Amendment Number 8 (10 PTV)
Contract #30-2020-052-DHB-X
Behavioral Health and Intellectual/ Developmental Disability Tailored Plan

This Amendment to the Contract #30-2020-052-DHB-X Behavioral Health and Intellectual/ Developmental Disability Tailored Plan ("Contract"), as subsequently amended, is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and BH I/DD Tailored Plan Name ("Contractor" or "BH I/DD Tailored Plan"), each, a Party and collectively, the Parties.

Background:

The purpose of this Amendment is to incorporate new requirements related to reimbursement and reporting for drugs appearing on the NC Select Drug List and to clarify requirements related to the risk mitigation provisions of the Contract for the rating period beginning July 1, 2025. Changes are related to the following Sections of the Contract:

I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
II. Section V. Scope of Services; and
III. Section VII Attachments.

The Parties agree as follows:

I. Modifications to Section III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, and Protections

Specific subsections are modified as stated herein.

a. *Section III. A. Definitions* is revised and restated to add the following:

274. **NC Select Drug:** A drug that meets the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, and has been listed on the NC Select Drug List by the Department.
275. **NC Select Drug List:** A list of drugs maintained by the Department and made available on its public-facing website that include but are not limited to Cell and Gene Therapies which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, that are covered under the NC Medicaid Benefit, and are carved out of the inpatient diagnosis-related group or outpatient ratio of cost to charges and claimed separately to allow the capture of rebates.

b. *Section III.B. Acronyms* is revised and restated to add the following:

260. AAC: Actual Acquisition Cost
261. ASP: Average Sales Price
262. DRG: Diagnosis-Related Group
263. RCC: Ratio of Cost to Charges

c. *Section III. D. General Terms and Conditions, 34. PAYMENT AND REIMBURSEMENT a.ii.,* is revised and restated in its entirety as follows:

ii. Maternity Event Payments and NC Select Drug Case Payments;

d. *Section III. D. General Terms and Conditions, 34. PAYMENT AND REIMBURSEMENT, c. Maternity Event Payment* is revised and restated in its entirety as follows:

c. **Maternity Event Payment and NC Select Drug Case Payment:**
   i. As provided in *Section V.B.7. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required

documentation of an eligible delivery event to the Department. The Contractor must accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.

ii. As provided in *Section V.B.7. Financial Requirements*, the BH I/DD Tailored Plan will be eligible to receive a separate NC Select Drug Case Payment as applicable. Payment will be made after the BH I/DD Tailored Plan submits required documentation of paid claims in the NC Select Drug Report and the encounter being accepted by the Department through the Encounter Processing System. The BH I/DD Tailored Plan must accept the NC Select Drug Case payment rates developed by the Department and its actuary and approved by CMS.

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

a. *Section V. A. Unified, 1. Administration and Management, i. Medicaid Program and State-Funded Services Administration, (ix), (n)* is revised and restated in its entirety as follows:

n) North Carolina Medicaid Transformation Clinical Supplemental Guidance;

b. *Section V.B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (t)* is revised and restated in its entirety as follows:

(t) The BH I/DD Tailored Plan shall adhere to the Department's North Carolina Medicaid Transformation Clinical Supplemental Guidance, which supplements NC Medicaid clinical coverage policies.

c. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package* is revised to add the following:

(xiii) NC Select Drugs Notification and Reporting

(a) The BH I/DD Tailored Plan shall notify the Department within fourteen (14) Calendar Days in accordance with the notification process outlined in the *North Carolina Medicaid Transformation Clinical Supplemental Guidance*, as received by the BH I/DD Tailored Plan via posted in the PCDU, when any of the following occurs:

(1) A hospital provider requests prior approval for a NC Select Drug, which requires prior approval from the BH I/DD Tailored Plan.

i. The notification by the BH I/DD Tailored Plan shall include the Member identification number, provider, drug name, and anticipated infusion date (if known).

(2) A claim is received by the BH I/DD Tailored Plan for an NC Select Drug.

i. The notification by the BH I/DD Tailored Plan shall include the Member identification number, provider, drug name, infusion date, and claim received date.

(3) A claim is paid by the BH I/DD Tailored Plan for an NC Select Drug.

i. The notification by the BH I/DD Tailored Plan shall include the Member identification number, provider, drug name, and claim payment date.

(b) To support Department reporting to CMS related to NC Select Drug usage, the BH I/DD Tailored Plan shall submit the NC Select Drug Report as described in *Section VII., Fifth Revised and Restated Attachment J: Reporting Requirements*.

d. *Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (10) Medical Professional Drug Claims* is revised and restated as follows with no revisions to subparts 1.-4.:

(10) Medical Institutional and Professional Drug Claims

e. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (10) Medical Professional Drug Claims*** **is revised to add the following:**

v. NC Select Drug List

a) Drugs on the NC Select Drug List, including but not limited to Cell and Gene Therapies (CGTs), which meet the definition of a covered outpatient drug, as defined in 42 C.F.R. § 447.502, are covered under the NC Medicaid Benefit.

i. The NC Select Drug List maintained by the Department can be found by the BH I/DD Tailored Plan here: https://medicaid.ncdhhs.gov/providers/pharmacy-services.

ii. The Department may modify the NC Select Drug List for the inclusion or exclusion of additional drugs.

iii. The BH I/DD Tailored Plan shall reimburse drugs added to the NC Select Drug List according to the reimbursement logic provided in this Section within forty-five (45) Calendar Days of notification from the Department that the NC Select Drug List has been modified.

b) Drugs administered in an inpatient hospital setting shall be reimbursed by the BH I/DD Tailored Plan based on the ingredient component of the NC Select Drug at the Actual Acquisition Cost (AAC) net of all costs, such as, rebates, and discounts, received by the hospital.

c) Drugs administered in an outpatient hospital setting shall be reimbursed by the BH I/DD Tailored Plan based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or Average Sales Price (ASP) net of all costs, such as, rebates, or discounts received by the hospital.

d) Drugs administered in a professional outpatient setting shall be reimbursed by the BH I/DD Tailored Plan based on the ingredient component of the NC Select Drug at the lesser of the Actual Acquisition Cost (AAC) or the Average Sales Price (ASP) net of all costs such as rebates or discounts received by the provider.

e) If the BH I/DD Tailored Plan enters a single case agreement with a non-participating provider related to NC Select Drugs, the BH I/DD Tailored Plan shall ensure that the NC Select Drugs are reimbursed in accordance with the reimbursement methodology described in this Section.

f) NC Select Drugs administered in any setting shall be reimbursed directly to the Network Provider or Non-Participating Provider through which the rendering provider or facility delivers the injection/infusion.

i. The BH I/DD Tailored Plan shall not reimburse point of sale pharmacies, including specialty pharmacies, directly for NC Select Drugs.

g) For inpatient and outpatient services related to administration of NC Select Drugs, the BH I/DD Tailored Plan shall require providers to bill NC Select Drugs separate from services reimbursed based on Diagnosis-Related Group (DRG) or Ratio of Cost to Charge (RCC) rate methodologies. The BH I/DD Tailored Plan shall require claims for NC Select Drugs to be billed by providers with both the HCPCS and NDC listed.

h) The BH I/DD Tailored Plan shall require providers to submit the actual invoice, which reflects the actual acquisition cost paid by the provider or hospital net of any rebates or discounts received by the hospital or provider, to demonstrate the actual drug acquisition cost paid. The BH I/DD Tailored Plan shall ensure that bona fide service fees, meeting the federal definition in 42 C.F.R. § 423.501, are not required to be reported as cost offsets by the provider. Bona fide service fees would be allowable under the federal definition of a service fee.

i. For NC Select Drugs administered in a hospital inpatient, hospital outpatient, or professional outpatient setting, the provider's Chief Executive Officer, Chief Financial Officer, or appropriate designee responsible for billing is required to attest that the net invoice cost reflects the actual costs incurred by the provider for the drug, to include all cost offsets such as rebates received by the provider, or discounts. The provider's designee can attest to the validity of the invoice cost by signing the submitted invoice, including their printed name and title.

i) The BH I/DD Tailored Plan shall not reimburse providers using 340B inventory for drugs on the NC Select Drug List furnished to Members.

j) The reimbursement methodology described in this Section for drugs on the NC Select Drug List is effective for claims reimbursed by the BH I/DD Tailored Plan for dates of service on or after January 1, 2025.

f. *Section V. B. Medicaid, 7. Financial Requirements, i. Capitation Payments, (i)* is revised and restated in its entirety as follows:

(i) Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of BH I/DD Tailored Plans. Capitation payments include monthly PMPM payments, maternity event payments, NC Select Drug Case Payments, and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Medicaid Tailored Plan Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFA. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Medicaid Tailored Plan Draft Rate Book.

g. *Section V. B. Medicaid, 7. Financial Requirements, i. Capitation Payments, (viii)* is revised and restated as follows:

(viii) The Department will reimburse BH I/DD Tailored Plan for additional directed payments to providers as required under *Section V.B.4.iv. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The BH I/DD Tailored Plan is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM, maternity event, and NC Select Drug Case capitation payments. The BH I/DD Tailored Plan shall provide the necessary data to support this process in a format and frequency to be defined by the Department

h. *Section V. B. Medicaid, 7. Financial Requirements, i. Capitation Payments* is revised to add the following:

(ix) The Department has established a separate NC Select Drug Case Payment for certain drugs on the NC Select Drug List as indicated on the rate sheets in *Section IX. Tailored Plan Rate Book* of this Contract, as amended. This payment will be made to the BH I/DD Tailored Plan based on the applicable NC Select Drugs reported as paid claims in the NC Select Drug Report as defined in *Section VII. Fifth Attachment J. Reporting Requirements, as amended* and the corresponding encounter being accepted by the Department through the Encounter Processing System.

(x) The Department will make capitation payments in accordance with the *Payment and Reimbursement* term in *Section III.D.34. PAYMENT AND REIMBURSEMENT*.

i. *Section V. B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio (ii)(b)(2)ii.a)* is revised and restated in its entirety as follows:

a) Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation, NC Select Drug Case Payments, and maternity event payments.

j. *Section V. B. Medicaid, 7. Financial Requirements, iii. Financial Management, (vii)(d)* is revised and restated in its entirety as follows:

(d) The Department will provide expected annual BH I/DD Tailored Plan Medicaid Capitation revenue for use in these calculations. Medicaid capitation revenue will include monthly PMPM capitation payments, NC Select Drug Case Payments, and maternity event payments, but exclude all other managed care payments defined in Section 5.a of the Terms and Conditions (i.e. Tailored Care Management payments, monthly single stream

allocations, additional directed payments to certain providers, and any Healthy Opportunity Pilot program payments.)

k. ***Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (i)(a)*** **is revised and restated in its entirety as follows:**

(a) The Risk Corridor Measurement Period is defined as:
   i. Period 1: July 1, 2024 to June 30, 2025.
   ii. Period 2: July 1, 2025 to June 30, 2026.

l. ***Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (i)(e)vii.*** **is revised and restated in its entirety as follows:**

vii. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation, NC Select Drug Case Payments, and maternity event payments.

m. ***Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (ii) Risk Corridor for Medicaid Expansion Eligible Member Population (b), i.*** **is revised to add the following:**

2. For Period 2: July 1, 2025 to June 30, 2026.

III. Modifications to Section VII. Attachments

a. ***Fourth Revised and Restated Attachment J. Reporting Requirements is revised and restated in its entirety as Fifth Revised and Restated Attachment J. Reporting Requirements and attached to this Amendment.***

IV. Effective Date

This Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, subject to approval by CMS.

V. Other Requirements

Unless expressly amended herein, all other terms and conditions of the Contract, as previously amended, shall remain in full force and effect.

Execution:
By signing below, the Parties execute this Amendment in their official capacities and agree to the amended terms and conditions outlined herein as of the Effective Date.

Department of Health and Human Services, Division of Health Benefits

_____ Date: _____
Jay Ludlam, Deputy Secretary
NC Medicaid

BH I/DD Tailored Plan Name

_____ Date: _____
CEO

Fifth Revised and Restated Attachment J. Reporting Requirements

The following tables detail the reports BH I/DD Tailored Plans must submit to Department. For select reporting requirements, the BH I/DD Tailored Plan is expected to submit a combined report with metrics for Medicaid and State-funded Services as identified in *Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State -funded Services* and *Fifth Revised and Restated Attachment J. Tables 2 BH I/DD Tailored Plan Data Extracts for Medicaid and State-funded Services*.

In addition, the BH I/DD Tailored Plan shall submit select reports that apply to only Medicaid, as identified in *Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *Fifth Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *Fifth Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Alerts and Notifications for Medicaid*.

The BH I/DD Tailored Plan shall also submit select reports that apply only to State-funded Services, as identified in *Fifth Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services*.

1. Although the Department has indicated the reports that are required, BH I/DD Tailored Plan may suggest additional reports.
2. As part of Readiness Review, BH I/DD Tailored Plan shall submit to the Department all reports for approval prior to commencing operations or performing services according to the terms of this Contract.
3. BH I/DD Tailored Plan shall submit complete and accurate data required by the department for tracking information on members and recipients obtaining Medicaid and State-funded Services in BH I/DD Tailored Plan and with provides contracted to provide those services.
    a. This information shall include information on consumer eligibility for services, shadow claims, demographics, adverse events and service outcomes for consumers served by BH I/DD Tailored Plan.
    b. For State-funded Services only, BH I/DD Tailored Plan shall cross-reference all State-funded Services recipients in the Department's Common Name Data Services.
4. BH I/DD Tailored Plan shall submit all data on a schedule provided by the Department.
5. BH I/DD Tailored Plan shall require and monitor the compliance of contract providers to comply with reporting requirements for data that providers submit directly to the Department.
6. BH I/DD Tailored Plan shall implement quality assurance processes to ensure accurate and timely reporting of data submitted by providers directly to the Department.

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Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Administration & Management		
1. Operating Report	Annual report of each entity identified under the BH I/DD Tailored Plan Operating Report, providing evidence of BH I/DD Tailored Plan oversight activities and entity performance (i.e. metrics, CAPs, sanctions).	Annually
B. Members and Recipients		
1. Member and Recipient Services Quality Assurance Report	Quarterly report of survey results which measures member and recipient ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member and Recipient Marketing and Educational Activities Report	Quarterly summary of member and recipient marketing and educational activities, including number/type of events hosted, event locations and number of members and recipients reached.	Quarterly
3. Member and Recipient Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the BH I/DD Tailored Plan including the total number of appeal and grievance requests filed with the BH I/DD Tailored Plan, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly
4. Monthly CWCN	Monthly report containing the names and Medicaid ID numbers, and all data fields as outlined in the approved DHHS CWCN data template of members identified as CWCN per the BH I/DD Tailored Plan's Region.	Monthly
5. Reserved.		
6. Enrollment Summary Report	Monthly summary report highlighting key member and recipient enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid or NC Health Choice eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
7. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver slots and reserved capacity, and list of members on the Registry of Unmet Need (waiting list).	Monthly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
8. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g. SMI, SED), and by setting (e.g. ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
9. TBI In Reach, Diversion, Transition Activity Report	This report is for TBI members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., TBI), and by setting (e.g., CF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities;	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
10. I/DD In Reach, Diversion, Transition Activity Report	This report is for IDD Members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
11. CIE Data Collection Tool	Report generated by completion of the CIE Data Collection Tool provided by the Department, regarding individuals receiving Adult Developmental Vocational Program (ADVP) services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment. This report includes without limitation and as applicable the following information regarding the individuals: involvement in post-secondary education, employment assessments, career planning, Supported Employment, Informed Choice Decision Making, engagement in CIE, and the Member's hire date. For members engaged in CIE, the following data is also included: wages earned, and average hours worked per week.	Quarterly
12. TBI Screening Report	Quarterly report on call center screenings that identify recipients with potential TBI and their access to mental health, SUD, I/DD, or other services.	Quarterly
C. Community Inclusion		
1. Daily Reporting on Community Integration Services and Supports	Daily report of information on community integration services (e.g., housing, in-reach and transition, diversion, Assertive Community Treatment (ACT), CST, supported employment, and other services) for members SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Transition to Community Living Database (TCLD), or other systems determined by the State.	Daily
2. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Daily reporting of rental subsidy information for, including but not limited to, individuals with SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) system.	Daily
3. IDD In Reach, Diversion, Transition Activity Report	This report is for I/DD members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	(e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
D. Providers		
1. Reserved.		
2. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
3. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where members or recipients live.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
5. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
6. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
7. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly until Tailored Plan launch; Quarterly thereafter
8. Reserved.		
9. NEMT Provider Contracting Report	Non emergency provider contracting report at a detailed and summary level from the BH I/DD Tailored Plans.	First and Third Friday each month
E. Quality and Value		
1. Reserved.		
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
F. Stakeholder Engagement		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by BH I/DD Tailored Plan to collaborate with county organizations to address issues by county/Region.	Monthly
G. Program Administration		
1. Service Line Report**	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
2. Service Line Issue Summary Report**	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
5. BH SFS Waitlist / Rate of Institutionalization Report	Quarterly report capturing metrics of individuals being placed on waitlists, including type of services requested, reason for removal from waitlist, and dates of requesting and receiving services.	Quarterly
6. Reserved.		
H. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the BH I/DD Tailored Plan, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by members and recipients, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries Report	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.	

Section VII. Fifth Revised and Restated Attachment J. Table 2: BH I/DD Tailored Plan Data Extracts for Medicaid and State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Providers		
1. Network Data Details Extract (TP)	Quarterly report containing demographic information on network providers. Note: Ad-hoc upon request.	Quarterly
B. Members		
1. Enrollment Extract	Weekly detail report, and underlying data, highlighting key member and recipient enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including enrollment and disenrollment by managed care eligibility category, provider directory, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Weekly

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Members		
1. Reserved.		
2. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
3. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
4. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
5. Nursing Facility Admission Disenrollment Report	Ad-hoc report including the process for a member's disenrollment from a BH I/DD Tailored Plan due to a Nursing Facility stay longer than ninety (90) days.	Ad-Hoc[7]
6. Monthly Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	Monthly
B. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-weekly summary of Members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, Provider name, Provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-Weekly
2. Pharmacy Benefit Determination / Prior Authorization Report	Monthly that lists prior approval requests by individual member, service type, determination date, and approval status.	Monthly
3. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
4. Top GCNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.	Quarterly
5. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
6. Financial Arrangements with Drug Companies Report	Description of all financial terms and arrangements between the Tailored Plan and any pharmaceutical drug manufacturer or distributor.	Annually
7. EPSDT Reports	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.	Quarterly
8. Non-Emergency Medical	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly

[7] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than ten (10) Calendar Days in advance or mutually agreed upon timeframe.*

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
Transportation (NEMT) Report		
9. Annual Prevention and Population Health Report	Annual report of all members outreached, utilization and key program metrics.	Annually
10. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
11. Reserved.		
12. Crossover- Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
13. UM and Clinical Coverage Report	The BH I/DD Tailored Plan shall provide analysis of their compliance with attestation upon request	Ad-Hoc[8]
14. Ongoing Transitions of Care Status Report	Monthly reporting identifying and reconciling data for members who are transitioning to and from the BH I/DD Tailored Plan on an ongoing basis.	Monthly
15. Reserved.		
16. Reserved.		
17. Innovations Waiver Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrated compliance with 1915(c) waiver assurances.	Quarterly
18. TBI Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
19. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(I) state plan performance measures.	Quarterly
20. 1915 Service Authorization Report	Authorized and billed 1915(i), 1915(c), 1915(b)(3) services for community living supports, community networking, supported employment, and supported living.	Quarterly
21. NC Select Drug Report	Report on Members requesting drugs on the NC Select Drug List, the status of PA requests, status of paid claims, time to complete PA reviews, and single case provider agreements.	Quarterly
C. Care Management		
1. CMHRP Corrective Action Plan Report	Quarterly Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.	Quarterly

[2] *Ad-Hoc deliverable, including all data elements and format, will be requested no less than ten (10) Calendar Days in advance or mutually agreed upon timeframe.*

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
2. Care Needs Screening Report	Quarterly report of member screening results, including Healthy Opportunity & Care Needs Screening of members who have opted out of Tailored Care Management or who are ineligible for Tailored Care Management due to receipt of a duplicative service.	Quarterly
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. Reserved.		
5. TCM Provider Contracting and Integration Report	Weekly TCM Provider contracting and integration status report.	Weekly
6. Nursing Facility Transitions Report	Quarterly report listing BH I/DD Tailored Plan members discharged from a nursing facility and to where they were discharged.	Quarterly
7. Reserved.		
8. Reserved.		
D. Reserved.		
1. Reserved		
E. Providers		
1. Reserved.		
2. Reserved.		
3. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.	Annually
4. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. Submit with Timely Access Physical Health Provider Appointment Wait Times Report.	Annually
5. Reserved.		
6. Reserved.		
7. Reserved.		
8. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
9. Reserved.		

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
10. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. BH I/DD Tailored Plans will include records of members where no payment was received from the State or payment received differed from the amount expected. BH I/DD Tailored Plans will only include member records with discrepancies on this report to the State. The BH I/DD Tailored Plan Capitation Reconciliation Report will be submitted on a monthly cadence. BH I/DD Tailored Plans will indicate expected values and values observed on ASC x12 834 monthly file for members.	Monthly
11. Reserved.		
12. PCP Tailored Plan Panel Capacity Limit Report	PCP Tailored Plan Panel Capacity Limit Report.	Weekly until launch and then monthly
F. Quality and Value		
1. Annual Quality Measures Report	Annual BH I/DD Tailored Plan performance on quality measures.	Annually
G. Stakeholder Engagement		
1. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
H. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others. Audited Financial Statements submitted as part of this reporting packet must comply with 42 CFR 438.3(m).	Monthly
2. Reserved.		
3. Reserved.		
4. Claims Monitoring Report	Monthly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were	Monthly

Section VII. Fifth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	
5. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the BH I/DD Tailored Plan template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
6. Emergency Department Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the Emergency Department over thirty (30) consecutive hours, document escalation to appropriate parties including but not limited to BH I/DD Tailored Plan Clinical Director or designee.	Weekly
7. Service Associated Request Report	Tailored Plan decision regarding the service requested on the Request to Move: Provider Form.	Monthly

Section VII. Fifth Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Members		
1. Clearinghouse Daily Uploads Extract	Daily extract of each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan to a member. In accordance with the Notice of Adverse Benefit Determination Clearinghouse Upload Instruction Policy.	Daily
B. Benefits and Care Management		
1. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
2. Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual member, service type, determination date, and approval status.	Weekly
3. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly
4. Reserved.		

Section VII. Fifth Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Medicaid Alerts and Notifications for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. Reserved.		

Section VII. Fifth Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Eligibility		
1. Reserved.		
B. Care Management and Prevention		
1. TBI Services Quarterly Expenditures Report*	Quarterly report on administration of State-funded TBI programming expenditures and associated services.	Quarterly
2. Reserved.		
3. Substance Abuse/Juvenile Justice Initiative Quarterly Report*	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
4. Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a Qualified Professional in Substance Abuse (QPSA).	Quarterly
5. TBI Annual Report	The annual report consists of a combination of both quantitative and qualitative information, which provides a more holistic understanding of service usage, trends and network adequacy for the TBI population within North Carolina's publicly funded service system.	Annually
C. Quality and Value		
1. Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems	Quarterly

Section VII. Fifth Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities. These performance indicators describe an observed level of activity (percent of persons that received a service for a MH, I/DD, or SUD condition or that received a timely follow-up service), but do not explain why the level is as it is. Results do not reveal the substantial "behind-the-scene" activities, processes and interactions involving service providers, LME-MCO and state staff, consumers, and family members, and cannot reveal which factors account for differences in measured levels of quality. Identifying and understanding these factors require additional investigation and may serve as the starting point for program management initiatives or quality improvement efforts. The performance indicators in this report were chosen to reflect: • accepted standards of care, • fair and reliable measures, and • readily available data sources.	
D. Financial Requirements		
1. Financial Status Report	Monthly report containing expenditure categories, allocation letter number, current period expenditures, approved budget, previously reported expenditures, YTD expenditures, and un-expended balance. This report will contain Federal Non-UCR and State Special Categorical expenditures. The Department may request additional submissions of information pertaining to use of these funds on an ad hoc basis.	Monthly
2. Reserved.		
3. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Narrative Compliance Report	Bi-annual narrative report on compliance with target and outcome prevention activities and measures for priority populations, as detailed in the SAPTBG.	Bi-Annual
4. Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR expenditures. This report will contain a certification portion attesting that all information included is accurate.	Monthly

* State-Funded Services-only report should include information related to all SFS recipients, including those who are enrolled in the Tailored Plan program, Medicaid Direct PIHP program, or a SFS program alone.
** Report should include data that represents the activities of both the BH/IDD Tailored Plan contract and the Medicaid Direct PIHP Contract.

Section VII. Fifth Revised and Restated Attachment J. Table 7: BH I/DD Tailored Plan Reporting Requirements for Healthy Opportunities Pilot (Required Only for TPs Participating in the Pilot) (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. Healthy Opportunities Pilot Key Metrics Report	Report of Healthy Opportunities Pilot key metrics, including at a minimum: Members served, services used, total service delivery costs, and Member cost and utilization metrics related to the Healthy Opportunities Pilot.	Quarterly
2. Healthy Opportunities Pilot Capped Allocation Adjustment Report	Optional report that the BH I/DD Tailored Plan may submit if the Department notifies the BH I/DD Tailored Plan that it is at risk of an adjustment to its Healthy Opportunities Pilot capped allocation. The report must explain the BH I/DD Tailored Plan's anticipated spending through the remainder of the Pilot service delivery year.	Optional, or at the discretion of the BH I/DD Tailored Plan
3. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of BH I/DD Tailored Plan Pilot service delivery spending.	Monthly
4. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of BH I/DD Tailored Plan Pilot administrative fund spending.	Quarterly
5. Reserved.		
6. Reserved.		

Section VII. Fifth Revised and Restated Attachment J. Table 8: TCL Reporting Requirements (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due 15th of the month, or the first Business Day following the 15th if the 15th falls on a weekend or holiday.
2. TCL Annual Service Capacity Report	Capacity analysis for ACT, CST, TMS, Crisis Services and IPS. Includes identification of barriers and projects/steps implemented to remove barriers	Annually Fiscal Year 2025
3. TCL Housing Performance Plan Measures Reporting Template	Report tracking TCL Housing Performance Plan Measures. This report indicates measures for each PHIP per quarter based on their reported Tier 1, Tier 2 Expectations, results provided by the BH I/DD Tailored Plan and the Department's verified results.	Quarterly
4. TCL IPS Population and Utilization Report	Report on IPS TCL population and utilization of the service, includes updates on IPS cohorts (as part of ACT and standalone IPS)	Monthly
5. TCL IPS Strategic Plan Progress Report	Report on TCL Strategic Plan progress, includes data required as part of the Department approved IPS Strategic Plan (as part of ACT and standalone IPS)	Quarterly