MEDICAID
PARTICIPATION ATTACHMENT TO THE
BLUE CROSS NC
MEDICAID PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the Blue Cross NC Medicaid Provider Agreement ("Agreement"), entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means, unless otherwise prohibited by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Blue Cross NC.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Blue Cross NC's Medicaid Program(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Blue Cross NC's Medicaid Program(s).

"Medically Necessary/Medical Necessity" Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

"State Agency" means the North Carolina Department of Health and Human Services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Blue Cross NC's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Blue Cross NC for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Blue Cross NC's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Blue Cross NC with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise prohibited under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Blue Cross NC's Policies, which may include, but is not limited to, arranging for call coverage or other backup. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.4 Provider must cooperate with Medicaid Member appeals and grievance procedures.

2.2.5 If Provider is a PCP, Provider shall perform EPSDT screenings for Medicaid Members less than twenty-one (21) years of age in accordance with the Government Contract.

2.3 Provider Responsibility. Blue Cross NC shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Blue Cross NC may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Blue Cross NC pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Blue Cross NC's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Blue Cross NC or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Blue Cross NC.

2.5 Blue Cross NC Marketing/Information Requirements. Provider agrees to abide by Blue Cross NC's marketing/information requirements. Provider shall forward to Blue Cross NC for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Blue Cross NC or the applicable State Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Blue Cross NC shall make available upon Provider's request the applicable Health Benefit Plan for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications.

2.7 Medicaid Member Verification. Provider shall verify a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Medical Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall verify a Medicaid Member's eligibility as soon as reasonably practical. Blue Cross NC shall provide a system for Providers to contact Blue Cross NC to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Blue Cross NC's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall maintain privileges to practice at one (1) or more of Blue Cross NC's Participating Provider hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Blue Cross NC in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, and unless prohibited under Regulatory Requirements, Provider acknowledges and agrees that Blue Cross NC is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management, care management, and provider sanctions programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s). None of the foregoing programs shall be construed to override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Medicaid Members. In accordance with N.C.G.S. § 58-3-200(c), if Blue Cross NC or its authorized representative determines that services, supplies, or other items are covered under a Health Benefit Plan, including any determination under N.C.G.S §. 58-50-61, Blue Cross NC shall not subsequently retract its determination after such services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Medicaid Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

2.10.1 Notice of Discharge from High Level Clinical Setting. Provider shall notify Blue Cross NC when a Medicaid Member in a high level clinical setting is discharged as listed in the provider manual.

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Blue Cross NC is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Blue Cross NC to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Blue Cross NC with written notice of any material changes to such information.

2.12 Credentialing; Compliance with Government Contract Requirements. In addition to the Provider Credentialing, Standards of Participation and Accreditation of this Agreement, and in accordance with 45 C.F.R. § 455.410, Provider must be enrolled in Medicaid Program(s) in which it offers Medicaid Covered Services. Failure to maintain enrollment in such Medicaid Program(s) may result in immediate termination of this Attachment as applied to such Medicaid Program(s). Provider shall complete re-enrollment/re-credentialing before contract renewal and in accordance with the following: (1) during the Provider Credentialing Transition Period, no less frequently than every five (5) years (as described in the Government Contract); (2) during Provider Credentialing under Full Implementation, no less frequently than every three (3) years (as described in the Government Contract), except as otherwise permitted by State Agency.

2.13 Obligation to Provide Data. Blue Cross NC shall provide data and information to Provider, such as: (1) performance feedback reports or information to Provider, if compensation is related to efficiency criteria, (2) information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies, and (3) notification of changes in these requirements, allowing Provider time to comply with such changes.

2.14 Provider Directory. Provider authorizes Blue Cross NC to include, and Blue Cross NC shall include, Provider's name in the provider directory distributed to Medicaid Members.

2.15 Interpreting and Translation Services. Provider must (1) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Medicaid Member, (2) ensure that Provider's staff are trained to appropriately communicate with patients with various types of hearing loss, and (3) report to Blue Cross NC, in a format and frequency to be determined by Blue Cross NC, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

2.16 Perinatal Care. If Provider provides perinatal Medicaid Covered Services, Provider will arrange for perinatal Medicaid Covered Services in a manner consistent with State Agency's Pregnancy Management Program (as defined and described in the Government Contract). Provider shall comply with State Agency's Pregnancy Management Program.

2.17 Advanced Medical Homes. If Provider is an Advanced Medical Home (as defined in the Government Contract), Provider will follow a care management model and requirements consistent with State Agency's Advanced Medical Home Program (as defined and described in the Government Contract). Provider agrees to comply with State Agency's Advanced Medical Home Program.

2.18 Local Health Departments. If Provider is a Local Health Department (as defined in the Government Contract) carrying out care management for high-risk pregnancy and for at-risk children, Provider will follow requirements consistent with State Agency's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy (each policy as defined and described in Addenda, attached hereto). Provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or prohibited by Regulatory Requirements, Provider shall submit Claims to Blue Cross NC, using appropriate and current Coded Service Identifier(s), within one hundred eighty (180) days from the date the Health Services are rendered, or, from the date the Medicaid Member is discharged, or Blue Cross NC may refuse payment. If Blue Cross NC is the secondary payor, the one hundred eighty (180) day period will not begin until Provider receives notification of primary payor's responsibility. Provider shall not submit Claims or Encounter Data (as defined in the PCS) for Medicaid Covered Services directly to State Agency to the extent Blue Cross NC covers such Medicaid Covered Services.

3.1.1 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Blue Cross NC either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to Blue Cross NC, unless otherwise instructed, at no cost to Blue Cross NC, or the Medicaid Member, all information necessary for Blue Cross NC to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If Blue Cross NC asks for additional information so that Blue Cross NC may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred eighty (180) day period referenced in Section 3.1 above, whichever is longer.

3.1.3 Once Blue Cross NC determines Blue Cross NC has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Blue Cross NC's Medicaid Program(s).

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Blue Cross NC has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 Medicaid Member Records. In accordance with 42 C.F.R. § 438.208(b)(5), Provider must (1) maintain confidentiality of Medicaid Member medical records and personal information and other health records as required by law; (2) maintain adequate medical and other health records according to industry and Blue Cross NC standards; and (3) make copies of such records available to Blue Cross NC and State Agency in conjunction with its regulation of Blue Cross NC. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

3.5 Access to Fee Schedules. Blue Cross NC shall make available its schedule of fees associated with the top thirty (30) services or procedures most commonly billed by Provider's class of provider. Upon the request of Provider, Blue Cross NC shall also make available the full schedule of fees for services or procedures billed by Provider's class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If Provider requests fees for more than thirty (30) services and procedures, Blue Cross NC may require Provider to specify the additional requested services and procedures and may limit Provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by Provider.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Blue Cross NC to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 Indemnification of State. In addition to the Indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.

5.2 Medicaid Hold Harmless. Provider agrees that Blue Cross NC's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event Blue Cross NC becomes insolvent.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Blue Cross NC and the applicable State Agency, which applicable terms are incorporated herein by reference. Blue Cross NC agrees to provide Provider with a description of the applicable terms upon request.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Blue Cross NC shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Dispute Resolution. Any disputes arising out of this Attachment or the Agreement shall be handled consistent with the provider grievances and appeals guidelines set forth in the Government Contract and the provider manual. To the extent there is a conflict between the provider grievances and appeals guidelines set forth in the Government Contract and the dispute resolution procedures set forth in the provider manual, this Attachment or the Agreement, the provider grievances and appeals guidelines set forth in the Government Contract shall govern. Except as otherwise set forth in this section, all other terms and conditions related to dispute resolution provided in the Agreement remain in full force and effect.

5.7 Government Funds. Provider acknowledges that the funds used for payments under this Attachment are government funds.

5.8 Provider Preventable Conditions. Provider shall comply with 42 C.F.R. § 438.3. Provider agrees to comply with the reporting requirements set forth under federal law and the Government Contract as a condition of payment from Blue Cross NC. Provider shall not be entitled to payment for provider preventable conditions.

5.9 Required Government Contract Language: All Provider Types. In the event of a conflict between this section and other terms and conditions in this Agreement, this section shall prevail. Except as otherwise provided in this section, all other terms and conditions provided in this Agreement remain in full force and effect.

5.9.1 Compliance with State and Federal Laws. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and the Government Contract, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the Government Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

5.9.2 Hold Medicaid Member Harmless. Provider agrees to hold the Medicaid Member harmless for charges for any Medicaid Covered Service. Provider agrees not to bill a Medicaid Member for Medically Necessary Covered Services covered by Blue Cross NC so long as the Medicaid Member is eligible for coverage.

5.9.3 Liability. Provider understands and agrees that State Agency does not assume liability for the actions of, or judgments rendered against, Blue Cross NC, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against State Agency for any duty owed to Provider by Blue Cross NC or any judgment rendered against Blue Cross NC.

5.9.4 Non-Discrimination: Equitable Treatment of Medicaid Members. Provider agrees to render Covered Services to Medicaid Members with the same degree of care and skills as customarily provided to Provider's patients who are not Medicaid Members, according to generally accepted standards of medical practice. Provider and Blue Cross NC agree that Medicaid Members and non-Medicaid Members should be treated equitably. Provider agrees not to discriminate against Medicaid Members on the basis of race, color, national origin, age, sex, gender, or disability.

5.9.5 Department Authority Related to the Medicaid Program. Provider agrees and understands that in the State of North Carolina, State Agency is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title

XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

5.9.6 Access to Provider Records. Provider agrees to provide at no cost to the following entities or their designees, prompt, reasonable, and adequate access to Blue Cross NC and the Agreement and any records, books, documents, and papers that relate to the Blue Cross NC and the Agreement and/or Provider's performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose State Agency deems necessary for contract enforcement or to perform its regulatory functions: i. The United States Department of Health and Human Services or its designee; ii. The Comptroller General of the United States or its designee; iii. State Agency, its Medicaid managed care program personnel, or its designee iv. The Office of Inspector General v. North Carolina Department of Justice Medicaid Investigations Division vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of State Agency; vii. The North Carolina Office of State Auditor, or its designee viii. A state or federal law enforcement agency. ix. And any other state or federal entity identified by State Agency, or any other entity engaged by State Agency. Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the NC Department of Health and Human Services. Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

5.9.7 Provider Ownership Disclosure. Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Provider agrees to notify, in writing, Blue Cross NC and State Agency of any criminal conviction within twenty (20) days of the date of the conviction.

5.9.8 N.C.G.S. § 58-3-225 Prompt Claim payments under Health Benefit Plans. Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, Provider shall submit all Claims to Blue Cross NC for processing and payments within one hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Provider's failure to submit a Claim within this time will not invalidate or reduce any Claim if it was not reasonably possible for Provider to submit the Claim within that time. In such case, the Claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the Claim is otherwise required. i. For Medical Claims (including behavioral health): 1. Blue Cross NC shall within eighteen (18) calendar days of receiving a Medical Claim notify Provider whether the Claim is a Clean Claim, or pend the Claim and request from Provider all additional information needed to process the Claim. 2. Blue Cross NC shall pay or deny a medical Clean Claim at lesser of thirty (30) calendar days of receipt of the Claim or the first scheduled provider reimbursement cycle following adjudication. 3. A medical pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information. ii. For Pharmacy Claims: 1. Blue Cross NC shall within fourteen (14) calendar days of receiving a pharmacy Claim pay or deny a pharmacy Clean Claim or notify Provider that more information is needed to process the Claim. 2. A pharmacy pended Claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information. iii. If the requested additional information on a medical or pharmacy pended Claim is not submitted within ninety (90) days of the notice requesting the required additional information, Blue Cross NC shall deny the Claim per § 58-3-225 (d). 1. Blue Cross NC shall reprocess medical and pharmacy Claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable). iv. If Blue Cross NC fails to pay a Clean Claim in full pursuant to this provision, Blue Cross NC shall pay Provider interest and penalty. Late Payments will bear interest at the annual rate of eighteen percent (18%) beginning on the date following the day on which the Claim should have been paid or was underpaid. v. Failure to pay a Clean Claim within thirty (30) days of receipt will result in Blue Cross NC paying Provider a penalty equal to one percent (1%) of the total amount of the Claim per day beginning on the date following the day on which the Claim should have been paid or was underpaid. vi. Blue

Cross NC shall pay the interest and penalty from subsections 58-3-225(e) and (f) as provided in that subsection, and shall not require Provider to request the interest or the penalty.

ARTICLE VI

6.1 This Article intentionally left blank.

ARTICLE VII
GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose to Blue Cross NC complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to Blue Cross NC at the time of initial contract, upon contract renewal, and/or upon request by Blue Cross NC. Provider further agrees to notify Blue Cross NC within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

ADVANCED MEDICAL HOME PROVIDER ADDENDUM
TO THE MEDICAID PARTICIPATION ATTACHMENT
OF THE BLUE CROSS MEDICAID PROVIDER AGREEMENT

The following are required provisions for Advanced Medical Home ("AMH") Providers. These provisions are independent of practices' agreements with the North Carolina Department of Health and Human Services and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all PHP (prepaid health plans) and AMH practice contract templates prior to use to ensure that standard contract terms are incorporated.

Any capitalized terms not otherwise defined herein shall have the meaning set forth in the Agreement or the Government Contract, as applicable.

ARTICLE I
SERVICES/OBLIGATIONS FOR AMH PRACTICES

1. Provider shall accept Medicaid Members and be listed as a PCP in Blue Cross NC's member-facing materials for the purpose of providing care to members and managing their health care needs.

2. Provider shall provide primary care and member care coordination services to each member.

3. Provider shall provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

4. Provider shall provide direct patient care a minimum of thirty (30) office hours per week.

5. Provider shall provide preventive services in accordance with the Preventive Health Requirements set forth in the Provider Manual and Government Contract.

6. Provider shall establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of Medicaid Members.

7. Provider shall maintain a unified medical record for each Medicaid Member following Blue Cross NC's medical record documentation guidelines.

8. Provider shall promptly arrange referrals for Medically Necessary Health Services that are not provided directly and document referrals for specialty care in the medical record.

9. Provider shall transfer the Medicaid Member's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Blue Cross NC (if applicable) and as authorized by the Medicaid Member within thirty (30) days of the date of the request.

10. Provider shall authorize care for Medicaid Members or provide care for Medicaid Members based on the standards of appointment availability as defined by Blue Cross NC's network adequacy standards.

11. Provider shall refer for a second opinion as requested by the Medicaid Member, based on State Agency guidelines and Blue Cross NC's standards.

12. Provider shall review and use Medicaid Member utilization and cost reports provided by Blue Cross NC for the purpose of AMH level utilization management and advise Blue Cross NC of errors, omissions, or discrepancies if they are discovered.

13. Provider shall review and use the monthly enrollment report provided by Blue Cross NC for the purpose of participating in Blue Cross NC or practice-based population health or care management activities.

ARTICLE II
Standard Terms and Conditions for Tier 3 AMH Practices

The terms and conditions set forth in this Article II shall apply to the extent Provider is a Tier 3 AMH practice (as defined in the Government Contract). Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network ("CIN") with which the practice has a contractual agreement that contains equivalent contract requirements.

2.1 Provider must be able to risk stratify all empaneled Medicaid Members.

2.1.1 Provider must ensure that assignment lists transmitted to the practice by Blue Cross NC are reconciled with the practice's panel list and up to date in the clinical system of record.

2.1.2 Provider must use a consistent method to assign and adjust risk status for each assigned Medicaid Member.

2.1.3 Provider must use a consistent method to combine risk scoring information received from Blue Cross NC with clinical information to score and stratify the Medicaid Member panel.

2.1.4 Provider must, to the greatest extent possible, ensure that the method is consistent with the State Agency's program Policy of identifying "priority populations" for care management.

2.1.5 Provider must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.

2.1.6 Provider must define the process and frequency of risk score review and validation.

2.2 Provider must be able to define the process and frequency of risk score review and validation.

2.2.1 Provider must use its risk stratification method to identify Medicaid Members who may benefit from care management.

2.2.2 Provider must perform a Comprehensive Assessment (as described below and in Policies) on each Medicaid Member identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:

1. Medicaid Member' immediate care needs and current services;

2. Other State or local services currently used;

3. Physical health conditions;

4. Current and past behavioral and mental health and substance use status and/or disorders;

5. Physical, intellectual developmental disabilities;

6. Medications;

7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);

8. Available informal, caregiver, or social supports, including peer supports.

2.2.3 Provider must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need Medicaid Members.

2.2.4 For each high-need Medicaid Member, Provider must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.2.5 Provider must use a documented Care Plan for each high-need Medicaid Member receiving care management.

2.2.6 Provider must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

2.2.7 Provider must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including Medicaid Member and family participation where possible.

2.2.8 Provider must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the Medicaid Member into the Care Plan.

2.2.9 Medicaid Member must include, at a minimum, the following elements in the Care Plan:

1. Measurable Medicaid Member (or Medicaid Member and caregiver) goals

2. Medical needs including any behavioral health needs;

3. Interventions; including medication management and adherence;

4. Intended outcomes; and

5. Social, educational, and other services needed by the Medicaid Member.

2.2.10 Provider must have a process to update each Care Plan as Medicaid Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

2.2.11 Provider must have a process to document and store each Care Plan in the clinical system of record.

2.2.12 Provider must periodically evaluate the care management services provided to high-risk, high-need Medicaid Members by the practice to ensure that services are meeting the needs of empaneled Medicaid Members, and refine the care management services as necessary.

2.2.13 Provider must track empaneled Medicaid Members' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled Medicaid Members are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

2.2.14 Provider or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below):

1. Real time (minutes/hours) response to outreach from EDs relating to Medicaid Member care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission;

2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;

3. Within a several-day period to address outpatient needs or prevent future problems for high risk Medicaid Members who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge).

2.3 Providers must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled Medicaid Members who have an ED visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

2.3.1 Provider must have a methodology or system for identifying Medicaid Members in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;

2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;

3. NICU discharges;

4. Clinical complexity, severity of condition, medications, risk score.

2.3.2 For each Medicaid Member in transition identified as high risk for admission or other poor outcome with transitional care needs, Provider must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.3.3 Provider must include the following elements in transitional care management:

1. Ensuring that a care manager is assigned to manage the transition;

2. Facilitating clinical handoffs;

3. Obtaining a copy of the discharge plan/summary;

4. Conducting medication reconciliation;

5. Following-up by the assigned care manager rapidly following discharge;

6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs;

7. Developing a protocol for determining the appropriate timing and format of such outreach.

2.3.4 Provider must use electronic data to promote care management.

1. Provider must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.

INDIAN HEALTH CARE PROVIDER ADDENDUM
TO THE MEDICAID PARTICIPATION ATTACHMENT
OF THE BLUE CROSS MEDICAID PROVIDER AGREEMENT

This Indian Health Care Provider Addendum ("Addendum") to the Medicaid Participation Attachment of the Blue Cross NC Provider Agreement ("Agreement"), is entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

1. Purpose of Article; Supersession. The purpose of this Addendum is to apply special terms and conditions necessitated by federal law and regulations to the network Indian Health Care Provider (IHCP) agreement by and between Blue Cross NC (herein "Managed Care Plan") and Provider (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Agreement, Medicaid Participation Attachment, or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Description of IHCP. The IHCP identified in Section 1 of this Addendum is:

IHS.

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

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

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

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

4. Cost-Sharing Exemption for Indians: No Reduction in Payments. No Reduction in Payments. The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services forthe furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

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

6. Agreement to Pay IHCP. The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP. (a) Nothing in this Agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. (b) No term or condition of the Managed Care Plan's network IHCP agreement or anyaddendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers. Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in within this Contract.

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

10. Insurance and Indemnification.

    (a) Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan

will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability to the extent that the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such Provider, any employee of such provider, or any personal services contractor to operate outside of the scope of FTCA coverage.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the Managed Care Plan will be held harmless from liability to the extent the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of the FTCA.

11. Licensure and Accreditation. Pursuant to 25 U.S.C. §§ 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

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

13. Governing Law. The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

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

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

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

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

18. Purchase/Referred Care Requirements. The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan. The Provider shall comply with coordination of care and referral obligations of the Managed Care Plan issuer except only in specific circumstances in which such obligations would conflict with requirements applicable to Purchased/Referred Care at 42 C.F.R. Part 136. The Provider will notify the Managed Care Plan issuer when such circumstances occur.

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

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

APPROVALS

For the Managed Care Plan: _____ For the IHCP: _____

Date: _____ Date: _____

(a) The IHS as an IHCP:
(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

(c) An urban Indian organization that is an IHCP:
(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b.

PERINATAL PROVIDER ADDENDUM TO THE MEDICAID PARTICIPATION ATTACHMENT OF THE BLUE CROSS NC MEDICAID PROVIDER AGREEMENT

The following are required provisions for Providers who offer prenatal, perinatal and postpartum services; and who, consequently, participate in the Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing health care costs among participating providers.

PREGNANCY MANAGEMENT PROGRAM REQUIREMENTS

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow Blue Cross NC or Blue Cross NC's designated vendor with access to medical records for auditing purposes to measure performance on specific quality indicators.
3. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation.
4. Commit to decreasing the cesarean section rate among nulliparous women.
5. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to pregnant Medicaid Members with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
6. Complete a high risk screening on each pregnant Medicaid Member in the program and integrate the plan of care with local pregnancy care management.
7. Decrease the primary cesarean delivery rate if the rate is over the State Agency's designated rate (Note: the State Agency will set the rate annually, which will be at or below twenty percent (20%)).
8. Ensure post-partum visits occur within fifty-six (56) days of delivery.
9. Blue Cross NC shall require that, within one business day of completion, its network providers shall send all screening information and applicable medical record information for Members in the Care Management of High-Risk Pregnancies to Blue Cross NC, Local Health Department or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy.

LOCAL HEALTH DEPARTMENT PROVIDER ADDENDUM FOR HIGH RISK PREGNANCY

TO THE MEDICAID PARTICIPATION ATTACHMENT

This Local Health Department Provider Addendum ("Addendum") to the Medicaid Participation Attachment of the Blue Cross NC Medicaid Provider Letter of Agreement ("Agreement"), is entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

The following are additional requirements for Providers who are Local Health Departments (LHD) and who provide care management services provided to a subset of high-risk pregnant women (the High Risk Pregnancy Program).

1. **General Contracting Requirement**

    a. LHDs shall accept referrals from Blue Cross NC for care management for high-risk pregnancy services.

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

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

    b. LHD shall contact Members identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of labor & delivery triage unit) for referral to prenatal care and to engage in care management.

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

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

    b. LHD shall utilize risk screening data, Member self-report information and provider referrals to develop strategies to meet the needs of those Members at highest risk for poor pregnancy outcome.

    c. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources, Member self-referral, and provide appropriate assessment and follow up to those Members based on the level of need.

    d. LHD shall review available Blue Cross NC data reports identifying additional pregnancy risk status data, including regular, routine use of the obstetric admission, discharge and transfer report, to the extent the report remains available to LHD.

    e. LHD shall collaborate with out-of-county Pregnancy Management Program providers and care management for high-risk pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all Members in the target population.

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

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

    b. LHD shall utilize assessment findings, including those conducted by the Blue Cross NC to determine level of need for care management support.

c. LHD shall document assessment findings in the care management documentation system.

d. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the Member and should be continually updated as new information is obtained.

e. LHD shall assign case status based on level of Member need.

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

a. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging Members and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.

b. LHD shall provide care management services based upon level of Member need as determined through ongoing assessment.

c. LHD shall develop Member-centered care plans, including appropriate goals, interventions and tasks.

d. LHD shall utilize NC resource platform and identify additional community resources once the Department has certified it as fully functional.

e. LHD shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Member's Blue Cross NC network.

f. LHD shall document all care management activity in the care management documentation system.

6. **Care Management for High-Risk Pregnancy: Integration with the Blue Cross NC and Healthcare Providers**

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

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

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

d. LHD shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of Members in the target population.

e. LHD shall ensure awareness of Blue Cross NC Members' "in network" status with providers when organizing referrals.

f. LHD shall ensure understanding of Blue Cross NCs' prior authorization processes relevant to referrals.

7. **Care Management for High-Risk Pregnancy: Collaboration with Blue Cross NC**

a. LHD shall work with the Blue Cross NC to ensure program goals are met.

b. LHD shall review and monitor Blue Cross NC reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk.

c. LHD shall communicate with Blue Cross NC regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

d. LHD shall participate in pregnancy care management and other relevant meetings hosted by the Blue Cross NC.

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

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

b. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Blue Cross NC and/or the department.

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

d. LHD shall ensure that pregnancy care managers and their supervisors utilize motivational interviewing and trauma informed care techniques on an ongoing basis.

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

a. LHD shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications:

i. Registered nurses; ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a council on social work education accredited social work degree program. Care managers for high-risk pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

b. LHD shall ensure that community health workers for care manager for high-risk pregnancy services work under the supervision and direction of a trained care manager.

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

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

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

f. LHD shall ensure that Pregnancy Care Managers must demonstrate:

i. A high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes ii. Proficiency with the technologies required to perform care management functions iii. Motivational interviewing skills and knowledge of adult

teaching and learning principles; iv. Ability to effectively communicate with families and providers; and v. Critical thinking skills, clinical judgment and problem-solving abilities.

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

i. Provision of program updates to care managers. ii. Daily availability for case consultation and caseload oversight. iii. Regular meetings with direct service care management staff. iv. Utilization of reports to actively assess individual care manager performance. v. compliance with all supervisory expectations delineated in the care management for high-risk Pregnancy Management Program manual.

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

i. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by Blue Cross NC.

LOCAL HEALTH DEPARTMENT PROVIDER ADDENDUM FOR AT-RISK CHILDREN

TO THE MEDICAID PARTICIPATION ATTACHMENT

This Local Health Department Provider Addendum ("Addendum") to the Medicaid Participation Attachment of the Blue Cross NC Medicaid Provider Letter of Agreement ("Agreement"), is entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

The following are additional requirements under the At-Risk Care Management Children Program for Providers who are Local Health Departments (LHD) and who provide care management services to a subset of the Medicaid population ages 0-5 identified as being "high-risk."

1. **Care Management for At-Risk Children: General Requirements**

LHD shall accept referrals from the Blue Cross NC for children identified as requiring Care Management for At-Risk Children.

2. **Care Management for At-Risk Children: Outreach**

a. LHD shall educate Members, advanced medical homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children referral form either electronically and/or in a paper version to potential referral sources.

b. LHD shall communicate regularly with the advanced medical homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care

c. LHD shall collaborate with out-of-county advanced medical homes and other practices to facilitate cross-county partnerships to optimize care for Members who receive services from outside their resident county.

d. LHD shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population.

e. LHD shall utilize the NC resource platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the Department.

3. **Care Management for At-Risk Children: Population Identification**

a. LHD shall use any claims-based reports and other information provided by Blue Cross NC, as well as Care Management for At-Risk Children referral forms received to identify priority populations.

b. LHD shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.

c. LHD shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

4. **Care Management for At-Risk Children: Family Engagement**

a. LHD shall involve families (or legal guardian when appropriate) in the decision-making process through a Member-centered, collaborative partnership approach to assist with improved self-care.

b. LHD shall foster self-management skill building when working with families of children.

c. LHD shall prioritize face-to-face family interactions (home visit, primary care office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

5. **Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level**

a. LHD shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description.

b. LHD shall review and monitor Blue Cross NC reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.

c. LHD shall use the information gained from the assessment to determine the need for and the level of service to be provided.

6. **Care Management for At-Risk Children: Plan of Care**

a. LHD shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.

b. LHD shall ensure children/families are well-linked to the child's advanced medical home or other practice; provide education about the importance of the medical home.

c. LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging Members, meeting their needs and achieving care plan goals.

d. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC resource platform) to ensure families are well linked to resources to meet the identified need.

e. LHD shall provide care management services based upon the Member's level of need as determined through ongoing assessment.

7. **Care Management for At-Risk Children: Integration with Blue Cross NC and Health Providers**

a. LHD shall collaborate with advanced medical home/primary care/care team to facilitate implementation of Member-centered plans and goals targeted to meet individual child's needs.

b. LHD shall ensure that changes in the care management level of care, need for Member support and follow up and other relevant updates (especially during periods of transition) are communicated to the advanced medical home, primary care and/or care team.

c. Where care management is being provided by a Blue Cross NC and/or advanced medical home practice in addition to the Care Management for At-Risk program, the Blue Cross NC/advanced medical home practice must explicitly agree on the delineation of responsibility and document that agreement in the child's plan of care to avoid duplication of services.

d. LHD shall ensure that changes in the care management level of care, need for Member support and follow up and other relevant updates (especially during periods of transition) are communicated to the advanced medical home primary care and/or care team and to the Blue Cross NC.

e. LHD shall ensure awareness of Blue Cross NC Member's "in network" status with providers when organizing referrals.

f. LHD shall ensure understanding of Blue Cross NCs' prior authorization processes relevant to referrals.

8. **Care Management for At-Risk Children: Service Provision**

a. LHD shall document all care management activities in the care management documentation system in a timely manner.

b. LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

9. **Care Management for At-Risk Children: Training**

a. LHD shall participate in Department/Blue Cross NC's - sponsored webinars, trainings and continuing education opportunities as provided.

b. LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

10. **Care Management for At-Risk Children: Staffing**

a. LHD shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications:

i. Registered nurses; ii. Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a council on social work education accredited social work degree program. iii. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a social worker under the Office of State Personnel guidelines.

b. LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of Members with both medically and socially complex conditions.

c. LHD shall ensure that Care Management for At-Risk Children Care Managers must demonstrate:

i. Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system; ii. Ability to effectively communicate with families and providers; and iii. Critical thinking skills, clinical judgment and problem-solving abilities. iv. Motivational interviewing skills, trauma informed care, and knowledge of adult teaching and learning principles.

d. LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.

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

f. LHD shall maintain services during the event of an extended vacancy.

g. In the event of an extended vacancy, LHD shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

h. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following department guidance regarding vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight.

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

j. LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include:

> i. Provision of program updates to care managers. ii. Daily availability for case consultation and caseload oversight. iii. Regular meetings with direct service care management staff. iv. Utilization of monthly and on-demand reports to actively assess individual care manager performance.

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