CONTRACT BETWEEN
THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND
MCO

Contract #

This Contract is hereby entered into by and between the North Carolina Department of Health and Human Services (the Department"), Division of Medical Assistance ("DMA") and LME name, (herein referred to as, "Contractor", or "MCO NAME"), a political subdivision of the State of North Carolina, organized under North Carolina General Statute Chapter 122C, with its principal place of business at _________in the city of ________, County of _______, State of North Carolina. (referred to collectively as the "Parties"). The MCO shall operate a Prepaid Inpatient Health Plan for Medicaid enrollees. The Contractor's federal tax identification number is_______.

1. **Contract Documents:** This Contract consists of the following documents:

(a) This master document
(b) The General Terms and Conditions (Attachment A)
(c) The Scope of Work (SOW) (Attachment B)
(d) Background, Goals and Purpose (Attachment C)
(e) HIPAA Business Associate Addendum (Attachment D)
(f) Federal Certification Regarding Environmental Tobacco Smoke (Attachment E)
(g) Federal Certification Regarding Lobbying (Attachment F)
(h) Federal Certification Regarding Debarment (Attachment G)
(i) Federal Certification Regarding Drug-Free Workplace (Attachment H)
(j) Definition of Terms (Attachment I)
(k) Eligibility Groups (Attachment J)
(l) Schedule of Benefits (Attachment K)
(m) Scope of EPSDT Services (Attachment L)
(n) Statistical Reporting Measures (Attachment M)
(o) Requirements for Performance Improvement Projects (Attachment N)
(p) Grievance and Appeal Procedures (Attachment O)
(q) Network Provider Qualifications (Attachment P)
(r) Capitation Rate-Setting Methodology (Attachment Q)
(s) Business Transactions (Attachment R)
(t) Provider Manuals and Bulletins (Attachment S)
(u) Access/Availability Standards (Attachment T)
(v) Guidelines for Stabilization Examination and Treatment for Emergency Medical Conditions and Women in Labor (Attachment U)
(w) Mixed Services Protocol (Attachment V)
(x) Financial Reporting Requirements (Attachment W)
(y) Medical Care Decisions and Advance Directives Brochure (Attachment X)
(z) Penalties (Y)

These documents constitute the entire agreement between the Parties and supersede all prior oral or written statements or agreements.

2. **Effective Period:** This Contract shall be effective on ________and shall terminate on ________**.**

3. **Contractor's Duties:** The Contractor shall provide the services as described in Attachment B, Scope of Work.

4. **Division's Duties:** DMA shall pay the Contractor in the manner and in the amounts specified in Attachment B, Scope of Work, and Attachment Q. The total amount paid by DMA to the Contractor under this Contract shall not exceed ________ without a written amendment approved by the Parties.

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5. Conflict of Interest Policy:

Contractor is a not a nonprofit agency; therefore, a conflict of interest policy is not required.

6. Reporting Requirements:

DMA has determined that this is a contract for purchase of goods and services, and therefore is exempt from the reporting requirements of N.C.G.S. § 143C-6-22 & 23.

7. Payment Provisions:

Payment shall be made as described in the Scope of Work, Attachment B and in the Capitation Rate-Setting Methodology, Attachment Q.

8. Contract Administrators: All notices permitted or required to be given by one Party to the other and all questions about the Contract from one Party to the other shall be addressed and delivered to the other Party's Contract Administrator. The name, post office address, street address, telephone number, fax number, and email address of the Parties' respective initial Contract Administrators are set out below. Either Party may change the name, post office address, street address, telephone number, fax number, or email address of its Contract Administrator by giving timely written notice to the other Party.

DMA's Contract Administrator for Program Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name Kelly Crosbie Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699 Telephone 919-855-4293 Fax 919-715-9451 Email Kelly.crosbie@dhhs.nc.gov	Name Kelly Crosbie Division of Medical Assistance Street Address 1985 Umstead Drive, Kirby Building Raleigh, NC Zip 27603

DMA's Contract Administrator for Contract Issues:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name, Title ____________ Chief of Contracting Division of Medical Assistance Mail Service Center Number 2501 Raleigh, NC 27699 Telephone _____________ Fax ___________________ Email ______________	Name, Title __________ , Contract Officer Division of Medical Assistance Street Address 1985 Umstead Drive, Kirby Building Raleigh, NC Zip 27603

Contract Administrator For the Contractor:

IF DELIVERED BY US POSTAL SERVICE	IF DELIVERED BY ANY OTHER MEANS
Name, Title ____________ Company Name _________ Address _______________ City State Zip __________ Telephone _________ Fax ______________ Email______________	

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9. Outsourcing:

The Contractor certifies that it has identified to DMA all jobs related to the Contract that have been outsourced to other countries, if any. Contractor further agrees that it will not outsource any such jobs during the term of this Contract without providing notice to DMA.

10. Signature Warranty:

The undersigned represent and warrant that they are authorized to bind their principals to the terms of this agreement.

In Witness Whereof, the Contractor, DMA, and the Department have executed this Contract in duplicate originals, with one original being retained by the Contractor and one being retained by DMA.

MCO

____

LME-MCO Vendor Date

ATTEST

____

Date

[CORPORATE SEAL]

North Carolina Department of Health and Human Services
Division of Medical Assistance

____

Craigan L. Gray, MD, MBA, JD Date

North Carolina Department of Health and Human Services

____

Lanier M. Cansler, Secretary Date

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ATTACHMENT A

GENERAL TERMS AND CONDITIONS

Relationships of the Parties

Independent Contractor: The Contractor is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or shall secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with, DMA.

Assignment: No assignment of the Contractor's obligations or the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

(a) Forward the Contractor's payment check(s) directly to any person or entity designated by the Contractor, or
(b) Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

Beneficiaries: Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to DMA and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of DMA and Contractor that any such person or entity, other than DMA or the Contractor, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

Indemnification

The Contractor agrees to indemnify and hold harmless DMA, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Contractor in connection with the performance of this contract to the extent permitted by law.

Default and Termination

Waiver of Default: Waiver by DMA of any default or breach in compliance with the terms of this contract by the Contractor shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Contractor and attached to the contract.

Availability of Funds: The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to DMA.

Force Majeure: Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

Survival of Promises: All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

Compliance with Applicable Laws

Compliance with Laws: The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

Confidentiality

Confidentiality: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of DMA, except when information, data, instruments , documentation or reports are covered under the North Carolina Public Records Act N.C.G. S. 132. The Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

Oversight

Access to Persons and Records: The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or

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political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions.

Record Retention: Records shall not be destroyed, purged or disposed of without the express written consent of DMA. The Department of Health and Human Services' basic records retention policy requires all records to be retained for a minimum of three years following completion or termination of the contract. If the contract is subject to Federal policy and regulations, record retention will normally be longer than three years since records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this contract has been started before expiration of the three year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three year period described above, whichever is later.

Miscellaneous

Choice of Law: The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The place of this contract and all transactions and agreements relating to it, and their sites and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.

Amendment: This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of DMA and the Contractor. The Purchase and Contract Divisions of the NC Department of Administration and the NC Department of Health and Human Services shall give prior approval to any amendment to a contract awarded through those offices.

Severability: In the event that a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.

Headings: The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.

Time of the Essence: Time is of the essence in the performance of this contract.

Key Personnel: The Contractor shall notify DMA in writing of any changes in any of the key personnel assigned to the performance of this contract. The term “key personnel” includes any and all persons identified as such in the contract documents and any other persons subsequently identified as key personnel by the written agreement of the parties.

Care of Property: The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished to it for use in connection with the performance of this contract and will reimburse DMA for loss of, or damage to, such property. At the termination of this contract, the Contractor shall contact DMA for instructions as to the disposition of such property and shall comply with these instructions.

Travel Expenses: MCO shall pay for all travel expenses incurred by MCO.

Sales/Use Tax Refunds: If eligible, the Contractor and all subcontractors shall: (a) ask the North Carolina Department of Revenue for a refund of all sales and use taxes paid by them in the performance of this contract, pursuant to N.C.G.S. 105-164.14; and (b) exclude all refundable sales and use taxes from all reportable expenditures before the expenses are entered in their reimbursement reports.

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ATTACHMENT B

SCOPE OF WORK (SOW)

SECTION 1 - GENERAL PROVISIONS

1.1 Definitions and Construction:

The terms used in this Contract shall have the definitions set forth in Attachment I, except where this Contract expressly provides another definition. References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed to be a part of this Contract.

1.2 Non-Discrimination:

MCO shall comply with all Federal and State laws which prohibit discrimination on the grounds of race, color, age, creed, sex, religion, national origin, or physical or mental handicap, including Title VI of the Civil Rights Act 42 U.S.C. 2000d and regulations issued pursuant thereto; the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto; Title IX of the Education Amendments of 1972 and regulations issued pursuant thereto; the Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et. seq., and regulations issued pursuant thereto; the Rehabilitation Act of 1974, as amended, 29 U.S.C. 794, and regulations issued pursuant thereto; and furthermore shall not use any policy or procedures that discriminate against eligible individuals on the basis of health status or need for health care services.

In the provision of services under this agreement, the Contractor and its subcontractors shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations.

1.3 Financial Status and Viability:

The MCO shall provide to DMA copies of the LME's most recent annual audit to verify its financial status, solvency and viability.

1.4 Departmental Monitoring Team:

DMA will monitor the Contractor throughout the term of the Contract. DMA will maintain an Intra-Departmental Monitoring Team (IMT) to provide monitoring and project oversight throughout the course of this Contract. This Monitoring Team shall meet at least four times a year and more often if determined necessary by DMA. The Monitoring Team shall conduct an Annual on-site review. The frequency of on-site reviews may be decreased to every two years at the discretion of DMA if DMA determines that other on-site review activities required by CMS are sufficient to assure the effective operation of MCO and compliance with State and Federal requirements. The Monitoring Team shall review Performance Indicators, reports and data, and timeliness of submission of reports. If required by the Monitoring Team and requested in writing by the DMA Contract Administrator, the MCO shall develop an Action Plan to correct deficiencies which are determined by DMA to be severe or recurrent or noted deficiencies that MCO fails to address in a timely manner. The Contractor shall provide the Action Plan to the DMA Contract Monitor for approval and monitoring until the problem is resolved.

DMA shall have the right to impose penalties and sanctions, arrange for Temporary Management, as specified under Section 13, or immediately terminate this Contract under conditions specified in 12.4, independent of the actions of the Intra-Departmental Monitoring Team.

DMA will lead the IMT, in collaboration with DMH/DD/SAS. At a minimum, the Intra-Departmental Monitoring Team shall include representatives from the following sections and offices:

a. DMA:

   1. Finance Management;

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2. Behavioral Health, Clinical Policies and Programs;
3. Quality, Evaluation and Health Outcomes (QEHO)
4. Waiver Development ; and
5. Budget Management.

b. DMH/DD/SAS: Division of Mental Health, Developmental Disabilities and Substance Abuse Services

1. Best Practice;
2. Budget;
3. LME Team;
4. Quality Management; and
5. Accountability.

c. MCO:

1. Management;
2. Finance;
3. Information System;
4. Operations (Access, Network, Waiver Implementation);
5. Quality; and
6. Others to be identified if needed.

d. The Department:

1. Office of the Controller; and
2. Office of Budget and Analysis.

1.5 <u>Scope of Monitoring Activities:</u>

The IMT shall conduct routine and random monitoring to identify problems, deficiencies, and barriers to desired performance, to develop improvement strategies, to determine the need for Corrective Action Plans, and monitor any Corrective Action Plans in place.

1.6 <u>Monitoring Process:</u>

The IMT shall use a Continuous Quality Improvement approach to review the performance of MCO. The Team shall routinely review, analyze, and interpret data. The purpose is to discover system performance problems, identify performance barriers, and develop improvement strategies, including Corrective Action Plans. The Team shall monitor improvement strategies and Corrective Action Plans to ensure that identified problems are properly addressed. This process shall document both the challenges and successes of this waiver expansion.

A written agenda shall identify the issues to be addressed at each team meeting. Those issues shall include, but not be limited to:

a. Performance;
b. State concerns and questions;
c. MCO's challenges, barriers, and need for assistance;
d. Project successes;
e. Need for changes, improvements, or Corrective Action Plans;
f. Progress on identified problems or Corrective Action Plans; and
g. Monitor expenditures and cost of the Contracted activities.

Minutes shall be kept of all meetings.

1.7 <u>Annual Monitoring Review:</u>

DMA and DMH/DD/SAS shall jointly conduct an Annual Monitoring Review on-site at MCO. The frequency of on-site reviews may be decreased to every two years at the discretion of DMA if it is determined that other on-site review

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activities required by CMS are sufficient to assure the effective operation of MCO and compliance with State and Federal requirements. The Monitoring Review shall include but may not be limited to a review of:

a. MCO's compliance with the requirements of this Contract;
b. MCO's compliance with State and Federal Medicaid requirements;
c. MCO's compliance with N.C.G.S. 122C-112.1; and

To the extent possible, the review will not duplicate areas assessed by the National Accrediting Body (once MCO accreditation has been achieved).

1.8 Conflict of Interest:

As stated in 42 C.F.R. 438.58**,** no officer, employee or agent of any State or Federal agency that exercises any functions or responsibilities in the review or approval of this Contract or its performance shall acquire any personal interest, direct or indirect, in this Contract or in any subcontract entered into by MCO. No official or employee of the MCO shall acquire any personal interest, direct or indirect, in any network provider.

MCO hereby certifies that:

a. no officer, employee or agent of MCO;
b. no subcontractor or supplier of MCO; and
c. no person with an ownership or control interest in MCO;

is employed by the State of North Carolina, the federal government, or the Fiscal Agent in any position that exercises any authority or control over MCO, this Contract, or its performance.

MCO further certifies that any State employee serving on MCO's Board of Directors shall be identified to DMA in writing and that such individual shall be required by MCO's Board of Director's to recuse himself or herself from participating in any manner in any discussion or action by the Board concerning the State agency that employs the Board member.

Pursuant to State Medicaid Director Letter 12/30/97 and 1932(d)(3) of the Social Security Act, the MCO shall not contract with the state unless MCO has safeguards in place that are at least equal to Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

1.9 Restricted Risk Reserve Account:

Restricted Risk Reserve Account:

The MCO shall maintain a restricted risk reserve account with a federally guaranteed financial institution licensed to do business in the state of North Carolina. The following requirements shall apply during the period of this contract:

a. Required Minimum Balance: MCO shall on a monthly basis deposit into the risk reserve account a minimum amount equal to two (2%) of the capitation payments received from DMA until the amount in the risk reserve account equals fifteen percent (15%) of the total annualized cost of this Contract.
b. Withdrawals or Disbursements: Withdrawals or disbursements may be made from the restricted risk reserve in order to fund payments to meet outstanding obligations, such as cost overruns related to program services covered by the Contract, or for any other purpose approved by DMA. For any withdrawals or disbursements that are made, the following requirements apply:
    1. Withdrawal or disbursement notifications: The MCO must first obtain DMA's prior written approval for any withdrawals or disbursements. Expenditures must conform to the requirements for the expenditure of funds under section 1915b of the Social Security Act (42 UCS 1396b). The restricted risk reserve shall not be used to pay for items that are not directly related to the provision of services.
    2. Replenishing restricted risk reserve account when below minimum: If the risk reserve account drops below the minimum balance required in paragraph (1) of this section, MCO shall deposit on a monthly basis into the restricted risk reserve account an amount not less than fifteen percent of the monthly capitation payments received from DMA until the amount in the reserve account is equal to the required minimum amount as described in 1.9.1 above. The MCO may make contributions to the reserve account in excess of the minimum balance required in paragraph (1).

c. Earnings: All earnings of the restricted risk reserve account shall remain in and become a part of the restricted risk reserve account.
d. Reporting: MCO shall report on the status of the restricted risk reserve account quarterly and annually as required by Section 9.3 and Attachment W of the Contract.
e. Failure to Make Required Deposits: If MCO fails to make deposits to the restricted risk reserve account as provided in items a. and b. of this section, DMA shall send a written notice to MCO requesting a corrective action plan. MCO shall submit a written corrective action plan to DMA within 30 working days of the date of the notice. If MCO fails to submit a corrective action plan that is acceptable to DMA or to implement a corrective action plan that has been approved by DMA, DMA may impose one or more of the sanctions described in Section 12.1 of the Contract.
f. Termination or Expiration of the Contract: Upon DMA's written satisfaction that MCO has met all outstanding obligations incurred pursuant to this Contract, the balance of the reserve account upon the date of termination or expiration of this Contract shall become the property of MCO.

1.10 <u>Financial Reporting and Viability Measures:</u>

All funds received by MCO pursuant to this Contract shall be accounted for by tracking Title XIX Medicaid expenditures separately from services provided using other funding, as specified in the Financial Reporting Requirements, Attachment W.

DMA shall monitor the Services Expense Ratio and the Administrative Cost Percentage. These expenses shall be analyzed as part of DMA's due diligence in financial statement monitoring and in order to enable DMA to report financial data to CMS.

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1.11 Disputes:

Disputes that arise out of this Contract shall be resolved by DMA's Contract Administrators. DMA may consult with DMH/DD/SAS on disputes related to the management and delivery of services covered under this Contract. If MCO is not satisfied with the Contract Administrator's decision, MCO may invoke any administrative or legal remedy available to it under State and federal law. Pending appeal, MCO shall proceed diligently with the performance of this Contract, unless MCO obtains a stay from an administrative law judge or court of competent jurisdiction.

1.12 Disclosure of Information on Ownership and Control:

MCO shall disclose to DMA all information on ownership and control of MCO prior to the beginning of the Contract term, as set forth in Title 42 C.F.R. 455.104.

1.13 Disclosure of Information on Business Transactions:

Contractors which are not Federally qualified HMOs shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act (see Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.). This requirement is detailed further in Attachment R.

1.14 Excluded Providers:

MCO shall not 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. DMA shall not reimburse MCO for any services rendered by Providers excluded as identified above.

1.15 Innovations Waiver Capacity:

DMA will regularly monitor the cost-effectiveness of the Innovations program and determine whether the number of slots should be modified. DMA will consult with DMH/DD/SAS in making this determination. If necessary, DMA will submit a waiver amendment to CMS for approval prior to the addition of any slots. Slot additions are subject to increase in (c) waiver funding allocations from the North Carolina General Assembly.

1.16 Prohibited affiliations with Individuals Debarred by Federal Agencies:

Pursuant to 42 CFR 438.610(a), 42 CFR 438.610(b) and State Medicaid Director Letter 2/28/98, .MCO may not knowingly have a relationship with the following:

a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

The relationship is described as follows:

a. A director, officer, or partner of MCO;
b. A person with beneficial ownership of five percent or more of MCO's equity;
c. A person with an employment, consulting or other arrangement with MCO for the provision of items and services which are significant and material to MCO's obligations under its contract with the State.

SECTION 2 - CONTRACTOR DESIGNATED AS A SINGLE PREPAID INPATIENT HEALTH PLAN

The North Carolina General Assembly, in Session Law 2001-437, designated the local mental health authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. The law redirects the mission of the local authorities from providers of MH/DD/SA services to managers of services and requires that each local authority develop a business plan for the management, delivery, and oversight of public MH/DD/SA services. The LME is a local mental health authority or a multi-county political subdivision of the State of North Carolina established and operating in accordance with N.C.G.S. 122C-116, and is known as an "area authority". Given the newly defined role of the area authorities to manage all publicly funded MH/DD/SA services, it is logical and efficient to establish LME-

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MCOs as the single Prepaid Inpatient Health Plan through which all mental health, substance abuse and developmental disability services shall be authorized for Medicaid Enrollees in LME-MCO catchment area. This shall facilitate comprehensive and integrated service delivery as referenced in 45 C.F.R. 74.4. The county/counties included in the LME-MCO's catchment area are an LME-MCO county/counties.

The LME-MCO has submitted an application in response to a request for applications to participate in the 1915(b)/(c) waiver expansion, issued by the North Carolina Department of Health and Human Services, Division of Medical Assistance, that fully describes its ability to meet the specifications of the Contract. The LME-MCO has provided detailed information on the Provider Network that has been developed under this prepaid health plan.

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SECTION 3 - ELIGIBILITY

3.1 Persons Eligible for Enrollment:

To be eligible to enroll in the MCO PIHP established pursuant to this Contract, a person shall be a recipient in the North Carolina Medical Assistance (Medicaid) Program in one of the aid categories listed below, and with county of residence for Medicaid eligibility purposes of MCO County.

a. Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC);
b. Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF);
c. Blind and Disabled Children and Related Populations (SSI);
d. Blind and Disabled Adults and Related Populations (SSI, Medicare);
e. Aged and Related Populations (SSI, Medicare);
f. Medicaid for the Aged (MAA);
g. Medicaid for Pregnant Women (MPW);
h. Medicaid for Infants and Children (MIC);
i. Adult Care Home Residents (SAD, SAA);
j. Foster Care Children;
k. Participants in Community Alternatives Programs (CAP/DA, CAP-MR/DD, CAP/AIDS);
l. Medicaid recipients living in ICF's-MR; or
m. Children, beginning the first day of the month following the third birthday (except for CAP-MR/DD).

3.2 Persons Ineligible for Enrollment:

The following categories of people receiving Medicaid are not eligible to enroll in the MCO PIHP:

a. Medicare Qualified Beneficiaries (MQB);
b. Non-qualified Aliens or Qualified Aliens during the five (5) year ban;
c. Medically Needy in deductible status;
d. Children within the age of 0-36 months, except for CAP-MR/DD participants;
e. Recipients with Presumptive Eligibility; and
f. Refugee Assistance.

SECTION 4 - ENROLLMENT

4.1 Plan Enrollment:

Individuals receiving Medicaid shall be enrolled in the PIHP based on county of residence of Medicaid eligibility. All individuals receiving Medicaid with county of Medicaid eligibility of MCO shall be subject to enrollment except those persons listed in Section 3.2, above.

4.2 Change of Household Composition:

MCO shall report to the County DSS any known change in the household composition affecting the Enrollee's eligibility for Medicaid, including changes in family size, marital status or residence, within five (5) days of such information being known to the MCO PIHP.

4.3 Children:

Eligibility for services for children shall begin the first day of the month following the third birthday, except for children participating in the home and community based services waiver, the "Innovations" program. Eligibility for participation in the Innovations waiver shall begin at birth.

4.4 Effective Date of Enrollment:

An enrollment period shall always begin on the first day of a calendar month and shall end on the last day of a calendar month, with the exception of the Innovations waiver participants whose enrollment shall be effective on the date of eligibility for participation in the Innovations waiver.

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4.5 Retroactive Disability Determination:

When a retroactive disability determination is made for an Enrollee, the change in payment category shall occur at the time of the change in the Recipient's aid program category within DMA's Eligibility Information System (EIS). Changes in recipient aid program categories are not generally retroactive for the Blind and Disabled.

4.6 Automatic Disenrollment:

An Enrollee shall be automatically disenrolled from the MCO PIHP if the Recipient:

a) Changes county of residence for Medicaid eligibility purposes to a county other than MCO.

b) Is deceased;

c) is admitted to a correctional facility for more than thirty (30) days;

d) No longer qualifies for Medicaid or becomes a Recipient ineligible for enrollment as defined in Section 3.2; or

e) Is admitted to an IMD (Institution for Mental Disease) and is between the ages of 22 and 64.

4.7 Involuntary Disenrollment:

Involuntary disenrollment does not apply because the MCO is a public agency and does not discharge consumers who need services and meet medical necessity requirements.

4.8 Disenrollment Date:

When an Enrollee changes county of residence for Medicaid eligibility purposes to a county other than MCO, the individual will continue to be enrolled in the MCO PIHP until the disenrollment is processed by the Eligibility Information System (EIS). DMA shall continue to pay the MCO PIHP a capitated PMPM payment for the Enrollee until disenrollment is effective in the EIS. Disenrollment due to change of residence is always effective at midnight on the last day of the month. The MCO PIHP shall be responsible for all medically necessary services to the Enrollee until EIS disenrollment occurs.

SECTION 5 – MARKETING

Because enrollment in the MCO PIHP is mandatory, the MCO PIHP shall not be required to comply with CMS's marketing regulations.

SECTION 6 - DUTIES AND RESPONSIBILITIES OF THE CONTRACTOR

6.1 Duties of MCO:

MCO shall:

a. Provide all statistical reports identified in Attachment N and update those reports as required under this Contract and Attachment M;

b. Provide timely and accurate clinical reports as delineated in Section 9.4 and Attachment M;

c. Provide Financial Reports as delineated in Attachment W;

d. Upon request by DMA, make available both financial and non-financial data involving Medicaid recipients enrolled with MCO;

e. Provide access to all files, data, and reports to other entities and organizations under contract to DMA for the purpose of conducting audits, studies, data validation and similar activities. Any disputes between the other

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DMA contract entities and MCO shall be resolved by DMA; except where those disputes are covered under NCGS 122C-151.4;

f. Have professional staff in place with clinical, administrative and financial expertise in managed behavioral health care operations to perform all functions of this Contract;

g. Have sufficient internal controls and systems in place to account for Contract-related and non-Contract-related revenues and expenses separately. Internal controls shall also be in place to prevent and detect fraud. These controls shall be included in the MCO's Corporate Compliance Plan;

h. Submit reports, as outlined in this Contract as developed and amended by DMA;

i. Submit ad-hoc reports requested by DMA at the times agreed upon by DMA and MCO;

j. Submit financial reports as delineated in Attachment W, in accordance with Generally Accepted Accounting Principals (GAAP);

k. Upon request by DMA, provide clarification on financial reports/accounting issues that arise as a result of analysis by DMA; and

l. Continue to meet the minimum requirements of the request for applications to participate in the 1915(b)/(c) waiver expansion issued by the Department of Health and Human Services, Division of Medical Assistance.

The MCO's annual financial reports shall be audited in accordance with Generally Accepted Auditing Standards (GAAS) by an independent Certified Public Accountant at MCO's expense. If determined applicable by DMA, MCO's annual financial reports shall also be audited in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A- 87. MCO's cost allocation plan shall be audited in accordance with OMB Circular A-122. The MCO shall provide copies of the annual audit to DMA.

In addition to the annual audit, a final reconciliation shall be completed by the independent auditing firm that conducted the annual audit. The final reconciliation will make any required adjustments to estimates included in the annual audit. The final reconciliation shall be completed no sooner than 6 months following the end of the State Fiscal Year on June 30.

The Claims Fund is comprised of unspent Medicaid service funds, and unspent Medicaid service funds that: (a) were set aside at the end of a fiscal year to cover outstanding claims from the previous fiscal year; and (b) were not needed to cover any outstanding claims. The final reconciliation shall verify the amount left in the Claims Fund at the end of the State Fiscal Year.

The annual financial audit and cost allocation plans are subject to annual independent verification and audit by a firm of DMA's choosing. Reimbursement for such audits shall be the responsibility of DMA.

6.2 <u>Covered Services:</u>

The MCO shall provide to Enrollees covered under this Contract, through arrangements with others, all of the Covered Services identified in Attachment K. These services shall be provided in the manner set forth in this Contract. The amount, duration, and scope of these services shall be no less than the amount, duration, and scope of the same services furnished to Enrollees under fee-for-service Medicaid. The amount, duration, and scope of services must reasonably be expected to achieve the purpose for which the services are furnished. Covered services shall be Medically Necessary and shall be provided by a qualified Provider. The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. MCO Covered Services are defined in the State's Medicaid Provider Manuals, Bulletins and Clinical Coverage Policies, which are incorporated herein by reference. The MCO shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with requesting Providers when appropriate. MCO may establish utilization management requirements that are different from State Plan requirements. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity and for utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.

The MCO and its subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.

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Attachment V specifies payment for mixed services; e.g., whether MCO or the Enrollee's Medical Plan pays for Medicaid covered services.

The MCO shall provide all of the 1915(b)(3) services in the approved waiver when the eligible enrollee meets the requirements and the service limitations are not exceeded. The MCO is paid capitation rates based on the expected average utilization of the 1915(b)(3) services.

6.3 Emergency Medical Services:

In accordance with Section1932(b)(2) of the Social Security Act, as amended by the Balanced Budget Act (BBA) of 1997, the MCO shall provide coverage for Emergency Behavioral Health Services consistent with the prudent layperson standard, as defined in Attachment I, Emergency Medical Condition. Such services shall be provided at anytime without regard to prior authorization and without regard to the emergency care provider's contractual relationship with MCO.

Pursuant to 42 CFR 438.114(d):

a. The MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;
b. The MCO shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, MCO, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;
c. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient

The MCO shall also comply with guidelines relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to a Medicaid Enrollee who is determined to be stable by a medical screening examination, as required under the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act (EMTALA). (Section 1867 of the Social Security Act). (See Attachment U). As specified in 42 CFR 438.114(e), post stabilization care services shall be covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). The MCO is financially responsible for post-stabilization services obtained within or outside the entity that are pre-approved by a plan provider or other entity representative. MCO is financially responsible for post-stabilization care services obtained within or outside MCO that are not pre-approved by a plan provider or other MCO representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the entity for pre-approval of further post-stabilization care services. MCO is financially responsible for post-stabilization care services obtained within or outside the entity that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if--

a. The MCO does not respond to a request for pre-approval within 1 hour;
b. The MCO cannot be contacted; or
c. The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

a. A physician enrolled with the MCO with privileges at the treating hospital assumes responsibility for the enrollee's care;
b. A physician enrolled with the MCO assumes responsibility for the enrollee's care through transfer;
c. A MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
d. the enrollee is discharged.

The MCO is responsible for educating Enrollees on the availability, location, and appropriate use of Emergency Services and informing the Enrollees of their right to use any hospital or other setting for emergency care, as required by 42 CFR 438.10.

The MCO shall not deny payment for treatment obtained when an Enrollee had an emergency medical condition, as that term is defined in 42 C.F.R. 438.114(a), even though the absence of immediate medical attention would not, in fact, have led to the outcomes specified in that definition. MCO shall not deny payment or treatment obtained when a

representative of the MCO instructs the Enrollee to seek Emergency Services. Refer to Attachment U Emergency Medical Services and Attachment V, Mixed Services Protocol.

6.4 Accessibility of Services:

The MCO shall establish and maintain a Provider Network with a sufficient number, mix, and geographic distribution of Providers to ensure that medically necessary Covered Services are delivered in a timely and appropriate manner, according to the Access Standards specified in Attachment T and elsewhere in this Contract.

The MCO shall establish policies and procedures to monitor the adequacy, accessibility, and availability of its Provider Network to meet the needs of all Enrollees, including Enrollees with limited proficiency in English.

The MCO shall conduct analyses of its Provider Network prior to entering into a contract with DMA; annually thereafter; and at any time there has been a significant change in the MCO's operations that would affect adequate capacity and services, including changes in services, geographic service areas, payments, or enrollment of a new population in the MCO. In conducting the analyses, the MCO shall consider:

a. Anticipated membership numbers, characteristics, and needs, including the cultural and language needs of Enrollees;

b. Anticipated service utilization;

c. Numbers and types of Providers required to provide the contracted services, including training, experience, and specialization;

d. The number of Network Providers who are not accepting new referrals; and

e. The geographic locations of Providers and recipients, considering travel distances, travel times, means of transportation, and physical access for Recipients with disabilities.

The MCO shall submit to DMA written reports of findings of the Provider Network analyses. Whenever network gaps are identified, the MCO shall submit to DMA a network development plan within a timeframe specified by DMA.

Provider selection procedures shall not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment. If specialty services are Medically Necessary but are not available in-network, the MCO shall arrange for these services to be provided out-of-network. The MCO shall adequately and timely cover these out-of-network services for as long as the MCO is unable to provide them in-network. MCO shall ensure that no incentive is given to Providers, monetary or otherwise, for withholding medically necessary services.

Upon request by the patient, the MCO shall provide an Enrollee with one second opinion from a qualified health care professional, at no cost to the Enrollee. The second opinion may be provided by a Provider that is in-network or one that is out-of-network. The MCO shall not be required to provide an Enrollee with a third or fourth opinion.

The Provider Network shall be documented by separate written agreements between MCO and each Provider. The provider agreement shall require the Provider:

a. To participate in MCO's utilization management, care management, quality management, qualification/accreditation and credentialing processes; and

b. To offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Enrollees.

The MCO shall:

a. Establish mechanisms to ensure that Network Providers comply with the timely access requirements specified in Sections 6.5 and 6.6 of this Scope of Work;

b. Monitor Providers regularly to determine compliance; and

c. Take corrective action if a Provider fails to comply.

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The MCO shall provide Enrollees with toll-free telephone access and emergency referral, either directly or through its Network Providers, twenty-four (24) hours per day, seven (7) days per week. The MCO shall maintain a record of telephone access-line encounters, including the date of call, type of call, and disposition. The MCO shall educate Enrollees on telephone access and emergency referral procedures.

DMA shall have the right to review periodically the adequacy of service locations, the hours of operation, and the availability and appropriateness of telephone response. DMA may require the MCO to take corrective action to improve access. DMA may terminate this Contract if MCO fails to take corrective action, as specified in Section 12, Default and Termination.

6.5 Access Standards - Appointment Availability:

The MCO shall ensure that appropriate services are provided as follows:

a. Emergency Services – Providers must provide face-to-face emergency care within two hours after a request for care is received by provider staff; the Provider must provide face-to-face emergency care immediately for life threatening emergencies;

b. Urgent Care Services -- Providers must provide initial face-to-face assessments and/or treatment within forty-eight (48) hours after the day and time a request for care is received by provider staff;

c. Routine Care Services -- Providers must provide initial face-to-face assessments and/or treatment within 10 working days of the date a request for care is received by provider staff;

d. Telephone Calls -- Provider staff must return telephone calls within one hour, 24-hours a day, seven days a week;

e. Emergency Referrals – Provider staff must respond to emergency referrals within one hour, 24-hours a day, seven days a week.

The MCO shall monitor provider performance and address problems through the Continuous Quality Improvement process.

6.6 Access Standards - Appointment Wait Time:

The MCO shall agree to provide services within the following wait times:

a. Scheduled Appointments – 60 minutes after the appointed meeting time;

b. Walk-Ins – within two (2) hours after the Enrollees' arrival. If that is not possible, MCO staff must schedule an appointment for another day;

c. Emergencies - MCO staff must provide face-to- face emergency care within two hours after the request for care is initiated; life threatening emergencies shall be managed immediately.

6.7 Customer Services:

MCO shall provide Customer Services that are responsive to the needs of Enrollees and their families. The MCO's Customer Services shall be monitored in the manner described in SOW Section 7.0, Quality Assurance and Performance Improvement. Such activities shall include but not be limited to patient satisfaction surveys (SOW Section 7.1); performance improvement projects (SOW Section 7.1); external quality reviews (SOW Section 7.2); and grievance and appeals data. **The** MCO shall:

a. Respond appropriately to inquiries by Enrollees and their family members (including those with limited English proficiency);

b. Connect Enrollees, family members, and stakeholders to crisis services when clinically appropriate;

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c. Provide information to Enrollees and their family members on where and how to access behavioral health services;

d. Log all grievances and appeals; arrange for appropriate follow-up; give notice of the outcome as required by law.

e. Train its staff to recognize third-party insurance issues, recipient appeals, and grievances and to route these issues to the appropriate individual;

f. Answer phones and respond to inquiries from 8:30 a.m. until 5:00 p.m. weekdays;

g. Process referrals 24 hours per day, 7 days per week; and

h. Process requests for services 24 hours per day, 7 days per week.

6.8 <u>Choice of Health Professional:</u>

To the extent reasonably possible, the MCO shall offer freedom of choice to Enrollees in selecting a Provider from within the MCO's qualified Provider Network. MCO shall ensure a choice of at least two Providers for each service, except specialties specifically approved by DMA in writing. Requests for exceptions may be based on such factors as medical necessity and demand. For example, exemptions may be granted if the demand for services, particularly facility based services or niche services, does not support two Providers.

An Enrollee who has received prior authorization from MCO for referral to a Network Provider or for inpatient care shall be allowed to choose from among all the available Network Providers and hospitals within MCO, to the extent reasonably possible.

MCO shall coordinate its services with the services its Enrollees receive from other MCOs, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) in order to avoid unnecessary duplication. In accordance with 42 CFR 438.208, MCO shall share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (see Section 6.13) so that those activities need not be duplicated.

6.9 <u>Facilities and Resources:</u>

MCO shall provide directly, or indirectly by contract, the following:

a. Sufficient numbers of experienced and qualified utilization and care management staff to meet the terms of this Contract. Utilization managers and care managers for individuals with mental health/substance abuse needs **shall be at minimum** Master's level Behavioral Health professionals **licensed by the State of North Carolina** with a minimum of two years post-Master's experience in a clinical setting with the population served. Utilization managers and care managers for developmental disabilities services shall be completed by a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR 483.430 (a) and N.C. Gen. Stat. §122C-3;

b. A designated emergency service facility providing care 24 hours per day, seven days per week;

c. Facilities that meet the applicable Federal, State, and local requirements pertaining to health care facilities and laboratories. All clinical laboratory testing sites shall have a CLIA identification number and either a CLIA certificate of compliance, a CLIA certificate of registration, or a CLIA certificate of waiver;

d. A telecommunications system sufficient to meet the needs of Enrollees 24 hours per day, seven days per week. The system shall have an intake line with clinical back-up by a licensed Master's level clinician 24 hours per day, seven days per week;

e. Sufficient support staff;

f. A physician, **licensed in the State of North Carolina and board certified in psychiatry,** to serve as Medical Director. The Medical Director shall oversee and be responsible for the proper authorization and

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review of covered services to Enrollees. The Medical Director shall ensure that all staff conducting reviews operate within the scope of their areas of clinical expertise;

g. A full-time contract manager with at least seven years of management experience, preferably in human services;

h. One full time director of management information systems with a minimum of five years experience in data management and IT project management in health care;

i. A full-time utilization management director that is a masters-level clinician licensed in North Carolina and has a minimum of five years utilization review and management experience in mental health, developmental disabilities and substance abuse care;

j. A full time Clinical Director for Innovations (I/DD) services that has a minimum of seven years utilization review , care management, and/or habilitative and case management experience in developmental disabilities care;

k. A full-time quality management director with at least five years recent quality management experience and two years managed care experience or experience in mental health, developmental disabilities and substance abuse care. The Quality Assurance Director shall have a Bachelor's Degree in a Human Services Field or a Master's Degree in a human services field.

l. A full-time finance director with at least seven years experience managing progressively larger budgets;

m. A full-time provider network director that is a licensed clinician with at least five years combined clinical, network operations, provider relations and management experience;

n. A full-time customer services director with at least five years combined customer service, clinical and management experience;

6.10 <u>Information for New Enrollees:</u>

Upon approval of an individual's Medicaid eligibility application, DMA shall send the new Enrollee a written description of the services and benefits provided by MCO, a written explanation of how to access those services from MCO, and MCO contact information.

6.11 <u>Enrollee Education:</u>

Within 14 days after an Enrollee makes a request for services, MCO shall provide the new Enrollee with written information on the Medicaid managed care program. The MCO may send information that directs recipients to the MCO website and instructs recipients to request additional information by mail if they do not have access to the webpage. The written information shall be available in Spanish and in any additional languages that are spoken by a substantial number of persons served by MCO. A "substantial number" is defined as the lesser of five percent of the MCO's Enrollees or 1,000 Enrollees. All new Enrollee material shall be approved in writing by DMA prior to its release, and shall include at least the following information, as specified in 42 C.F.R 438.10 (f)(6) and 42 C.F.R. 438.10 (g):

a. A description of the benefits and services provided by MCO and of any limitations or exclusions applicable to covered services. These descriptions must have sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;

b. A description of all Innovations services and supports, including a description of Community Guide services and Self-Directed care model(s).

c. Updates regarding program changes;

d. A description of the procedures for obtaining benefits, including authorizations;

e. A description of the Enrollee's responsibilities and rights and protections, as set forth in 42 C.F.R. 438.100;

f. An explanation of the Enrollee's right to select and change Network Providers;

g. The restrictions, if any, on the Enrollee's right to select or change Network Providers;

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h. The procedures for selecting and changing Network Providers;

i. A list of all Network Providers, including their names, addresses, telephone numbers, qualifications, and whether they are accepting new patients;

j. The non-English languages, if any, spoken by each Network Provider;

k. The extent to which, and how, after-hours and emergency coverage are provided, including:

   1. What constitutes an Emergency Behavioral Health Condition, Emergency Services, and Post Stabilization Services (Attachment U of this document);

   2. The process and procedures for obtaining Emergency Services, including the use of 911 telephone services or the equivalent;

   3. The locations at which Providers and hospitals furnish the Emergency Services and Post Stabilization services covered under this Contract;

   4. That, subject to the provisions of this Contract, the Enrollee has a right to use any hospital or other setting for Emergency Care;

l. MCO's policy on referrals for Specialty Care:

   1. Cost sharing if any; and

   2. How to access Medicaid benefits that are not covered under this contract;

m. Any limitations that may apply to services obtained from Out-of Network Providers, including disclosure of the Enrollee's responsibility to pay for unauthorized behavioral health care services obtained from Out-of-Network Providers, and the procedures for obtaining authorization for such services;

n. Procedures for obtaining out-of-area coverage or services;

o. Information about medically necessary transportation services provided by the Department of Social Services in each county;

p. Policies regarding the treatment of minors;

q. The Enrollee's right to recommend changes in MCO's policies and services;

r. The procedures for recommending changes in MCO's policies and services;

s. The Enrollee's right to formulate Advance Directives;

t. The accommodations made for non-English speakers, as specified in 42 C.F.R. 438.10 (c) (5);

u. Written information shall be made available in the non-English languages prevalent in MCO's service area. Pursuant to 42 C.F.R. 438.10(c)(1), ""Prevalent" means a non-English language spoken by a significant number or percentage of potential Enrollees and Enrollees in the State";

v. The availability of oral interpretation service for non-English languages and how to access the service;

w. The availability of interpretation of written information in prevalent languages and how to access those services; and

x. Upon an Enrollee's request, MCO shall provide information on the structure and operation of the agency and any physician incentive plans.

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The following requirements apply to all printed materials produced for Enrollee use. MCO shall produce all printed materials in simple, easily understood language and shall produce the materials in more than one format. MCO shall describe the formats and the means to access them to all Enrollees. MCO shall produce all printed materials in a manner that accommodates the special needs of those Enrollees with intellectual and developmental disabilities, who are visually limited and those Enrollees who have limited reading proficiency. MCO shall translate all printed materials into the catchment area's prevalent languages. All printed materials intended for Enrollee use must be approved by DMA in writing before the materials are printed for distribution and use.

MCO shall make oral interpretation of all non-English languages available free of charge to all Enrollees.

MCO shall give each Enrollee written notice of any "significant change" in the information specified in 42 C.F.R. 438.10(f)(6) and 42 C.F.R. 438.10(g) at least 30 days before the intended effective date of the change. A "significant change" is a change that requires modifications to the MCO Waiver or the Medicaid State Plan.

At least once each year, MCO shall notify all Enrollees of their right to request and obtain the information described above.

6.12 <u>Notice of Provider Termination:</u>

When either DMA or MCO terminates the services of a Provider, the MCO shall give written notice of the termination to all Enrollees who have been receiving services from the terminated Provider on a regular basis. MCO shall make good faith efforts to give that notice within 15 days after MCO receives notice that DMA has terminated the Provider or within 15 days after MCO terminates the Provider.

6.13 <u>Care Management:</u>

MCO shall manage Enrollee care by performing, at a minimum, the following Care Management functions:

a. The MCO shall be available 24 hours per day, seven days per week, to perform telephone assessments and crisis intervention;
b. MCO shall determine which Behavioral Health Services are Medically Necessary for each Enrollee;

c. MCO shall perform Quality Monitoring of the Behavioral Health Services provided to Enrollees by Network Providers;

d. MCO shall coordinate and monitor Behavioral Health hospital and institutional admissions and discharges, including discharge planning;

e. MCO shall ensure the coordination of care with each Enrollee's primary care Provider/CCNC physician /Health Home;

f. MCO shall provide follow-up activities to high risk Enrollees who do not appear for scheduled appointments; to Enrollees for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; and to individuals discharged from 24 hour care;

g. MCO shall ensure that each Enrollee's privacy is protected in accordance with State and federal law.

Care Management for Enrollees with Special Health Care Needs:

h. The MCO shall identify enrollees who have special health care needs. Individuals with special health care needs are defined as:

<u>Intellectual and/or Developmental Disabilities:</u>

Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, who are not living in an ICF-MR facility; **OR**

Individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom the LME has received notification of discharge.

Child Mental Health:

Children who have a diagnosis within the diagnostic ranges defined below:

293-297.99	298.8-298.9	300-300.99	302-302.6	302.8-302.9
307-307.99	308.3	309.81	311-312.99	313.81
313.89	995.5-995.59		V61.21	

AND

Current CALOCUS Level of VI, **OR**

who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom the LME has received notification of discharge.

Adult Mental Health:

Adults who have a diagnosis within the diagnostic ranges of:

295-295.99	296-296.99	298.9	309.81

AND

Current LOCUS Level of VI.

Substance Dependent:

Individuals with a substance dependence diagnosis

AND

Current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent:

Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past 30 days

Co-occurring Diagnoses:

Individuals with both a mental illness diagnosis and a substance abuse diagnosis

AND

current LOCUS/CALOCUS of V or higher, **OR** current ASAM PPC Level of III.5 or higher

a. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis

   AND

   current LOCUS/CALOCUS of IV or higher

b. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis

   AND

current ASAM PPC Level of III.3 or higher

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i. Pursuant to 42 CFR Part 438.208(c), the MCO shall implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring ; assessment mechanisms must use appropriate health care professionals, including the recipients primary care physician/CCNC Health Home.

j. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the MCO shall produce a treatment plan. The treatment plan must meet the following requirements:
   i. Developed by enrollees' care manager with enrollee participation, and in consultation with any specialists' care for the enrollee.

   ii. Approved by the MCO in a timely manner (if approval required by plan).

   iii. In accord with any applicable State quality assurance and utilization review standards.

k. If a treatment plan or regular care monitoring is in place for an enrollee with special health care needs, the MCO shall allow enrollees to directly access specialists as appropriate for the enrollee's condition and identified needs.

l. The MCO shall use Quality Monitoring and the Continuous Quality Improvement Process:

   i. To ensure that individual treatment plans are developed consistent with 42 C.F.R. Part 438.208 and Part 456; and

   ii. To ensure Enrollee participation in the treatment planning process;

6.14 Behavioral Health Education Services:

The MCO shall, on an on-going basis, make Behavioral Health Education Services available at convenient times, in accessible locations, and at no cost to the Enrollees and/or the legally responsible persons. The MCO shall provide education on issues identified by Enrollees, stakeholders and other interested persons. Topics may include:

a. Behavioral Health Referral;
b. Access to Care;
c. Appeals and Grievances;
d. Recipient Rights;
e. Suicide Prevention;
f. Signs of Mental Illness;
g. Risks of Substance Abuse; and
h. Substance Abuse Prevention;
i. Community Guide
j. Self Directed Service Model(s)
k. Supports Intensity Scale(SIS)
l. Supports Needs Matrix (SNM)

The MCO shall keep attendance records at all Behavioral Health Education Activities. The MCO shall make the attendance records available for review by DMA and/or the NC DHHS monitoring team during on-site reviews.

The MCO shall develop stakeholder group(s) of recipients, families, advocates, and providers around Innovations waiver services, including Community Guide, MCO Care Management procedures, the use of the Supports Intensity Scale (SIS) and the Support Needs Matrix (SNM). The MCO shall keep meeting notes and records of these stakeholder meetings. The MCO shall make these records available for review by DMA and shall report on these efforts at IMT meetings.

6.15 Enrollee Rights:

MCO must have written policies/procedures regarding the rights of Enrollees in accordance with Article 3, Part 1 of N.C.G.S. Chapter 122C and the rules promulgated there under. The MCO must ensure that its staff and Network Providers follow these policies and procedures when furnishing services to Enrollees. Enrollees are free to exercise

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their rights and the exercise of those rights shall not adversely affect the way that MCO or its Providers treat the Enrollee. Rights include:

a. The right to be treated with respect and due consideration of dignity and privacy;

b. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

c. The right to participate in decisions regarding health care, including the right to refuse treatment;

d. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

e. The right to request and receive a copy of his or her medical record, except as set forth in N.C.G.S. 122C-53(d), and to request that the medical record be amended or corrected in accordance with 45 C.F.R. Part 164.

6.16 Anti-Gag Clause:

The MCO may not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient:

a. For the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. For any information the Enrollee needs in order to decide among all relevant treatment options;

c. For the risks, benefits, and consequences of treatment or non-treatment; and

d. For the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.17 Support Services:

The MCO shall develop strategies for addressing the special needs of the Medicaid population. Strategies should incorporate staff and Network Provider training to increase awareness and sensitivity to the needs of persons who may be disadvantaged by low income, disability and illiteracy, or who may be non-English speaking. Staff and Network Provider training shall include topics such as sensitivity to different cultures and beliefs, the use of bilingual interpreters, the use of Relay Video Conference Captioning, Relay NC, TTY machines, and other communication devices for the disabled, overcoming barriers to accessing medical care, understanding the role of substandard housing, poor diet, and lack of telephone or transportation for health care needs.

The MCO shall provide the following services as necessary to ensure Enrollee access to and appropriate utilization of Medically Necessary services covered under this Contract:

a. **Transportation**: MCO shall provide information about the availability of non-emergency transportation for Enrollees through available public and private services. MCO shall provide Enrollees with verbal and written information concerning resources for transportation offered by the Medicaid Program and available in the county.

b. **Interpreter Services:** Interpreter services shall be made available by telephone or in-person to ensure that Enrollees are able to communicate with MCO and Network Providers. MCO shall make oral interpretation services available free of charge to each Enrollee. This applies to non-English languages as specified in 42 C.F.R. 438.10(c)(5).

c. **Coordination and Referral to Community Resources:** MCO shall provide referral to available community services, including but not limited to those identified in Attachment K. MCO shall have staff who are familiar with these resources and shall maintain a written description of appropriate referral procedures.

6.18 Payment to Out-of-Network Providers:

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The MCO shall consider each claim for reimbursement for Emergency Services provided to Enrollees by Out-of-Network Providers based upon its own merits and the requirements of this Section, and shall not routinely deny such claims based upon failure to obtain prior authorization.

The MCO shall reimburse Out-of-Network Providers for Covered Services, which may be obtained by Enrollees without prior authorization from MCO for Emergency Services which could not be provided by an MCO Network Provider because the time to reach MCO Network Provider capable of providing such services would have meant risk of serious damage or injury to the Enrollee's health;

The Enrollee may be required to provide information to MCO to assist in proper and prompt payment of services. The MCO shall describe in writing the procedures whereby Out-of-Network Providers can appeal claims denied by MCO;

MCO shall ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the Network.

6.19 Advance Directives:

The MCO shall maintain written policies and procedures concerning Advance Directives as specified in Article 3, Part 2 of N.C.G.S. Chapter 122C. MCO shall distribute written information regarding Advance Directive policies to adult Enrollees, including a description of applicable State and Federal laws as outlined in Medicaid Special Bulletin on Advance Directives, May 1999 (See Attachment X) or found at the DMA website at:

http://www.dhhs.state.nc.us/dma/Forms/advdirective.pdf.

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The MCO's written information regarding Advance Directives shall cover the following topics:

a. Enrollee rights under State law;

b. MCO policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

c. Information on the Advance Directive policies of MCO; and

d. The Enrollee's right to file a grievance with the State Certification and Survey Agency concerning any alleged noncompliance with the advance directive law.

As specified in 42 CFR 438.6(i), the written information provided by MCO shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

6.20 Payments From Enrollees:

The MCO shall not require co-payments, deductibles, or other forms of cost sharing from Medicaid Enrollees for Medicaid services covered under this Contract, nor shall MCO charge Enrollees for missed appointments. Enrollees who obtain services from Out-of-Network Providers without MCO authorization, except those services specified in Sections 6.3 and 6.18, shall be responsible for payment of costs associated with such services. As specified in 42 CFR 438.114(e), the MCO shall limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through MCO. Enrollees shall not be held liable for payments to Providers in the event that MCO or its subcontractors become insolvent or DMA does not pay MCO.

6.21 Inpatient Hospital Services:

DMA shall be responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Medicaid recipients who are hospitalized before the effective date of their enrollment in the MCO and shall remain responsible for those costs until such Medicaid recipients are discharged from the hospital.

The MCO shall be responsible for the cost of Medicaid covered inpatient psychiatric treatment provided to Medicaid recipients who are hospitalized on or after the effective date of their enrollment in the MCO and shall remain responsible for these costs until such Medicaid recipients are discharged from the hospital.

6.22 Confidentiality:

MCO shall adopt and implement policies and procedures to ensure that it complies with all applicable State and federal confidentiality laws, rules, and regulations, including but not limited to:

a. N.C. Gen. Stat. § 108A-73 and -80;
b. N.C. Gen. Stat. § 122C-52 through -56;
c. Subchapter 26B of Title 10A of the North Carolina Administrative Code;
d. the Health Information Portability and Accessibility Act (HIPAA);
e. the rules that implement HIPAA (45 C.F.R. Parts 160 and 164); and
f. 42 CFR §§ 2.1 through 2.67.

6.23 Indian Health Services:

The MCO shall comply with the protections outlined in section 5006 of the American Reinvestment and Recovery Act regarding the provision of services by Indian health care providers to the extent that services covered by this contract are provided by Indian health care providers.

The MCO shall not charge premiums or cost sharing for services provided to Indian enrollees by Indian health care providers.

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The MCO shall reimburse Indian health care providers, regardless of whether such providers are participating in the MCO provider network, for covered Medicaid managed care services provided to Indian enrollees who are eligible to receive services at a rate equal to the rate negotiated between such entity and the provider involved. If such a rate has not been negotiated, the MCO shall pay the Indian health care provider at a rate that is not less than the amount of payment which the MCO would make for the services if the services were furnished by a provider participating in the MCO network who is not an Indian health care provider.

The MCO shall reimburse Indian health care providers according to the prompt pay requirements in section 1932(f) of the Social Security Act, regardless of whether such providers are participating in MCO provider network.

The MCO shall reimburse any Indian health care provider that is a federally qualified health center (FQHC), which is not participating in the MCO provider network, for the provision of services covered by this contract to an Indian enrollee at a rate equal to the amount of payment that the entity would pay a FQHC that is participating in the MCO network but is not an Indian health care provider for such services. Nothing in this section of the contract shall be construed as a waiver of Section 1902(bb)(5) of the Social Security Act regarding the Medicaid State plan requirement to make any supplemental payment due for services provided by a FQHC.

If the amount paid by the MCO to a non-FQHC Indian health care provider for services covered under the contract to an Indian enrollee is less than the Medicaid State plan payment rate, DMA shall provide for payment of the difference between the State plan rate and MCO rate to the Indian health care provider, regardless of whether the provider is participating in MCO provider network.

SECTION 7 - QUALITY ASSURANCE and QUALITY IMPROVEMENT

7.1 Internal Quality Assurance/Performance Improvement Program

The MCO shall establish and maintain a written program for Quality Assurance/Performance Improvement ("QA/PI") consistent with 42 CFR 438.240 and with the utilization control program required by CMS for DMA's overall Medicaid program as described in 42 CFR 456 and the CMS Quality Framework.

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The MCO shall maintain an active QA/PI committee or other structure, which shall be responsible for carrying out the planned activities of the QA/PI program. This committee shall have regular meetings, shall document attendance by Providers, and shall be accountable to, and report regularly to, the governing board or its designee concerning QA/PI activities. MCO shall maintain records documenting the committee's findings, recommendations, and actions.

The MCO shall designate a senior executive who shall be responsible for QA/PI program implementation. The MCO's Medical Director shall have substantial involvement in QA/PI program functions, such as credentialing, utilization review, and the monitoring of the MCO's Network Providers.

MCO's written QA/PI program shall describe, at a minimum, how the MCO shall:

a. Meet or exceed CMS, DMA, and MCO defined minimum performance levels on standardized quality measures annually as described in Attachment M;

b. Develop and implement performance improvement projects using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and Enrollee satisfaction;

c. Have in effect mechanisms to detect both over and under utilization of services;

d. Have in effect mechanisms to assess the quality and appropriateness of care furnished to Enrollees with behavioral health care needs;

e. Include all demographic groups, care settings, and types of services over multiple review periods;

f. Measure the performance of Network Providers and conduct peer review activities such as: identification of practices that do not meet Plan standards; recommendation of appropriate action to correct deficiencies; and monitoring of corrective action by Providers;

g. Measure provider performance through medical record audits;

h. Provide performance feedback to Providers, including detailed discussions of clinical standards and the expectations of MCO;

i. Develop and adopt clinically appropriate practice parameters and protocols/guidelines and provide MCO's Providers enough information about the protocols/guidelines to enable them to meet the established standards; and

j. Evaluate access to care for Enrollees according to Sections 6.4, 6.5 and 6.6 of this Contract, and implement a process for ensuring that Network Providers achieve and maintain these standards. The evaluation should include an analysis of the accessibility of services to Enrollees with disabilities.

By no later than July 31 of each calendar year, the MCO shall submit to DMA a revised and updated QA/PI program and a report on the MCO's progress toward performance improvement goals during the last 12 months.

The MCO shall develop and implement the self-funded, MCO-specific performance improvement projects described in Contract Attachment N.

At DMA's request, the MCO shall participate in at least one statewide performance improvement project each year at its own expense

The MCO shall conduct a patient satisfaction survey annually using a survey instrument approved by DMA. The MCO will be required to use some statewide standardized questions on each survey. The MCO must have the patient satisfaction survey created and administered by an outside vendor. The survey shall utilize the sampling and format defined by the National Committee for Quality Assurance (NCQA). The results of the survey must be submitted to DMA as stated in Contract Attachment M, Statistical Reporting Requirements.

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7.2 Annual External Quality Reviews

Pursuant to 42 CFR 438.310 through 438.370, DMA shall contract with an external quality review organization (EQRO) to conduct an annual independent external quality review (EQR). Three (3) activities are mandatory during these reviews: (1) determining MCO compliance with federal Medicaid managed care regulations; (2) validation of performance measures produced by the PHIP; and (3) validation of performance improvement projects undertaken by MCO. CMS-published protocols shall be utilized by the organization conducting the EQR activities. In addition, based on the availability of encounter data, the EQRO shall conduct encounter data validation per the CMS protocols.

7.3 Inspection and Monitoring:

Pursuant to 42 C.F.R. 438.66, DMA shall monitor MCO's enrollment and disenrollment practices and the MCO’s implementation of the MCO's grievance and appeal procedures.

Pursuant to 42 C.F.R. 438.6(g), DMA, the United States Department of Health and Human Services, and any other authorized Federal or State personnel or their authorized representatives may inspect and audit any financial records of MCO or its subcontractors relating to MCO's capacity to bear the risk of potential financial losses.

Pursuant to 42 C.F.R. 434.6(a)(5), and as otherwise provided under this Contract, the Department, DMA, and any other authorized Federal or State personnel or their authorized representatives shall evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under this Contract.

7.4 Utilization Management:

Utilization Management Program: MCO shall have a Utilization Management Program that is consistent with the requirements of 42 C.F.R. 456 and 42 C.F.R. 438, Subpart D. The Utilization Management Program shall include a written Utilization Management Plan which describes the mechanisms used to detect underutilization of services as well as overutilization. The written Utilization Management Plan shall address procedures used by MCO to review and approve requests for medical services, and shall identify the clinical criteria used by the MCO to evaluate the medical necessity of the service being requested. The MCO shall ensure consistent application of review criteria and shall consult with requesting providers when appropriate. The MCO shall conduct an annual appraisal that assesses the MCO’s adherence to the requirements of the Utilization Management Plan and identifies the need for changes in the Utilization Management Plan.

The MCO will use a DMA-standardized Authorization Request Form. The MCO will use LOCUS and CALOCUS scores for medical necessity reviews for mental health services and ASAM for substance abuse services. The MCO will use SIS scores and the Supports Needs Matrix in their Innovations Utilization Management program.

The MCO must develop a plan for transitioning recipients from the Supports and Comprehensive CAP Waivers to the Innovations waiver. The MCO shall work with DMA and DHHS to develop a plan for planned implementation of the Support Needs Matrix, including the development of a network of master trainers and SIS evaluators.

The Innovations Utilization Management and Care Management (Tx Planning) sections of the MCO must be kept completely separate. This separation will be monitoring at all IMT on-site reviews and validated by external monitors (as needed).

The MCO shall have an information technology system that collects, stores, and retrieves the data necessary to perform the required utilization management functions.

Practice Guidelines: The MCO shall develop a Clinical Advisory Committee consisting of licensed Network Providers. Practice Guidelines shall be developed in consultation with this committee. Practice guidelines shall be based on valid and reliable clinical evidence (Evidence Based Practice) or a consensus of professionals in the field. Practice guidelines shall address the needs of Enrollees and shall be reviewed and updated periodically as appropriate and in accordance with changes and developments in clinical research. Practice Guidelines shall be disseminated to Providers and, upon request, to Enrollees. All utilization management decisions, Enrollee education decisions, coverage of services decisions, and all other decisions covered by the Practice Guidelines shall be consistent with the Practice Guidelines.

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Requests for authorization to be admitted to, or to remain in, inpatient or intermediate care, shall be reviewed by behavioral health professionals, as defined in 42 C.F.R Part 456. Inpatient and intermediate care in an institution shall be approved by a physician or physician's assistant as required by 42 C.F.R. Part 456.

Requests for authorization to receive or to continue to receive, outpatient services, shall be reviewed by behavioral health professionals, as defined in 42 C.F.R Part 456. A denial of a request for outpatient services shall be made by a licensed clinician whose license is comparable to the license of the Provider requesting the service.

A decision to deny a service or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

MCO's provider contracts shall require that each individual, group, and organizational Provider comply with all applicable federal, State, and MCO requirements regarding:

a. access to care:
b. utilization review;
c. clinical studies; and
d. all other utilization management, Care Management, Quality Management and credentialing activities prescribed in 42 C.F.R. Parts 441 and 456.

The MCO shall utilize the DMA-approved evergreen contract for providers. The MCO may utilize provider contract amendments if needed to include network-specific performance measures or other MCO-specific measures. MCO shall develop policies and procedures for monitoring provider compliance with these requirements. The MCO shall utilize the DMA-approved provider monitoring tools and protocol.

THE MCO SHALL NOT IMPLEMENT ANY UTILIZATION MANAGEMENT POLICIES OR PROCEDURES THAT PROVIDE INCENTIVES FOR UTILIZATION REVIEWERS TO DENY, LIMIT, OR DISCONTINUE MEDICALLY NECESSARY SERVICES TO ANY ENROLLEE.

Timeframes for Standard Decisions: MCO shall issue a decision to approve or deny a service within 14 calendar days after it receives the request for services, provided that the deadline may be extended for up to 14 additional calendar days if:

a. The Enrollee requests the extension; or
b. The Provider requests the extension; and
c. MCO justifies (to DMA upon request):

    1. A need for additional information; and
    2. How the extension is in the Enrollee's interest.

Notwithstanding the foregoing deadlines, MCO shall always issue a decision to approve or deny a service as expeditiously as the Enrollee's health condition requires.

Timeframes for Expedited Decisions: In those cases in which a Provider indicates, or the MCO determines, that adherence to the standard timeframe could seriously jeopardize an Enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO shall issue a decision to approve or deny a service within three calendar days after it receives the request for services, provided that the deadline may be extended for up to 14 additional calendar days if:

a. The Enrollee requests the extension; or
b. The Provider requests the extension; and
c. MCO justifies (to DMA upon request):

    1. A need for additional information; and
    2. How the extension is in the Enrollee's interest.

Notice of Termination, Suspension or Reduction of Services: When MCO decides to terminate, suspend, or reduce a previously authorized Medicaid-covered service, the MCO shall mail notice of the action at least 10 days before the effective date of the action. The MCO may shorten the period of advance notice to five days if:

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a. MCO has facts indicating that action should be taken because of probable fraud by the recipient; and
b. The facts have been verified, if possible, through secondary sources.

Notices shall be sent to the Enrollee in accordance with 42 C.F.R. 438.210 (c). See Attachment O, Grievance and Appeal Procedures.

Service Authorization: The MCO shall define service authorization in a manner that at least includes a managed care enrollee's request for the provision of a service as required by 42 CFR 431.201.

7.5 Grievances and Appeals:

MCO shall adopt and implement grievance and appeal procedures that meets the requirements of 42 C.F.R. 438.228; 42 C.F.R. 438 Subpart F; and Contract Attachment O. The grievance and appeal procedures must:

a. Be approved in writing by DMA;
b. Provide for prompt resolution of Enrollee grievances and appeals; and
c. Assure the participation of individuals with the authority to require the MCO to take corrective action when appropriate.

The MCO shall use grievance and appeal data for quality improvement and shall report Enrollee grievances and appeals to DMA by number, type, and outcome by no later than forty five (45) calendar days after the end of each quarter of the State fiscal year.

The MCO will attend training on the enrollee appeal process from DMA. The MCO will use DMA-developed letters to notify recipients of their rights to appeal.

7.6 Credentialing:

Subject to DMA's prior review and written approval, the MCO shall adopt and implement written policies and procedures governing the qualification, credentialing, re-credentialing, accreditation, and re-accreditation of its Network Providers. The MCO shall maintain records of its qualification, credentialing, and accreditation activities in order to demonstrate its compliance with these policies and procedures. Upon request, the MCO shall make its records available to DMA for inspection and copying during normal business hours. The MCO's credentialing and accreditation criteria shall be consistent with State and Federal rules and regulations governing the subject behavioral health and medical professions. The MCO shall routinely monitor the licensure, certification, registration, and accreditation status of its Network Providers.

If the MCO declines to accept an individual Provider or Provider agency as a member of its Provider Network, it shall give the affected Provider written notice of the reasons for its decision.

The MCO shall not be required to review the qualifications and credentials of Providers that wish to become Network Members if the Network has sufficient numbers of Providers with the same or similar qualifications and credentials to meet existing Enrollee demand.

The MCO shall, at a minimum, consider the following information when deciding whether to re-accredit and re-credential a Network Provider:

a. Data collected through the MCO's Utilization Management Program;
b. Data collected through the MCO's Quality Management Program;
c. Accreditation outcomes;
d. Grievances procedure outcomes;
e. Complaint logs;
f. Enrollee satisfaction survey results; and
g. The results from other quality improvement activities.

MCO shall apply these criteria consistently to all Providers.

Insurance: MCO shall require all Network Providers to obtain and maintain:

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a. General Liability Insurance;
b. Automobile Liability Insurance;
c. Worker's Compensation Insurance;
d. Employer's Liability Insurance; and
e. Professional Liability Insurance;

in amounts that equal or exceed the limits established by the MCO. MCO shall review these insurance limits annually and revise them as needed. MCO shall require all Network Providers to obtain coverage that cannot be suspended, voided, canceled or reduced unless the carrier gives 30-days prior written notice to MCO. MCO shall require Network Providers to submit certificates of coverage to the MCO. Upon DMA's request, MCO shall submit copies of these certificates to DMA.

7.7 Provider Selection:

MCO shall have written policies and procedures for the selection and retention of Network Providers. Qualification of Providers shall be conducted in accordance with the procedures delineated in Attachment P. MCO shall not discriminate, solely on the basis of the Provider's license or certification, for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law.

During the initial year of the DMA contract, the MCO is required to extend a Provider contract to all Medicaid providers in good-standing with NC Medicaid. Subsequent provider contract extensions are subject to the MCO's process for re-credentialing and reenrollment.

In all contracts with health care professionals, the MCO shall comply with the requirements of 42 C.F.R. 438.214 regarding the selection and retention of Providers, the credentialing and re-credentialing of Providers, and non-discrimination in the selection of Providers. The MCO shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment. MCO shall not 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. The MCO shall consult the United States Department of Health and Human Services, Office of the Inspector General's List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), and the Excluded Parties Listing System (EPLS) to ensure that Providers who are excluded from participation in Federal programs are not enrolled in MCO network.

MCO is not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

For the first three years of the DMA contract, the MCO is required to maintain state-established rates for ICF-MRs and established procedures for timely filling of beds.

The MCO must develop a provider network for Innovations Services by the start-date of operations.

7.8 Provider Manual:

The MCO shall develop, maintain, and distribute a Provider manual that provides information and education to Providers about the MCO. This distribution may occur by making the manual available electronically on its website. DMA shall have the right to review and approve the Provider manual prior to its release. The manual shall be updated at least annually. At a minimum, the Provider manual shall cover the areas listed below.

a. Purpose and mission;

b. Treatment Philosophy and Community Standards of Practice;

c. Behavioral health Provider Network requirements, including: nondiscrimination, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;

d. Appointment access standards;

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e. Authorization, utilization review, and care management requirements;

f. Care Coordination and discharge planning requirements;

g. Documentation requirements, as specified in APSM 45-2 or as required by the Physician's Services Manual;

h. Provider appeals process;

i. Complaint investigation and resolution procedures;

j. Performance improvement procedures, including at a minimum: Recipient satisfaction surveys; Provider satisfaction surveys; clinical studies; incident reporting; and outcomes requirements;

k. Compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements; and

l. Patient rights and responsibilities.

The MCO shall provide to Providers any and all training and technical assistance it deems necessary regarding administrative and clinical procedures and requirements, as well as clinical practices.

7.9 <u>Health Information System:</u>

MCO's information system needs to perform, at a minimum, the following components in a manner consistent with industry standards:

a. A system with real-time access to claims history, member and provider information.
b. Ability to receive inbound member demographic and eligibility files from the state via an 834
c. Maintain member demographic, enrollment and disenrollment information.
d. Produce error reports for mismatched eligibility and establish a correction process.
e. Maintain Provider data including NPI, taxonomy and demographics for billing and rendering/attending providers.
f. Maintain Provider Fee Schedules with effective and termination dates.
g. Ability to link provider data to claims and clinical modules in the system.
h. Ability to receive inbound claims in both paper and electronic HIPAA 837I and 837P formats.
i. Ability to receive sub-capitated provider encounters in the same format as fee-for-service contracted providers.
j. Ability to time stamp and track all claims received.
k. Ability to reject incomplete claims upfront and provide error report to provider.
l. Ability to adjudicate claims, resulting in payments and denials to providers.
m. Ability to create system generated remittance advice in HIPAA 835 and paper formats and payments to providers in electronic fund transfer (EFT) and paper checks if necessary.
n. Maintain edits in claim system to identify non-eligible claims, members or services.
o. Ability to apply reason codes why a payment is less than the amount billed by the provider.
p. Ability to apply adjustments to processed claims with adjustment reasons including audit trails of all data activity.
q. Maintain third party liability information data to ensure coordination of benefits.
r. Perform coordination of benefits during the claims adjudication process.
s. Maintain authorization data to match to the claims for adjudication.
t. Documented software maintenance cycle which describes how changes are implemented into the production environment including version control.
u. Ability for system backups and retrieval with disaster recovery contingency processes that are established and tested routinely.
v. Have data repositories used for statistical and financial reporting and the creation of encounter data for submission as directed by DMA.
w. On-line reporting capabilities for daily monitoring of clinical and claim operations.
x. Reporting for claims that have been received but not paid used to monitor claims payment timeliness.
y. Perform random claims audit for all claims processed.
z. Processes to perform a capitation payment reconciliation.
aa. Maintain security standards for data consistent with Federal and State personal health information (PHI) security standards.

The MCO shall maintain a health information system that collects, analyzes, integrates, and reports data for recipients with behavioral health, developmental disability, and substance abuse treatment needs. At a minimum, the system shall

provide information on utilization management, provider network management, quality management, financial operations, grievances, appeals, and member disenrollment for reasons other than loss of Medicaid eligibility.

The MCO shall be able to transfer data electronically using secure File Transfer Protocols (FTP) and file formats as directed by DMA.

The MCO shall collect data on Enrollee and Provider characteristics as specified by DMA and on services furnished to Enrollees through an encounter claims data system or other methods as specified by DMA.

The MCO shall collect service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.

The MCO shall have the ability to send and receive the HIPAA transaction formats. Formats that will be used beginning on program inception include the following:

a. 820 – Premium Payment
b. 834 – Member Enrollment and Eligibility Maintenance
c. 835 – Remittance Advice
d. 837P – Professional claims
e. 837I – Institutional claims

The MCO shall have the ability to receive the DMA Global Eligibility File and use this file for mailing recipient notices and UR decisions.

Other transactions that the MCO may need to have the capability to process include the following:

a. 270/271 – Eligibility Inquiry and Response
b. 276/277 – Claim Inquiry and Response
c. 278 – Authorization

The MCO must document all Information obtained through paper, telephone, fax, or electronic methods and enter that data into MCO's database. All documentation must be available in an electronic format.
MCO shall ensure that data received from Providers is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data; and
b. Screening all data for completeness, logic, and consistency.

The MCO shall make all collected data available to DHHS entities and/or upon request, to CMS. MCO must provide reports of collected data to DMA as requested in a frequency, form and format necessary to meet operational needs, as described in sections 9.3 and 9.4 in the scope of work of the DMA contract and in Contract Attachments M, N and W. Typically, ad hoc reports will be required within 1 to 2 days of the request.

SECTION 8 - RECORDS

8.1 <u>Clinical Records:</u>

Network Provider Medical Records: MCO shall require network providers to maintain clinical records that meet the requirements in the NC DHHS documents captioned *Records Management and Documentation Manual for Providers* (APSM 45-2) and *Rules for MH/DD/SAS Facilities and Services* (APSM 30-1) and in the *Basic Medicaid Billing Guide.* Medical Records shall be maintained at the Provider level; therefore Enrollees may have more than one record if they receive services from more than one Provider. The MCO shall monitor Medical Record documentation to ensure that the standards are met. The MCO shall have the right to inspect Provider records without prior notice. The MCO's Network Provider contracts shall require Providers to transfer original Medical Records to the MCO in the event that the Provider closes its North Carolina business operations, whether the closure is due to retirement, bankruptcy, relocation to another state, or any other reason.

MCO Service Management Records: The MCO shall maintain all Service Management Records in accordance with the terms of this Contract and with all specifications for record keeping established by DMA for purposes of audit and program management. All books and records shall be maintained to the extent and in such detail as shall properly reflect each service provided. The MCO may maintain records in an electronic format. The MCO's Service Management Records shall contain at least the following information:

Documentation for all Enrollees:

a. Demographic information, including:

1. Name;
2. Medicaid ID number;
3. Birth date;
4. Sex;
5. Address and phone number; and
6. Parent or guardian if under 18;

b. Referral or Utilization Management contact information:

1. Date of the contact;
2. Service requested; and
3. If the requested service meets medical necessity:

A. The amount, duration, and scope of the authorized service; and
B. The basis of, or the information used to make, the medical necessity determination;

c. If the requested service does not meet medical necessity:

1. The rationale for the denial, including the criteria or benefits provision used;

2. The proposed alternative service that does meet medical necessity for the individual, if any;

3. The notice of adverse action, including the timetable and method for informing the Enrollee and Provider of the denial, reduction, or termination of the authorization for the requested service and the Enrollee Grievance and Appeal rights; and

4. Documentation that the denial of the authorization was made by a physician or practitioner operating within the scope of his/her license;

d. The name and credentials of the individual conducting the review;

e. The name, signature, and credentials of the individual who made the decision to deny, reduce or terminate authorization for the requested service; and

f. A record of the services authorized by the MCO and billed by Network Providers.

Additional Information to be Obtained as Appropriate:

a. For 24-hour care:

1. Date of admission;
2. Date of discharge;
3. For inpatient discharges, evidence of an appropriate discharge plan; and
4. For inpatient discharges, follow-up authorization for outpatient care.

b. Coordination of care information, which should include:

1. Name of primary care/CCNC physician or other key Providers; and
2. Other systems of care involved, such as educational system, Department of Social Services, and Criminal Justice.

c. In the presence of risk factors, evidence of education, outreach and follow up as appropriate for the individual.

8.2 <u>Financial Records:</u>

The MCO and the Network Providers shall maintain detailed records of the administrative costs and expenses incurred pursuant to this Contract including provision of Covered Services and all relevant information relating to

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individual Enrollees for the purpose of audit and evaluation by DMA and other Federal or State personnel. Records shall be maintained in compliance with all State and Federal requirements including HIPAA for use in treatment, payment or operations. Records shall be maintained and available for review by authorized Federal and State personnel during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit is in progress. When an audit is in progress or audit findings are unresolved, records shall be kept until all issues are finally resolved.

8.3 Access to Records:

All disclosure of records shall be performed in compliance with the HIPAA Privacy Standards. Any records requested pursuant to monitoring, audit or inspection as called for in this Contract shall be produced immediately for on-site review or sent to the requesting authority by mail within fourteen (14) days following the request. The MCO Network Provider Contract shall contain provisions requiring all Network Providers to comply with requests for information and that all requested records shall be provided to DMA within fourteen (14) days, at the sole cost and expense of the Network Provider. DMA shall have unlimited rights to use, disclose, and duplicate information and data developed, derived, documented, or furnished by MCO and in any way relating to this Contract.

SECTION 9 - REPORTS AND DATA

9.1 Enrollment Report:

DMA shall provide to the MCO a monthly Enrollment Report no earlier than the fourth to the last working day before the end of each month and no later than the first day of the ensuing month. The enrollment report shall list all Medicaid recipients who will be enrolled in the MCO during the ensuing month. The list of Medicaid recipients shall serve as the basis for the ensuing month's capitated payment to the Plan.

DMA shall pay the MCO a capitated payment for each Enrollee listed on the report according to the rate methodology listed in Contract Attachment Q. All enrollment and disenrollment, with the exception of Innovations waiver participants, shall be effective on the first day of the calendar month for which the enrollment or disenrollment is listed on the electronic data file. Enrollment for Innovations participants shall be effective retroactive to the date that all eligibility requirements for participation in Innovations are met.

9.2 Encounter Data:

When the MMIS is revised to accept and process encounter data, the MCO shall submit to DMA an electronic record of every encounter between a network Provider and an Enrollee within fifteen (15) days of the close of the month in which the specific encounter occurred, was paid for, or was processed, whichever is later, but no later than 180 days from the encounter date. DMA shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The MCO shall report all encounters that occur up to the date of the termination of this Contract. The MCO is subject to sanctions for late or incomplete submissions in accordance with the terms of SOW Section 13. If the Contract terminates while payments are being withheld by DMA due to inaccurate or late reporting of encounter data, DMA shall continue the withhold until the MCO reports all encounter data according to Contract Attachment W, Financial Reporting Requirements.

Until the MMIS is revised to accept and process encounter data, the MCO shall submit electronic records of encounters to DMA -- or contractors acting on DMA's behalf -- on an as-needed basis for the purposes of rate-setting, quality assurance, waiver amendments, renewals, mandatory external review activities, and other activities deemed necessary by DMA. Encounter data submitted to DMA from the MCO must be signed by the MCO's Chief Financial Officer and must contain a statement certifying the accuracy of the data.

All encounter data submitted by the MCO to DMA, the MMIS or a contractor acting on DMA's behalf shall include the Medicaid provider number of the Network Provider IF the Network Provider is enrolled in DMA's fee-for-service Medicaid program. All encounter data submitted by the MCO to DMA, the MMIS or a contractor acting on DMA's behalf shall include the National Provider Identification (NPI) of each MCO Network Provider.

9.3 Financial Reporting Requirements:

Within 60 days after the end of each State fiscal year quarter, and 90 days after the end of the State fiscal year, financial reports shall be submitted in accordance with the reporting requirements delineated in Attachment W. The MCO shall submit financial reports that are timely, accurate, and complete. The submission of late, inaccurate, or

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otherwise incomplete reports shall constitute a failure to report and the MCO shall be subject to corrective actions or penalties and sanctions as specified in SOW Section 13. Financial statements shall be presented to DMA in comparative format. For example: Compare month in current year to month in prior year; compare quarter I in current year to quarter I in prior year; compare current quarter to prior quarter; compare current month to prior month. Analysis by the MCO must include, but not be limited to, trend analysis, comparison of actual to the budget, and reconciliation of the account. The DMA Contract Administrator shall furnish the MCO with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission. DMA shall furnish such technical assistance in filing reports and data as may be permitted by the DMA's available resources. DMA reserves the right to modify from time to time the form, content, instruction, and timetables for collection and reporting of data. DMA agrees to involve the MCO in the decision process prior to implementing changes in format, and shall ask the MCO to review and comment on format changes before they go into effect. The timetable for new reports shall be negotiated by the MCO and DMA, taking into consideration the complexity and availability of the information needed.

Timelines: Reports or other data shall be received on or before the scheduled due date. All required reports shall be received by DMA no later than 5:00 p.m. Eastern Time on the due date. Requests for extensions shall be submitted to DMA in writing. All reports remain due on the schedule due date unless DMA approves the extension request in writing.

Each of MCO's Network Providers shall have a unique identifier.

9.4 Clinical Reporting Requirements:

The MCO shall submit utilization data, report on performance measurements and implement and report on performance improvement projects as described in Attachment M and Attachment N, respectively. Reports shall identify trends and patterns, when appropriate, and describe how the findings are used in MCO's clinical management and decision making processes. Other quality measures may be phased in over the term of the contract at the discretion of DMA. DMA will provide guidance to the MCO in meeting the clinical reporting requirements of this contract. DMA will work with MCO vendors to collect and report additional state-wide performance and outcome measures.

The MCO shall submit clinical reports that are timely, accurate, and complete. The submission of late, inaccurate, or otherwise incomplete reports shall constitute a failure to report and the MCO shall be subject to corrective actions or penalties and sanctions as specified in SOW Section 13. The DMA Contract administrator or QEHO unit shall furnish the MCO with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission and such technical assistance in filing reports and data as may be permitted by the DMA's available resources. DMA reserves the right to modify from time to time the form, content, instructions, and timetables for collection and reporting of data. DMA agrees to involve the MCO in the decision process prior to implementing changes in format, and shall ask the MCO to review and comment on format changes before they go into effect. The timetable for new reports shall be negotiated by the MCO and DMA, taking into consideration the complexity and availability of the information needed.

9.5 Fraud and Abuse:

The MCO shall adopt and implement policies and procedures to guard against fraud and abuse. At a minimum, these policies and procedures shall include the following:

a. A procedure to verify whether services paid for by Medicaid were actually furnished to Enrollees by Providers and subcontractors;

b. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable Federal and State standards;

c. The designation of a compliance officer and a compliance committee that are accountable to the MCO's senior management;

d. Effective training and education for the compliance officer and the MCO's employees;

e. Effective lines of communication between the compliance officer and the MCO's employees;

f. Enforcement of standards through well-publicized disciplinary guidelines;

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g. Provision for internal monitoring and auditing; and

h. Provision for prompt response to detected offenses, and for development of corrective action initiatives.

The MCO shall develop and maintain a mandatory Compliance Plan to guard against and identify fraud and abuse. The MCO shall forward all credible allegations of fraud or abuse to DMA Program Integrity.

In each case of suspected Provider fraud or abuse, the MCO shall provide DMA Program Integrity with:

a. The Provider's name and NPI;
b. The source of the allegation;
c. The type of provider;
d. The nature of the allegation;
e. The approximate range of dollars involved; and
f. The legal and administrative status of the case.

In each case of suspected Enrollee fraud and abuse, the MCO shall provide DMA Program Integrity with:

a. The recipient's name and Medicaid number;
b. The source of the allegation; and
c. The nature of the allegation.

DMA Program Integrity shall conduct a preliminary investigation of each allegation to determine whether there is sufficient evidence to warrant a full investigation.

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9.6 Financial Reports Certification:

Within sixty (60) days after the end of each State fiscal quarter, the MCO shall submit a quarterly financial report to DMA as specified in Attachment W.

All reports, information, and data, including but not limited to encounter data, which this Contract requires the MCO to submit to DMA, shall be certified by MCO as set forth in 42 C.F.R. 438.606. The certification shall be made by one of the following individuals:

a. The MCO's Chief Executive Officer;
b. The MCO's Chief Financial Officer; or
c. An individual who has been authorized to sign for, and who reports directly to, MCO's Chief Executive Officer or Chief Financial Officer.

The person signing the certification on the MCO's behalf shall attest that the attached report, information, or data is accurate, complete, and truthful, to that person's best knowledge, information, and belief. The MCO shall submit the certification concurrently with the certified data and documents.

SECTION 10 - PAYMENTS TO MCO

10.1 Monthly Payment:

Capitated payments shall be made on a Per Member Per Month (PMPM), prospective and pre-paid basis at the first check-write of each month. The check-write schedule is provided on the DMA website at:

http://www.ncdhhs.gov/dma/provider/calendar.htm.

In full consideration of all services rendered by the MCO under this Contract, DMA shall remit to the MCO the Capitation Rate determined using the methodology in Attachment Q by **multiplying the number of Medicaid Eligibles in each Rate Cell** (whose county of residence for Medicaid purposes is within the MCO's geographic area as determined by the monthly cutoff date in DMA's Medicaid Eligibility data system) **by the payment rates for the respective Rate Cells.**

The capitation rate is specified in **Appendix Y.**

However, payments shall be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements at 42 C.F.R. 438.730. Payments made by DMA pursuant to this Contract are conditioned upon the availability to DMA of funds authorized for expenditure in the manner and for the purposes provided herein. DMA shall not be liable for any purchases or subcontracts entered into by any subcontracted Provider in anticipation of funding.

In accordance with the rate setting methodology, individuals are considered a year older on the first day of the month following their birthday, regardless of the person's day of birth. For example, a person born August 30, 2002 shall be considered 1 year old on September 1, 2003. As Enrollees transition into different rate bands due to age, the new rate is effective on the first of the month following the month in which the person was born.

The payment is contingent upon satisfactory performance by the MCO of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers. The MCO shall set up the necessary bank accounts and provide written authorization to DMA's Fiscal Agent to generate and process monthly payments through the MMIS.

The MCO shall not use Title XIX funds to pay for:

a. Services or administrative costs related to non-Title XIX clients; or
b. Non-Title XIX services rendered to Title XIX clients.

The MCO shall maintain separate accounting for revenue and expenses for the Title XIX program in accordance with CMS requirements as delineated in Attachment W.

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10.2 Payment in Full:

The MCO shall accept the capitation rate paid each month by DMA for each Medicaid recipient listed on the 820 Premium Payment Remittance transaction, including retroactive payments and adjustments as described in SOW Section 10.1, as payment in full for all services to be provided pursuant to this Contract, including all administrative costs associated therewith. Enrollees shall be entitled to receive all covered services for the entire period for which payment has been made by DMA. Interest generated through investment of funds paid to the MCO pursuant to this Contract shall be the property of MCO.

10.3 Retroactive Payment Adjustments:

DMA shall make retroactive capitated payments for waiver participants when recipients are determined to be eligible for participation retroactively. Payments are made prospectively thereafter.

Payment adjustments may be initiated by DMA when keying errors or system errors affecting correct capitation payments to MCO occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying information and the payment adjustment amount.

10.4 Calculation of Rates:

The MCO and DMA shall negotiate capitation rates in good faith. These rates shall be certified as compliant with the Centers for Medicare and Medicaid Services requirements under 42 C.F.R. 438.6(c) by actuaries meeting the qualification standards of the American Academy of Actuaries.

The actuary for DMA shall develop capitation rate ranges in accordance with CMS regulations for the populations and services covered under the managed care contract. DMA reserves the right to determine and/or adjust the populations and services covered under this Contract prior to the beginning of each State fiscal year. The State fiscal year (SFY) begins each July 1 and ends on the following June 30.

Reimbursement provided under this Contract is intended for the coverage of medically necessary behavioral health services covered under the North Carolina State Plan, as well as those services identified under section 1915(b)(3) of the CMS approved MCO waiver and the section 1915 c Innovations waiver.

Attachment Q describes the rate setting methodology for the capitated payments. Using the methodology in Attachment Q, the rates shall be recalculated each year. DMA shall notify the MCO by May 1 of the new rates that will be effective on July 1, the first day of the next State fiscal year. The MCO shall have sixty (60) days to review the proposed rates. At the end of the sixty (60) day review period, the MCO may choose to accept the new rate or to terminate the Contract with DMA. The MCO shall give DMA sixty (60) days written notice of its intent to terminate the Contract.

10.5 Rate Adjustments:

Substantive changes in Medicaid services may occur during the Contract year due to Medicaid Program policy changes or mandated legislative changes. If DMA requires the MCO to add or subtract services during any given State fiscal year, DMA shall make appropriate adjustments to the capitation rate for the remainder of that State fiscal year.

10.6 Recoupment:

If the MCO:

a. Erroneously reports (intentionally or unintentionally);
b. Fraudulently reports; or
c. Knowingly fails to report;

any information affecting payments to the MCO and DMA consequently overpays the MCO, DMA may either:

a. request a refund of the overpayment; or
b. recoup the overpayment by withholding payments due in any one or more subsequent months.

DMA may also recoup erroneous overpayments made to the MCO as a consequence of keying errors or system errors. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying Enrollee information and the recoupment amount.

10.7 Third Party Resources:

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties for some of the services rendered to Enrollees. The MCO shall make every reasonable effort to determine the liability of third parties, including casualty and other tort liability, to pay for services rendered to Enrollees pursuant to this Contract and to assign Coordination of Benefits responsibility to Network Providers. All funds recovered by the MCO from third party resources shall be treated as income to the MCO.

The MCO shall contractually require its Network Providers to report any third party coverage of its Enrollees to the appropriate county DSS within five (5) days of obtaining the information from a source other than DSS.

If the MCO does not identify and/or collect third party resources within 12 months from the date of service MCO shall relinquish all rights to such resources and, DMA may collect and retain any third party recoveries that it should discover.

SECTION 11 - SUBCONTRACTS

11.1 Requirements:

The MCO may enter into subcontracts for the performance of its administrative functions and for the provision of covered services to Enrollees and for the following administrative functions: Information Technology/System; Claims Processing; Customer Service; Provider Enrollment; Credentialing, and Monitoring; Professional Consultation and Peer Review.

All subcontracts and amendments to subcontracts shall be in writing, shall meet the requirements of 42 C.F.R. 434.6 and 42 C.F.R. 438.6, and shall:

a. Clearly identify the functions that are subcontracted;

b. Identify the Enrollee population covered by the subcontract;

c. Specify the amount, duration and scope of services to be provided by the subcontractor;

d. Specify the procedures and criteria for the extension, re-negotiation, and termination of the subcontract;

e. Fully disclose the method and amount of compensation or other consideration to be received from MCO;

f. Provide that the MCO shall monitor the quality of services rendered to Enrollees;

g. Provide that the MCO shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards;

h. Contain a provision that, upon the MCO's identification of deficiencies or areas for improvement in the subcontractor's performance, the subcontractor shall take corrective action;

i. Contain no provision which provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services from Enrollees;

j. Prohibit the subcontractor, without the MCO's prior written consent, from assigning the subcontract and subcontracting with lower tier subcontractors;

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k. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the subcontract, including without limitation, the obligation to comply with all applicable Federal and State laws and regulations, all rules, policies and procedures of the Department and DMA, and all standards governing the provision of Covered Services and information to Enrollees; all quality assurance requirements; all record keeping and reporting requirements; the obligation to maintain the confidentiality of information; all rights of DMA and other officials to inspect, monitor and audit operations; the rights of DMA and other State/Federal officials to inspect and audit any financial records; all indemnification and insurance; and

l. Contain the subcontractor's National Provider Identifier (NPI) if applicable (and the subcontractor's Medicaid provider number, until that number is no longer needed for Medicaid reimbursement).

The MCO shall not sign a subcontract with any subcontractor that is not eligible for participation in the Medicaid program. No subcontract shall in any way relieve the MCO of any responsibility for the performance of its duties under this Contract. Upon DMA's request, the MCO shall provide DMA with copies of the results of any audits or reviews of the performance of the MCO's subcontractors.

11.2 <u>Timeliness of Provider Payments:</u>

Payments to Providers by the MCO shall be made on a timely basis, consistent with claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act and 42 C.F.R. 447.45. The MCO shall ensure that ninety percent (90%) of all Clean Claims for covered services, for which no further written information or substantiation is required in order to make payment, are paid within thirty (30) days of the date of approval; and that ninety-nine percent (99%) of such claims are paid within one hundred eighty (180) days of the date of receipt. The MCO is not responsible for processing or payment of claims that are submitted 90 days after the date of service. Date of receipt is the date MCO receives the claim, as indicated by electronic data records and the 835 Health Care Claim Payment/Advice Transaction (Electronic Remittance Advice [ERA]) generated for the Provider. The date paid is the date of the check or other form of payment.

The MCO shall follow North Carolina Prompt Pay Requirements as follows: Within eighteen (18) calendar days after the MCO receives an invoice/claim from a Provider, MCO shall either:

a. approve payment of the invoice/claim;
b. deny payment of the invoice/claim; or
c. determine that additional information is required for making an approval or denial.

If payment is approved, the claim shall be paid within 30 calendar days after it is approved. If the MCO fails to pay Providers within these parameters, the MCO shall pay to the Providers interest in the amount of 8% of the claim amount beginning on the date following the day on which the payment should have been made.

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11.3 DMA's Remedies Against Subcontractors:

DMA shall have the right to invoke against the MCO's subcontractors any or all of the remedies available to DMA under this Contract, including the right to inspect records, the right to terminate the subcontract, the fight to require the subcontractor to establish a plan of correction, the right to stop payment, and the right to recoup erroneous payments.

SECTION 12 - DEFAULT AND TERMINATION

12.1 MCO Breach; Remedies:

If the MCO breaches the terms of this Contract, DMA may issue a written notice of breach to the MCO that describes the breach and requires the MCO to submit to DMA, within thirty (30) days, a corrective action plan for DMA's approval. If the MCO does not timely cure the breach to DMA's satisfaction, DMA may impose one or more or all of the sanctions listed below:

a. The suspension, recoupment, or withholding of monthly capitation payments;
b. The assessment of refundable or non-refundable penalties;
c. The assessment of monetary damages; and
d. The termination of this Contract.

Notwithstanding the foregoing, DMA may impose any of these sanctions, or any other available sanctions, against the MCO without first giving the MCO an opportunity to cure the deficiency.

12.2 Termination Without Cause:

This Contract may be terminated without cause by either party by giving ninety (90) days prior written notice to the other party. The termination shall be effective at 11:59:59 p.m. on the last day of the calendar month in which the 90-day notice period expires. In the event of termination by either party without cause:

a. DMA and the MCO shall work together to minimize any disruption of services to clients;
b. The MCO shall perform all of the duties specified in SOW Section 12.5 below; and
c. The MCO shall pay DMA in full any refunds or other sums due DMA under to this Contract.

If the MCO exercises its right to terminate this Contract without cause, DMA may require the MCO to pay the non-federal share of the transition costs; i.e., the costs of EIS, MMIS, and recipient notifications.

12.3 Termination For Cause:

DMA shall have the right to terminate this Contract immediately for cause -- and provide Medicaid benefits to Enrollees through other options in the State Plan -- if DMA determines that:

a. The MCO or one of its subcontractors or Providers has substantially failed to comply with the material terms of this Contract and the MCO fails to take appropriate action immediately to correct the problem;

b. The MCO or one of its subcontractors or Providers has substantially failed to comply with the applicable requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act and the MCO fails to take appropriate action immediately to correct the problem;

c. The MCO or one of its subcontractors or Providers has substantially failed to comply with the requirements of any other State or federal Medicaid or MH/DD/SAS statute, rule, or regulation and the MCO fails to take appropriate action immediately to correct the problem;

d. The performance of the MCO or one of its subcontractors or Providers threatens to place the health or safety of any Enrollee in jeopardy and MCO fails to take appropriate action immediately to correct the problem;

e. The MCO becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);

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f. The MCO or one of its subcontractors or Providers fraudulently misleads any Enrollee or fraudulently misrepresents the facts or law to any Enrollee; and the MCO fails to take appropriate action immediately to correct the problem; and

g. Gratuities of any kind are offered to or received by any public official, employee or agent of the State by or from the MCO, its agents, employees, subcontractors or Providers.

12.4 Automatic Termination:

This Contract shall immediately and automatically terminate without further obligation to the Division of Medical Assistance if:

a. Either of the two sources of reimbursement for Medical Assistance (appropriations from the North Carolina General Assembly and appropriations from the United States Congress) no longer exists; or

b. In the event that the sum of all contractual obligations of DMA for Medical Assistance Benefits, equals or exceeds the balance of funds available to DMA for Medical Assistance Benefits for the contract year in which this Contract is effective, then this Contract shall immediately terminate

Written certification by the Director of the Division of Medical Assistance that one or the other or both of the conditions described in subsections (a) and (b) has been met shall be conclusive and binding upon the parties. The Division of Medical Assistance shall attempt to provide MCO with ten (10) days notice of the possible occurrence of events described in subsections (a) and (b) of this section.

12.5 MCO's Obligations Upon Contract Expiration or Termination:

Upon the expiration or termination of this Contract, the MCO shall:

a. Continue to perform all of the duties described in this SOW until 11:59:59 p.m. on the last day of the calendar month for which DMA has paid the monthly capitation rate;

b. Continue to provide authorization and payment for inpatient psychiatric hospital services and any services directly related to psychiatric inpatient care, to any Enrollees who are hospitalized on the termination date, until each such Enrollee is discharged;

c. Provide DMA with a report of all active authorizations and authorization limits, as of the date of termination;

d. Provide DMA with a list of Enrollees who are hospitalized, and where each Enrollee is hospitalized, as of the date of termination;

e. Provide DMA with a list of patients in psychiatric residential treatment facilities (PRTFs), and where each PRTF patient is hospitalized, as of the date of termination;

f. Arrange for the transfer of Enrollees to other appropriate Medicaid Providers;

g. Promptly provide DMA with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;

h. Take such action as may be necessary, or as DMA may direct, for the protection of property related to this Contract, which is in the possession of MCO and in which DMA has or may acquire an interest;

i. Arrange for the secure maintenance of all the MCO records for audit and inspection by DMA, CMS, and other authorized government officials, in accordance with Section 8 of this Contract;

j. Provide for the transfer of all data, including encounter data and records, to DMA or its agents as may be requested by DMA;

k. Provide for the preparation and delivery of any reports, forms or other documents to DMA as may be required pursuant to this Contract or any applicable policies and procedures of DMA; and

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l. Notify all Enrollees in writing of the pending expiration or termination of the Contract no less than forty-five (45) days prior to the date of the expiration or termination. If DMA terminates the Contract immediately for cause, pursuant to SOW Section 12.3, MCO shall provide notice of termination as promptly as possible after MCO receives the notice of termination from DMA. Similarly, if the Contract is terminated immediately because of a lack of funds, pursuant to SOW Section 12.4, MCO shall provide notice of termination as promptly as possible after MCO receives the notice of termination from DMA. In all cases, the MCO's notification letter must be approved by DMA before MCO mails the notice to Enrollees.

The obligations set forth in this SOW Section 12.5 shall survive the expiration or termination of this Contract and shall remain fully enforceable by DMA against MCO. In the event that the MCO fails to fulfill each obligation set forth in this Section, DMA shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such obligations, all at the sole cost and expense of MCO and MCO shall refund to DMA all sums expended by DMA, in writing in so doing.

SECTION 13 – PENALTIES, SANCTIONS and TEMPORARY MANAGEMENT:

13.1 DMA may use any one or more of the following options to ensure compliance with the provisions of this SOW:

a. Corrective Action Plan: To be developed by the MCO at the request of DMA. The Plan must be approved by DMA, in writing and shall be monitored by the Monitoring Team and DMA (SOW Section 1.6: Monitoring Process);

b. Penalties and Sanctions: (SOW Section 13.2:– Monetary Penalties; SOW 13.3 Sanctions; and .

c. Temporary Management: (SOW Section 13.4: Temporary Management); and

d. Termination: (SOW Section 12: Default and Termination).

13.2 Monetary Penalties

If the MCO does not adhere to the reporting and data submission requirements and deadlines specified within this Contract, DMA may impose monetary penalties. DMA shall communicate the penalties in writing to the MCO and DMA's fiscal agent.

All financial reports prepared and submitted by the MCO subsequent to the imposition of penalties shall reflect the penalties.

DMA shall have the right to assess monetary penalties pursuant to SOW Section 11.2: Timeliness of Provider Payments and Section 9.3: Reporting Requirements.

13.3 Sanctions

DMA may impose sanctions authorized by 42 C.F.R. 438.702.

For any of the violations under paragraphs 42 C.F.R. 438.700(d)(1) and (d)(2), only the sanctions specified in 42 C.F.R. 438.702, paragraphs (a)(3), (a)(4), and (a)(5) may be imposed.

13.4 Temporary Management

DMA shall impose temporary management (regardless of any other sanction that may be imposed) if it finds that the MCO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act.

DMA may not delay imposition of temporary management in order to provide a hearing before imposing this sanction. DMA may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior shall not recur.

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ATTACHMENT C

BACKGROUND, PURPOSE, AND GOALS

PURPOSE:

The purpose of the waiver expansion is to actualize the Mission and Vision of DHHS and DMA in providing MH/DD/SA services to Medicaid recipients.

DHHS MISSION:

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DMA MISSION:

The mission of the Division of Medical Assistance is to provide access to high quality, medically necessary healthcare for eligible North Carolina residents through cost effective purchasing of healthcare services and products.

VISION:

Responsible change to achieve easy access, better quality and cost-effectiveness:

1. Public and social policy toward people with disabilities shall be respectful, fair and recognize the need to assist all that need help.

2. The state's service system for persons with mental illness, developmental disabilities and substance abuse problems shall have adequate, stable funding.

3. System elements shall be seamless: consumers, families, policymakers, advocates and qualified Providers shall unite in a common approach that emphasizes support, education/training, rehabilitation and recovery.

4. All human service agencies that serve people with mental health, developmental disabilities, and/or substance abuse problems shall work together to enable consumers to live successfully in their communities.

5. Within this vision, Consumers shall have:

    a. Meaningful input into the design and planning of the services system;

    b. Information about services, how to access them and how to voice grievances;

    c. Opportunities for employment in the system;

    d. Easy, immediate access to appropriate services;

    e. Educational, employment or vocational experiences that encourage individual growth, personal responsibility and enjoyment of life;

    f. Safe and humane living conditions in communities of their choice;

    g. Reduced involvement with the justice system;

    h. Services that prevent and resolve crises;

    i. Opportunities to participate in community life, to pursue relationship with others and to make choices that enhance their productivity, well being and quality of life;

    j. Satisfaction with the quality and quantity of services; and

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k. Access to an orderly, fair and timely system of arbitration and resolution.

6. Within this vision, Providers and Care Managers shall have:

a. The opportunity to participate in the development of a state system that clearly identifies target groups, core functions and essential service components;

b. Access to an orderly, fair, and timely system of arbitration and resolution;

c. Documentation and reimbursement systems that are clear, that accurately estimate costs associated with services and outcomes provided, and that contain only those elements necessary to substantiate specific outcomes required; and

d. Training in Services that are provided.

The values of Recovery, Self Determination, Person Centered Planning and Consumer and Family driven services are the basis for this waiver expansion, and are in the North Carolina State Plan.

7. GOALS OF THE EXPANSION:

a To provide a funding strategy that includes single management of all resources through a public local system manager in order to provide for coordination and blending of funding resources; collaboration with out- of-system resources; appropriate and accountable distribution of resources; and allocation of the most resources to the people with the greatest disabilities;

b To transition the local system toward treatment with effective practices that result in real life recovery outcomes for people with disabilities;

c To promote community acceptance and inclusion of people with disabilities, to provide outreach to people in need of services, to promote and ensure accommodation of cultural values in services and supports, and to serve people in their local communities whenever possible;

d To provide for easy access to the system of care;

e To ensure quality management that focuses on health and safety, protection of rights, achievement of outcomes, accountability, and that strives to both monitor and continually improve the system of care;

f To empower consumers and families to set their own priorities, take reasonable risks, participate in system management, and to shape the system through their choices of services and Providers;

g To empower the LME-MCO to build local partnerships with the people who depend on the system for services and supports, with community stakeholders and with the providers of service; and

h To demonstrate an interactive, mutually supportive, and collaborative partnership between the State Agencies and the LME-MCO in the implementation of public policy at the local level and realization of the state's goals of system reform delineated in the Blueprint for Change.

The LME-MCO, as a public local system manager and implementer of the State's public policy, has developed the infrastructure and functional capacity to direct, coordinate, manage, and ensure accountability in this transformation of the local system and to attain the goals established in this Contract.

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ATTACHMENT D

North Carolina Department Of Health And Human Services
Division Of Medical Assistance

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made by and between the Division of Medical Assistance ("DMA" or "Covered Entity") and the LME-MCO ("Contractor" or "Business Associate"). DMA and Contractor are collectively referred to hereinafter as the "Parties." This Agreement shall become effective when DMA awards a contract to Contractor. This Agreement shall become effective on, and terminate on, the same dates as said contract.

1. BACKGROUND

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

b. If DMA awards a contract to Contractor, the relationship between DMA and Contractor will be such that the Parties believe Contractor will be DMA's "business associate" of within the meaning of the HIPAA Privacy and Security Rules.

c. The Parties enter into this Business Associate Agreement with the intention of complying with the HIPAA Privacy and Security Rules provision that a covered entity may disclose electronic protected health information or other protected health information to a business associate, and may allow a business associate to create or receive electronic protected heath information or other 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 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

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.

c. "Individual" shall have the same meaning as the term "individual" in 45 CFR160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

d. "Privacy and Security Rules" shall mean the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information set out in 45 CFR part 160 and part 164, subparts A and E.

e. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 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 CFR 164.103.

g. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

h. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR 164.304.

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i. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy and Security Rules.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose electronic protected health information or other protected health information other than as permitted or required by this Agreement or as required by law.

b. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information and other protected health information that it creates, receives, maintains, or transmits on behalf of Covered Entity, as required by the Privacy and Security Rules.

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 electronic protected health information or other protected health information by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity (i) any use or disclosure of electronic protected health information or other protected health information not provided for by this Agreement of which it becomes aware and (ii) any security incident of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides electronic protected health information and/or other protected health information received from, or created or received by Business Associate on behalf of Covered Entity (i) agrees to be bound by the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information, and (ii) agrees to implement reasonable and appropriate safeguards to protect such information.

f. Business Associate agrees to provide access, at the request of Covered Entity, to electronic protected health information and other protected health information in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR 164.524.

g. Business Associate agrees, at the request of Covered Entity, to make any amendment(s) to electronic protected health information and other protected health information in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526.

h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records, including policies and procedures concerning electronic protected health information and other protected health information, relating to the use and disclosure of electronic protected health information and other protected health information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules.

i. Business Associate agrees to document such disclosures of electronic protected health information and other protected health information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of electronic protected health information and other protected health information in accordance with 45 CFR 164.528, and to provide this information to Covered Entity or an individual to permit such a response.

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 electronic protected health information and other 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 and Security Rules if done by Covered Entity; or

(2) would not violate the minimum necessary policies and procedures of the Covered Entity.

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b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other protected health information as necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose electronic protected health information and other protected health information for the proper management and administration of the Business Associate, provided that:

(1) 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.

d. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use electronic protected health information and other protected health information to provide data aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

e. Notwithstanding the foregoing provisions, Business Associate may not use or disclose electronic protected health information or other 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 and Security Rules.

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 electronic protected health information and other protected health information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to electronic protected health information and other protected health information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the electronic protected health information or other protected health information.

(2) In the event that Business Associate determines that returning or destroying the electronic protected health information or other 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 electronic protected health

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information and other protected health information and limit further uses and disclosures of such electronic protected health information and other protected health information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such electronic protected health information and other protected health information.

6. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. 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.

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

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

____

Contractor's/Business Associate's Name

____

Signature Date

____

Printed Name Title

[This Agreement Must Be Signed By The Same Individual Who Signed The Contract Execution Page]

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ATTACHMENT E

North Carolina Department of Health and Human Services
Division of Medical Assistance

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

____

Signature   Title

____

Agency/Organization   Date

[This Certification Must Be Signed By The Same Individual Who Signed The Contract Execution Page]

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ATTACHMENT F

North Carolina Department of Health and Human Services
Division of Medical Assistance

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of $100,000.00 or more and that all subrecipients shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

____

Signature **Title**

____

Agency/Organization **Date**

[This Certification Must Be Signed By The Same Individual Who Signed The Contract Execution Page]

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ATTACHMENT F
(Cont'd)
DISCLOSURE OF LOBBYING ACTIVITIES
Approved by OMB 0344-0046

[Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352]

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	a. Bid/offer/application b. initial award c. post-award	a. initial filing b. material change **For Material Change Only:** year quarter_________ date of last report____________

4. Name and Address of Reporting Entity: Prime Subawardee Tier ________, *if known*: Congressional District, *if known*	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, *if applicable*: ________________
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $
10. a. Name and Address of Lobbying Entity (*if individual, last name, first name, MI*):	b. Individuals Performing Services (*including address if different from No. 10a.*) (*last name, first name, MI*):

(*attach Continuation Sheet(s) SF-LLL-A, if necessary*)

11. Amount of Payment (*check all that apply*): $ _________________ actual planned 12. Form of Payment (*check all that apply*): a. cash b. In-kind; specify: nature _____________________ value _____________________	13. Type of Payment (*check all that apply*): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other; specify: ______________________

14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11:

(*attach Continuation Sheet(s) SF-LLL-A, if necessary*)

15. Continuation Sheet(s) SF-LLL-A attached: Yes No

16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: ____ Print Name: ____ Title: ____ Telephone No: _________________ Date: _________________
Federal Use Only	Authorized for Local Reproduction Standard Form - LLL

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ATTACHMENT F

(Cont'd)

INSTRUCTIONS FOR COMPLETION OF SELF DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

11. (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

12. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

13. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

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14. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

15. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

16. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

17. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

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ATTACHMENT G

North Carolina Department of Health and Human Services
Division of Medical Assistance

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION LOWER TIER COVERED TRANSACTIONS

[Note: The phrase "prospective lower tier participant" means the Division's Contractor]

Instructions for Certification

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

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Certification

1. The prospective lower tier participant certifies, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Signature **Title**

Agency/Organization **Date**

[This Certification Must Be Signed By The Same Individual Who Signed The Contract Execution Page]

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ATTACHMENT H

North Carolina Department Of Health And Human Services
Division Of Medical Assistance

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

1. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:

   A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

   B. Establishing a drug-free awareness program to inform employees about:

      (1) The dangers of drug abuse in the workplace;

      (2) The Contractor's policy of maintaining a drug-free workplace;

      (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

      (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

   C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);

   D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:

      (1) Abide by the terms of the statement; and

      (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

   E. Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;

   F. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:

      (1) taking appropriate personnel action against such an employee, up to and including termination; or

      (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

   (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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2. The site(s) for the performance of work done in connection with the specific agreement are listed below:

Street Address No. 1: ________________________________

City, State, Zip Code: ________________________________

Street Address No. 2: ________________________________

City, State, Zip Code: ________________________________

Street Address No. 3: ________________________________

City, State, Zip Code: ________________________________

Street Address No. 4: ________________________________

City, State, Zip Code: ________________________________

Street Address No. 5: ________________________________

City, State, Zip Code: ________________________________

3. Contractor will inform the Department of any additional sites for performance of work under this agreement.

4. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

____

Signature **Title**

____

Agency/Organization **Date**

[This Certification Must Be Signed By The Same Individual Who Signed The Contract Execution Page]

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ATTACHMENT I

DEFINITIONS

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the MCO to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one MCO, the denial of a Medicaid Enrollee's request to obtain services outside the network:

a. From any other provider in terms of training, experience, and specialization) not available in the Network

b. From a provider not part of the network who is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the Network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.

c. Because the only plan or provider available does not provide the service because of moral or religious objections.

d. Because the Enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.

Appeal: A request for administrative review of an action.

Best Practices: Recommended practices, including Evidence Based Practices that consist of those clinical and administrative practices that have been proven to consistently produce specific, intended results.

Capitation Payment: The amount to be advanced monthly to the MCO for each Enrollee covered by the MCO's Benefit Plan based on Eligibility Category, age, regardless of whether the Enrollee receives services during the period covered by the payment.

Care Management: A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.

Catchment Area: Geographic Service Area meaning a defined grouping of counties.

C.F.R.: Code of Federal Regulations

Clean Claim: A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a Provider that is under investigation by a governmental agency for fraud or abuse.

CMS: Centers for Medicare and Medicaid Services

Concurrent Review: A review conducted by the MCO during a course of treatment to determine whether services meet Medical Necessity and quality standards and whether services should continue as prescribed or should be terminated, changed or altered.

Contract Term: The initial term of this Contract.

Covered Services: The services identified in Attachment K which the MCO agrees to provide or arranges to provide to all s pursuant to the terms of this Contract.

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Cultural Competency: The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

DHHS: The North Carolina Department of Health and Human Services

Days: Except as otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DMA is officially open to conduct its affairs.

Denial of Services: A determination made by MCO (in response to a Provider's request for authorization to provide in-plan services of a specific duration and scope) which:

a. Disapproves the request completely; or

b. Approves provision of the requested service(s), but for a lesser scope or duration than requested by the provider; (an approval of a requested services which includes a requirement for a concurrent review by MCO during the authorized period does not constitute a denial); or

c. Disapproves provision of the requested service(s), but approves provision of an alternative service(s).

Department: The North Carolina Department of Health and Human Services

Disenrollment: Action taken by DMA to remove an Enrollee's name from the monthly Enrollment following DMA's determination that the Enrollee is no longer eligible for enrollment in the MCO PIHP.

DMA: The Division of Medical Assistance

DMH/DD/SAS: The Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DSS: The county Department of Social Services

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

b. Serious impairment to bodily functions, or

c. Serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an , covered inpatient and outpatient services that:

a. Are furnished by a provider that is qualified to furnish such services; and

b. Are needed to evaluate or stabilize an emergency medical condition as defined above.

Emergent Need (Mental Health): 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.

Emergent Need (Substance Abuse): 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 abuse or dependence.

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Encounter Data: A record of a Covered Service rendered by a provider to an Enrollee who is enrolled in the MCO PIHP during the date of service. It includes all services for which the MCO PIHP incurred any financial responsibility; in addition, it may include claims for reimbursement, which were denied by the MCO PIHP.

Enrollment : Action taken by the DMA to add a Medicaid recipient's name to the monthly Enrollment Report following the receipt and approval by DMA of Medicaid Eligibility for a person living in the defined catchment area.

Enrollees: A Medicaid recipient that is currently enrolled in the PIHP.

Enrollment Period: The time span during which a recipient is enrolled with a PIHP.

Expanded Services: Services included in Covered Services, which are in addition to the minimum coverage required by DMA and which MCO agrees to provide throughout the term of this Contract in accordance with the standards and requirements set forth in this Contract.

Facility: Any premises (a) owned, leased, used or operated directly or indirectly by or for MCO for purposes related to this Contract; or (b) maintained by a sub-contractor to provide services on behalf of MCO as part of this Contract.

Fee-for-Service: A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.

Fiscal Agent: An agency that processes and audits Medicaid provider claims for payment and performs certain other related functions as an agent of DMA.

Grievance: An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at MCO level and access to the State fair hearing process. (Possible subjects for grievances 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 Enrollee's rights).

Grievance and Appeal Procedure: The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by MCO and the methods for resolution of Enrollee grievances and appeals by MCO

Hearing: A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DMA shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.

Health Plan Employer Data and Information Set (HEDIS): is a set of standardized performance measures designed to reliably compare the performance of managed health care plans.

Individuals with Disabilities Education Act (IDEA): A federal law (PL 99-457) which requires special services for children with special needs from birth to age twenty one (21) years.

Innovations Waiver: The Section 1915(c) Home and Community Based Services Waiver that operates in the geographic area covered by this Contract. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in these counties.

In-Plan Services: Services which are included in the behavioral health capitation rate and are the payment responsibility of MCO.

Insolvency: The inability of MCO to pay its obligations when they are due.

LME: Local Management Entity, a local political subdivision of the state of North Carolina as established under General Statute 122C.

Managed Care Organization: An umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals

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Medicaid Identification (MID) Card: The Medical Assistance Eligibility Certification card issued monthly by DMA to Recipients.

Medicaid for Infants and Children (MIC): A program for medical assistance for children under the age of nineteen (19) whose countable income falls under a specific percentage of the Federal Poverty Limit and who are not already eligible for Medicaid in another category.

Medicaid for Pregnant Women (MPW): A program for medical assistance for pregnant women whose income falls under a specified percentage of the Federal Poverty Limit and who are not already eligible in another category.

Medical Assistance Program (Medicaid): DMA's program to provide medical assistance to eligible citizens of the State of North Carolina, established pursuant to Chapter 58, Articles 67 and 68 of the North Carolina General Statutes and Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.

Medical Record: A single complete record, maintained by the Provider of services, which documents all of the treatment, plans developed for, and behavioral health services received by, an Enrollee.

Medically Necessary Treatment: Medically necessary treatment means those procedures, products and services that are provided to Medicaid recipients (excluding Qualified Medicare Beneficiaries) that are:

a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition;

b. Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided;

c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care;

d. Not provided solely for the convenience of the recipient, recipient's family, custodian or provider;

e. Not for experimental, investigational, unproven or solely cosmetic purposes;

f. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives;

g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and

h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment.

Within the scope of the above guidelines, medically necessary treatment shall be designed to:

a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team;

b. Conform with any advanced medical directive the individual has prepared;

c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and

d. Prevent the need for involuntary treatment or institutionalization.

Medicaid Management Information System (MMIS): The mechanized claims processing and information retrieval system used by state Medicaid agencies and required by federal law.

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Network Provider: A provider of behavioral health services that meets the MCO's criteria for enrollment, credentialing and/or accreditation requirements and has signed a written agreement to provide services.

Out-of-Area Services: In-plan behavioral health services provided to an Enrollee while the Enrollee is outside the catchment area.

Out-of-Plan Services: Health care services, which MCO is not required to provide under the terms of this Contract. The services are Medicaid covered services reimbursed on a fee-for-service basis.

Out-of-Network Provider: Any person or entity providing services who does not have a written provider agreement with MCO and is therefore not included or identified as being in the MCO's Provider Network.

Potential Enrollee: A Medicaid recipient who is subject to mandatory enrollment.

Prepaid Inpatient Health Plan (PIHP): An entity that provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and does not have a comprehensive risk contract.

Prior Authorization: The act of authorizing specific services before they are rendered.

Provider: Any person or entity providing behavioral health services.

Provider Network: The agencies, professional groups, or professionals under contract to MCO that meet MCO standards and that provide authorized Covered Services to eligible and enrolled persons.

Qualified Professional: Any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Abuse Services in the fields of mental health or developmental disabilities or substance abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (N.C.G.S. 122C-3).

Recipient: An Enrollee who is receiving services.

Reconsideration Review: An informal hearing before a DMA Hearing Officer and Medical Policy Director wherein an , affected by an action or an intended action by MCO, shall be allowed to present and discuss information as to why such action should or should not be taken, and described more specifically in NCAC T10: 22H (for s) and NCAC T10: 22J (for MCO). The decision of the Hearing Officer is subject to appeal through the Office of Administrative Hearings (OAH).

Risk Contract: A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because MCO assumes the risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DMA.

Routine Need (Mental Health): A condition in which the person describes signs and symptoms resulting in impaired behavioral, mental or emotional functioning which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life.

Routine Need (Substance Abuse): A condition in which the person describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a substance use disorder according to the current version of the Diagnostic and Statistical Manual.

Service Management Record: A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers.

State: The State of North Carolina

State Plan: The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS.

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Subcontract: An agreement which is entered into by MCO in accordance with Section 11.

Subcontractor: Any person or entity which has entered into a subcontract with MCO.

Third Party Resource: Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans.

Urgent Need (Mental Health): 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 will progress to the need for emergent services and care.

Urgent Need (Substance Abuse): 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 their substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance.

Utilization Management: The process of evaluating the necessity, appropriateness, and efficiency of behavioral health care services against established guidelines and criteria.

WFFA: Work First for Family Assistance

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ATTACHMENT J

ELIGIBILITY CATEGORIES

a. Individuals covered under Section 1931 of the Social Security Act (1931 Group, TANF/AFDC);
b. Optional Categorically and Medically Needy Families and Children not in Medicaid deductible status (MAF);
c. Blind and Disabled Children and Related Populations (SSI);
d. Blind and Disabled Adults and Related Populations (SSI, Medicare);
e. Aged and Related Populations (SSI, Medicare);
f. Medicaid for the Aged (MAA);
g. Medicaid for Pregnant Women (MPW);
h. Medicaid for Infants and Children (MIC);
i. Adult Care Home Residents (SAD, SAA);
j. Foster Care Children;
k. Participants in Community Alternatives Programs (CAP/DA, CAP-MR/DD, CAP/AIDS);
l. Medicaid recipients living in ICF's-MR; or
m. Children, beginning the first day of the month following the third birthday (except for CAP-MR/DD).

* **Children under the age of three years are NOT eligible for any services covered under this contract EXCEPT for the HCBS Innovations Waiver services.**

RATE CELLS FOR CAPITATED PAYMENTS

1. TANF – Adults and children over age 3

2. Foster Children—Over age 3

3. Aged – Ages 65 and above

4. Blind/Disabled – Ages 3-20

5. Blind/Disabled – Ages 21+

6. HCBS Innovations Waiver Participants - All Ages

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ATTACHMENT K

SCHEDULE OF BENEFITS

MCO shall provide the following services:

1. All Medicaid MH/DD/SA services described in clinical coverage policies 8A through 8J located on the DMA website at http://www.ncdhhs.gov/dma/mp/index.htm

2. Medicaid covered MH/DD/SA emergency room services, including all professional charges, x ray and lab work

3. All Medicaid covered services provided by psychiatrists

4. 1915(c) HCBS waiver services as defined in the "Innovations" waiver at: http://www.ncdhhs.gov/dma/piedmont/InnovationsRenewal0408.pdf

5. Section 1915(b)(3) waiver services as defined in the 1915(b) MH/DD/SAS waiver at: http://www.ncdhhs.gov/dma/piedmont/PiedmontRenewal040109.pdf

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ATTACHMENT L

SCOPE OF EPSDT SERVICES

Section 1905(r)(5) of the Social Security Act sets forth the basic requirements for the EPSDT program. The Act requires that any service that is covered under Section 1905(a) of the Social Security Act which is medically necessary to treat or ameliorate a defect, physical illness, or condition identified through screening must be provided to EPSDT participants. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration and scope of EPSDT services may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

Treatment for MH/SA Conditions identified in EPSDT screenings will be furnished through the MCO. Agencies conducting the screenings will coordinate with service providers.

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ATTACHMENT M

STATISTICAL REPORTING MEASURES

The MCO shall submit data and measurements to DMA annually for quality of care and service measures and performance improvement projects as defined in Attachment N and as directed by DMA. Additional quality measures may be phased in over the term of the Contract at the discretion of DMA. DMA will provide guidance to the MCO in meeting the statistical and other reporting requirements of this Contract.

The MCO shall complete and submit the annual reports described below to DMA by June 30 of each year. The annual reports submitted on June 30 shall contain data collected from January 1 through December 31 of the preceding calendar year. Note, however, that the MCO shall submit Grievance and Appeal Reports to DMA on a quarterly basis consistent with the MCO complaint reporting schedule. The MCO shall use the HEDIS Technical Specifications applicable to the subject reporting year. The MCO may seek and receive written approval from DMA for revisions or amendments to the HEDIS specifications, provided it does so before April 1st. For all measurements without pertinent HEDIS specifications, the MCO shall use technical specifications provided by DMA. Each annual report shall contain an explanation of how the data was calculated. Questions regarding reporting requirements may be addressed through quarterly MCO Quality Management or IMT meetings. As used below, "member" includes **all** of the MCO's Medicaid Enrollees, unless some other meaning is specified.

NOTE: All items marked with an asterisk (*) require a subset report for Section 1915(c) waiver Enrollees.

A. EFFECTIVENESS OF CARE MEASURES

1. **Follow-up After Hospitalization for Mental Illness :** Report the percentage of discharges for Medicaid Enrollees, 6 years of age and older, who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for 30 days after discharge (without gaps) and who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider.

2. **Readmission Rates for Mental Health :** Report the number and proportion of Medicaid Enrollees readmitted to inpatient psychiatric hospital care within 30 calendar days.

3. **Readmission Rates for Substance Abuse:** Report the number and proportion of Medicaid Enrollees readmitted to substance abuse treatment facilities within 30 calendar days.

4. **Ambulatory Follow-Up within 7 Calendar Days Of Discharge for Substance Abuse therapy:** Report the number and proportion of adult Enrollees, age 21 and over, with Substance Abuse diagnoses who have a visit within 7 days of discharge from a Substance Abuse facility.

5. **Ambulatory Follow-Up within 7 Calendar Days Of Discharge for Mental Health:** Report the number and proportion of Medicaid Enrollees with a mental health diagnosis, excluding Substance Abuse, that had an ambulatory follow-up visit within 7 calendar days after discharge from inpatient psychiatric hospital care. This measure will be subdivided into adults, age 21 and over, and children, under age 21.

6. **Number of Consumers Moved from Institutional Care to Community Care :** Report the number of Medicaid Enrollees discharged from Institutional Care in an ICF-MR into the community through use of Section 1915(c) waiver funding.

B. ACCESS/AVAILABILITY

1. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** Report the percentage of adults diagnosed with AOD dependence who initiate treatment through one of the following: an inpatient AOD admission or an outpatient service for AOD abuse or dependence and any additional AOD services within 14 days of diagnosis.

2. **Call Answer Timeliness:** Report the percentage of calls received by the member services call centers (during the member services operating hours) during the measurement year that were answered by a live voice within 30 seconds.

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3. **Call Abandonment:** Report the percentage of calls received by the member services call center (during operating hours) during the measurement years that were abandoned by the caller before being answered by a live voice.

4. **Service Availability/Accessibility:** Report the number and type of calls received and the disposition of the calls.

5. **Payment Denials:** Report the number and percentage of visits for services (ER, consulting specialists, ancillary) obtained but not authorized by the MCO.

6. **Out of Network Services: Report the number of services, by individual service, that are rendered by out-of-network providers ; and the percentage of services, by individual service, that are rendered by out-of-network providers.**

7. **Timeliness of Initial Service Delivery (*):** Report the average amount of time from CAP-MR/DD "C" waiver services level of care determination to approval for initiation of services, the average amount of time from approval for initiation of services to plan of service development, and the average amount of time from plan of service development to implementation of direct care services.

C. PATIENT AND PROVIDER SATISFACTION

1. **Provider Satisfaction Survey:** Report Provider satisfaction with program areas such as claims submission and payment, assistance from MCO, communication, etc. This survey shall be developed by MCO and approved by DMA prior to use. The MCO shall use statewide standardized measures in addition to local measures.

2. **Grievances/Appeals (*):** Report separately all Medicaid Enrollee grievances, and appeals including the total number of Enrollees served, total number of grievances categorized by reason, reported separately; the number of grievances referred to second level review or appeal, reported separately; and the number of grievances resolved at each level, total time of resolution and outcome, reported separately. Reports are due to DMA on a quarterly basis, consistent with MCO Complaint reporting schedule

3. **Patient Satisfaction Survey or Other Comparable Patient Satisfaction Survey(*):** Report Medicaid Enrollee satisfaction with MCO performance regarding access to and quality of services rendered through MCO. Report results for adults and children. This survey will be developed by MCO and must be approved by DMA prior to use. The MCO shall use statewide standardize measures in addition to local measures. The survey results must separate Medicaid recipient and IPRS recipients. The Patient Satisfaction Survey must be created and conducted by an outside agency with no vested interest in the MCO.

D. USE OF SERVICES

1. **Mental Health Utilization - Inpatient Discharges and Average Length of Stay:** Report the utilization of inpatient mental health services, stratified by age and sex.

2. **Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/ Night Care, Ambulatory and Other Support Services:** Report the number and percentage of Medicaid s receiving mental health services during the measurement year in the above categories, giving an overview of the extent to which the organization uses the different levels of mental health care. In addition to rates of utilization, report which services are included in each category.

3. **Chemical Dependency Utilization Inpatient Discharges and Average Length of Stay:** Report the utilization of inpatient chemical dependency services, stratified by age and sex.

4. **Chemical Dependency Utilization Percentage of Members Receiving Inpatient, Day/ Night Care, Ambulatory and Support Services:** Report the number and percentage of Medicaid s receiving chemical dependency services during the measurement year in the above categories, giving an overview of the extent to which the organization uses the different levels of chemical dependency care. In addition to rates of utilization, report which services are included in each category.

5. **Identification of Alcohol and Other Drug Services:** Report the number and percentage of members with an alcohol and other drug (AOD) claim. AOD claims contain a diagnosis of AOD abuse or dependence and a specific AOD-related service during the measurement year.

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6. **Utilization Management of the Provision of High Use Services:** Report the number and percentage of s receiving Personal Care Services, Habilitation Services, and Respite Services, and the average amount of Personal Care Services, Habilitative Services, and Respite Services used per receiving services.

E. HEALTH PLAN STABILITY

1. **Network Capacity:** Report the number and type of all Providers in the network by the type of services rendered.

F. PLAN DESCRIPTIVE INFORMATION:

1. **Unduplicated Count of Medicaid Members:** Report the age, sex, Medicaid eligibility category of each Enrollee served and enrolled by MCO and the average number of months Medicaid members are served by the MCO and enrolled in the MCO.

2. **Diversity of Medicaid Membership(*):** Report the number and percentage of Medicaid members served versus enrolled at any time during the measurement year by race/ethnicity, Hispanic origin, and spoken language. This measure is required only if MCO has received the necessary information from DMA by May 1st to calculate the measure for the calendar reporting year.

G. HEALTH AND SAFETY

1. **Critical Incident Reports(*):** Report the number and percentage of Critical Incident reports received requiring MCO intervention, categorized by reason. (Section 1915(c) waiver s only)

2. **Crisis Plans(*):** Report the number and percentage of s who are in need of a crisis plan and for whom a crisis plan has been developed, by category of need. (1915(c) waiver s only)

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ATTACHMENT N

REQUIREMENTS FOR PERFORMANCE IMPROVEMENT PROJECTS

The MCO shall develop and implement performance improvement projects as referenced in SOW Section 7.1 and in compliance with 42 CFR 438.240 and the CMS Quality Framework. Project topics will be determined jointly by the MCO and DMA from the list of clinical and non-clinical focus areas listed below. Over the two-year term of the Contract, the MCO shall develop and implement a minimum of three performance improvement projects. During year one of the Contract, the MCO shall develop and implement a minimum of two performance improvement projects. One project shall focus on a clinical area and one shall focus on a non-clinical area. During year two of the Contract, the MCO shall develop and implement at least one additional performance improvement project for a total of three performance improvement projects. Baselines will be established the first year of each project and the MCO shall set benchmarks for each project based on currently accepted standards, past performance data, or available national data. The MCO shall obtain the approval of DMA before terminating any of the required performance improvement projects. Reports on all performance improvement projects shall be submitted to DMA no later than July 31st of each year.

a. Primary, secondary and/or tertiary prevention of acute mental illness conditions;
b. Primary, secondary and/or tertiary prevention of chronic mental illness conditions;
c. Care of acute mental illness conditions;
d. Recovery/outcome measures;
e. Care of chronic mental illness conditions;
f. High-volume services;
g. High-risk services;
h. Continuity and coordination of care;
i. Availability, accessibility, and cultural competency of services;
j. Quality of provider/patient encounters; or
k. Appeals and grievances.

1. Topics shall be identified through continuous data collection and analysis by MCO of comprehensive aspects of patient care and member services. Topics shall be systematically selected and prioritized to achieve the greatest practical benefit for Enrollees. .
2. The Quality Assurance/Performance Improvement program shall provide opportunities for Enrollees to participate in the selection of project topics and the formulation of project goals.

3. The MCO's performance improvement for each selected topic is measured using one or more quality indicators. All indicators measure changes in health status, functional status, or satisfaction . Indicators shall be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The MCO shall select some indicators for which data are available that allow comparison of the MCO's performance to that of similar Plans or to local, state, or national benchmarks.

4. The MCO shall establish a baseline measure of its performance on each selected indicator, shall measure changes in performance, and shall continue measurement for at least one year after the desired level of performance is achieved.

5. A project demonstrates improvement by achieving a benchmark level of performance defined in advance by CMS or DMA. Benchmarks shall be based on currently accepted standards, past performance data, or available national data.

6. When a project measures performance on quality indicators by collecting data on a subset (sample) of the units of analysis in the population to be studied, the sample must be sufficiently large to detect the targeted amount of improvement.

7. The sample or subset of the study population shall be obtained through random sampling. The samples used for the baselines and repeat measurements of the indicators shall be chosen using the same sampling frame and methodology.

8. The MCO must be able to demonstrate that any observed improvement is reasonably attributable to interventions undertaken by MCO (i.e., a project and its results have face validity).

9. The MCO must be able to sustain any observed performance improvements for at least one year after the performance improvement is first achieved. Sustained improvement is documented through the continued measurement of quality indicators for at least one year after the performance improvement project is completed.

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10. The MCO is expected to collect and use data from multiple sources, such as medical record reviews, focused care studies, claims and encounter data, HEDIS, grievances, utilization review and member satisfaction surveys. The MCO is expected to use findings from performance improvement projects to analyze:

   a. the delivery of services;
   b. quality of care;
   c. over and under utilization of services;
   d. disease management strategies; and
   e. outcomes of care.

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ATTACHMENT O

GRIEVANCE AND APPEAL PROCEDURES

The MCO shall have an internal grievance and appeal system with written policies and procedures. The grievance and appeal system shall meet all regulatory requirements in 42 CFR Part 438 Subpart F, "Grievance System" and shall include a process for filing a grievance, filing an appeal, and accessing the State's fair hearing system. The MCO will attend training through DMA on the Medicaid managed care appeal process. The MCO will use DMA-approved letters for recipient denials (adverse actions) and appeal rights.

A grievance is an expression of dissatisfaction about matters involving the MCO. Possible subjects for grievances include, but are not limited to, the quality of services provided through the MCO, and aspects of interpersonal relationships such as rudeness of a Network Provider or an employee of the MCO, or failure by the MCO or a Network Provider to respect the rights of an Enrollee.

An appeal is a request for review of an "action" taken by MCO. "Action" is defined as:

a. The denial or limited authorization of a requested service (including the type or level of service);

b. The reduction, suspension, or termination of a previously authorized service;

c. The denial, in whole or in part, of payment for a service;

d. The failure to provide services in a timely manner. (MCO must ensure that appropriate services are available as stated in Section 6.5, Appointment Availability of this Contract); or

e. The failure of MCO to act within the timeframes in 42 CFR 438.408(b).

Enrollees may file a grievance or an appeal with the MCO either orally or in writing. However, an oral appeal must be followed by a written, signed appeal unless expedited resolution, as described in section G below, is requested.

Enrollees must exhaust the MCO appeal process before requesting a State fair hearing.

A. <u>General Requirements of Grievance and Appeal System:</u>

1. MCO must:

a. Provide Enrollees any reasonable assistance in completing forms and other procedural steps, including but not limited to, providing interpreter services and toll free numbers with TTY/TDD and interpreter capability;

b. Acknowledge receipt of each grievance and appeal;

c. Ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making; and

d. Ensure that decision makers on grievances and appeals are health care professionals with clinical expertise in treating the member's condition or disease if any of the following apply:

i. an appeal of a denial based on lack of medical necessity;
ii. a grievance regarding the MCO's denial of a request for an expedited review of an appeal;
iii. any grievance or appeal involving clinical issues;
iv. an appeal of a denial of a service authorization request; or
v. an appeal of a decision to authorize a service in an amount, duration or scope than is less than requested.

2. Pursuant to 42 C.F.R. 438.414 and 42 CFR 438.10(g), the MCO shall provide the following information on grievance, appeal, and fair hearing procedures and timeframes to all Providers and subcontractors at the time they enter into a contract. The MCO shall also provide the following information to all Enrollees:

a. The Enrollee's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing;

b. The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;

c. The availability of assistance in filing;

d. The toll free numbers to file oral grievances and appeals; and

The Enrollee's right to request continuation of benefits during an appeal or State fair hearing filing and that, if MCO's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

f. Any state determined provider appeal rights to challenge the failure of the organization to cover a service.

B. **Recordkeeping and Reporting**: MCO must maintain records of grievances and appeals as follows:

1. The MCO shall maintain records that include a copy of the original grievance or appeal, the response, and the resolution; and

2. The MCO must provide for the retention of the records described above for five (5) years following a final decision or the close of the grievance or appeal. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later**.**

C. **Timeframe for Resolution of Grievances and Format of Disposition Notice: The** MCO shall resolve grievances and provide notice to all affected parties within 90 days of the date the MCO received the grievance. The MCO may extend the timeframe by up to 14 days if:

1. The Enrollee requests the extension; or

2. The MCO demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee .

Pursuant to 42 CFR 438.408(d), the State establishes the method by which the MCO notifies enrollees of the disposition of the grievance. The MCO shall notify enrollees of their findings in writing if the grievance is about quality of care. If the grievance does not involve quality of care, the MCO may provide notification verbally by telephone or face-to-face. The MCO may also provide notification verbally if the person filing the grievance requests that the notification not be put in writing.

D. **Service Authorizations and Notices of Action:**

1. Requests for service authorizations must be processed within the following timeframes and requirements:

a. For standard authorization decisions, MCO must provide notice within fourteen (14) calendar days following receipt of request for the service, with a possible extension of up to fourteen (14) additional calendar days if:

i. The Enrollee or provider requests extension; or

ii. MCO demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee

b. MCO must make an expedited service authorization decision within three (3) working days after receipt of the request, when following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, with a possible extension of up to fourteen (14) additional calendar days if:

i. The Enrollee requests an extension; or

ii. MCO demonstrates to DMA that there is need for additional information and the delay is in the best interest of the Enrollee.

c. If MCO extends the timeframe, it must give the written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d. Untimely service authorizations constitute a denial and are thus adverse actions. Service authorizations are considered untimely if they are not made within the standard timeframe or expedited timeframe, whichever is applicable.

2. MCO must notify the requesting Provider and Enrollee of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice of adverse action to the Provider need not be in writing; however, the Enrollee notice must be in writing.

3. The Notice of Adverse Action must explain:

a. The action MCO has taken or intends to take;

b. The reasons for the action;

c. The Enrollee's right to file an appeal;

d. How to contact the consumer relations or member services office and how to file an appeal with MCO;

e. The circumstances under which an expedited resolution is available and how to request it;

f. For Enrollees, the right to file an informal or formal appeal with the State pursuant to 10 NCAC 22H; how to obtain more information about those procedures; and the circumstances under which health services must be continued;

g. For Providers and subcontractors, the right to file an appeal with the State pursuant to 10 NCAC 22J;

h. That filing or resolving an appeal through MCO's internal grievance and appeal system is a prerequisite to filing an informal or formal appeal with the State pursuant to 10 NCAC 22H;

i. How to request that benefits be continued pending resolution of the grievance, appeal or state fair hearing and the circumstances under which the Enrollee may be required to pay the costs of these services;

j. The right of the Enrollee in an informal appeal to represent himself or use legal counsel, a relative, a friend, or other spokesman, and of the potential availability of free legal services;

k. That Enrollees have a right to a second opinion, at MCO's expense;

l. How to exercise the right to a second opinion; and

m. The specific regulations that support the denial of the service authorization request.

4. MCO must make the information and notices described in this Attachment readily available orally and in writing in the recipient's primary language and in each prevalent non-English language in its service area. Written material must use easily understood language and format, be available in alternative formats, and be presented in an appropriate manner that takes into consideration those with special needs.

5. All Enrollees and potential Enrollees must be informed that information is available in alternative formats and how to access those formats. MCO must make these services available free of charge.

E. <u>Timeframes for Notice of Action:</u>

1. MCO gives notice at least ten (10) days before the date of action when the action is a termination, suspension or reduction of previously authorized Medicaid covered services, except:

a. The period of advanced notice is shortened to five (5) days if probable recipient fraud has been verified; and

b. The notice may be given on the date of the action for the following:

i. Upon the death of an Enrollee;

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ii. A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);
iii. The Enrollee's admission to an institution where he/she is ineligible for further services;
iv. The Enrollee's address is unknown and mail directed to him/her has no forwarding address;
v. The Enrollee has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth;
vi. The Enrollee's physician prescribes the change in the level of medical care;
vii. An adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or,
viii. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days (applies only to adverse actions for NF transfers).

2. MCO may give notice on the date of the action when the action is a denial of payment.

F. <u>Appeal Process</u>

1. MCO must define appeal as the request for review of an "action", as defined in Attachment I. Pursuant to 42 CFR 438.402(b), the Enrollee may file a MCO level appeal; a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal.

2. The Enrollee must file an appeal within twenty (20) days after the date on the notice of action.

3. The Enrollee may file an appeal either orally or in writing and must follow an oral filing with a written, signed appeal. MCO shall:

   a. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Enrollee requests expedited resolution;

   b. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing;

   c. Allow the Enrollee and the Enrollee's representative opportunity, before and during the appeals process, to examine the 's case file, including medical records, and any other documents and records;

   d. Consider the Enrollee, the Enrollee's representative, or estate representative of a deceased Enrollee as parties to the appeal.

4. MCO must resolve each appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within State established timeframes not to exceed forty five (45) days from the day the MCO receives the appeal.

5. MCO must provide written notice of disposition. The written resolution notice must include:

   a. The results and date of the appeal resolution;

   b. For decisions not wholly in the Enrollee's favor:
      i. The right to request a State fair hearing;
      ii. How to request a State fair hearing;
      iii. The right to continue to receive benefits pending a hearing;
      iv. How to request the continuation of benefits; and
      v. If MCO's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

6. MCO must continue the Enrollee's benefits if:

   a. The appeal is filed timely, meaning on or before the later of the following:
      i. Within eleven (11) days of MCO mailing the notice of action; or

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ii. The intended effective date of MCO's proposed action;

b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were ordered by an authorized provider;

d. The authorization period has not expired; and

e. The Enrollee requests extension of benefits.

7. If MCO continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. The Enrollee withdraws the appeal;

b. The Enrollee does not request a fair hearing within eleven (11) days from when MCO mails an adverse MCO decision;

c. A State fair hearing decision adverse to the Enrollee is made;

d. The authorization expires or authorization service limits are met.

8. MCO may recover the cost of the continuation of services furnished to the Enrollee while the appeal was pending if the final resolution of the appeal upholds MCO's action.

9. MCO must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the appeal is pending and MCO, or the State fair hearing officer reverses a decision to deny, limit, or delay services.

10. MCO or the State must pay for disputed services, in accordance with State policy and regulations, if MCO, or the State fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending.

G. <u>Expedited Appeal Process:</u>

1. MCO must establish and maintain an expedited review process for appeals for situations in which MCO determines, based on a request from the Enrollee or from a provider on behalf of the Enrollee, that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

2. Expedited appeals are just a "special type" of appeals. MCO is required to follow all standard appeal regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

3. The Enrollee may file an expedited appeal either orally or writing. No additional Enrollee follow-up is required.

4. MCO must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

5. MCO must resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within State-established timeframes not to exceed three (3) working days after MCO receives the appeal.

6. For any extension not requested by the Enrollee, MCO must give the member written notice of the reason for the delay.

7. In addition to written notice, MCO must also make reasonable efforts to provide oral notice.

8. MCO must ensure that punitive action is not taken against a Provider who either requests an expedited resolution or supports an Enrollee's appeal.

9. If MCO denies a request for expedited resolution of an appeal, it must:

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a. Transfer the appeal to the standard timeframe of no longer than forty five (45) days from the day MCO received the appeal,

b. Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days. The notice should include the information listed under Section D. Service Authorizations and Notices of Action, of this attachment and Notice of Adverse Action included in Section D of this attachment;

H. The State Fair Hearing:

1. An Enrollee may request a State fair hearing. The State must permit the Enrollee to request a State fair hearing within a reasonable time period specified by the State, but not less than twenty (20) or in excess of ninety (90) days from the date on MCO's notice of action;

2. Pursuant to 42 CFR 408(f), the parties to the State Fair Hearing include MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

3.

4. The State must reach its decisions within the timeframes specified in 42 CFR 431.244(f), as follows:

   a. Standard resolution: within ninety (90) days of the date the Enrollee filed the appeal with MCO (excluding the number of days the Enrollee took to subsequently file for a State fair hearing); or

   b. Expedited resolution: No later than three (3) working days after the agency receives from MCO notification of the appeal of a denied service that:
      i. meets the criteria for expedited resolution but was not resolved by MCO within the timeframe for expedited resolution; or
      ii. was resolved within the timeframe for expedited resolution, but the decision was wholly or partially adverse to the Enrollee.

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ATTACHMENT P

NETWORK PROVIDER ENROLLMENT AND RE-ENROLLMENT

The MCO shall maintain a Provider Network that provides culturally competent services. The Provider Network is composed of providers that demonstrate competencies in best practices and consumer outcomes, ensure health and safety for consumers, and demonstrate ethical and responsible practices. The MCO is committed to the achievement of positive outcomes for consumers, as well as consumer satisfaction. The MCO depends on its network of providers to offer quality services and to demonstrate accountability for the well being of consumers that are served in the MCO system.

The MCO will use standardized provider enrollment applications as provided by DMA.

A. TYPES OF PROVIDERS ENROLLED IN THE MCO NETWORK

1. **Agency-Based Providers:** An agency-based provider is a business, either for-profit or not-for-profit, engaged in the provision of the mental health, developmental disabilities and substance abused services covered under this Contract. Employees of the agency provide the services to the Enrollee, and agency management assures that the employees meet the qualifications to provide services and that all other requirements of the contract between MCO and the agency-based provider are met. Qualifications for service provision are described in B-18 below. There are two types of agency-based providers:

   a. **Specialty Providers**: Specialty providers are providers that specialize in a specific service (such as vocational or residential) or in serving a specific disability area, or both. Specialty providers are important components of the network because they can focus their efforts on best practice strategies for a specific population. The majority of MCO providers are specialty providers. These providers offer best practice service options to consumers such as Assertive Community Treatment Team, Multi-systemic Therapy, Mobile Crisis, and Innovations Waiver Services.

   b. **Critical Access Behavioral Health Agency (CABHA):** The CABHA is a new category of provider agency for the delivery of mental health and substance abuse services developed to ensure that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a robust array of services. The CABHA will move the public system over time to a more coherent service delivery model that reduces clinical fragmentation, ensure that consumer care is based upon a comprehensive clinical assessment and provide access to an appropriate array of services for the population to be served. CABHAs are required to provide 24/7 crisis coverage to all of their consumers.

2. **Licensed Practitioners and Professional Practice Groups**: Licensed Practitioners in the areas of Psychiatry, Psychology, and Social Work are enrolled in the MCO Provider Network. Licensed Practitioners provide Outpatient services such as psychiatric care, assessment and outpatient therapy. Consumers are offered a choice of independent practitioners or CABHAs when calling the Access line and requesting evaluation or outpatient treatment services.

B. NETWORK ENROLLMENT REQUIREMENTS FOR AGENCY-BASED PROVIDERS

1. Providers shall have a valid North Carolina license issued by the North Carolina Division of Health Service Regulation (if applicable for type of provider) before applying to the network.

2. Providers shall complete an application to join the network, agreeing: (a) to comply with all network requirements for reporting, inspections, monitoring, consumer choice requirements; and (b) to participate in the corporate compliance process and the network continuous quality improvement process.

3. Providers shall disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.

4. Providers shall disclose any actions listed in # 3, which are pending.

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5. Providers shall furnish the MCO a history of names if the entity has done business under other names or is using a "doing business as" (d/b/a) name.

6. The Provider shall identify ownership of the entity. A list of all owners of more than 5% interest and a list of all parent, sister, and subsidiary entities in the entire chain of ownership, including an organizational flow chart, up to the ultimate owner of the holding company shall be provided.

7. Providers shall furnish the MCO a list of the names and addresses of all members of the Provider's Board of Directors and the addresses of the Provider and any parent, sister or subsidiary entities.

8. Providers shall disclose if it is affiliated by contract or otherwise, with any other provider.

9. Providers shall supply at least two references, which will be evaluated by the MCO.

10. Providers shall have a "no-reject policy" for referrals within the capacity and the 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 MCO and the Provider.

11. Providers shall demonstrate experience and competency. Stability of past operations is important. An assessment of the Provider agency's past record of services, compliance with applicable laws, standards and regulations, the qualifications and competency of its staff, the satisfaction of consumers and family members served, systems of oversight, adequacy of staffing infrastructure, use of best practices, and quality management systems will be evaluated by the MCO prior to enrollment and at regular intervals thereafter.

12. Providers shall be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the MCO's web based billing process.

13. Providers shall demonstrate consumer friendly services and attitudes. During the application process, providers may be asked to demonstrate how consumers and families are involved in treatment and services. Providers shall have a good system of communication with consumers.

14. Providers shall have the clinical infrastructure either through their own agency or through collaboration with other providers to address challenges in meeting specific client needs (such as challenging behaviors or medical problems).

15. Providers shall have the capacity to respond to emergencies for assigned consumers according to the availability standards for emergent needs as defined in Attachment T of this contract and the service definition requirements for First Responder capacity. Services which must have First Responder capacity are identified in Medicaid Clinical Coverage Policy 8A, "Enhanced Mental Health and Substance Abuse Services," which can be accessed on the DMA website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. If required, an adequate clinical back up system shall be in place to respond to emergencies after hours and on weekends.

16. Providers shall demonstrate that they have in place accounting systems sufficient to ensure fiscal responsibility and integrity.

17. Providers shall have liability and medical malpractice insurance as defined in the MCO-Provider Contract.

18. Providers' staff must meet the qualifications to provide behavioral health and developmental disability services, as defined in Medicaid Clinical Coverage Policy, Section 8, and in the Innovations waiver. The policy and waiver can be accessed at the DMA website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

19. MCO's Quality Management Team shall conduct a qualifying review to assess the provider's compliance, competencies and qualifications. A minimum score of 85% must be achieved on the MCO qualification tool for the provider to be enrolled in MCO Network. If the provider does not achieve a score of 85%, the provider will be offered an opportunity to implement a Plan of Correction to address deficit areas. Failure to complete an appropriate plan of correction will result in a denial to enter the network. Within six months of enrollment, the provider must achieve a score of 100% on MCO required competencies to remain in the Network.

    If there is a competitive Request for Proposal, a scoring process will be developed to assess the provider's competencies specific to the requirements of the Request for Proposal, the service definition, and enrollment requirements as delineated above.

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For all initial enrollment, MCO shall complete an on-site review within 6 months of service initiation.

In order to achieve cultural competency, it is important for the MCO Network of Providers to have a diversity of providers and staff and ensure the cultural sensitivity of its staff. This can be accomplished by participation in MCO's Cultural Competency Plan, which has been developed and approved by the MCO Provider Council. This requirement shall be met within the strictures of state and federal laws, which require equal opportunity in employment and bar illegal employment discrimination on the grounds of race, gender, religion, national origin or disability.

C. NETWORK ENROLLMENT FOR LICENSED PRACTITIONERS:

Licensed practitioners shall demonstrate compliance with the following requirements:

1. Licensed Practitioners shall meet state licensure requirements and hold a valid North Carolina license.
2. The MCO shall independently verify from original sources the educational and licensure status of the Licensed Practitioner
3. Insurance coverage shall meet minimum requirements as specified in MCO-Licensed Practitioner contract.
4. Providers shall be able to submit electronic claims or use the MCO web based billing system.
5. A Licensed Provider's on-call designee shall be a member of the network or approved by the MCO, and must have the same credentials or higher.
6. The licensed practitioner shall also provide the following information:
    i. History of loss of license and/or criminal convictions; actions by licensing board
    ii. Names of hospitals at which the practitioner has had admitting privileges (physicians)
    iii. History of loss or limitation of privileges or disciplinary activity (physicians)
    iv. Languages spoken proficiently
    v. At least two peer references
    vi. Areas of specialized practices
7. The Licensed Practitioner shall disclose any sanctions under the Medicare or Medicaid programs including paybacks, lawsuits, insurance claims or payouts, and disciplinary actions of the applicable licensure boards or adverse actions by regulatory agencies within the past five years.
8. The Licensed Practitioner shall disclose any actions listed in # 7 which are pending.

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D. MAINTENANCE IN THE MCO NETWORK

Maintenance of agency-based providers depends on the performance of the agency as measured against identified indicators and benchmarks as described above, as well as the MCO's needs as identified in the annual Network Capacity assessment. A provider's performance shall be routinely measured through MCO Monitoring and through the Continuous Quality Improvement Process. The MCO must utilize the state provider rating (report card) system in coordination with DMA and other state MCOs.

Licensed Independent Practitioners shall be re-credentialed at least every three years.

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ATTACHMENT Q

CAPITATION RATES AND RATE SETTING METHODOLOGY

I. Rate Setting Methodology #1 — Use of Historical Fee-For-Service Data

Initially, the rates will be calculated using a fee-for-service (FFS) data source. This will allow for the collection of managed care encounter and financial data for the first two years of the program.

To develop capitation rates on an actuarially-sound basis for MCO using historical FFS data, the following general steps are performed:

Summarize the FFS Claims and Eligibility Data,
Combine the Multiple Years of FFS Data Together,
Project the FFS Base Data Forward,
Include the Effect of Program/Policy Changes, and
Adjust the FFS Data to Reflect Managed Care Principles.

Summarize the FFS Claims and Eligibility Data — DMA provides FFS claims and eligibility data for the recipients and services to be covered under MCO PIHP. Normally, three years of FFS data are made available for rate-setting purposes. This data is then adjusted to account for items not included in the initial FFS data collection process. These adjustments (positive and negative) generally include, but are not limited to: completion factors, cost settlements, and other adjustments needed to match the coverage responsibilities of the MCO PIHP.

Combine the Multiple Years of FFS Data Together — To arrive at a single year of FFS data to serve as the basis for rate setting, the multiple years of FFS data are combined together. Through this process, the older data is projected forward to be comparable to the most recent information. All the data is then blended together to form a single set of base data (with the most recent year of data receiving more weight).

Project the FFS Base Data Forward — The blended base data is then projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the FFS program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under the MCO PIHP. These changes are included in the capitation rates by either increasing or decreasing the FFS data by a certain percentage amount.

Adjust the FFS Data to Reflect Managed Care Principles — Since the MCO PIHP is a managed care program and not FFS, the projected FFS data needs to be adjusted to reflect the typical changes that occur when changing from an FFS program to a managed care program. This generally involves increasing the cost/use of preventative services, and decreasing hospital and emergency room cost/use. To compensate the managed care plans for managing and coordinating the care of their Members, an additional administration/profit amount is added to arrive at the final capitation rates.

II. Rate Setting Methodology #2 — Use of Managed Care Data

Likely in the third or fourth year of the program, credible managed care encounter and financial data will become available for rate –setting. Once this data is validated, managed care data will become the base data for all future rate-setting years.

To develop capitation rates on an actuarially-sound basis for the MCO PIHP using actual managed care data, the following general steps are performed:

Summarize, Analyze, and Adjust The Managed Care Data,
Project the Managed Care Base Data Forward,
Include the Effect of Program/Policy Changes, and
Add an Appropriate Administration/Profit Load.

Summarize, Analyze, and Adjust the Managed Care Data — DMA will collect data from MCO. This data is summarized, analyzed, and adjustments (positive and negative) are applied, as needed. These adjustments can account for items such

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as collection of third-party liability/coordination of benefits (TPL/COB), over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations. After adjusting the MCO's data, MCO's medical claims costs are aggregated together to arrive at a set of base data for each population group.

Project the Managed Care Base Data Forward — The aggregate base of managed care data is projected forward to the time period for which the capitation rates are to be paid. Trend factors are used to estimate the future costs of the services that the covered population would generate in the managed care program. These trend factors normally vary by service and/or population group.

Include the Effect of Program/Policy Changes — DMA may occasionally change the services or populations covered under the MCO PIHP. Any new program/policy changes that were not already reflected in the managed care data are included in the capitation rates by either increasing or decreasing the managed care data by a certain percentage amount.

Add an Appropriate Administration/Profit Load — After the base data has been trended to the appropriate time period, and adjusted for program/policy changes, an administration/profit load will be added to the medical claim cost component to determine the overall capitation rates applicable to each population group. The administration/profit load is applied as a percentage of the total capitation rate (e.g., percent of premium) and does not vary by population group.

III. Rate Setting Methodology #3 – Blending of FFS and Managed Care Data

If updated FFS data is unavailable and actual managed care experience first becomes available (year 3 of the program), capitation rates for the MCO PIHP can be developed on an actuarially-sound basis using a blending of both data sources using the following two track approach:

Project the Prior Year's Rates Forward (Track 1),
Summarize and Adjust the Managed Care Data (Track 2),
Include the Effect of New Program/Policy Changes and Trend (Track 1 and Track 2), and
Apply Credibility Factors to Each Track and Blend Together.

Project the Prior Year's Rates Forward (Track 1) — The first step of Track 1 is to begin with the previous year's capitation rates that were originally developed using historical FFS claims and eligibility data. This data is projected forward to the time period for which the new capitation rates are to be paid. Trend factors are used to estimate the future costs of the services the covered population would generate under managed care. These trend factors normally vary by service and/or population group.

Summarize and Adjust the Managed Care Data (Track 2) — The more recent managed care data is collected from the MCO PIHP, summarized, and analyzed to support rate setting. Adjustments (positive and negative) are applied to the managed care data as needed. These adjustments can account for items such as collection of TPL/COB, over- or under-reserving of unpaid claims, management efficiency, and provider contracting relations.

Include the Effect of New Program/Policy Changes (Track 1) — In Track 1, any new program/policy changes implemented by DMA, that were not already accounted for in the previous year's rates, are included in the new capitation rates by either increasing or decreasing the rates by a certain percentage amount. An additional administration/profit amount is added to arrive at the final capitation rates under Track 1.

Include the Effect of Trend and New Program/Policy Changes (Track 2) — In Track 2, the managed care data is projected forward to the time period the capitation rates are to be paid. Trend factors may vary by service and/or population group, and are used to estimate the future costs of the services that the covered population would generate under managed care. Any new program/policy changes that were not already reflected in the managed care data are included in the rates by either increasing or decreasing the data by a certain percentage amount. An additional administration/profit amount is added to arrive at the final capitation rates under Track 2.

Apply Credibility Factors to Each Track and Blend Together — After separately developing capitation rates using Track 1 and Track 2, the two sets of rates are combined together. This blending involves applying a credibility weight to each track (e.g., 50/50 split) and adding the two components together. The credibility weights may vary between the population groups.

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ATTACHMENT R

BUSINESS TRANSACTIONS

The MCO, shall disclose to DMA information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

A. Definition of a Party in Interest - As defined in Section 1318(b) of the

Public Health Service Act, a party in interest is:

(1) Any director, officer, partner or employee responsible for management or administration of MCO; any person who is directly or indirectly the beneficial owner of more than five (5) % of the equity of MCO; any person who is the beneficial owner of more than five (5) % of MCO or, in the case of An MCO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation laws;

(2) Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five (5)% of the equity of the MCO ; or has a mortgage, deed of trust, note, or other interest valuing more than five (5) % of the assets of MCO ;

(3) Any person directly or indirectly controlling, controlled by, or under common control with a MCO; or

(4) Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

B. Types of Transactions Which Must Be Disclosed - Business transactions which must be disclosed include:

(1) Any sale, exchanges or lease of any property between MCO and a party interest;

(2) Any lending of money or other extension of credit between MCO and a party interest; and

(3) Any furnishing for consideration of goods, services (including management services) or facilities between MCO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

C. The information, which must be disclosed in the transactions, listed in subsection B between MCO and a party in interest includes:

(1) The name of the party in interest for each transaction;
(1) A description of each transaction and the quantity or units involved;
(2) The accrued dollar value of each transaction during the fiscal year; and
(3) Justification of the reasonableness of each transaction.

If this MCO contract is being renewed or extended, the MCO must disclose information on these business transactions, which occurred during the prior contract period. If the contract is an initial contract with Medicaid, but MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions, which must be reported, are not limited to transactions related to serving the Medicaid enrollment. All of these MCO business transactions must be reported.

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ATTACHMENT S

CLINICAL COVERAGE POLICIES, BULLETINS and MANUALS

Clinical Coverage Policy #3 – Community Based Services: Private Duty Nursing; CAP/C; CAP/DA; Prior Approval for MPW Recipients; Home Health; Personal Care Services; Personal Care Services-Plus; Hospice; Home Infusion Therapy (Available on DMA web site at:

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

Clinical Coverage Policy #4 – Medical Equipment: Durable Medical Equipment; Orthotics and Prosthetics
Available on DMA web site at:

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

Clinical Coverage Policy #8 – Behavioral Health: Enhanced Mental Health and Substance Abuse Services; Inpatient Behavioral Health Services; Outpatient Behavioral Health Services; Psychiatric Residential Treatment Facilities; Residential Treatment Services; Intermediate Care Facilities for Individuals with Mental Retardation; Psychological Services in Health Departments and School Based Health Centers; Children's Developmental Service Agencies. Available on DMA web site at:

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

Basic Medicaid Billing Guide
Available on DMA web site at:

http://www.dhhs.state.nc.us/dma/medbillcaguide.htm

Medicaid Bulletins: general and specific
Available on DMA website at:

http://www.dhhs.state.nc.us/dma/bulletin.htm

Transportation Policy
Available on DMA web site at:

http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/

and

http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/

Administrative Procedures Services Manual 30-1
Administrative Procedures Services Manual 45-2
Administrative Procedures Services Manual 95-1
Available on DMH/DD/SAS web site at:

http://www.ncdhhs.gov/mhddsas/statspublications/manualsforms/index.htm

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ATTACHMENT T
ACCESS AND AVAILABILITY STANDARDS

ACCESSIBILITY

A. Geographic Location: The Provider Network for all covered in-plan services must be as geographically accessible to Medicaid Enrollees as to non-Medicaid Enrollees.

B. Distance/Travel Time: Medicaid Enrollees should have access to Network Providers within thirty (30) miles distance or thirty minutes drive time, 45 miles or 45 minutes in rural areas. Longer distances as approved by DMA are allowed for facility based or specialty Providers.

C. Facility Accessibility: Contracted Provider facilities must be accommodating for persons with physical disabilities. MCO must observe for handicapped parking and entrance ramps; wheelchair accommodating door widths; and bathrooms equipped with handicapped railing.

D. New Enrollee Orientation: Enrollee materials and information shall be sent to each new Enrollee by MCO within fourteen (14) days of effective date of enrollment.

E. Enrollee Services: Medicaid Enrollees must have toll-free telephone access to a Customer Services department to provide assistance, information, and education to members.

F. Support Services:

Transportation: Assistance with arrangement for transportation to medically necessary services through public and private means must be made available and communicated to Medicaid Enrollees.

Interpreters: Language interpretation services must be made available by telephone and/or in person; enabling Medicaid Enrollees to effectively communicate with MCO and Providers. TDD (telecommunication devices for the deaf) must also be made available for persons who have impaired hearing or a communication disorder.

AVAILABILITY

A. Appointments

1. Emergency Care: Receive face-to- face emergency care within no more than two hours after the request for care is initiated; life threatening emergencies: immediately.
2. Urgent Care: Receive first face-to-face service (assessment and/or treatment) within forty-eight (48) hours of the request for care.
3. Routine Care: Receive first face-to-face service (assessment and/or treatment) within 10 working days (14 calendar days) of the date of request for care.

B. Office Wait Times

1. Scheduled appointment: Within one hour
2. Walk-in: Within two (2) hours or schedule for subsequent appointment
3. Emergencies: Receive face-to- face emergency care within no more than two hours after the request for care is initiated; life threatening emergencies: immediately.

C. After Hours Emergency and Referral

1. MCO will provide toll-free telephone emergency and referral line twenty four (24) hours per day.
2. Return Calls to Enrollees: Telephone inquiries made by Enrollees after hours for access/information must be responded to within one (1) hour of receiving the call.

D. The Enrollee has a right to a second opinion from a qualified health care professional within or outside the network, at no cost to the Enrollee

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ATTACHMENT U

GUIDELINES FOR STABILIZATION
EXAMINATION AND TREATMENT FOR EMERGENCY
MEDICAL CONDITIONS AND WOMEN IN LABOR

(a) SEC. 1867. [42 U.S.C. 1395dd] (a) MEDICAL SCREENING REQUIREMENT--In the case of a hospital that has a hospital emergency department, if any individual (whether eligible or not for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists.

NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND LABOR--

(1) IN GENERAL--If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--
  (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
  (B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) REFUSAL TO CONSENT TO TREATMENT--A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment

(3) REFUSAL TO CONSENT TO TRANSFER**--**A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) RESTRICTING TRANSFERS UNTIL INDIVIDUAL STABILIZED--

(1)RULE**.--**If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B)), the hospital may not transfer the individual unless--

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility.

(ii) a physician (within the meaning of section 1861(r)(1)) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1861(r)(1)), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

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(B) the transfer is an appropriate transfer (within the meaning of paragraph 2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) APPROPRIATE TRANSFER**--**An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--
(i) has available space and qualified personnel for the treatment of the individual, and
(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C)) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) ENFORCEMENT

(1)CIVIL MONETARY PENALTIES—

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than fifty thousand ($50,000) or not more than twenty-five thousand ($25,000) in the case of a hospital with less than one hundred (100) beds) for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—
(i) signs a certification under subsection (c)(1)(A) that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or
(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than fifty thousand ($ 50,000) for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in the title and State health care programs. The provisions of section 1128A (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1128A(a).

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1866(a)(1)(I)) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

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(2) CIVIL ENFORCEMENT--

(A) PERSONAL HARM**--**Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY**--**Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) LIMITATIONS ON ACTIONS--No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) CONSULTATION WITH PEER REVIEW ORGANIZATIONS--In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least sixty (60) days for such review.

(e) DEFINITIONS--In this section:

(1) The term "emergency medical condition" means—

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(ii) Serious impairment to bodily functions, or
(iii) Serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant women who is having contractions--

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery, or
(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in outside a hospital's facilities at the direction of any person employed by (or paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual whom:

(A) Has been declared dead; or
(B) Leaves the facility without the permission of any such person.

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(5) The term "hospital" includes a critical access hospital (as defined in section 1861(mm)(1)).

(f) PREEMPTION--The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) NONDISCRIMINATION--A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units), or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) NO DELAY IN EXAMINATION OR TREATMENT--A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status.

1. WHISTLEBLOWER PROTECTIONS--A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

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ATTACHMENT V

Mixed Services Payment Protocol

Services	Claim Processing And/Or Financial Liability
Inpatient Charges for Psychiatric and Substance Abuse Diagnostic Related Groupings (DRGs)	**MCO**
Outpatient X-ray and Lab Work	**DMA fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: 290-319**
Prescribed by an MCO network provider on an Inpatient basis such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.	**DMA fee-for-service Medicaid fee-for-service Medicaid except when provided during emergency room visits where the primary diagnosis is in the following range: 290-319**
Prescribed by MCO network provider on an outpatient basis such as therapeutic drug levels.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**
Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**
Other tests ordered by non-MCO physician	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**
Drugs	
Outpatient prescription drugs and take home drugs.	DMA fee-for-service Medicaid
Ambulance	
Transport to the hospital when the primary diagnosis is behavioral care	DMA fee-for-service Medicaid
Transport to a hospital prior to a medical emergency when the primary diagnosis is medical	DMA fee-for-service Medicaid
Transfers authorized by MCO from non-network facility to a network facility	MCO
Consults	
Mental Health or Alcohol/Substance Abuse on Medical Surgical Unit	MCO
Mental Health or Alcohol/Substance Abuse in a Nursing Home or Assisted Living Facility	MCO
Medical/Surgical on Mental Health/Substance Abuse Unit	DMA fee-for-service Medicaid
Emergency Room Charges – Professional Services	
Emergency Mental Health, Alcohol/Substance Abuse services provided by MH/SA practitioners	MCO
Emergency room services **where the primary diagnosis on the claim is in the following range: 290-319**	MCO
Emergency room services **where the primary diagnosis on the claim is NOT**	DMA fee-for-service Medicaid

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Services	Claim Processing And/Or Financial Liability
in the following range: 290-319	
Emergency Room Facility Charge.	
Emergency room services **where the primary diagnosis on the claim is in the following range: 290-319**	MCO
Emergency room services **where the primary diagnosis on the claim is NOT in the following range: 290-319**	DMA fee-for-service Medicaid
Medical/Neurological/Organic Issues	
Stabilization of self-induced trauma poisoning.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**
Treatment of disorders which are primarily neurologically/organically based, including delirium, dementia, amnesic and other cognitive disorders.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**
Miscellaneous	
Pre-Authorized, Mental Health, Alcohol/Substance Abuse admission, History and Physical	MCO
Adjunctive alcohol/substance abuse therapies when specifically ordered by a network or MCO authorized physician	MCO
Alcohol Withdrawal Syndrome and Delirium Tremens	
Alcohol withdrawal syndrome. Ordinary Pharmacologic syndrome characterized by Elevated vital signs, agitation, perspiration, Anxiety and tremor that is associated with the abrupt cessation of alcohol or other Addictive substances. Detoxification services authorized by MCO. Not included: fetal alcohol Syndrome or other symptoms exhibited by newborns whose mothers abused drugs except when services are provided in the emergency room and the primary diagnosis is in the following range: **290-319**.	MCO
Delirium tremens (DTs), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening.	DMA fee-for-service Medicaid **except for emergency room visits where the primary diagnosis is in the following range: 290-319**

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ATTACHMENT W

Financial Reporting Requirements

	REPORT	FREQUENCY	REQUIREMENTS
1.	ENROLLMENT Table Report	Quarterly report due 60 days following end of the quarter Annual report due 90 days from the end of the year.	Total Eligibles Report by Eligibility Category and Eligibles in Service. Number of Retroactive eligibility. Quarterly Reconciliation of Eligibles with payments.
2.	Related Party Transactions and Obligations	Annual	Do not have Related Parties. Annual Certification that Related Party Transactions/relationships do not exist.
3.	Risk Reserve Analysis	Quarterly/Annually	End of year reconciliation to be addressed in the Annual Audit
4.	IBNR (Claims lag report)	Quarterly	Include the following: • Month paid • Dates of services (months) • Total paid for month • Less; estimated total claims expense (total expense = 100%) • Estimated IBNR = “0” (Total paid for month less estimated total claims expense plus adjustments) • On column for greater than 180 days
5.	Claims Processing report	Quarterly	Clean Claims, Pended Claims, Approved but unpaid Claims, Denied Claims: number received and amount paid, pended, unpaid, and denied. Include reporting on Prompt Pay Requirements.
6.	Analysis of Revenues and Expenses	Quarterly	Revenue and expenses by major program category. Admin accounted for separately and quarterly cost allocation. Note: added B-3 services as a revenue and service category
7.	Coordination of Benefits	Monthly	837 COB/CAS
8.	Reinvestment Report	Annual	Based on savings from expenses.
9.	Statement of Financial Position (Balance Sheet)	Quarterly	Assets, other debits, liabilities, fund equity and other credits
10.	Statements of Activities	Quarterly	Included on Balance Sheet
11.	Statement of Activities and Changes in Net Assets	Annual	Balance Sheet in Annual audit
12.	Retained Earnings (Deficit)/Fund Balance	Annual	Balance Sheet in Annual Audit
13	Statement of Cash Flows	Annual	Audit
14.	Independent Audit—financial audit and supplemental schedules	Annual	Per requirements in Contract
15.	Statement of Financial Position Reconciliation	Annual	Audit
16.	OMB Circular A-133	Annual	Audit
17.	Annual Disclosure Statement	Annual	Audit
18.	Cost Allocation Plan	Annual	60 days prior to beginning of fiscal year.
19.	Physician Incentive Arrangement (if any)	Annual	Physicians at risk over 25% of salary; ensure that care is not limited by this incentive.

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The following sample reports reflect agreement on report content and formats:

 # 9, 10, 11: SAMPLE Balance Sheet:

Cash and cash equivalents	$ 15,386,329
Receivables:	
Accounts Receivable	790,909
Sales tax	33,519
Total receivables	824,428
Prepaid expenses	135,629
Cash restricted for health benefit payments	228,611
Capital Assets	8,955,761
Amount to be provided for the retirement of general long-term debt	1,829,763
Total assets and other debits	$ 27,360,521
Accounts payable and accrued expenses	$ 2,048,735
Incurred but not received claims	2,184,000
Compensated absences payable	1,186,629
Notes payable	643,134
Liabilities payable from restricted assets	228,611
Total Liabilities	6,291,109
Investment in fixed assets	8,955,761
Fund balances:	
Reserved	5,197,526
Unreserved	
Designated for subsequent year's expenditures	1,212,309
Undesignated	5,703,815
Total fund equity	21,069,411
Total liabilities and fund equity	$ 27,360,521

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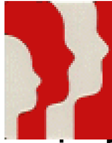
MCO Behavioral Healthcare
SAMPLE



#4 & 5: Claims Processing Report

	Dates of Service			
	July	August	September	Total
Total Number of Claims Received	16,800	15,200	13,564	45,564
Clean Claims				
Number Received	13,085	12,000	11,200	36,285
Total Amount Paid	3,325,000	3,260,000	2,890,000	9,475,000
Current Pended Claims				
Number Received	935	900	500	2,335
Total Amount	101,000	89,000	78,000	268,000
Approved But Unpaid Claims				
Number Received	125	200	75	400
Total Amount	65,000	75,000	45,000	185,000
Denied Claims due to ineligible service or client				
Number Received	1,655	1,400	1,200	4,255
Total Amount Billed	28,000	21,000	17,000	66,000
Denied Claims not due to ineligible service or client				
Number Received	1,000	700	589	2,289
Total Amount Billed	22,000	18,000	12,000	52,000
Total - Should equal total number of received claims listed above	16,800	15,200	13,564	45,564
Unpaid clean claims past prompt pay requirements				
Number Received	0	0	0	0
Total Amount Outstanding	0	0	0	0
Total Amount of Interest Paid or Due	0	0	0	0

Month Paid	
July	450,000

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August	1,750,000	425,000					
September	825,000	1,800,000	455,000				
October	300,000	780,000	1,805,000	445,000			
November	110,000	305,000	805,000	1,801,000	435,000		
December	63,000	150,000	295,000	825,000	1,760,000	440,000	
January	2,000	88,500	155,000	300,000	750,000	1,795,000	425,000
February		1,300	60,000	160,000	275,000	805,000	1,805,000
March			24,600	60,000	165,000	325,000	800,000
Additional Payments	-	200	400	-	-	-	-

Dates of Service	July	August	September	October	November	December	January
Total Paid for Month	3,500,000	3,550,000	3,600,000	3,591,000	3,385,000	3,365,000	3,030,000
Estimated Total Claims Expense	3,500,000	3,550,000	3,600,000	3,650,000	3,450,000	3,565,000	3,500,000
Estimated IBNR **	-	-	-	(59,000)	(65,000)	(200,000)	(470,000)
Percent of Estimated Total Claim Expense Paid	100.00%	100.00%	100.00%	98.38%	98.12%	94.39%	86.57%

**Estimated IBNR is the Total Paid for Month less the Estimated Total Claims Expense

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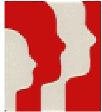
SAMPLE ENROLLMENT REPORT:



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	October Eligibles	October Clients Receiving Services	October Retro-Activity	November Eligibles	November Clients Receiving Services	November Retro-Activity	December Eligibles	December Clients Receiving Services	December Retro-Activity	Total Eligibles for Quarter	Total Clients Receiving Services for Quarter
TANF	20,000	14,840	81	20,000	14,700	61	20,000	14,333	46	60,000	43,873
Foster Care	30,000	14,840	81	30,000	14,700	61	30,000	14,333	46	90,000	43,873
Aged	15,000	9,000	81	15,000	10,000	61	15,000	11,000	46	45,000	30,000
Blind/Disabled < 21	10,000	9,000	81	10,000	8,500	61	10,000	8,300	46	30,000	25,800
Blind/Disabled > 21	5,000	4,000	81	5,000	3,000	61	5,000	3,500	46	15,000	10,500
CAP - MR/DD	20,000	14,840	81	20,000	14,700	61	20,000	14,333	46	60,000	43,873
Grand Total	100,000	66,520	567	100,000	65,600	427	100,000	65,799	322	300,000	197,919

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Financial Reports: 6A

MCO
Report Format
Analysis of Revenues and Expenses

Analysis of Revenues and Expenses	**Medicaid B Wavier Capitation**	**Medicaid Fee For Service**	**Medicaid C Wavier Capitation**	**Medicaid Cap Supplies Fee For Service**	**Medicaid B-3 Service**	**State And Federal**	**Other**	**County**	**Total**
REVENUE:									
SERVICE REVENUE									
ADMIN REVENUE					N/A				
TOTAL REVENUE									
Risk Reserve Funds		N/A		N/A	N/A	N/A	N/A	N/A	
SERVICE EXPENDITURES:									
Inpatient									
Outpatient									
Residential									
ICF/MR									
CAP									
CAP Supplies									
Community Service									
B-3 Services									

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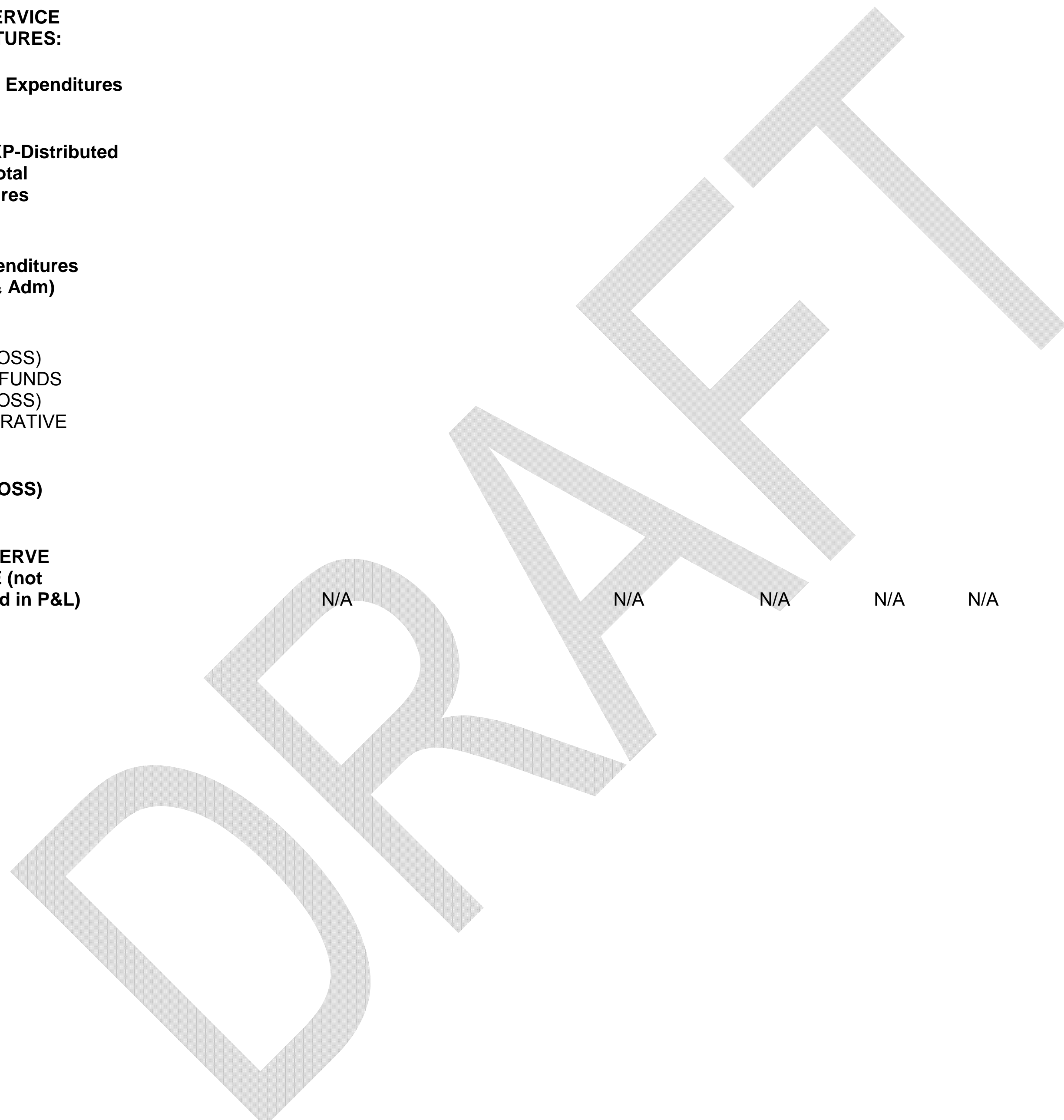

TOTAL SERVICE EXPENDITURES:						
% of Total Expenditures						
ADMIN EXP-Distributed on % of Total Expenditures						
Total Expenditures (Service & Adm)						
PROFIT(LOSS) SERVICE FUNDS						
PROFIT(LOSS) ADMINISTRATIVE FUNDS						
PROFIT(LOSS)						
RISK RESERVE BALANCE (not considered in P&L)	N/A	N/A	N/A	N/A	N/A	N/A

ATTACHMENT X

Medical Care Decisions
And Advance Directives

WHAT YOU SHOULD KNOW

What are My Rights?

Who decides about my medical care or treatment?

If you are 18 or older and have the capacity to make and communicate health care decisions, you have the right to make decisions about your medical/mental health treatment. You should talk to your doctor or other health care provider about any treatment or procedure so that you understand what will be done and why. You have the right to say yes or no to treatments recommended by your doctor or mental health provider. If you want to control decisions about your health/mental health care even if you become unable to make or to express them yourself, you will need an "advance directive."

What is an "advance directive"?

An advance directive is a set of directions you give about the health/mental health care you want if you ever lose the ability to make decisions for yourself. North Carolina has three ways for you to make a formal advance directive. One way is called a "living will"; another is called a "health care power of attorney"; and another is called an "advance instruction for mental health treatment."

Do I have to have an advance directive and what happens if I don't?

Making a living will, a health care power of attorney or an advance instruction for mental health treatment is your choice. If you become unable to make your own decisions; and you have no living will, advance instruction for mental health treatment, or a person named to make medical/mental health decisions for you ("health care agent"), your doctor or health/mental health care provider will consult with someone close to you about your care.

Doctor and each health care agent you named of the change. You can cancel your advance instruction for mental health treatment while you are able to make and make known your decisions, by telling your doctor or other provider that you want to cancel it.

Whom should I talk to about an advance directive?

You should talk to those closest to you about an advance directive and your feelings about the health care you would like to receive. Your doctor or health care provider can answer medical questions. A lawyer can answer questions about the law. Some people also discuss the decision with clergy or other trusted advisors.

Where should I keep my advance directive?

Keep a copy in a safe place where your family members can get it. Give copies to your family, your doctor or other health/mental health care provider, your health care agent, and any close friends who might be asked about your care should you become unable to make decisions.

What if I have an advance directive from another state?

An advance directive from another state may not meet all of North Carolina's rules. To be sure about this, you may want to make an advance directive in North Carolina too. Or you could have your lawyer review the advance directive from the other state.

Where can I get more information?

Your health care provider can tell you how to get more information about advance directives by contacting:

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Living Will

What is a living will?

In North Carolina, a living will is a document that tells others that you want to die a natural death if you are terminally and incurably sick or in a persistent vegetative state from which you will not recover. In a living will, you can direct your doctor not to use heroic treatments that would delay your dying, for example by using a breathing machine ("respirator" or "ventilator"), or to stop such treatments if they have been started. You can also direct your doctor not to begin or to stop giving you food and water through a tube ("artificial nutrition or hydration").

Health Care Power of Attorney

What is a health care power of attorney?

In North Carolina, you can name a person to make medical/mental health care decisions for you if you later become unable to decide yourself. This person is called your "health care agent." In the legal document you name who you want your agent to be. You can say what medical treatments/mental health treatments you would want and what you would not want. Your health care agent then knows what choices you would make.

How should I choose a health care agent?

You should choose an adult you trust and discuss your wishes with the person before you put them in writing.

Advance Instruction for Mental Health Treatment

What is an advance instruction for mental health treatment?

In North Carolina, an advance instruction for mental health treatment is a legal document that tells doctors and health care providers what mental health treatments you would want and what treatments you would not want, if you later become unable to decide yourself. The designation of a person to make your mental health care decisions, should you be unable to make them yourself, must be established as part of a valid Health Care Power of Attorney.

This document was developed by the North Carolina Division of Medical Assistance in cooperation with the Department of Human Resources Advisory Panel on Advance Directives 1991. Revised 1999.

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Other Questions

How do I make an advance directive?

You must follow several rules when you make a formal living will, health care power of attorney or an advance instruction for mental health treatment. These rules are to protect you and ensure that your wishes are clear to the doctor or other provider who may be asked to carry them out. A living will, a health care power of attorney and an advance instruction for mental health treatment must be written and signed by you while you are still able to understand your condition and treatment choices and to make those choices known. Two qualified people must witness all three types of advance directives. The living will and the health care power of attorney also must be notarized.

Are there forms I can use to make an advance directive?

Yes. There is a living will form, a health care power of attorney form and an advance instruction for mental health treatment form that you can use. These forms meet all of the rules for a formal advance directive. Using the special form is the best way to make sure that your wishes are carried out.

When does an advance directive go into effect?

A living will goes into effect when you are going to die soon and cannot be cured, or when you are in a persistent vegetative state. The powers granted by your health care power of attorney go into effect when your doctor states in writing that you are not able to make or to make known your health care choices. When you make a health care power of attorney, you can name the doctor or mental health provider you would want to make this decision. An advance instruction for mental health treatment goes into effect when it is given to your doctor or mental health provider. The doctor will follow the instructions you have put in the document, except in certain situations, after the doctor determines that you are not able to make and to make known your choices about mental health treatment. After a doctor determines this, your Health Care Power of Attorney may make treatment decisions for you.

What happens if I change my mind?

You can cancel your living will anytime by informing your doctor that you want to cancel it and destroying all the copies of it. You can change your health care power of attorney while you are able to make and make known your decisions, by signing another one and telling your doctor or other provider that you want to cancel it.

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Y. PENALTIES

Any instance of contract non-compliance described below except early termination will first result in implementation of a Corrective Action Plan. If this does not resolve the problem, the penalties described below may be initiated by DMA. The Corrective Action Plan must be submitted within 30 days of the date requested by DMA. The Corrective Action Plan will be subject to the approval of the DMA Director or his designee. Once the plan is approved, the MCO has 60 days to implement the plan. The DMA Director or his designee will determine whether, once implemented, the plan is resolving the problem. Failure to resolve the problem may result in the penalties below:

Compliance Issue	Resolution/Penalty
Non-compliance with Federal, and State laws; placing health and safety of recipients in jeopardy and not acting to solve the problem; providing fraudulent information to recipients; offering or providing gratuities to public officials creating a conflict of interest as described in Part II, Section 1.0, Conflict of Interest; State and Federal Medicaid funds no longer available to provide payment.	Immediate termination
Claims are not paid by MCO to providers in a timely manner as specified in the contract. MCO shall follow North Carolina Prompt Pay Requirements as follows: within eighteen (18) calendar days after MCO receives an invoice/claim from a provider, MCO shall either: (a) approve payment of the invoice/claim, (b) deny payment of the invoice/claim, or (c) determine that additional information is required for making an approval or denial. If payment is approved, the claim shall be paid within 30 calendar days after it is approved.	IF MCO fails to pay providers within these parameters, MCO shall pay to the providers interest in the amount of 8% of the amount owed in excess of the Prompt Pay Requirements.
Early contract termination by MCO.	MCO shall provide DMA with a plan to effectively transition consumers to Medicaid fee-for-service as specified in Part II 12.4. DMA may require MCO to pay the non-federal share of transitions (cost of EIS and MMIS and recipient notification)
Failure to submit encounter data, enrollment reconciliation reports or financial reports	Financial penalties may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of the MCO's monthly capitation payment due shall be subject to financial penalties. (refundable upon receipt).
Failure to provide Medically Necessary services; inappropriate charges to Enrollees; Physician Incentive Plan non-compliance; falsifying information to Enrollees, DMA or THE DEPARTMENT; discrimination due to health status/service needs of Enrollees.	Financial penalties may be imposed by reducing the monthly premium payment(s) by up to 5% of the subsequent month(s) capitation payment, pending receipt and acceptance of the respective report or data by DMA. One hundred percent (100%) of the MCO's monthly capitation payment due shall be subject to financial penalties.

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APPENDIX Y: MEDICAID PAYMENT AMOUNTS

Below are the rates for SFY 2011.

SFY 2011 Medicaid Capitation Rates

Rating Group	Ages	SFY 2011 Contract Rate
AFDC	3+	
Foster Children	3+	
Aged	65+	
Blind/Disabled	3-20	
Blind/Disabled	21+	
CAP-MR	All Ages	
Total (w/o CAP-MR)	All Ages	
Total	**All Ages**	

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MCO Provider Representative
Approved/Accepted ___________________________ Date _________

DHHS Representative Approved/Accepted ___________________________ Date _________

CMS Representative Approved/Accepted ___________________________ Date _________