing of Member complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
Recipient Explanation of Medical Benefits (REOMB) Report	Quarterly summary of potential and actual fraud, waste and abuse by providers including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
Critical Incident Reports	Report of incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance use disorder services.	Ad hoc
Benefits		
Institution for Mental Disease (IMD) Report	Bi-weekly summary of Members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-weekly
Medical Prior Authorization Report	Monthly report that lists each prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
Pharmacy Benefit Determination/Prior Authorization Report	Monthly that lists prior approval requests by individual Member, service type, determination date, and approval status.	Monthly
ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Top GCNs and GC3s	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
Annual Prevention and Population Health Report	Annual report of all Members outreached, utilization and key program metrics.	Annually
Advanced Medical Home (AMH) Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.	Monthly
EPSDT Reports	Quarterly reports of provider/Member outreach and education on EPSDT.	Quarterly
Non-Emergency Medical Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
Psychotropic Medications for Youth Report	Monthly report to identify trends/usage of psychotropic medications in children 17 years of age and younger.	Monthly
Crossover-Related NEMT Appointments Scheduled	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
Ongoing Status Reports on Transitions of Care	Monthly reporting identifying and reconciling data for Members who are transitioning to and from the CFSP on an ongoing basis.	Monthly
Quarterly Admission & Readmission Report	Quarterly summary report of admission and readmission.	Quarterly
1915(i) Performance Measures Report	Report is to demonstrate ongoing compliance with annual/semiannual/quarterly 1915(i) state plan performance measures.	Quarterly
1915 (i) Service Authorization Report	The CFSP will report semi-annually on units authorized vs. units billed for certain 1915(c) waiver, 1915(i), and 1915(b)(3) services.	Semi-Annually
In-Reach and Transitions		
Rate of Institutionalization	Number and percentage of Members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported overall, by setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH) and by age.	Quarterly
In-Reach Activity Report	Number and percentage of Members eligible for In-Reach activities who are engaged for In-Reach activities; number and percentage of Members who began transition planning following In-Reach. To be reported overall, by	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	setting (e.g., state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV) and by age.	
IDD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly
Transition Activity Report for Members age 18 and above	Number and percentage of Members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a Member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall and by setting where Member was discharged (e.g., state psychiatric hospital).	Quarterly
Transition Activity for PRTF Residents, Members Under Age 18 in a State Psychiatric Facility, and Members Receiving Residential	• Average length of stay; • Total number of Members in a PRTF, Members under age 18 in a state psychiatric facility, and Members receiving Residential Treatment Levels II/Program Type, III, and IV; and	Quarterly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Treatment Levels II/Program Type, III, and IV	• Percentage of Members under age 18 in a PRTF, Residential Treatment Levels II/Program Type, III, and IV, or state psychiatric facility.	
Healthy Opportunities Pilot		
Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the CFSP may submit if the Department notifies the CFSP that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the CFSP's anticipated spending through the remainder of the Healthy Opportunities Pilot service delivery year.	N/A
Healthy Opportunities Pilot Service Delivery Report	Monthly summary of Human Services Organization invoices at the Member Level that have activity during the reporting period.	Monthly
Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of CFSP administrative fund spending.	Quarterly
Healthy Opportunities Pilot Care Management Assignment Report (if applicable)	Monthly report of Healthy Opportunities Pilot Care Management Assignment. This will be used by the Department to verify Care Management payments for Healthy Opportunities Pilot Enrolled Beneficiaries.	Monthly
Healthy Opportunities High Priority Population Report	Report that the CFSP will submit outlining the CFSP's plan for enrolling priority populations—including historically marginalized populations & communities in the pilot region—to understand the CFSP's enrollment plans and ensure inclusive representation of priority populations.	Annually
Healthy Opportunities High Priority Population Report	Report that the CFSP will submit outlining aggregate enrollment data for priority populations—including historically marginalized populations & communities in the pilot region—to understand the CFSP's progress towards meeting target enrollment as outlined in the Priority Populations Report (a). Please include all members who are part of a high priority population in the report.	Quarterly
Financial Requirements		
Financial Reporting Template	Monthly financial report providing the Department with details on CFSP financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, and expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to Encounter submissions to identify discrepancies.	Monthly
Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR	Monthly

Section VII. Attachment I. Table 1: CFSP Reporting Requirements		
CFSP Report Name	**CFSP Report Description**	**Frequency**
	expenditures. This report will contain a certification portion attesting that all information included is accurate.	
Financial Status Report	Monthly report containing expenditure categories, allocation letter number, current period expenditures, approved budget, previously reported expenditures, YTD expenditures, and un-expended balance. This report will contain Federal Non-UCR and State Special Categorical expenditures. The Department may request additional submissions of information pertaining to use of these funds on an ad hoc basis.	Monthly
Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the TP template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.	Annually
Unaudited Financial Statements	Annual submission of the unaudited financial schedule that includes restated monthly and quarterly financials, as well as a preliminary MLR.	Annually
Annual CFSP Medical Loss Ratio (MLR) Report	Annual MLR report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).	Annually
Total Cost of Care (TCOC) and Cost Growth Report	As required in Section 5.(6)a. of Session Law 2015-245, annual report to monitor cost growth. Report will also provide a summary of cost drivers and steps the CFSP is taking to address the cost drivers and mitigate future cost growth.	Annually
NC PHP Claims Monitoring Report	Monthly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	Monthly

Attachment I. Table 2: CFSP Data Extracts		
CFSP Report Name	**CFSP Report Description**	**Frequency**
Providers		
Network Data Details Extract	Quarterly report containing demographic information on network providers. *Note: Ad-hoc upon request.*	Monthly Until Children and Families Specialty Plan Launch, then Quarterly and Ad Hoc thereafter
Members		
CFSP Enrollment Extract	Weekly detail report, and underlying data, highlighting key Member Enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including Enrollment and disenrollment by managed care eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Weekly
Monthly CFSP Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to 7/1/2021, the extract would include member eligibility as of 7/1/2021. See the "Appx-Members Included" tab for more details.	Monthly
Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of ABD issued by the CFSP to a Member and each Grievance received by the CFSP from Members.	Daily
Benefits and Care Management		
Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual Member, service type, determination date, and approval status.	Weekly
Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly

Attachment J: Risk Level Matrix

The CFSP agrees and acknowledges that the Risk Level Matrix is intended to be an illustrative, non-exhaustive list of the types of acts, failures to act, behaviors, and/or practices that may be assigned to a specific level by the Department upon consideration of some or all of the factors described in the Contract.

If the CFSP is found to be noncompliant with the terms, conditions, or requirements of the Contract or of any other violation by the Department, the CFSP agrees and acknowledges that the Risk Level Matrix, as provided in the Contract, is for demonstrative purposes only, and the Department retains the sole discretion to assign an appropriate level to each type of noncompliance or violation by the CFSP based on the nature of the noncompliance or violation as described in the Contract.

The CFSP further agrees and acknowledges that the content included in the examples of noncompliant behavior and/or practices in the Risk Level Matrix are not the full scope of violations subject to a Risk Level assignment by the Department and that if a specific example of noncompliant behavior or practice identified in the Matrix occurs, the Department is not obligated to assign the noncompliant behavior or practice in accordance with the level provided in this Matrix.

Section VII. Attachment J. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Member(s); reduces Members' access to care; and/or the integrity of Medicaid Managed Care	• Failure to substantially provide Medically Necessary covered services • Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract • Imposing on Members premiums or cost sharing that are in excess of that permitted by the Department • Failure to substantially meet minimum Care Management and Care Coordination requirements • Failure to substantially meet minimum Transition of Care Policy requirements • Failure to substantially meet or failure to require network providers to meet the Network Adequacy Standards established by the Department (without an approved exception) • Denying coverage for OON care when no reasonable access to an in-network provider is available • Continuing failure to resolve Member and Provider Appeals and Grievances within specified timeframes • Failure to maintain CFSP license in good standing with DOI, as applicable • Failure to timely submit accurate and/or complete Encounter data in the required file format • Misrepresenting or falsifying information that it furnishes to CMS or to the Department • Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation • Failure to substantially comply with the claims processing requirements and standards

Section VII. Attachment J. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	• Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) • Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation • One or more Level 2 violations within a Contract Year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize Member(s) health, safety, and welfare or access to care	• Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract • Failure to comply with established rate floors and fee schedules as required under the Contract • Failure to make additional directed payments to certain providers as required under the Contract • EQRO or other program audit reports with substantial findings • Failure to comply with Member services requirements (including hours of operation, call center, and online portal) • Failure to maintain the privacy and/or security of data containing Protected Health Information (PHI) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PHI • Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation • Two or more Level 3 violations within a Contract Year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program	• Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval • Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) • Failure to notify the Department and Members of terminated network providers within required timeframes • Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested • Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) • Using unapproved Member notices, educational materials, and handbooks and Marketing Materials • Engaging in prohibited Marketing activities and practices • Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation

Section VII. Attachment J. Table 1: Risk Level Matrix	
Level	**Examples of Noncompliant Behavior and/or Practices**
	• Three or more Level 4 violations within a Contract Year
LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation of the managed care program	• Submission of a late, incorrect, or incomplete report or deliverable (excludes Encounter data and other financial reports) • Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation • Failure to comply with time frames for distributing (or providing access to) Member Handbooks, identification cards, provider directories, and educational materials to Members (or Potential Members) • Failure to meet minimum requirements requiring coordination and cooperation with external entities • EQRO or other program audit reports with non-substantial findings • Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements) • Failure to timely furnish a policy, handbook, directory, or manual upon request by a Member or Potential Member as required under the Contract • Failure to substantially comply with the Preferred Drug List requirements

Attachment K: Managed Care Terminology Provided to the CFSP for Use with Members Pursuant to 42 C.F.R. § 438.10

1. Appeal: A review by the Plan of an Adverse Benefit Determination.
2. Co-Payment: Also known as a "Copay" is a fixed amount paid by the Member for certain covered health care services. The copay amount may vary by service or provider. Example: A member cost of $1.00 for a generic prescription.
3. Durable Medical Equipment: Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is appropriate for home use and is not useful to a person without illness or injury. For devices classified as DME after January 1, 2012, has an expected life of three (3) years.
4. Emergency Medical Condition: A medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.
5. Emergency Medical Transportation: Medically Necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.
6. Emergency Room Care: Care given for a medical emergency, in a part of the hospital where emergency diagnosis and treatment of illness or injury is provided, when it is believed that one's health is in danger and every second counts.
7. Emergency Services: Inpatient and outpatient services by a qualified provider needed to evaluate or stabilize an emergency medical condition.
8. Excluded Services: Services that are not covered by the CFSP.
9. Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes the Member's right to dispute an extension of time proposed by the CFSP to make an authorization decision.
10. Habilitation Services and Devices: Health care services that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings.
11. Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.
12. Home Health Care: Certain medically necessary services provided to Members in any setting in which normal life activities take place other than a hospital, nursing facility, or intermediate care facility. Services include skilled nursing, physical therapy, speech-language pathology, and occupational therapy, home health aide services, and medical supplies.
13. Hospice Services: Special services for patients and their families during the final stages of illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.
14. Hospitalization: Care in a hospital that requires admission as an inpatient for a duration lasting more than twenty-four (24) hours. An overnight stay for observation could be outpatient care.
15. Hospital Outpatient Care: Care for a Member in a hospital, or distinct part of a hospital, for professional services of a duration less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

16. Medically Necessary: Those covered services that are within generally accepted standards of medical care in the community and not experimental.
17. Network: A group of doctors, hospitals, pharmacies, and other health care experts contracted by the CFSP to provide health care services.
18. Non-Participating Provider: Non-Par or Non-Participating Providers are physicians or other health care providers that have not entered into an agreement with the CFSP and are not part of the Network, unlike participating providers. They may also be called OON providers.
19. Participating Provider: Par or participating providers are physicians or other health care providers that have an agreement with the CFSP and are part of its Network. These agreements outline the terms and conditions of participation for both the payer and the provider.
20. Physician Services: Health care services a licensed medical physician, or physician extender such as a nurse practitioner or physician assistant, provides, orders, or coordinates.
21. Plan (or Health Plan): The company providing you with health insurance.
22. Preauthorization: The approval needed from your plan before you can get certain health care services or medicines.
23. Premium: The amount paid for health insurance monthly. In addition to a premium, other costs for health care, including a deductible, copayments, and coinsurance may also be required.
24. Prescription Drug Coverage: Refers to how the CFSP helps pay for its Members' prescription drugs and medications.
25. Prescription Drugs: Also known as prescription medication or prescription medicine, is a pharmaceutical drug that legally requires a medical prescription to be dispensed.
26. Primary Care Physician: A licensed medical doctor (MD) or doctor of osteopathy (DO) that provides and coordinates patient needs and initiates and monitors referrals for specialized services when required. See Primary Care Provider.
27. Primary Care Provider (PCP): The participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.
28. Provider: A health care professional or a facility that delivers health care services, like a doctor, hospital, or pharmacy.
29. Rehabilitation Services and Devices: Health care services and equipment that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to sickness, injury, or disablement. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.
30. Skilled Nursing Care: Care that requires the skill of a licensed nurse.
31. Specialist: A provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
32. Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get Urgent Care in a walk-in clinic for a non-life-threatening injury (like the flu or sprained ankle).

Attachment L: POLICIES

1. North Carolina Medicaid Managed Care and CFSP Enrollment Policy

a. Background

The Department will ensure that Medicaid Beneficiaries and their families and caregivers are supported in the transition to Medicaid Managed Care and the CFSP throughout the Enrollment process, including enrolling in the CFSP and selecting a Primary Care Provider (PCP). The Department will ensure Beneficiaries and their families experience a smooth transition from NC Medicaid Direct and LME/MCOs or from a Standard Plan, BH I/DD Tailored Plan, or Tribal Option to the CFSP and have the tools and resources to access care throughout CFSP implementation.

b. Scope

The North Carolina Medicaid Managed Care and CFSP Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the CFSP in the Enrollment of Beneficiaries into the CFSP. The intent of this Policy is not to replace any existing Enrollment processes related to NC Medicaid Direct.

c. Identification and Enrollment of Beneficiaries in the Auto-Enrolled Groups Eligible for the CFSP

i. Medicaid Beneficiaries meeting one of the following criteria will be eligible for Enrollment in the CFSP and referred to as the "auto-enrolled groups" unless they are otherwise part of a group excluded from managed care Enrollment:

a) Beneficiaries who are in Foster Care;
b) Beneficiaries receiving adoption assistance;
c) Beneficiaries who are enrolled in the Former Foster Youth eligibility group; and
d) Minor children of populations described in *Section VII. Attachment L.1.c.i.a - c* as long as their Parent is enrolled.

ii. The Department will employ the processes described below for the auto-enrolled group:

a) In the period between BH I/DD Tailored Plan and CFSP launch:

1. Beneficiaries eligible for the CFSP receiving services in NC Medicaid Direct will have the option to enroll in a Standard Plan, or BH I/DD Tailored Plan, as eligible, upon BH I/DD Tailored Plan launch.
2. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who become eligible for the CFSP will remain in the Standard Plan or BH I/DD Tailored Plan but will have the option of moving to NC Medicaid Direct.
3. Upon CFSP launch, Beneficiaries eligible for the CFSP in NC Medicaid Direct, enrolled in a Standard Plan or a BH I/DD Tailored Plan will be disenrolled (as applicable) and moved to the CFSP.

A. Prior to CFSP launch, the Department will send Beneficiaries who meet the "auto-enrolled groups" CFSP eligibility criteria, except as outlined below, a notice indicating that they will be auto-enrolled in the CFSP and can elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable) at any point during the coverage year.

I. CFSP excluded populations shall include Beneficiaries eligible for the CFSP:

i. Who are enrolled in the Innovations or TBI waivers;
ii. Residing in or receiving respite services at an ICF-IID;
iii. Ages 18 and older who are receiving State-funded BH, I/DD and TBI services that are not otherwise available through Medicaid,

iv. Beneficiaries receiving State-funded residential services, including group living, family living, supported living, and residential supports; and

v. Recipients enrolled in and being served under Transitions to Community Living.

II. CFSP excluded populations will instead be enrolled into BH I/DD Tailored Plans.

III. Beneficiaries enrolled in the Innovations and TBI waiver who wish to enroll in the CFSP will be required to disenroll from their respective waivers prior to submitting a disenrollment request.

IV. Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a) are exempt from Medicaid Managed Care and are auto-enrolled in the Tribal Option or NC Medicaid Direct depending on their county of residence, but will have the choice to enroll in a Standard Plan, the CFSP (as applicable), or a BH I/DD Tailored Plan (as applicable).

V. The Department will transmit CFSP assignment to the CFSP through a standard eligibility file.

4. For a Beneficiary who is eligible for the CFSP and is either auto-enrolled to the CFSP or selects a Standard Plan or BH I/DD Tailored Plan, coverage by the CFSP, Standard Plan or BH I/DD Tailored Plan begins on the first day of CFSP launch.

b) Period after CFSP Launch (ongoing Enrollment)

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the auto-enrolled groups:

A. The Department will send a notice to Standard Plan and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.

B. Beneficiaries enrolled in a Standard Plan or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria will be auto-enrolled in the CFSP effective the first of the month when CFSP eligibility was determined, unless the Member calls to request to continue Enrollment in the Standard Plan or BH I/DD Tailored Plan.

C. The following BH I/DD Tailored Plan members will remain in the BH I/DD Tailored Plan:

I. Beneficiaries enrolled in the Innovations or TBI waivers;

II. Recipients enrolled in and being served under Transitions to Community Living;

III. Beneficiaries obtaining state-funded BH, I/DD or TBI services not otherwise available through Medicaid;

IV. Beneficiaries living in state-funded residential treatment;

V. Beneficiaries residing in or receiving respite services at an ICF-IID.[15]

D. Beneficiaries who are auto-enrolled in the CFSP will have the option to re-enroll in a Standard Plan or BH I/DD Tailored Plan at any time during the coverage year.

E. If a Medicaid applicant is determined newly eligible for Medicaid, and is eligible for the CFSP, the Department will auto-enroll the applicant to the CFSP through a standard eligibility file (unless they are in a Managed Care Exempt or a CFSP excepted population).

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined. CFSP Members will have an opportunity to select a

[15] BH I/DD Tailored Plan Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan and transfer to a CFSP.

Standard Plan or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

d. **Identification and Enrollment of Beneficiaries Eligible for the CFSP on an Opt-in Basis**

i. Pending CMS approval, the following populations who are not otherwise excluded from Medicaid Managed Care as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care* shall be eligible for Enrollment in the CFSP on an opt-in basis at a date that may be later than CSFP launch. They shall have the option of enrolling in the CFSP unless they are otherwise exempt or meet an exception outlined above in *Section VII. Attachment L.1.c.ii.b.1.C.:*

a) Parents, Caretaker Relatives, Guardians and Custodians of Beneficiaries in Foster Care working toward family reunification;[16,17]
b) Minor siblings of Beneficiaries in Foster Care working toward family reunification;
c) Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home;
d) Adults identified in an open Eastern Band of Cherokee Indians Department of Public Health and Human Services Family Safety program case and any children living in the same home; and
e) Any other Beneficiary that has been involved with the child welfare system who the Department determines would benefit from Enrollment.

ii. The Department will employ the processes described below for the opt-in groups:

a) In the period prior to CFSP launch:

1. Medicaid Beneficiaries in the opt-in groups will enroll in Standard Plans or BH I/DD Tailored Plans, as eligible.

b) In the period after CFSP launch (ongoing Enrollment which may start at a date later than CFSP launch):

1. Standard Plan and BH I/DD Tailored Plan Members Who Are Newly Eligible for the CFSP and in the opt-in groups:

A. The Department will send a notice to Standard Plan, Tribal Option and BH I/DD Tailored Plan Members who become newly eligible for the CFSP.
B. Beneficiaries enrolled in a Standard Plan, Tribal Option, or BH I/DD Tailored Plan who newly meet CFSP eligibility criteria shall have the option of enrolling in the CFSP at any point during the coverage year effective the first of the month following their election.
C. Beneficiaries who elect to enroll in the CFSP will have the option to re-enroll in a Standard Plan, Tribal Option or BH I/DD Tailored Plan, as eligible at any time during the coverage year.
D. A Medicaid applicant determined newly eligible for Medicaid, and eligible for the CFSP on an opt-in basis will have the option of enrolling in a Standard Plan, Tribal Option (if applicable), BH I/DD Tailored Plan (if applicable) or CFSP.

I. Coverage by the CFSP begins on the first day of the month in which Medicaid eligibility is determined for members who select the CFSP. CFSP Members will have an opportunity to select a Standard Plan, Tribal Option or BH I/DD Tailored Plan (if applicable) at any point during the coverage year.

[16] Pending CMS approval.
[17] The CFSP will recognize the Tribal definition of "parents, guardians, and custodians" in determining Tribal member eligibility for the Plan.

iii. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Available in the CFSP

a) Beneficiaries enrolled in Standard Plans who have a need for a service only available in the CFSP (i.e., a service-related request) and are eligible for Enrollment in the CFSP on an opt-in basis will be able to transfer to the CFSP in an expedited manner through the standard process that the Department will define.

e. Continuing Enrollment in the CFSP

i. CFSP Plan-eligible and enrolled individuals will continue to be eligible for the CFSP if they meet the eligibility criteria described in *Section V.B.1. Eligibility and Enrollment for CFSP*.

ii. Children in Foster Care whose Foster Care eligibility category status changes and who return to the custody of their Parents, Guardians, or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., the date their eligibility category changes).

iii. Minor children in the auto-enrolled groups shall remain eligible for CFSP Enrollment provided their Parent remains eligible for the CFSP.

iv. Parents, Guardians and Custodians of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their child remains eligible for the CFSP and County DSS is working toward family reunification.

v. Minor siblings of Beneficiaries in Foster Care shall remain eligible for the CFSP provided their sibling remains eligible for the CFSP and County DSS is working toward family reunification.

vi. DSS shall notify the Department and the CFSP in cases where they are no longer working toward family reunification.

vii. Adults identified on an open CPS In-Home Family Services Agreement case and any minor children living in the same home shall remain eligible for the CFSP if they continue to receive CPS In-Home Services.

a) County DSS shall notify the Department and the CFSP upon the conclusion of CPS In-Home Services Agreement.

viii. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan or BH I/DD Tailored Plan (if applicable) at Redetermination and noticed as part of their Redetermination process.

f. Medicaid Eligibility Redeterminations

i. At a CFSP Member's Medicaid renewal, if a Member is redetermined eligible for Medicaid and continues to be eligible for the CFSP, the Department will auto-enroll the Member into the CFSP, unless the Member chooses to enroll in a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment).

a) The Member will continue to have the opportunity to elect to enroll in a Standard Plan or BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment at any point during the coverage year.

b) Members who enroll in the Innovations or TBI waiver, residing in or receiving respite services at an ICF-IID, ages 18 and older who require State-funded BH, I/DD and TBI services, including residential services, that are not otherwise available through Medicaid, and recipients enrolled in and being served under Transitions to Community Living will be disenrolled and transferred to the BH I/DD Tailored Plan effective on the first day of the month following the service request.

c) If the Member selects a Standard Plan, BH I/DD Tailored Plan (as applicable), Tribal Option (as applicable) or NC Medicaid Direct (as applicable for Beneficiaries exempt from mandatory Managed Care Enrollment), the Enrollment Broker will transmit the selection to the Department. The Department will in turn transmit the selection to the Standard Plan, BH I/DD Tailored Plan or Tribal Option through a standard eligibility file. Coverage of the Member by the Standard Plan, BH I/DD Tailored Plan, or Tribal Option will begin on the first day of the next month in which the Member selected the Standard Plan, BH I/DD Tailored Plan or Tribal Option.

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

g. **Special Enrollment Cases**

i. Exempt Populations

a) Exempt Population as defined in *Section V.B.1.c.ii.* that are CFSP eligible will be able to enroll in the CFSP on an opt-in basis.
b) The Enrollment Broker will provide Choice Counseling to Exempt Populations and support BH I/DD Tailored Plan (as applicable), Standard Plan, NC Medicaid Direct, CFSP, Tribal Option (as applicable), and PCP selection throughout the Beneficiary's eligibility year.
c) If a Beneficiary in an Exempt Population selects the CFSP, the Enrollment Broker will transmit the CFSP selection to the Department. The Department will transmit CFSP selection to the CFSP through a standard eligibility file.
d) If a Beneficiary in an Exempt Population elects to move from the CFSP to a Standard Plan, BH I/DD Tailored Plan or other delivery system (such as NC Medicaid Direct or Tribal Option) at any point during the Beneficiary's eligibility year, coverage of the Beneficiary by the Standard Plan, BH I/DD Tailored Plan or other delivery system begins on the first day of the next month in which the Beneficiary selected the Standard Plan, BH I/DD Tailored Plan or other delivery system.[18]
e) Beneficiaries who are eligible for the Tribal Option will be permitted to transfer to the Tribal Option from any delivery system at Redetermination and at any point during the year.

ii. Deemed newborns

a) If a Member is known to be pregnant, the CFSP shall validate that the Member selects an AMH/PCP for the child prior to the birth.
b) Upon delivery, a deemed newborn will be assigned to the CFSP unless the newborn is the child of an enrollee who meets the definition of Indian under 42 C.F.R. § 438.14(a), and the CFSP will begin providing coverage to the newborn immediately. The CFSP is responsible for the provision and payment of services for the deemed newborn in the hospital or birthing center, even if the deemed newborn has not appeared on the CFSP's roster.
c) If the CFSP receives notification of birth prior to discharge, the CFSP must ensure the deemed newborn is linked to an AMH/PCP before discharge from the hospital or birthing center.
d) The CFSP shall report the deemed newborn's birth to the Department within five (5) Calendar Days upon learning of the birth and, at a minimum, provide the Department with the mother's name, social security number, NC FAST case number, Member identification number, residing county, and the newborn's name, sex, and date of birth.
e) If the CFSP has not received confirmation of a deemed newborn's Enrollment in the CFSP through a standard eligibility file following the deemed newborn's birth, the CFSP shall notify the Department and the Enrollment Broker and send notification of the birth within sixty (60) Calendar Days from the date of delivery.

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

f) If the newborn is enrolled in Medicaid, the CFSP shall send a notification of the newborn's Enrollment and issue a Member identification card for the newborn to the mother within fourteen (14) Calendar Days of learning of the birth. This notice must include information on how the mother or caregiver can access care for the newborn.

h. **Disenrollment from the CFSP and Medicaid Managed Care**

i. Member disenrollment from the CFSP may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from the CFSP to a Standard Plan, BH I/DD Tailored Plan (as applicable) or Tribal Option (as applicable).

ii. Member requested disenrollment

a) A Member, or an Authorized Representative, may submit a verbal or written request for disenrollment from the CFSP to the Enrollment Broker by phone, mail, in-person, or electronically.
b) A Member may request disenrollment from the CFSP and transfer to a Standard Plan, BH I/DD Tailored Plan (if applicable) or the Tribal Option (if applicable) any time during the coverage year.
c) The Member, or the Authorized Representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
d) At the time of the disenrollment request, Choice Counseling for the Member or the Member's Authorized Representative will be available from the Enrollment Broker.
e) The Enrollment Broker will process disenrollment requests in accordance with the following:

1. The Enrollment Broker will evaluate the request and will approve it.
2. The Enrollment Broker will notify the Department of its decision by the next Business Day following receipt of the request.

f) Notice of disenrollment determination

1. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval of the disenrollment request in accordance with G.S. 108D-5.7 and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
2. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the Member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.[19]

g) Expedited review of Member-initiated requests for disenrollment

1. A Member, or an Authorized Representative, may request an expedited review of the Member's disenrollment request when the Member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued Enrollment in the CFSP could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
2. The Enrollment Broker will process requests for expedited review in accordance with the following:

A. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
B. The Department will evaluate and decide whether to approve or deny the request.

[19] 42 C.F.R. § 438.56(e).

3. The Department will notify the Member, or Authorized Representative, and the CFSP of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) Calendar Days of receipt of the request by the Enrollment Broker.

iii. Disenrollment required by the Department

a) The Department shall disenroll Beneficiaries from the CFSP who are no longer eligible for the CFSP who remain Medicaid Managed Care eligible at Redetermination as follows:

1. CFSP Members no longer eligible for the CFSP who remain Medicaid Managed Care mandatory will be notified by the Department that they are no longer eligible for the CFSP, that they will be auto-enrolled into a Standard Plan or BH I/DD Tailored Plan (as applicable) and that they can select a different plan. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.
2. Children in Foster Care who return to the custody of their Parents, Guardians or Custodians shall have the option of remaining enrolled in the CFSP for an additional twelve (12) months from the date of reunification (e.g., when their eligibility category changes).

b) The Department may disenroll a Member from Medicaid Managed Care for any of the following reasons:

1. Loss of eligibility

A. If the Department determines that a Member is no longer eligible for Medicaid, the Member will be notified by the Department and the Member will be disenrolled from the CFSP. The disenrollment effective date will be the last date of the Member's date of Medicaid eligibility.

B. If a Member is disenrolled from a CFSP solely because the Member loses his or her eligibility for Medicaid for a period of two (2) months or less, the Member will automatically be reenrolled in the CFSP upon reenrollment in Medicaid. 42 C.F.R. § 438.56(g).

2. Change in Medicaid eligibility category

A. If the Department determines that a Member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.c. Populations Excluded, Exempt and Delayed from Medicaid Managed Care,* the Member will be notified by the Department and the Department will disenroll the Member from the CFSP. The disenrollment effective date will be the date when the Member's change in eligibility category was effective.

3. Nursing facility long-term stays

A. A Member with a nursing facility stay that exceeds ninety (90) continuous Calendar Days will be disenrolled from the CFSP on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[20]

B. The CFSP shall utilize the Department-developed standardized process for monitoring length of stay for Members in nursing facilities to ensure Members receive appropriate levels of care and to report to the Department Members who need to be disenrolled due to stays that exceed ninety (90) Calendar Days.

C. To monitor and report a Member's length of stay in a nursing facility the CFSP must use the following process:

[20] Session Law 2015-245, as amended by Session Law 2018-49.

I. Within thirty (30) days of admission to a nursing facility, the CFSP will assess a Member's health care needs and estimate the potential length of stay. If the Member requires a stay for longer than ninety (90) Calendar Days, the CFSP must notify the Department in writing within five (5) Calendar Days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.

II. The CFSP is responsible for tracking the total continuous length of stay for each Member residing in a nursing facility.

III. The Department will send the CFSP and the Member, or Authorized Representative, a written notice of disenrollment at least fourteen (14) Calendar Days before the effective date of the Member's disenrollment from the CFSP.

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

V. Coverage of the Member by the CFSP will end on the effective date provided by the Department.

c) Neuro-Medical Centers and Veterans Homes

1. A Beneficiary, otherwise eligible for Enrollment in the CFSP, residing in a state-owned Neuro-Medical Center[21] or a DMVA-operated Veterans Home[22] when the Department implements the CFSP is excluded and will receive care in these facilities through NC Medicaid Direct.
2. A Member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of the CFSP will be disenrolled from the CFSP by the Department.

   A. The Neuro-Medical Center or Veterans Home will submit the Member's information including date of admission to the Department within fourteen (14) Calendar Days of admission.

   B. The Department will notify the Member and the CFSP of the disenrollment and the disenrollment effective date.

   C. Coverage of the Member by the CFSP will end on the effective date provided by the Department.

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

i. **CFSP and Managed Care Enrollment Policy Changes**

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

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

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

2. CFSP Advanced Medical Home Program Policy

a. Background

i. The AMH program refers to an initiative under which a Standard Plan, a BH I/DD Tailored Plan, or the CFSP must pay Medical Home Fees to all participating primary care practices that act as PCPs. The CFSP must include the standard terms and conditions below in contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.E.4.p. Payments of Medical Home Fees to Advanced Medical Homes*

ii. An AMH "practice" will be defined by an NPI and service location.

b. Standard Terms and Conditions for CFSP Contracts with All AMH Providers

i. General requirements:

a) Accept Members and be listed as a PCP in the CFSP's Member-facing materials for the purpose of providing care to Members and managing their healthcare needs;
b) Provide primary care and patient Care Coordination services to each Member, in accordance with CFSP policies;
c) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for Emergency Medical Conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;
d) Provide direct patient care a minimum of thirty (30) office hours per week;
e) Provide preventive services, in accordance with *Section VII. Attachment L.2. Table 1: Required Preventive Services*;
f) Maintain a unified patient medical record for each Member following the CFSP's medical record documentation guidelines;
g) Promptly arrange referrals for Medically Necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record;
h) Transfer the Member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or CFSP (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge;
i) Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by the CFSP's Network Adequacy Standards;
j) Refer for a second opinion as requested by the Member, based on Department guidelines and CFSP standards;
k) Review and use Member utilization and cost reports provided by the CFSP for the purpose of AMH-level UM and advise the CFSP of errors, omissions or discrepancies if they are discovered; and
l) Review and use the monthly Enrollment report provided by the CFSP for the purpose of participating in CFSP or practice-based population health or Care Management activities.

ii. Requirements specific to Members in Foster Care:

a) Review all available clinical documentation prior to each visit.
b) Coordinate with the Member's assigned care manager and/or County Child Welfare Worker, as appropriate, and make best efforts to ensure the following occur:

1. Initial physical examination within seven (7) days of entering County DSS custody; and
2. Comprehensive physical examination within thirty (30) days of entering County DSS custody.

c) Complete DSS Child Health Summary forms during required physical examinations and return forms to the assigned County DSS.

1. For the initial 7-day physical examination, complete and return Form DSS-5206; and
2. For the comprehensive 30-day physical examination, complete and return Form DSS-5208.

d) Make best efforts to schedule and conduct follow-up well visits in accordance with the AAP Health Care Standards for Members in Foster Care:

1. Members from ages zero (0) to six (6) months: every month;
2. Members from ages six (6) to twenty-four (24) months: every three (3) months; and
3. Members from ages two (2) to twenty-one (21) years: every six (6) months.

e) Conduct required health screenings in accordance with required timeframes (as appropriate based on age and the Member's clinical condition):

1. Screening for evidence of ACEs and trauma: within thirty (30) days of entry into Foster Care and as determined necessary after that;
2. General developmental and behavioral screening (e.g., ASQ-3, PEDS, PEDS DM): within thirty (30) days of entry into Foster Care and at six (6), twelve (12), eighteen (18) and twenty-four (24) months, and three (3), four (4), and five (5) years of age;
3. Psychosocial assessment (e.g., ASQ-SE, PSC, PSC-Y, SDQ, PSQ-A, Beck's, CRAFFT, Vanderbilt, Conners, Bright Futures Adolescent Questionnaire, GAPS, HEADSSS): within thirty (30) days of entry into Foster Care and every well visit thereafter as Medically Necessary;
4. Autism Spectrum Disorder screening (e.g., MCHAT R/F, STAT): at eighteen (18) and twenty-four (24) months; and
5. Oral health screening and risk assessment (e.g., NC Priority Oral Risk and Referral Tool, Bright Futures Oral Health Risk Tool): within thirty (30) days of entry into Foster Care all subsequent well visits up to age three-and-a-half (3 ½).

f) As appropriate, coordinate with care manager to refer Member to a dental home.

g) As appropriate, utilize best practices described in "Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System" from the American Academy of Child and Adolescent Psychiatry (AACAP) when treating Members served by the child welfare system.

Section VII. Attachment L.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening						Y		Y		Y	Y	Y

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

3. CFSP Pregnancy Management Program Policy

a. Background

i. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among Participating Providers. Refer to the Contract for additional detail regarding the Pregnancy Management Program.

b. Scope

i. The scope of this Policy covers the requirements that must be in agreements between the CFSP and providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program outlined below and in *Section V.D.4.c. Pregnancy Management Program in Coordination with Care Management for High-Risk Pregnant Women.*

c. Pregnancy Management Program Requirements

i. The CFSP shall incorporate the following requirements into their contracts with all providers of prenatal, perinatal and postpartum care, including the following requirements for providers of the Pregnancy Management Program:

a) Complete the standardized risk-screening tool at each initial visit.
b) Allow the CFSP or the CFSP's designated Vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
c) Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
d) Commit to decreasing the cesarean section rate among nulliparous women.
e) Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
f) Complete a high-risk screening on each pregnant CFSP Member in the program and integrate the plan of care with CFSP Care Management and/or CMHRP.
g) Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty percent (20%)).
h) Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
i) Require that CFSP network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for Members in CMHRP to the CFSP or LHD that is responsible for the provision Care Management services for high-risk pregnancy.

4. CFSP Care Management for High-Risk Pregnancy Policy

a. **Background**

i. "Care Management for High-Risk Pregnancy" refers to Care Management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs). Refer to the Contract for additional detail regarding CMHRP in *Section V.D.4.b. Local Health Departments*.

ii. For Contract Year 1, LHDs shall have "right of first refusal" as contracted providers of CMHRP Women. Women participating in CMHRP with an LHD are also eligible for CFSP Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.

iii. After Contract Year 1, CMHRP shall be fully subsumed into the CFSP Care Management model.

b. **Scope**

i. The scope of this Policy covers the agreement between the CFSP and LHD providers offering CMHRP, as outlined below and in the Contract.

c. **General Contracting Requirement**

i. LHD shall accept referrals from the CFSP for CMHRP services.

d. **Care Management for High-Risk Pregnancy: Outreach**

i. LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in Care Management.

e. **Care Management for High-Risk Pregnancy: Population Identification and Engagement**

i. LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated Care Management documentation system within five (5) Calendar Days of receipt of risk screening forms.

ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

iii. LHD shall accept pregnancy Care Management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Division of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

iv. LHD shall review available CFSP data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and CMHRP teams to facilitate cross-county partnerships to ensure coordination of care and appropriate Care Management assessment and services for all patients in the target population.

f. **Care Management for High-Risk Pregnancy: Assessment and Risk Stratification**

i. LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider, and other methods on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for Care Management for level of need for Care Management support.

ii. LHD shall utilize assessment findings, including those conducted by the CFSP, to determine level of need for Care Management support.

iii. LHD shall document assessment findings in the Care Management documentation system.

iv. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.

v. LHD shall assign case status based on level of patient need.

g. **Care Management for High-Risk Pregnancy: Interventions**

i. LHD shall provide Care Management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients and meeting their needs. This includes in-person Encounters (practice visits, home visits, hospital visits, community Encounters), telephone outreach, professional Encounters and/or other interventions needed to achieve Care Plan goals.

ii. LHD shall provide Care Management services based upon level of patient need as determined through ongoing assessment.

iii. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.

iv. LHD shall utilize NCCARE360 to identify and connect Members with additional community resources.

v. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the Member's CFSP Network.

vi. LHD shall document all Care Management activity in the Care Management documentation system.

h. **Care Management for High-Risk Pregnancy: Integration with the CFSP and Health Care Providers**

i. LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.

ii. LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.

iii. LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice in the county or serving residents of the county.

iv. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.

v. LHD shall ensure awareness of CFSP Members' "in network" status with providers when organizing referrals.

vi. LHD shall ensure understanding of the CFSP's prior authorization processes relevant to referrals.

i. **Care Management for High-Risk Pregnancy: Collaboration with CFSP**

i. LHD shall work with the CFSP to ensure program goals are met.

ii. LHD shall review and monitor CFSP reports created for the Pregnancy Management Program and CMHRP services to identify individuals at greatest risk.

iii. LHD shall communicate with the CFSP regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

iv. LHD shall participate in pregnancy Care Management and other relevant meetings hosted by the CFSP.

j. **Care Management for High-Risk Pregnancy: Training**

i. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy Care Management training offered by the CFSP and/or the Department, including webinars, new hire orientation or other programmatic training.

ii. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the CFSP and/or the Department.

iii. LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based Care Management of pregnancy and postpartum women at risk for poor birth outcomes.

iv. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and Trauma-Informed Care techniques on an ongoing basis.

k. **Care Management for High-Risk Pregnancy: Staffing**

i. LHD shall employ care managers meeting pregnancy Care Management competencies, defined as having at least one of the following qualifications:

a) Registered nurses
b) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
c) Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

ii. LHD shall ensure that Community Health workers for CMHRP services work under the supervision and direction of a trained care manager.

iii. LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.

iv. If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

v. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.

vi. LHD shall ensure that pregnancy care managers demonstrate:

a) A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes
b) Proficiency with the technologies required to perform Care Management functions
c) Motivational interviewing skills and knowledge of adult teaching and learning principles
d) Ability to effectively communicate with families and providers
e) Critical thinking skills, clinical judgment and problem-solving abilities

vii. LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

a) Provision of program updates to care managers
b) Daily availability for case consultation and caseload oversight
c) Regular meetings with direct service Care Management staff
d) Utilization of reports to actively assess individual care manager performance
e) Compliance with all supervisory expectations delineated in the CMHRP Program Manual

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following CFSP/Department guidance about communication with the CFSP about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

ix. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the CFSP.

5. CFSP Uniform Credentialing and Re-credentialing Policy

a. Background

This Uniform Credentialing and Re-credentialing Policy outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a CFSP in determining whether to allow a provider to be included in the CFSP's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider.

b. Scope

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

c. Policy Statement

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

i. Centralized Provider Enrollment and Credentialing

a) The Department, or Department designated Vendor, will implement a CCRP with the following features:

1. The Department, or Department designated Vendor, shall collect information and verify credentials, through a centralized Credentialing process for all providers currently enrolled or seeking to enroll in the North Carolina's Medicaid program.

   A. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider.

   B. The Department may, at its option, contract with a Vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

2. The Department shall apply the Credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for the Medicaid services, including all providers that must be credentialed under Credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
3. The process and information requirements shall meet the most current data and processing standards for a Credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization.

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

4. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid enrolled provider, with the application

serving for enrollment as a Medicaid Fee-for-Service provider as well as a Medicaid Managed Care Provider.

A. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the State Medicaid Fee-for-Service program.

5. Providers will be reverified and recredentialed as permitted by the Department in the Contract.
6. The CFSP shall use its Provider Credentialing and Re-credentialing Policy to decide whether to contract with a Medicaid Enrolled provider in accordance with the standards contained in this Policy.
7. The Department, or its designated Vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled Providers.

A. The CFSP shall use the Provider Enrollment File to identify active Medicaid Enrolled Providers who are eligible for contracting.

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

a) The CFSP shall develop and implement, as part of its Credentialing and Re-credentialing Policy, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:

1. Meet the requirements specified in 42 C.F.R. § 438.214;
2. Meet the requirements specified in this Contract;
3. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, behavioral, substance use disorders, and long-term services and supports providers;
4. Establish that the CFSP shall accept provider Credentialing and verified information from the Department and shall not request any additional Credentialing information without the Department's approval.
5. Establish a documented process for determining if a provider is an active Medicaid Enrolled Provider and therefore eligible for contracting;
6. Prohibit the CFSP from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
7. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
8. Prohibit the CFSP to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
9. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E;
10. If the CFSP requires a provider to submit additional information as part of its contracting process, the CFSP's Policy shall include a description of all such information.

A. The CFSP shall make network contracting decisions based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates.

B. Examples of valid additional information include the provider's office hours, accepting new patients, ages served, and EFT information.

11. CFSP shall re-credential providers as follows:

A. The CFSP shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.

B. After the Provider Credentialing Transition Period, no less frequently than every three (3) year

12. Include all previous versions, be published on the CFSP's website and include the Policy effective dates.

b) CFSP shall follow this Policy and its Provider Credentialing and Re-credentialing Policy when making a Quality Determination and contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state network providers.

c) CFSP shall have discretion to make contracting determinations consistent with the Policy and the CFSP's Provider Credentialing and Re-credentialing Policy.

d) CFSP shall publish its approved Provider Credentialing and Re-credentialing Policy, including all previous versions, on the CFSP's website and include the effective date of each Policy. The CFSP shall make the Credentialing/Recredentialing Policy available, within ten (10) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.

6. CFSP Management of Inborn Errors of Metabolism Policy

a. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.

b. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.

c. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that CFSP cover the full cost of evidence-based therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized Care Plan.

d. Once a client is established with a specialized treatment facility a nutrition Care Plan is developed and products prescribed. The current system of product coverage is four pronged:

    i. Clients with Health Insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers.

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

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

    iv. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC

agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

e. The CFSP will need to establish working relationships with the NSB, Specialty Treatment Centers, and metabolic formulas suppliers/manufacturers.

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

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

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

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

7. CFSP Behavioral Health Service Definition Policy

a. Background

The CFSP Behavioral Health Service Definitions Policy provides the CFSP with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

b. Behavioral Health Services Definitions

i. 1915(i) Services: The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members covered by this Contract.

ii. Opioid Treatment Program (adults only): a location-based service for the purpose of Network Adequacy Standards.

iii. Adult Facility-Based Crisis Services: a crisis service for the purpose of Network Adequacy Standards.

iv. Facility-based Crisis Services for Children and Adolescents: a crisis service for the purpose of Network Adequacy Standards.

v. Professional treatment services in facility-based crisis: a crisis service for the purpose of Network Adequacy Standards.

vi. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of Network Adequacy Standards.

vii. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

viii. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of Network Adequacy Standards.

ix. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

x. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xi. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xii. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiii. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xiv. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xv. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvi. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xvii. Acute Care Hospitals with Child Inpatient Psychiatric Beds as inpatient BH services for the purpose of Network Adequacy Standards.

xviii. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of Network Adequacy Standards.

xix. Partial Hospitalization: partial hospitalization for children and adults for the purposes of the Network Adequacy Standards.

xx. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xxi. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxii. Urgent care for SUD:
   a) Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
   b) Services to treat a condition in which a person displays a condition which could without Diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxiii. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxiv. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxv. Urgent Care for Mental Health:
   a) Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without Diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.

b) Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxvi. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.

xxvii. Specialized Services: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

Attachment M: Addendum for Division of State Operated Healthcare Facilities

1. **Background**

The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.[23] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The CFSP shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

2. **Scope**

The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, Grievances and Appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the CFSP and DSOHF facilities.

3. **Admissions.**

When admitting a Member to a DSOHF facility, the CFSP must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:

a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):

i. The CFSP or CFSP designated community provider (e.g., BH community provider or hospital/emergency department) shall complete and submit a Regional Referral Form available on the Department's website[24] or initiate referral via the North Carolina behavioral health/psychiatric bed registry and referral system designated by DMH/DD/SUS).

ii. The CFSP must review the admission based on review of the information provided in the Regional Referral Form or behavioral health/psychiatric bed registry and referral system designated by DMH/DD/SUS.

iii. In cases where the Member presents directly to a psychiatric hospital or ADATC for admission, the CFSP shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.

iv. The CFSP shall ensure that a CFSP-employed utilization management staff Member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;

v. *For Members subject to involuntary commitment proceedings, the CFSP must provide information or a representative who can assist the district court in determining if the Member requires continued services. If the CFSP elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the CFSP.*

[23] DSOHF also serves individuals with neuro-medical needs in specialized treatment centers that are carved out of Medicaid Managed Care and therefore not included in the CFSP contract.

[24] The Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC is available at https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf. https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf.

vi. Prior to referral or authorization of any Member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the CFSP must verify that the referral is in accordance with the requirements of N.C.G.S. 122C-261 and any other applicable North Carolina law governing the admission of Members with intellectual disabilities to a State psychiatric hospital.

vii. For Members who have multiple disorders and medical fragility or have multiple disorders and deafness, the CFSP shall be designated by the Department to determine whether Members have a high level of disability that alternative care is inappropriate, consistent with N.C.G.S. 122C-261(e)(4).

viii. In determining whether Members are eligible for referral and/or authorization for admission to a State psychiatric hospital, the CFSP must utilize and complete the I/DD Diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.

4. **Authorization**

The CFSP must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid clinical coverage policies as detailed in *Section V.C.1.e. Utilization Management*, as well as the specific requirements listed below.

a. General Requirements for State Psychiatric Hospitals and ADATCs:

i. Emergency Services:

a) The CFSP must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.
b) The CFSP cannot refuse to cover Emergency Services based upon the DSOHF facility failing to notify the Member's PCP or the CFSP of the individual's screening and treatment following presentation for Emergency Services.
c) For Members who present directly to the psychiatric hospital or ADATC as an emergency commitment or as a self-referral, the DSOHF facility shall submit a completed Electronic Authorization Request (EAR) to the CFSP the next Business Day following an admission to request admission authorization.
d) Upon receipt of the EAR, the CFSP must authorize and cover ongoing emergency medical services in accordance with applicable clinical coverage policies and consistent with the prudent layperson standard, as defined in EMTALA (Section 1867(a) of the Social Security Act).

ii. Inpatient Services:

a) The CFSP must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services, provided that the deadline may be extended for one additional Business Day if: (i) the individual or DSOHF facility requests the extension; and (ii) the CFSP justifies to the DSOHF facility a need for additional information and how the extension is in the Member's interest.
b) The CFSP must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.
c) Following initial admission authorization, the CFSP must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.
d) To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the CFSP prior to the expiration of the prior authorization no later than the last covered day of the existing authorization, or the previous Business Day if the last covered day occurs on a weekend or holiday.

e) The CFSP must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.

b. Requirements for Assessment and Stabilization

i. The CFSP shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of Members who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

ii. The CFSP must identify an appropriate discharge plan for all such Members beginning at admission.

5. **Member Grievances**

a. The DSOHF facility and the Department will manage and resolve all Member clinical concerns, or Grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility Grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with Grievance procedures established by the Department.

b. The CFSP must agree that DSOHF facilities shall refer any unresolved patient Grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and Grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the CFSP Hotline number for reporting any Grievances.)

6. **Event Reporting and Abuse/Neglect/Exploitation.**

a. The CFSP must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to Members receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.

b. The CFSP must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.

c. The DSOHF facility will cooperate with the CFSP's written request for information regarding any individual safety events/allegations involving Members to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the CFSP with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the CFSP's request.

d. The CFSP shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The CFSP shall provide the DSOHF a written summary of its finding within thirty (30) days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

Attachment N: Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

Table 1: Liquidated Damages for Compliance Issues

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$500 per Calendar Day
2.	Failure to comply with conflict of Interest requirements described in *Section III.D.17. Disclosure of Conflicts of Interests and Section V.A.9.m. Conflicts of Interest.*	$1000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.D.18. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.*	$100 per Calendar Day
B. Member		
1.	Engaging in prohibited Marketing activities or discriminatory practices or failure to market statewide as prescribed in *Section V.B.5. Marketing*	$5000 per occurrence
2.	Failure to comply with Member Enrollment and disenrollment processing timeframes as described in *Section V.B.2. Medicaid Managed Care Enrollment and Disenrollment.*	$50 per occurrence per Member
3.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section V.B.4.p. Engagement with Consumers.*	$5,000 per required occurrence
4.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.7. Member Grievances and Appeals.*	$50 per occurrence
5.	Failure to comply with all orders and final decisions relating to claim disputes, Grievances, Appeals and/or State Fair Hearing as issued or as directed by the Department.	$500 per occurrence
6.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing Appeal procedures as they become effective as described in *Section V.B.7. Member Grievances and Appeals.*	$50 per Calendar Day for each day the CFSP fails to provide continuation or restoration as required by the Department.

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
7.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.7. Member Grievances and Appeals.*	$100 for each mediation or hearing that the CFSP fails to attend as required
8.	Failure to comply with Transition of Care requirements as specified *Section V.B.3. Transition of Care Across Plans and Delivery Systems.*	$10 per Calendar Day per Member
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a Member as prohibited under the Contract or not in accordance with an approved policy.	$500 per occurrence per Member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.C.1. Benefits Package and V.C.3. Pharmacy Benefits.*	$500 per standard authorization request $750 per expedited authorization request
3.	Failure to allow a Member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section V.E.1. Provider Network.*	$100 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.C.1. Benefits Package.*	$250 per occurrence
5.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.C.3. Pharmacy Benefits.*	$250 per Calendar Day per occurrence
6.	Failure to comply with driver requirements as defined in the Department's NEMT Policy.	$150 per occurrence per driver
7.	Failure to comply with the assessment and scheduling requirements as defined in the Department's NEMT Policy.	$25 per occurrence per Member
8.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	$150 per Calendar Day per vehicle
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management Policy as required by *Section V.D.5 Care Management Policy.*	$25 per Calendar Day
2.	Failure to timely notify the Department of a notice of underperformance sent to a LHD or the termination of a contract with an LHD.	$50 per Calendar Day

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
3.	Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the CFSP or failure to use CFSP capitation to cover Member's benefits prior to use of Healthy Opportunities Pilot Program funds in at least 98% of Healthy Opportunities Pilot service authorizations, as required in *Section V.D.9. Healthy Opportunities*.	$20 per occurrence AND Refund of the CFSP's Healthy Opportunities Pilot Program budget for total amount spent on Healthy Opportunities Pilot service in each identified instance
E. Quality and Value		
1.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.F.1. Quality Management and Quality Improvement.*	$500 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.F.1. Quality Management and Quality Improvement.*	$100 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section V.F.1. Quality Management and Quality Improvement.*	$100 per Calendar Day
4.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.3. National Committee for Quality Assurance (NCQA) Accreditation.*	$10,000 per month for every month beyond the month NCQA accreditation must be obtained until such time as the CFSP is terminated in accordance with *Section V.A.3. National Committee for Quality Assurance (NCQA) Accreditation*.
5.	Failure to timely submit monthly Encounter data set certification.	$100 per Calendar Day
F. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Attachment I: Reporting Requirements.*	$200 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VII. Attachment I: Reporting Requirements.*	$100 per Calendar Day

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
3.	Failure to timely and accurately submit the MLR Report in accordance with the timeframe described in *Section V.J.2 Medical Loss Ratio* and *Attachment VII. Attachment I. Reporting Requirements.*	$200 per Calendar Day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Attachment I. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$100 per Calendar Day
G. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.K.3. Fraud, Waste and Abuse Prevention.*	$500 per Calendar Day that the Department determines the CFSP is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.K.1. Compliance Program* and *Section VII. Attachment I: Reporting Requirements.*	$100 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.K.4. Third Party Liability* and *Section VII. Attachment I: Reporting Requirements.*	$25 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or Grievance.	$250 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the CFSP's own conduct, a provider, or a Member.	$25 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section V.K.3. Fraud, Waste and Abuse Prevention* and *Section VII. Attachment I: Reporting Requirements.*	$200 per Calendar Day

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
H.	**Technical Specifications**	
1.	Failure by the CFSP to ensure that all data containing PHI, as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$50 per Member per occurrence
2.	Failure by the CFSP to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, BAA or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$50 per Member per occurrence
3.	Failure by the CFSP to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$50 per Member per occurrence, not to exceed $1,000,000
I.	**Directives and Deliverables**	
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$50 per Calendar Day that the Department determines the CFSP is not in compliance
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$100 per occurrence per committee that the Department determines CFSP is not in compliance
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$50 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain a plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g. prevention and population health management programs, drug utilization review program).	$150 per occurrence per plan/program

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
5.	Failure to provide a timely corrective action plan or comply with a corrective action plan as required by the Department.	$50 per Calendar Day for each day the corrective action plan is late, or for each day the CFSP fails to comply with an approved corrective action
6.	Failure to complete design, development, and testing of beneficiary assignment file, pharmacy lock in file and/or claims and encounter files with any contracted AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$50 per Calendar Day per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
7.	Failure to transmit a beneficiary assignment file or claims/encounter data file to an AMH Tier 3 practice (or CIN/Other Partner on its behalf), within the Department's published data specifications and timeframes.	$100 per occurrence per contracted data recipient (AMH Tier 3 practice/CIN/other technology partner)
8.	Failure to implement and maintain a Member Lock-In Program as described in *Section V.D.8.c. Opioid Misuse Prevention and Treatment Program.*	$50 per calendar day per member that the CFSP is not meeting Lock-In Requirements outlined in *Section V. D.8.c. Opioid Misuse Prevention and Treatment Program* and N.C. Gen. Stat. § 108A-68.2.
9.	Failure to remove providers that are not actively enrolled in NC Medicaid within the CFSP Network File within one (1) Business Day as specified in *Section V.E.2. Provider Network Management.*	$10 per provider per Business Day
10.	Engaging in gross customer abuse of Members by CFSP service line agents as prohibited by *Section V.H.1.w. Gross Customer Abuse*.	$100 per occurrence
11.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.H.1.w. Gross Customer Abuse*.	$25 per Business Day the CFSP fails to timely report to the Department
12.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the CFSP in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the CFSP in connection with the internal plan appeal within the requirements in *Section V.B.7.f. State Fair Hearing Process*.	$50 per occurrence

Section VII. Attachment N: Table 1: Liquidated Damages for Compliance Issues		
No.	**PROGRAM ISSUES**	**DAMAGES**
13.	Failure to upload Notices of ABD and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$50 per occurrence
14.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.L. Technical Specifications*.	$100 per occurrence
15.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in *Section V.L.10. Healthy Opportunities Pilot*.	$50 per Calendar Day that the Department determines the CFSP is not in compliance
16.	Failure to authorize or deny Healthy Opportunities Pilot services for Members within the Department's required authorization timeframes as specified in *Attachment O. Timeframes for Health Opportunities Pilot Service Authorization*.	$50 per Calendar Day
17.	Failure to pay Healthy Opportunities Pilot invoices to HSOs within the Department's required payment timeframes as specified in *Section V.E.4. Provider Payments*.	$50 per Calendar Day
18.	Failure to comply with the following provisions enumerated in *Attachment P. Healthy Opportunities Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that CFSP workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials • Ensure that care managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such care manager initiating a Member contact or an initial Healthy Opportunities Pilot assessment	$50 per occurrence beginning ninety (90) Calendar Days after Interpersonal Violence services become available to Members.

Table 2: Performance Metrics, SLAs and Liquidated Damages

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The CFSP shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the CFSP to its system to trigger Enrollment and disenrollment processes.	Daily	$100 per 24-hour period Note: Effective one month prior to CFSP launch
B. Member Grievances and Appeals					
1.	Member Appeals Resolution -Standard	The CFSP shall resolve at least ninety-eight percent (98%) of CFSP internal Appeals within the specified timeframes for standard Appeals.	The number of internal Appeals with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Appeal divided by the total number of internal Appeals filed during the measurement period.	Monthly	$1000 per month
2.	Member Appeals Resolution -Expedited	The CFSP shall resolve ninety-nine and one-half percent (99.5%) of internal Appeals within the specified timeframes for expedited Appeals.	The number of internal Appeals with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Appeal divided by the total number of internal Appeals filed during the measurement period.	Monthly	$1000 per month
3.	Member Grievance Resolution	The CFSP shall resolve at least ninety-eight percent (98%) of Member Grievances within the specified timeframes.	The number of Grievances with notices of resolution issued by the CFSP within the required timeframe of the filing date of the Grievance divided by the total number of Grievances filed during the measurement period.	Monthly	$500 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
C. Pharmacy Benefits					
1.	Adherence to the Preferred Drug List	The CFSP shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$10,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
D. Service Lines					
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$500 per service line per month
2.	Call Response Time/Call Answer Timeliness –Member Service Line	The CFSP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
3.	Call Wait/Hold Times – Member Service Line	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
4.	Call Abandonment Rate – Member Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
5.	Call Wait/Hold Times-Behavioral Health Crisis Line	The CFSP shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,500 per month
6.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$1,500 per month
7.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$1,500 per month
8.	Call Response Time/Call Answer Timeliness –Provider Support Service Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$500 per month
9.	Call Wait/Hold Times – Provider Support Service Line	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$500 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
10.	Call Abandonment Rate – Provider Support Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$500 per month
11.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$1,000 per month
12.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
13.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month
14.	Call Response Time/Call Answer Timeliness -Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
15.	Call Wait/Hold Times - Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The number of incoming calls answered by a live operator within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
16.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$1,000 per month
17.	Call Response Time/Call Answer Timeliness - NEMT	The CFSP shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month
18.	Call Wait/Hold Times - NEMT	The CFSP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$1,000 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
19.	Call Abandonment Rate - NEMT	The call abandonment rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$1,000 per month
20.	NEMT – Trip Completion Rate	The CFSP shall complete ninety-nine and one-half percent (99.5%) of all scheduled trips.	The number of trips completed by the NEMT provider over the number of trips scheduled (minus any member cancelations).	Monthly	0.51% - 0.75% Missed Trip Rate = $1,500 per month 0.76% - 0.99% Missed Trip Rate = $2,000 per month 1.0% or over Missed Trip Rate = $2,500 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
21.	Service Line Gross Customer Abuse	There shall be no occurrences of Gross Customer Abuse identified on any of the CFSP's service lines.	Gross Customer Abuse is any time an agent uses profanity, yells or screams at a caller, hangs up on a caller without warning, is condescending to a caller, dismisses a caller's complaint, does not attempt to assist a caller or engages in call avoidance. The Department can identify gross Customer Abuse through Call Listening or external complaints. Call avoidance is defined as disconnecting a call, transferring a call unnecessarily, keeping a caller on the line after the call reason has been resolved, not answering a call during an active period, being unresponsive to a caller to the point the caller disconnects or keeping a caller on hold for an extended period to the point the caller disconnects.	Quarterly	$100 per occurrence of gross customer abuse

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
E. Encounters					
1.	Encounter Data Timeliness/ Completeness – Medical	The CFSP shall submit ninety-eight percent (98%) of Medical Encounters within thirty (30) Calendar Days after payment whether paid or denied. For purposes of this standard, Medical Encounters include 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, and Healthy Opportunities payments.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an Encounter.	Monthly	$50 per claim per Calendar Day
2.	Encounter Data Timeliness/ Completeness – Pharmacy	The CFSP shall submit ninety-eight percent (98%) of Pharmacy Encounters within seven (7) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an Encounter.	Weekly	$100 per claim per Calendar Day

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Encounter Data Accuracy – Medical	The CFSP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical Claims. For purposes of this standard, medical encounters include 837-P encounters and 837-I encounters. This includes encounter data for monthly medical home and care management fees, including AMH monthly medical home and care management fees, and CMHRP, and Healthy Opportunities payments.	A paid claim submitted as an Encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$2,500 per month
4.	Encounter Data Accuracy – Pharmacy	The CFSP shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Pharmacy Claims.	A paid claim submitted as an Encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	$5,000 per week
5.	Encounter Data Reconciliation—Medical	The Encounters submitted by the CFSP shall reconcile to at least ninety-eight percent (98%) of paid Medical Claims amounts reported on financial reports.	The paid amounts on submitted individual Encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the CFSP.	Monthly	$1,000 per month

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
6.	Encounter Data Reconciliation—Pharmacy	The Encounters submitted by the CFSP shall reconcile to at least ninety-eight percent (98%) of paid pharmacy claims amounts reported on financial reports.	The paid amounts on submitted individual Encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the CFSP.	Daily	$100 per day
F. Website Functionality					
1.	Website User Accessibility	The CFSP's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.	Any occurrence during which the website is not accessible, except for those occurrences that have been Department approved and pre-announced.	Daily	$250 per occurrence
2.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$250 per month
3.	Timely response to electronic inquiries	The CFSP shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) Business Days of receipt.	Electronic inquires include communications received via email, fax, web or other communications received electronically by the CFSP (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
G. Care Management					
1.	Notification of Department of Social Services (DSS) Boarding	The CFSP shall notify the Department within twelve (12) hours of identifying any instances of a juvenile experiencing DSS boarding (boarding in a local Department of Social Services office).	Occurrence to be assessed based on the demonstration of a timelapse greater than twelve (12) hours between when the CFSP is notified by the DSS if any instance of DSS boarding and when notification is submitted to the Department.	Daily	$1,000 per day without notification to the Department beyond twelve (12) hours
2.	Notification of Emergency Department (ED) Boarding	The CFSP shall notify the Department within twelve (12) hours of identifying any instances of a juvenile experiencing ED boarding (boarding in the Emergency Department).	Occurrence to be assessed based on the demonstration of a timelapse greater than twelve (12) hours between when the CFSP is notified by the Emergency Department of any instance of ED boarding and when notification is submitted to the Department.	Daily	$1,000 per day without notification to the Department beyond twelve (12) hours
3.	Department of Social Services (DSS) Boarding Rapid Response Plan Submission	The CFSP shall provide the Department with a response plan within twenty-four (24) hours of identifying any instances of a juvenile experiencing DSS boarding that outlines a clear plan for provisioning adequate placement via appropriate Medicaid funded services.	Occurrence to be assessed based on the demonstration of a timelapse greater than twenty-four (24) hours between when the CFSP is notified by the DSS if any instance of DSS boarding and when a Rapid Response Plan is submitted to the Department.	Daily	$1,000 per day that Contractor fails to provide plan

Section VII. Attachment N: Table 2: Performance Metrics, Service Level Agreements and Liquidated Damages					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Emergency Department (ED) Boarding Rapid Response Plan Submission	The CFSP shall provide the Department with a response plan within twenty-four (24) hours of identifying any instances of a juvenile experiencing ED boarding that outlines a clear plan for provisioning adequate placement via appropriate Medicaid funded services.	Occurrence to be assessed based on the demonstration of a timelapse greater than twenty-four (24) hours between when the CFSP is notified by the Emergency Department of any instance of ED boarding and when a Rapid Response Plan is submitted to the Department.	Daily	$1,000 per day that Contractor fails to provide plan

Attachment O: Timeframes for Healthy Opportunities Pilot Service Authorization

Domain	Healthy Opportunities Pilot Service Name	Service Authorization Timelines
Housing Services	Housing Navigation, Support and Sustaining Services	Three (3) Business Days
	Inspection for Housing Safety and Quality	Seven (7) Business Days
	Housing Move-In Support	Seven (7) Business Days
	Essential Utility Set-Up	Three (3) Business Days
	Home Remediation Services	Seven (7) Business Days
	Home Accessibility and Safety Modifications	Seven (7) Business Days
	Healthy Home Goods	Seven (7) Business Days
	One-Time Payment for Security Deposit and First Month's Rent	Seven (7) Business Days
	Short-Term Post Hospitalization Housing	Three (3) Business Days

Domain	Healthy Opportunities Pilot Service Name	Service Authorization Timelines
Food Services	Food and Nutrition Access Case Management Services	Seven (7) Business Days
	Evidence-Based Group Nutrition Classes	Seven (7) Business Days
	Diabetes Prevention Program	Seven (7) Business Days
	Fruit and Vegetable Prescription	Passthrough; Expedited Referral
	Healthy Food Box (For Pick-Up)	Passthrough; Expedited Referral
	Healthy Food Box (Delivered)	Passthrough; Expedited Referral
	Healthy Meal (For Pick-Up)	Passthrough; Expedited Referral
	Healthy Meal (Home Delivered)	Passthrough; Expedited Referral
	Medically Tailored Home Delivered Meal	Seven (7) Business Days

Domain	Healthy Opportunities Pilot Service Name	Service Authorization Timelines
Interpersonal Violence Services	IPV Case Management Services	Seven (7) Business Days
	Violence Intervention Services	Seven (7) Business Days
	Evidence-Based Parenting Curriculum	Seven (7) Business Days
	Home Visiting Services	Seven (7) Business Days
	Dyadic Therapy	Seven (7) Business Days
Transportation Services	Reimbursement for Health-Related Public Transportation	Passthrough; Expedited Referral
	Reimbursement for Health-Related Private Transportation	Passthrough; Expedited Referral
	Transportation PMPM Add-On for Case Management Services	Seven (7) Business Days
Cross-Cutting Services	Holistic High Intensity Enhanced Case Management	Seven (7) Business Days
	Medical Respite	Three (3) Business Days
	Linkages to Health-Related Legal Supports	Seven (7) Business Days

Attachment P: Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services: Conditions, Requirements and Standards

All capitalized terms used in this Attachment not otherwise defined herein shall have the meanings ascribed to them as set forth in the Contract.

a. **Access to IPV-Related Information**

i. The CFSP shall consider any authorizations, Services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member as "IPV-Related Service Data."

ii. The CFSP shall ensure that all members of the CFSP's workforce (which term, as used in this Attachment, includes CFSP's employees and contractors, whether or not they are care managers) with access to Healthy Opportunities Pilot-related data, including from NCCARE360, complete IPV- Related Data Training prior to IPV service launch, including:

a) IPV-Related Services;
b) Handling of, privacy of security of, and access to IPV-Related Service Data;
c) All such other trainings as required by the Contract and by the Department in its sole discretion. The Department shall provide at least ninety (90) Calendar days notice of any changes to the Healthy Opportunities Pilot IPV Protocol.

iii. Upon a CFSP workforce member's completion of such trainings, the CFSP may designate such individual as an "IPV-Trained Individual."

iv. The CFSP shall keep current records of each IPV-Trained Individual's completion of IPV-Related Data Training for as long as such IPV-Trained Individual is employed or contracted by the CFSP and, following termination or expiration of such individual's employment or contract, for the greater of any period of time as required by applicable law or one (1) year following such termination or expiration.

v. The CFSP shall ensure that only IPV-Trained Individuals are authorized to access and view IPV-Related Service Data. The CFSP shall ensure that any CFSP workforce member or care manager who is not an IPV-Trained Individual does not have authorization to access and may not access any IPV-Related Service Data.

b. **IPV-Related Data Standards**

i. The CFSP agrees to conduct routine and ongoing monitoring of IPV-Related Service Data, which monitoring shall include at a minimum:

a) internal auditing of the CFSP's adherence to the IPV-Related Data Policies (as referenced in Section f of this Attachment and reporting to the Department on the same, such auditing and reporting each occurring no less than annually or as frequently as otherwise directed by the Department in its sole discretion;
b) reporting to the Department within the timeframes specified in *Section III.E.5.D. Duty to Report* of identifying any incident or breaches of IPV-Related Service Data in the custody of or maintained by the CFSP or its contractors; and
c) reporting to the Department within one (1) Business Day upon identification of any material non-compliance with any of the CFSP's IPV-Related Data Policies.

ii. In the event that the CFSP discovers an incident or breach of IPV-Related Service Data, the CFSP shall send written notice to each care manager within one (1) Business Day (as defined in Section c of this Attachment and HSO whose IPV-Related Service Data was or may have been affected by the incident or breach, informing the care manager and HSO of the nature and extent of the unauthorized access or breach, and providing the care manager and HSO with a list of Members whose data was or may have been affected by the unauthorized access or breach.

iii. The CFSP shall ensure that all of its CFSP workforce members and care managers who have Healthy Opportunities Pilot responsibilities complete required Healthy Opportunities Pilot-related training on privacy, security, and access controls related to IPV-Related Service Data and on relevant CFSP policies and procedures relating to usage, storage and sharing of IPV-Related Service Data, including but not limited to the CFSP's IPV-Related Data Policies prior to IPV service launch and annually thereafter.

c. **Care Manager Training**

i. The CFSP shall ensure that care managers with Healthy Opportunities Pilot responsibilities are designated as IPV-Trained Individuals and receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such care manager initiating a Member contact or an initial Healthy Opportunities Pilot assessment , including but not limited to the below trainings:

a) IPV-Related Data Training;
b) Working with IPV survivors;
c) Trauma-Informed Care delivery;
d) Cultural humility and/or Competency training;
e) The Healthy Opportunities Pilot consent process, including how to communicate to Members that while an initial Healthy Opportunities Pilot consent is obtained by the care manager, HSOs may request that the Member execute additional consents depending on the services the HSO furnishes to the Member or the services that the Member may be eligible to access or receive.

d. **Healthy Opportunities Pilot Enrollee Contact Preferences**

i. The CFSP shall ensure that:

a) When obtaining and recording a Member's contact preferences pursuant to *Section V.D.f.xxii. Healthy Opportunities Pilot Enrollee Communication Requirements*, and such Member is authorized to receive, has received, or is currently receiving IPV-Related Services, care managers shall adhere to Department standards as defined in the IPV-Related Data Training with respect to the level of specificity in recording Member contact preferences as provided for in the Care Manager IPV-Related Trainings.

e. **Member Opt-In/Opt-Out Preferences**

i. In all communications with Members who are authorized to receive, have received, or are currently receiving IPV-Related Services, the CFSP shall, and shall cause care managers and individuals in the CFSP's workforce to, properly consider IPV survivor safety guidelines as set forth in the IPV-Related Data Training and the Care Manager IPV-Related Trainings.

ii. The CFSP shall ensure that no member-facing materials targeting individuals who may be, or are currently, experiencing IPV are distributed without Department review and approval.

iii. When communicating with a Member pursuant to *Section V.D.f.xxii. Healthy Opportunities Pilot Enrollee Communication Requirements* and the Member in question is authorized to receive, has received, or is currently receiving IPV-Related Services, care managers and individuals in the CFSP's workforce may send such communications only if adhering to the requirements set forth in Section d of this Attachment and taking all care necessary as directed by the Care Manager IPV-Related Trainings.

f. **IPV-Related Policies and Enforcement**

i. The CFSP shall develop a Healthy Opportunities Pilot Interpersonal Violence (IPV) Related Services Policy (IPV Policy) for review by the Department, and at the Department's request. The IPV Policy shall include all of the requirements of the CFSP as defined in the Contract.

Attachment Q: Healthy Opportunities Screening Questions

The screening questions listed below shall be incorporated into the CFSP's Care Needs Screening tool in accordance with *Section V.D.3.f.v.* and *Section V.D.9.f.ix.3)* of the Contract.

Opportunities for Health Screening Questions

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

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

Attachment R: Tailored Plan Medicaid Managed Care Catchment Areas

The Department has defined four (4) Tailored Plan Medicaid Managed Care Catchment Areas within North Carolina as provided below and effective as of January 31, 2024.

Tailored Plan Medicaid Managed Care Catchment Areas	
TP	**Counties in Catchment Area**
Alliance	Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange and Wake
Partners	Burke, Cabarrus, Catawba, Cleveland, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, and Yadkin
Trillium	Anson, Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Guilford, Halifax, Hertford, Hoke, Hyde, Jones, Lee, Lenoir, Martin, Montgomery, Moore, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Randolph, Richmond, Robeson, Sampson, Scotland, Tyrrell, Warren, Washington, Wayne and Wilson
Vaya	Alexander, Alamance, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rockingham, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey

VIII. CFSP Data Book and Capitation Rate Methodology

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. The Draft Rate Book shall be provided via an addendum. See *Section II.D. Schedule of Important Events*. The final rates shall be provided in advance of the launch of the CFSP.