NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Solicitation Addendum

Solicitation Number:	30-2024-001-DHB
Solicitation Description:	Children and Families Specialty Plan (RFP)
Deadline to Submit Proposals:	May 6, 2024, by 2:00 p.m. EST
Solicitation Opening Date and Time:	May 7, 2024, by 2:00 p.m. EST
Addendum Number:	#5
Addendum Date:	April 11, 2024
Addendum Description/Purpose:	Revisions to the RFP
Contract Specialist:	Danielle Dodson Medicaid.Procurement@dhhs.nc.gov

NOTIFICATIONS AND INSTRUCTIONS:

1. **Carefully read, review, and adhere to all revisions to the RFP in this Addendum #5.**
2. **Return one properly executed copy of this Addendum #5 with response. Failure to sign and return this Addendum #5 may result in the rejection of Offeror's proposal.**

1. ***RFP Section III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections, A. Definitions, 126. Medicaid Managed Care*** **is revised and restated as follows:**

126. **Medicaid Managed Care**: A NC Medicaid Managed Care plan that will serve members as described in Section 9E.22 of Session Law 2023-134.

2. ***RFP Section III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. Terms and Conditions, 18. Disclosure Conflicts of Interest*** **is renamed as follows with no other revisions to this subsection 18.:**

18. <u>DISCLOSURE OF CONFLICTS OF INTEREST</u>:

3. ***RFP Section V. Scope of Services, B. Members, 1. Eligibility and Enrollment for the CFSP, b. CFSP Eligible Populations, ii.*** **is revised and restated as follows:**

ii. No sooner than June 30, 2026, 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 and shall have the option of enrolling in the CFSP unless they otherwise meet an exception as outlined below:

4. ***RFP Section V. Scope of Services, B. Members, 4. Member Engagement, l. Member Welcome Packet, ii.1)d)*** **is revised and restated as follows:**

d) The toll-free service line numbers which a Member may call for the Member Service Line, Behavioral Health Crisis Line, NEMT Member Service Line, Nurse Line and Pharmacy Service Line;

5. ***RFP Section V. Scope of Services, B. Members, 4. Member Engagement, m. Member Identification Cards, i.4)*** **is revised and restated as follows:**

4) The toll-free help line numbers for the Member Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Support Service Line, and Pharmacy Service Line;

6. ***RFP Section V. Scope of Services, D. Care Management, 2. CFSP Care Management, e. Initiation of Care Management, ix*****. is revised and restated as follows:**

ix. In instances where a Member has relocated permanently, the CFSP may, with the Member's consent, re-assign the Member to a care manager located closer to the Member's place of residence. "Relocated permanently" for this requirement means when a Member moves from one place to another without expecting to return to their original or previous location.

7. ***RFP Section V. Scope of Services, D. Care Management, 2. CFSP Care Management, f. Collaboration with County DSS, ii. Coordination with County Child Welfare Workers, 7)*** **is revised and restated as follows:**

7) The CFSP shall make "best efforts" to communicate with a Member's County Child Welfare Worker within twenty-four (24) hours of being informed about any of the following occurring in order to determine needed interventions, coordinate those interventions with the County Child Welfare Worker, and update the Member's Care Plan/ISP, as needed (this may be the assigned care manager or another care manager/supervising care manager providing coverage if the assigned care manager is not available). For this requirement, the Department defines "best efforts" as including at least three (3) documented follow-up attempts to contact the Member's County Child Welfare Worker if the first attempt is unsuccessful.
   a) Member is admitted to or discharged from an inpatient level of care;
   b) Member visits an ED;

c) Member is admitted to an institutional level of care or other congregate setting;
d) Member experiences a BH crisis;
e) Member experiences a disruption in school enrollment (e.g., Member is expelled or is required to change schools);
f) Member becomes involved with the justice system; or
g) Member is boarding in County DSS Office or other location awaiting access to medically necessary behavioral health treatment.

8. *RFP Section V. Scope of Services, E. Providers, 2. Provider Network Management, a.ii.* is revised and restated as follows:

ii. CFSP shall have the authority to maintain a closed network for the following services:
1) Intensive In-Home Services;
2) Multi-systemic therapy;
3) Residential treatment services; and
4) PRTFs.

9. *RFP Section V. Scope of Services, E. Providers, 2. Provider Network Management, h.i.* is revised and restated as follows:

i. The CFSP shall follow the Department's uniform Credentialing and Re-credentialing Policy.
1) The CFSP shall follow documented processes and procedures for credentialing and re-credentialing Network Providers in accordance with 42 CFR § 438.214.

10. *RFP Section V. Scope of Services, L. Technical Specifications, 7. Technology Documents, b.* is revised and restated in entirety to make a technical correction to the embedded hyperlinks as follows:

b. Security Documentation: The CFSP must comply with all State and DHHS security policy as outlined in the State and DHHS Security manuals. These manuals are available here: https://it.nc.gov/documents/statewide-information-security-manual, https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/, and https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security.

In compliance with this policy, the DHHS Privacy and Security Office and the Department of Information Technology require, at a minimum, three (3) documents to be submitted by the CFSP. Two of the three documents as detailed below must be submitted using the State's templates.

i. Vendor Readiness Assessment Report (VRAR) – The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the information system. The template for the VRAR can be accessed here: https://it.nc.gov/documents/vendor-readiness-assessment-report.

ii. System Security Plan (SSP): The CFSP shall provide a SSP that details how the CFSP will comply with all of the Departments' Confidentiality, Privacy and Security Protection requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above. After approval by the Department, the SSP shall be updated annually and resubmitted to the Department for review. The template which must be used to submit the SSP may be downloaded by clicking the following link: https://files.nc.gov/ncdit/documents/files/NC%20DIT%20SSP%20Template.20180112.docx. The SSP must be updated and submitted annually. The SSP must include at a minimum:

1) Approach to customer and Member data protection including internal programs and policies;
2) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;

3) Approach to complying with HITECH and HIPAA;
4) Approach to risk analysis and assessment associate with NIST;
5) Processes for monitoring for security vulnerabilities including the use of external organization such as US CERT;
6) Processes and plans for vulnerability and breach management including response processes; and
7) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).

iii. SOC 2 Type 2 Report – The CFSP must submit a completed Soc 2 Type 2 report. If the technology platform used to deliver the services under this contract has not been used in a production setting prior to the go live of the CFSP, a Self-Assessment must be performed on the technology platform and submitted in lieu of the Soc 2 Type 2. After a minimum of one hundred eighty (180) Calendars Days of production activity, a Soc 2 Type 2 assessment must be performed, and the resulting report submitted to the State. The Soc 2 Type 2 must be updated and submitted annually. If a Self-Assessment is required, it must be completed on the template provided by the DHHS Privacy and Security Office.

11. *RFP Section VII. Attachment A: CFSP Organization Roles and Positions* is revised and restated in its entirety as *Section VII. First Revised and Restated Attachment A. CFSP Organization Roles and Positions* to make technical corrections to Section VIII. Attachment A. Table 1: CFSP Organization Roles and Positions, Role #11- Pharmacy Director for the Pharmacy Service Line, to strike language in the Duties and Responsibilities of the Role column and is attached to this Addendum #5.

12. *RFP Section VII. Attachment F: Required Standard Provisions for CFSP and Provider Contracts* is revised and restated in its entirety as *Section VII. First Revised and Restated Attachment F. Required Standard Provisions for CFSP and Provider Contracts* to make technical corrections to the number of Calendar Days for claims processing and payments and is attached to this Addendum #5.

13. *RFP Section IX.D. Contractor's Contract Administrators* is revised and restated in its entirety as *Section IX.D. First Revised and Restated Contractor's Contract Administrators* to update the Department's Contract Administrator for day-to-day activities and is attached to this Addendum #5.

14. RFP *Section IX.I. Subcontractor Identification Form* is revised and restated in its entirety as *Section IX.I. First Revised and Restated Subcontractor Identification Form* to make technical corrections to RFP Section references in the first paragraph to Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections and correct the title of Table 2, and is attached to this Addendum #5.

15. RFP *Section IX.J. Business Associate Agreement* is revised and restated in its entirety as *Section IX.J. First Revised and Restated Business Associate Agreement* to make technical corrections and is attached to this Addendum #5. Revisions are as follows:

In the first paragraph, the first sentence is revised to reflect "This Business Associates Agreement ("Agreement") is made effective upon the later of the execution dates of this Agreement ("Effective Date") by and between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Covered Entity") and Click or tap here to enter text. ("Business Associate") (collectively the "Parties").

Section 1. Background, a., is revised to "a. Covered Entity and Business Associate are parties to a contract entitled #30-2024-001-DHB Children and Families Specialty Plan, (the "Contract") whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity."

Section 6. General Terms and Conditions is revised to remove "a. This Business Associate Agreement amends and is part of the Contract".

16. **RFP *Section IX.L. Location of Workers Utilized* by the Contractor is revised and restated in its entirety as *Section IX.L. First Revised and Restated Location of Workers Utilized by the Contractor* to make technical corrections and is attached to this Addendum #5. Revisions are as follows:**

    In the first paragraph, the last sentence "The Department will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Items a, b, and c below MUST BE COMPLETED" has been removed.

    In a)., "If the Contractor answered "YES" above, the Contractor shall complete items 1 and 2 below:" has been revised to "If "Yes":"

17. **RFP *Section IX.P. Request for Proposed Modifications to the Terms and Conditions* is revised and restated in its entirety as *Section IX.P. First Revised and Restated Request for Proposed Modifications to the Terms and Conditions* to make technical corrections to the RFP Section reference in the first paragraph to Section II.C.3., and is attached to this Addendum #5.**

18. **Offerors must request the MS Word version of *Section IX.D. First Revised and Restated Contractor's Contract Administrators, Section IX.I. First Revised and Restated Subcontractor Identification Form, Section IX.J. First Revised and Restated Business Associate Agreement, Section IX.L. First Revised and Restated Location of Workers Utilized by the Contractor, and Section IX.P. First Revised and Restated Request for Proposed Modifications to the Terms and Conditions* from Medicaid.Procurement@dhhs.nc.gov.** Offerors are responsible for obtaining and using the revised templates and tables.

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VII. Attachments A. – R.

First Revised and Restated 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. First Revised and Restated 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 the role of ACEs in the CFSP population and	• 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. First Revised and Restated 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**
	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, Behavioral Health, juvenile justice or early childhood systems).

Section VII. First Revised and Restated 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**
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.	• 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. First Revised and Restated 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.[1]	• 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.

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

First Revised and Restated 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 three hundred sixty-five (365) 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]

D. First Revised and Restated Contractor's Contract Administrators

Contract Administrators are the persons to whom notices provided for in this Contract shall be given, and to whom matters relating to the administration of this Contract shall be addressed. The Department and Contractor may change its respective administrator, address, and telephone number by providing written notice.

A. **For the Department**

1. Contract Administrator for contractual issues:

Name & Title	Danielle Dodson Senior Contract Development Specialist
Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7231
Email Address	Danielle.Dodson@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

2. Contract Administrator for day-to-day activities:

Name & Title	Chameka L. Jackson, MSSA, LCSW, Associate Director, Children and Families Specialty Plan
Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-417-8145
Email Address	Chameka.l.jackson@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

3. Contract Administrator for Federal, State, and Department security matters:

Name & Title	Pyreddy Reddy, NCDHHS CISO
Address 1	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

4. Contract Administrator for HIPAA and Policy Coordinator for Federal, State, and Department privacy matters:

Name & Title	Andrew Albright, Privacy Officer
Physical Address	1985 Umstead Drive, Kirby Building Raleigh, NC 27603
Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7747
Email Address	andrew.a.albright@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

B. **For the Contractor**

1. Contract Administrator for contractual issues:

Name & Title	Click or tap here to enter text.
Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

2. Contract Administrator for day-to-day activities:

Name & Title	Click or tap here to enter text.
Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

3. Contractor's Coordinator for Privacy and Security matters:

Name & Title	Click or tap here to enter text.
Address	Click or tap here to enter text.
Telephone Number	Click or tap here to enter text.
Email Address	Click or tap here to enter text.

I. First Revised and Restated Subcontractor Identification Form

The Offeror must complete a *Subcontractor Identification Form* for each known Subcontractor, as defined in Contract *Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions & Protections, A. Definitions*, who will be used to meet the Contract requirement or otherwise perform any services pursuant to the Contract (i.e., there should be one form for each Subcontractor). Offeror is not required to submit a completed Subcontractor Identification Form for entities that are included in *Section IX. Offeror's RFP Proposal and Response, Question #2* where a *Section IX. Offeror's RPF Proposal and Response First Revised and Restated Table 2: Entities Performing Core Medicaid Operational Functions or with Proposed Experience* was included. After Contract Award, the *Subcontractor Identification Form* must be submitted by the Contractor to the Department in accordance with Contract *Section III.D.51.* ***SUBCONTRACTORS*** for review and approval of all new subcontractors.

By executing the Contract, or submitting this form after Contract Execution in accordance with the **Subcontractor** clause of the Contract, the Offeror:

1. Certifies that the information provided in this section is true to the best of its information and belief;
2. Acknowledges the requirements set forth in the Terms and Conditions related to Subcontractors and the resulting obligations, including requiring Department approval of any Subcontractors used in the performance of the Contract; and
3. Agrees to notify the Department of any material changes to the information provided in this form that arise prior to execution or during the term of the Contract.

A: Subcontractor Identification	
1. Business Information. Provide the requested Information in the space provided:	
Legal Name of Subcontractor	Click or tap here to enter text.
Name Used for Business if Different	Click or tap here to enter text.
FEIN/Taxpayer ID	Click or tap here to enter text.
Address	Click or tap here to enter text.
Contract Executed	☐Yes ☐No
Term of Contract	Click or tap here to enter text.
Name of Contact Person Title Phone Number Email Address	Click or tap here to enter text.
2. Scope of Subcontracted Services. Identify the scope of services and activities that will be provided by the Subcontractor; cite specific Sections of the Contract as applicable:	
Click or tap here to enter text.	
3. Is Subcontractor a government entity? If no, complete Section B: Historically Underutilized Businesses below.	

☐ Yes ☐ No

B: Historically Underutilized Businesses (HUB)

1. Is proposed non-government entity Subcontractor **owned** by a HUB?

- ☐ **Yes** (if yes, complete Question 2)
- ☐ **No** (if no, skip to Question 3)
- ☐ **Unknown** (if unknown, skip to Question 3)

Owned means at least fifty-one percent (51%) of the business is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in question b. below, or in the case of a corporation, at least fifty-one percent (51%) of the stock is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in Question 2. below.

2. Identify the Type of minority business group(s). Check all that apply.

- ☐ **Black** A person having origins in any of the black racial groups of Africa.
- ☐ **Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- ☐ **Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- ☐ **American Indian** A person having origins in any of the original Indian peoples of North America.
- ☐ **Female**
- ☐ **Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- ☐ **Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

3. Is the proposed non-government Subcontractor **operated** by a HUB?

- ☐ **Yes** (if yes, complete Question 4)
- ☐ **No** (if no, skip to Question 5)
- ☐ **Unknown** (if unknown, skip to Question 5)

Operated means the management and daily business operations are controlled by one or more owners of the business who are citizens or lawful permanent residents of the United States of at least one of the groups listed in Question 4. below

4. Identify the type of minority business group(s). Check all that apply.

- ☐ **Black** A person having origins in any of the black racial groups of Africa.

☐ **Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.

☐ **Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.

☐ **American Indian** A person having origins in any of the original Indian peoples of North America.

☐ **Female**

☐ **Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.

☐ **Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

5. Is the proposed non-government Subcontractor Certified with North Carolina as a HUB?

☐ Yes ☐ No ☐ Unknown

J. First Revised and Restated Business Associate Agreement

NORTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BUSINESS ASSOCIATE AGREEMENT

This Business Associates Agreement ("Agreement") is made effective upon the later of the execution dates of this Agreement ("Effective Date") by and between the North Carolina Department of Health and Human Services, Division of Health Benefits ("Covered Entity") and **Click or tap here to enter text.** ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled **#30-2024-001-DHB Children and Families Specialty Plan** (the "Contract") whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

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

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

d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

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

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

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

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

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

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

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

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

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

3. OBLIGATIONS OF BUSINESS ASSOCIATE

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

b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

4. PERMITTED USES AND DISCLOSURES

a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
    1) Would not violate the Privacy Rule if done by Covered Entity; or
    2) Would not violate the minimum necessary policies and procedures of the Covered Entity.
b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
    1) The disclosures are Required by Law; or
    2) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

5. TERM AND TERMINATION

a. Term. This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

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

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

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

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

c. Effect of Termination.

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

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

6. GENERAL TERMS AND CONDITIONS

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

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

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

BUSINESS ASSOCIATE

_____

Name: Date

Title:

COVERED ENTITY

_____

Name: Date

Title:

NC Medicaid

L. First Revised and Restated Location of Workers Utilized by the Contractor

In accordance with G.S. § 143-59.4, the Contractor shall detail the location(s) at which performance will occur, as well as the manner in which it intends to utilize resources or workers outside of the United States in the performance of this Contract.

a) Will any work under this Contract be performed outside the United States?

☐ YES

☐ NO

If "YES":

1. List the location(s) outside the United States where work under this Contract will be performed by the Contractor, any subcontractors, employees, or other persons performing work under the Contract:

   Click or tap here to enter text.

2. Specify the manner in which the resources or workers will be utilized:

   Click or tap here to enter text.

b) Where, within the U.S., will work be performed? List all U.S. locations.

Click or tap here to enter text.

The undersigned acknowledges and agrees that:

1. The Department will evaluate the additional risks, costs, and other factors associated with the utilization of workers outside the United States prior to making an award or executing a contract.
2. Contractor shall provide written notice to the Department of the relocation of the Contractor, its employees or subcontractors, or other persons performing services under the Contract, to a location outsideof the United States.
3. All Contractor or subcontractor personnel providing call or contact center services to the State of North Carolina under this Contract, if applicable, **shall disclose** to inbound callers the location from which the call or contact center services are being provided.

_____ Click or tap here to enter text.

Signature of Authorized Representative — Entity Name

Click or tap here to enter text. _____

Name and Title — Date

P. First Revised and Restated Request for Proposed Modifications to the Terms and Conditions

As provided in *Section II.C.3.,* Offeror may submit proposed modifications to the terms and conditions of the RFP for consideration by the Department. The proposed modifications do not alter the terms and conditions of the RFP and have no force or effect on the RFP or any resulting Contract unless accepted by the Department and incorporated through a BAFO, negotiation document, addenda to the RFP or amendment to the Contract.

The Department at its sole discretion may consider any proposed modifications submitted in this Attachment.

The Offeror must check one of the boxes below to indicate whether it is proposing modifications to the terms and conditions of the RFP:

☐ The Applicant **DOES NOT** propose modifications.

☐ The Applicant **DOES** propose modifications as provided in the following table:

	RFP Citation	**Redline of Proposed Modification**
	(i.e., section & page number)	(i.e., include text as published in RFP and strikethrough words, phrases or sentences proposed to be deleted and underline words, phases, or sentences proposed to be added)
1.	Click or tap here to enter text.	Click or tap here to enter text.
2.	Click or tap here to enter text.	Click or tap here to enter text.
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5.	Click or tap here to enter text.	Click or tap here to enter text.

Execute Addendum #5:

Offeror: _____

Authorized Signature: _____

Name and Title (Typed): _____

Date: _____