Amendment Number 2

Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

THIS Amendment to Contract #30-2020-052-DHB-# as amended (Contract), is between the North Carolina Department of Health and Human Services, Division of Health Benefits (Division), and *TP Name* (Contractor), each, a Party and collectively, the Parties.

Background:
North Carolina will launch the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disability Tailored Plan October 1, 2023. This plan is an integrated health plan for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians.

Request for Application #30-2020-052-DHB Behavioral Health and Intellectual/Developmental Disability Tailored Plan (RFA) was issued by the North Carolina Department of Health and Human Services, Division of Health Benefits (Division) on November 13, 2020. The Division awarded this Contract to Contractor on July 26, 2021, to serve as a BH I/DD Tailored Plan. The Parties executed Amendment Number 1 to revise and restate the Contract in its entirety. The purpose of this Amendment Number 2 is to modify existing requirements and incorporate new requirements.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

a. *Section III. A. Definitions.* The following defined terms are revised and restated as identified herein.

1. **1115 Demonstration Waiver:** As defined by Section 1115 of the Social Security Act, state demonstrations that give states additional flexibility to design and improve their programs by demonstrating and evaluating state-specific policy approaches to better serving Medicaid populations. Specifically, North Carolina's amended 1115 demonstration waiver application to the federal Centers for Medicare & Medicaid Services (CMS) focuses on the specific items of the Medicaid Managed Care transformation that require CMS waiver approval (waiver #11-W00313/4).

11. **Appeal**: As relates to Members, has the same meaning as Appeal as defined in 42 C.F.R. 438.400(b).

13. **Area Director:** The Area Director is the administrative head of the BH I/DD Tailored Plan. The Area Director is an employee of and serves at the pleasure of the entity's governing board and shall be appointed in accordance with N.C. Gen. Stat. § 122C-117(a)(7). It is synonymous with Chief Executive Officer (CEO).

21. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid program but who may or may not be enrolled in the Medicaid Managed Care program.

46. **Clean Claim:** A Claim submitted to a BH I/DD Tailored Plan by a service provider that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is suspended, under investigation for fraud or abuse, or a claim under review for medical necessity. 42 C.F.R. § 447.45(b). Determination of whether a claim is a "clean claim" rests with the Contractor and must be determined for each claim, provided applied consistently and reasonably. 85 FR 72754, 72819.

59. **Contract Year:** The period where the BH I/DD Tailored Plan covers services under this Contract for Years 1 – 4 as indicated below:
    a. Contract Year 1: October 1, 2023 through June 30, 2024
    b. Contract Year 2: July 1, 2024 through June 30, 2025
    c. Contract Year 3: July 1, 2025 through June 30, 2026
    d. Contract Year 4: July 1, 2026 through September 30, 2027

63. **Cross-over Population:** Refers to North Carolina Medicaid beneficiaries that are enrolled in the NC Medicaid Direct program and will transition to Medicaid Managed Care at a specific date determined by the Department.

81. **Enrollment:** The process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, BH I/DD Tailored Plan, Medicaid Direct PIHP, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid benefits through the Medicaid Managed Care program.

85. **Exclusion Lists**: Lists the BH I/DD Tailored Plan must check to ensure that the BH I/DD Tailored Plan does not pay federal funds to Excluded Person(s) or entities, including:
    a. State Excluded Provider List;
    b. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
    c. The System of Award Management (SAM);
    d. The Social Security Administration Death Master File (SSADMF);
    e. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
    f. Office of Foreign Assets Control (OFAC).

89. **Fee-for-Service:** A payment model in which Providers are paid for each services provided. NC Medicaid's Fee-for-Service program is also known as Medicaid Direct.

96. **Healthy Opportunities Pilot Program (the Pilot program or Pilot)**: The Enhanced Case Management and Other Services Pilot Program authorized by North Carolina's 1115 Demonstration waiver, referred to as the "Healthy Opportunities Pilot Program." The Pilot program will evaluate the effectiveness of a set of select, evidence-based, non-medical interventions and the role of the Network Lead on improving health outcomes and reducing healthcare costs for high-need Medicaid Members. The Healthy Opportunities Pilot Program refers to the overall Pilot program.

102. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a). In North Carolina, an IHCP is a provider of service which includes all services that Cherokee Indian Hospital Authority or the Eastern Band of Cherokee Indians offer under Medicaid.

109. **Lead Pilot Entity:** Has the same meaning of Healthy Opportunities Network Leads.

123. **Medicaid Managed Care (MMC):** North Carolina's program under which contracted Managed Care Organizations arrange for integrated medical, physical, pharmacy, behavioral and other services to be delivered to Medicaid enrollees. Medicaid Managed Care will include three types

of plans: (1) Standard Plans, (2) BH I/DD Tailored Plans, and (3) Statewide Foster Care Plan. The use of Medicaid Managed Care is also inclusive of EBCI Tribal Option, operating as a primary care case management entity (PCCMe).

130. **Members:** Medicaid Beneficiaries specifically enrolled in and receiving benefits through the BH I/DD Tailored.

138. **NCTracks**: The Department's multi-payer Medicaid Management Information System (MMIS). NCTracks adjudicates claims for multiple NC DHHS divisions, including DHB, DMH/DD/SAS, Division of Public Health, and Office of Rural Health. NCTracks also serves as a central repository for Medicaid and State-funded Services Provider, Member and Recipient data.

144. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department's integrated case management system that provides eligibility and enrollment for Medicaid, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.

145. **Reserved**.

175. **Provider Enrollment:** The process by which a Provider is enrolled in the North Carolina's Medicaid or State-funded Services programs with credentialing as a component of enrollment. A Provider who has enrolled in North Carolina's Medicaid programs (or both) shall be referred to as a "Medicaid Enrolled provider" or an "Enrolled Medicaid provider." A provider who has enrolled in North Carolina's State-funded Services program shall be referred to as a "State-funded Services Enrolled provider" or an "Enrolled State-funded Services provider."

185. **Redeterminations:** The annual review of Beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid.

191. **Settlement Agreement:** Means the court-enforceable Settlement Agreement between the United States and the State of North Carolina files with the Court on August 23, 2012 and modified in October 2017 and which created the Transition to Community Living (TCL) program.

227. **1915(i) Services:** The Section 1915(i) SPA - Home and Community-Based Services (HCBS) for eligible members that the BH I/DD Tailored Plan offers in the geographic area covered by this Contract.

228. **Designated Pilot Care Management Entity:** The entity assuming care management responsibilities specifically related to the Healthy Opportunities Pilots. For the purposes of this Agreement, Designated Pilot Care Management Entities shall include, but shall not be limited to:
    a. The BH I/DD Tailored Plan;
    b. Advanced Medical Home Plus (AMH+) practices; and
    c. Care Management Agencies (CMAs).

229. **Episode of Care:** A treatment or intervention covered under the Tailored Plan benefit, initiated prior to NC Medicaid Managed Care Tailored Plan Launch and evidenced by a current treatment plan, which is related to a Member's condition or circumstance and is provided to the Member by the non-participating provider within the first sixty (60) Calendar Days after Tailored Plan Launch.

230. **Healthy Opportunities Network Lead (Network Lead):** Formerly known as a Lead Pilot Entity (LPE), a Network Lead is an organization contracted with the Department to create and oversee a network of HSOs for the Healthy Opportunities Pilot. A Network Lead serves as a connection

between BH I/DD Tailored Plans and HSOs and facilitates collaboration between health care and human service organizations for the Pilot.

231. **Independent Assessment:** Required assessment of needs used to establish a service plan for 1915(i) services. 42 C.F.R. § 441.720.

232. **Independent Evaluation:** Required evaluation used to determine eligibility for 1915(i) services. The Department shall provide a standardized tool to be used for the required independent evaluation. 42 C.F.R. § 441.715(d)

233. **Indian Managed Care Entity (IMCE):** Means an ICME as defined by 42 C.F.R. § 438.14(a). In North Carolina, the IMCE is referred to as the Eastern Band of Cherokee Indian Tribal Option. It provides care management for all members enrolled in Tribal Option and is separate from the Indian Health Care Provider.

234. **Interpersonal Violence (IPV)-Related Healthy Opportunity Pilot Services (IPV-Related Services):** Any services authorized to be furnished under the Healthy Opportunities Pilot to Members experiencing or at risk of experiencing interpersonal violence or other threats to personal safety, not only including services described in the Interpersonal Violence/Toxic Stress domain and the Cross-Domain categories of the Healthy Opportunities Pilot fee schedule, but also include any services in the Housing, Food, or Transportation domains set forth in the Healthy Opportunities fee schedule that are recommended to a Member to help address interpersonal violence. The Healthy Opportunities Pilot fee schedule is located at https://www.ncdhhs.gov/media/14071/open as amended from time to time.

235. **IPV-Related Service Data:** Any authorizations, Services, data, information, reports, invoices, or other sources of information relating to or referencing IPV-Related Services authorized to be furnished to a Member or actually furnished to a Member.

236. **IPV-Trained Individual:** All members of the PHP's workforce (including PHP's employees and contractors, whether or not they are Care Managers) with access to IPV-Related Service Data who have completed all Pilot-related IPV-trainings provided or approved in advance by the Department.

237. **IPV-Related Data Training:** All relevant trainings, each as provided or approved in advance by the Department, prior to PHP's workforce initiating a Member contact or an initial Pilot assessment.

238. **Pilot Eligibility and Service Assessment (PESA):** A Department-standardized tool in NCCARE360 that facilitates the documentation of a member's eligibility for the Healthy Opportunities Pilot and Pilot services, and the authorization of Pilot services.

239. **Pilot Implementation Period:** A period of time during which BH I/DD Tailored Plans, Network Leads, HSOs, and Designated Pilot Care Management Entities build the capacity and infrastructure to participate in the Healthy Opportunities Pilot and prepare for Pilot service delivery.

240. **Pilot Service Delivery Period: A** period of time during which Healthy Opportunities Pilot services are delivered to Pilot enrollees. The Pilot Service Delivery Period is divided into sub-periods to align with State Fiscal Years.

241. **Work Hour:** Includes each traditional work hour of a Business Day.

b. *Section III. B. Abbreviations and Acronyms.* The following acronyms are modified or new and incorporated into the Contract:

i. Modified Acronyms:

38. Reserved
150. Reserved
181. PIP: Performance Improvement Project
189. QAPI: Quality Assessment and Performance Improvement
221. TCL: Transitions to Community Living

ii. New Acronyms:

235. ACGME: Accreditation Council for Graduate Medical Education
236. ANSA: Adult Needs and Strengths Assessment
237. IDM Tool: Informed Decision Making Tool
238. IPV: Interpersonal violence
239. PESA: Pilot Eligibility and Service Assessment
240. PHE: Public Health Emergency
241. TCM: Tailored Care Management
242. QMIP: Quality Management and Improvement Plan

c. *Section III. C. Contract Term and Service Commencement* is revised and restated in its entirety as follows:

1. The Contract Term will be from July 26, 2021, through September 30, 2027, and shall include an implementation period and Contract Years 1 through 4 as follows:

Contract Period	July 26, 2021 through September 30, 2027
Implementation Period	July 26, 2021 through September 30, 2023
Contract Year 1	October 1, 2023 through June 30, 2024
Contract Year 2	July 1, 2024 through June 30, 2025
Contract Year 3	July 1, 2025 through June 30, 2026
Contract Year 4	July 1, 2026 through September 30, 2027

d. *Section III. D. General Terms and Conditions,* ***11: CONTRACT ADMINISTRATORS:*** *For the Department, Department's HIPAA and Policy Coordinator for all Federal, State, and Department privacy matters:* is revised and restated in its entirety as follows:

Name & Title	Andrew A. Albright Privacy Officer
Physical Address	1985 Umstead Drive, Kirby Building Raleigh, NC 27603
Mail Service Center Address	2501 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7749
Email Address	Andrew.a.albright@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

e. *Section III. D. General Terms and Conditions,* ***29. MEDIA CONTACT APPROVAL AND DISCLOSURE*** is revised and restated in its entirety as follows:

29. MEDIA CONTACT APPROVAL AND DISCLOSURE: Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract, the Contractor shall contact the Department as soon as practical. Contractor must submit any proposed media release regarding the terms of this Contract to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure, to the extent practicable. The Department may, to the extent reasonable and lawful, timely object to its publication or require changes to the information intended for public release. The requirements of this Section shall not apply to any information the Contractor is required by law or by any court of competent jurisdiction to disclose.

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

34. PAYMENT AND REIMBURSEMENT:

a. **BH I/DD Tailored Plan Payments:** The Department will make the following payments to the Contractor, as applicable:
   i. Monthly per member per month (PMPM) capitated payments;
   ii. Maternity event payments;
   iii. Tailored Care Management payments;
   iv. Additional directed payments to certain providers;
   v. Healthy Opportunities Pilot Program payments;
   vi. Monthly Single Stream Fund Base allocation;
   vii. Tailored Care Management Capacity Building Performance Incentive Payments; and
   viii. COVID-19 Vaccine Administration and Testing reimbursements.

b. **PMPM Capitated Payments**
   i. The Contractor must accept capitation rates methodology developed by the Department and its actuary and approved by CMS as follows:
      a. The Department will send the Contractor a written Notification of CMS Approved Capitation Rates (Notification of Approved Rates) within ten (10) State Business Days of receipt of CMS approval of the capitation rates for a Contract Year or other applicable rating period. The Notification of Approved Rates will be incorporated into the Contract as though originally set forth herein.
   ii. Capitated payments shall be made on a PMPM, prospective basis at the first check-write of each month, unless another schedule is set by the Department.
   iii. The Department will make PMPM capitation payments to the Contractor based on the number of members in each rate cell (as defined in the Rate Book applicable to the rating period and as determined by the monthly cutoff date in Medicaid Eligibility data system). The payment amount will be pro-rated for partial-month enrollment.
   iv. PMPM capitation payments will be reconciled on a regular schedule to account for enrollment and eligibility changes not reflected in the initial monthly payment to the Contractor and may result in changes to a subsequent monthly capitation payment.

Additional details on reconciliation can be found in *Section V.B.8. Technical Specifications*.

v. The PMPM capitated rates are specified in the Rate Book. However, capitated payments shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements at 42 C.F.R. § 438.730.

c. **Maternity Event Payments**: 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.

d. **Tailored Care Management Payments**: The Department will make payments to the Contractor to support Tailored Care Management. The Contractor will make the following payments to certified AMH+ practices and Care Management Agencies for Tailored Care Management in accordance with Section V.B.4.e. Provider Payments:

i. Tailored Care Management payment per member per month in which the AMH+ or CMA performed Tailored Care Management. Payment will be at a fixed rate and acuity-tiered. It will not be placed at risk.

e. **Additional Directed Payments for Certain Providers**: The Department will make payments to the Contractor to support additional, utilization-based, directed payments to certain providers as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) and in accordance with *Section V.B.4.iv. Provider Payments*.

f. **Healthy Opportunities Pilot Program**: If the Contractor covers a Catchment Area that includes a Healthy Opportunity Pilot and provides Healthy Opportunity Pilot services under the Contract, the Contractor shall receive, separate from capitation payments and subject to availability, the following funds from the Department to use for the Pilot Program:

i. Capped Allocation

a. The Department will set an initial capped allocation amount for each Pilot Service Delivery Period as defined in the Department's Healthy Opportunities Pilot Payment Protocol.

b. The Department will notify Contractor of its capped allocation amount, including the amounts for Pilot service delivery payments and Pilot administrative payments, at least thirty (30) Calendar Days prior to the start of each Pilot Service Delivery Period.

c. The Department reserves the right to adjust Contractor's capped allocation during the Pilot Service Delivery Period based on actual spending on Pilot services or due to significant changes to enrollment from that assumed in the allocation formula (e.g., if the Department determines Contractor is at significant risk of not expending eighty percent (80%) of its allocation within the Pilot Service Delivery Period).

1. Before adjusting Contractor's capped allocation, the Department will inform Contractor within sixty (60) Calendar Days that it is at risk of an adjustment and allow Contractor to submit a report explaining its anticipated spending through the remainder of the Pilot Service Delivery Period for the Department's consideration. Contractor shall submit this report within ten (10) Calendar Days of being informed by the Department that it is at risk of an adjustment.

d. Pilot Service Delivery Payments
    1. The Department shall distribute monthly, prospective payments to Contractor from the Pilot service delivery payment component of its capped allocation.
    2. The Department shall distribute the first payment at least thirty (30) Calendar Days prior to the Pilot Service Delivery Period.
e. Pilot Administrative Payments:
    1. The Department shall distribute, as part of Contractor's capped allocation, Pilot administrative payments for Contractor to retain to cover administrative costs associated with Pilot operations.
    2. The Department shall determine the amount of Contractor's Pilot administrative payments.
    3. The Department shall distribute the Pilot administrative payment for each Pilot Service Delivery Period at a frequency as defined in the Department's Healthy Opportunities Pilot Payment Protocol.
f. Pilot Care Management Payments:
    1. The Department shall make fixed payments to Contractor, and Contractor shall make Pilot care management payments to Designated Pilot Care Management Entities. The Department will determine Pilot care management payments and document them in the Department's Healthy Opportunities Pilot Payment Protocol.
g. Pilot Value-Based Payments:
    1. The Department shall establish a Pilot-specific value-based payment (VBP) program.
    2. The Contractor will be eligible to receive separate Pilot-specific value-based payments from the Department. Payment will be made after the Department has reviewed documentation of the Contractor's performance against the targets and benchmarks. The value-based payments made by the Department to Contractor will be subject to adjustments in accordance with the Department's assessment of Contractor's performance against specific targets and benchmarks to be detailed in the Department's Healthy Opportunities BH I/DD Tailored Plan Implementation Period Incentive Payments Milestone Guide.
    h. The Contractor shall participate in the reconciliation of actual Pilot spending against Pilot payments received from the Department and be required to return all unused Pilot funds to the Department at the end of the Pilot program in accordance with the Department's Healthy Opportunities Pilot Payment Protocol.

g. **Monthly Single Stream Fund Base allocation:** DMH/DD/SAS shall distribute to Contractor not less than one twelfth (1/12) of Contractor's Single Stream Fund (SSF) continuing allocation on a monthly basis, subject to adjustments and availability of funds allocated by the General Assembly for this purpose.

h. **Payment in Full**:
    i. The BH I/DD Tailored Plan shall accept BH I/DD Tailored Plan Payments under this Section as payment in full for the services provided under Contract, unless otherwise specified by the Contract.
    ii. Members shall be entitled to receive all covered services as provided in *Section V.B.2.i. Physical Health, Behavioral Health, and I/DD Benefits Package* for the entire period for which payment has been made by the Department.

i. **Payment Adjustments**: Payment adjustments may be initiated by the Department based on the eligibility and enrollment reconciliation or when keying errors or system errors affecting correct BH I/DD Tailored Plan Payments to the Contractor occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying information and the payment adjustment amount.

j. **Overpayment and Recoupment**:
   i. If the Contractor erroneously reports (intentionally or unintentionally), fraudulently reports, or knowingly fails to report any information affecting BH I/DD Tailored Plan Payments to the Contractor, and is consequently overpaid, the Department may request a refund of the overpayment or recoup the overpayment by adjusting payments due in any one or more subsequent months.
   ii. The Department may also recoup erroneous overpayments made to the Contractor as a consequence of keying errors or system errors. Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying member information and the recoupment amount.
   iii. The Department shall provide at least ten (10) Calendar Days' notice to Contractor of its intent to recoup overpayments and shall offer Contractor the opportunity to contest any such alleged overpayments. If the Parties cannot come to agreement, the Contractor may utilize the Dispute Resolution process described in this Contract. The Department shall not take any collection action under this Contract, including recoupment while the dispute is pending and unresolved, unless otherwise allowed by law.

k. **Other BH I/DD Tailored Plan Payment Terms and Conditions**:
   i. Payment will only be made for services provided and is contingent upon satisfactory performance by the Contractor of its responsibilities and obligations under the Contract.
   ii. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other or adjustments as described in *Section V.B.5.i. Quality Management and Quality Improvement* and *Section VI. Contract Performance for Medicaid and State-funded Services* to any payment due to Contractor.
   iii. The Contractor is responsible for all payments to its Subcontractors under the Contract. The Department shall not be liable for any purchases or Subcontracts entered into by the Contractor or any subcontracted Provider in anticipation of funding.
   iv. All payments shall be made by electronic funds transfers. Contractor shall set up the necessary bank accounts and provide written authorization to Medicaid's Fiscal Agent to generate and process monthly payments.
   v. Contractor shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).
   vi. Contractor shall maintain separate accounting for revenue and expenses for payments under this Contract in accordance with CMS requirements.

l. **Third-Party Resources**:

   The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties for some of the services rendered to members. As required in *Section V.A.3.iv. Third Party Liability (TPL) for Medicaid* the Contractor shall be responsible

for actively seeking and identifying the liability of third parties and engaging in third party resource recovery and cost avoidance to pay for services rendered to members pursuant to this Contract. All funds recovered by the Contractor from third party resources shall be treated as income to Contractor.

m. **Tailored Care Management Capacity Building Performance Incentive Program Payments**

i. Beginning in Contract Year 1, and in accordance with 42 C.F.R. § 438.6(b)(2), the Contractor will be eligible to receive quarterly Tailored Care Management Capacity Building Performance Incentive Program payments for the achievement of certain milestones specified in *Section.V.B.7.* and aligned with the Department's quality strategy.

a. Incentive payments will be separate from and in addition to the capitation payments made to the Contractor under this Contract and will be specifically identified as the "performance incentive payment" in any distribution to the Contractor.

b. The incentive payment is not premium revenue and will not be considered as such for purposes of calculating the Contractor's Medical Loss Ratio or premium tax liability.

c. In no event will payments exceed five percent (5%) of total capitation revenue that the Contractor receives during the Contract Year.

d. Eligibility to participate in the Performance Incentive Program is not linked to whether the Contractor is a public or private entity or whether the Contractor has provided an intergovernmental transfer to the Department.

e. Payments are for performance on a quarterly basis under the Contract Year in which the performance incentive arrangement is applied.

f. The program will not be renewed automatically, but DHHS may include the program in subsequent Contract Years. The Department will notify the Contractor ninety (90) Calendar Days prior to the start of the Contract Year whether the program will be in effect for that Contract Year.

g. *Section III. D. General Terms and Conditions,* ***35. PERFORMANCE BOND*** is revised and restated in its entirety as follows:

35. PERFORMANCE BOND:

a. The BH I/DD Tailored Plan shall furnish a performance bond to the Department within thirty (30) Calendar Days after award of the Contract. This security will be in the form a surety bond licensed in North Carolina with an A.M. Best's rating of no less than A-.

b. The amount of the performance bond shall be a minimum of $10,000,000 adjusted upwards based on the overall population in each Catchment Area as calculated using the 2018 population data by county in which the BH I/DD Tailored Plan is awarded a Contract as set forth in the table below. If a BH I/DD Tailored Plan is awarded a Contract in multiple Catchment Areas, then BH I/DD Tailored Plan shall furnish a single bond for the total amount. The 2018 county population information can be found at https://files.nc.gov/ncosbm/demog/countytotals_2010_2019.html.

Population Range	Performance Bond
1 - 1,500,000	$10,000,000
1,500,001 – 2,500,000	$15,000,000
2,500,001 – 3,500,000	$20,000,000
3,500,001 – 4,500,000	$25,000,000

4,500,001 – 5,500,000	$30,000,000
5,500,001 – 6,500,000	$35,000,000
6,500,001 –7,500,000	$40,000,000
7,500,001 – 8,500,000	$45,000,000
8,500,001 – 9,500,000	$50,000,000
9,500,001 – 10,500,000	$55,000,000

c. Reserved.
d. The BH I/DD Tailored Plan shall bear the cost of the performance bond.
e. The performance bond must be made payable to the North Carolina Department of Health and Human Services.
f. The Contract number and Contract period must be specified on the performance bond.
g. For as long as the BH I/DD Tailored Plan has liabilities of $50,000 or more outstanding under this Contract, or fifteen (15) months following the termination date of this Contract, whichever is later, the performance bond must be maintained to guarantee payment of the BH I/DD Tailored Plan's obligations.
h. In the event of a default by the BH I/DD Tailored Plan, the Department shall obtain payment under the performance bond for the purposes of the following:
    i. Paying any damages sustained by Providers, non-contracting providers, non-providers, and other subcontractors by reason of a breach of the BH I/DD Tailored Plan's obligations under this Contract;
    ii. Reimbursing the Department for any payments made by the Department on behalf of the BH I/DD Tailored Plan, including payment of the BH I/DD Tailored Plan's obligations to Providers;
    iii. Reimbursing the Department for any administrative expenses incurred by reason of an uncured breach of the BH I/DD Tailored Plan 's obligations under this Contract, including expenses incurred after termination of this Contract; and
    iv. In the event the BH I/DD Tailored Plan terminates the Contract prior to the end of the Contract period, a claim against the bond may be made by the Department to cover cost of issuing a new solicitation and selecting a new BH I/DD Tailored Plan or transitioning members to another BH I/DD Tailored Plan.

h. *Section III. D. General Terms and Conditions,* ***46. TERMINATION,*** *b. Termination without Cause* is revised and restated in its entirety as follows:

b. Termination without Cause:

This Contract may be terminated, in whole or in part, without cause by the Department by giving at least one hundred and eighty (180) Calendar Days' prior written notice to the other Party. The termination shall be effective at 11:59:59 p.m. on the last day of the calendar month in which the one hundred and eighty (180) Calendar Days' notice period expires. In the event of termination without cause:

i. Department and Contractor shall work together on a daily basis in good faith to minimize any disruption of services to Members;
ii. Contractor shall perform all of the Contractor transition and other obligations specified in the Contract;
iii. Department and Contractor shall resolve any outstanding obligations under this Contract; and
iv. Contractor shall pay Department in full any refunds or other sums due to Department under this Contract.

i. *Section III. D. General Terms and Conditions,* ***46. TERMINATION,*** *c. Termination for Cause, i.* is revised and restated in its entirety as follows:

i. In accordance with 42 C.F.R. § 438.708, Department shall have the right to terminate this Contract with Contractor and to enroll Contractor's members in other managed care plans if Department determines that Contractor has materially breached (and subsequently failed to cure) this Contract or has failed to meet applicable requirements in Sections 1905(t), 1903(m), and/or 1932 of the Social Security Act.

j. *Section III. D. General Terms and Conditions,* ***46. TERMINATION,*** *c. Termination for Cause, viii.* is revised and restated in its entirety as follows:

viii. Reserved.

k. *Section III. D. General Terms and Conditions,* ***49. USE OF THIRD PARTY ADMINISTRATOR*** is revised and restated in its entirety as follows:

49. USE OF THIRD PARTY ADMINISTRATOR: If Contractor uses the services of a Third Party Administrator (TPA) to adjust or settle claims for members, then the Contractor shall do all of the following contingent upon a change in state-law to require the BH I/DD Tailored Plan be licensed as a Prepaid Health Plan (PHP) set forth by the North Carolina Department of Insurance (DOI), as outlined in Article 93 of Chapter 58 of the N.C. General Statutes:

a. Ensure the TPA has a current license issued by, and is in good standing with DOI, as required by N.C. Gen. Stat. §§ 58-56-2(5) and 58-56-51;
b. Have a written agreement with the TPA that is compliant with Article 56 of Chapter 58 of the General Statutes, as applicable, and includes a statement of the duties the TPA is expected to perform on behalf of the Contractor, as specified in N.C. Gen. Stat. § 58-56-6;
c. Establish the rules, in accordance with this Contract, pertaining to claims payment and shall provide the TPA with the rules in accordance with N.C. Gen. Stat. § 58-56-26; and
d. Submit to the Department an attestation that the Contractor understands it is solely responsible to provide for competent administration of its claims under the Contract, as provided in N.C. Gen. Stat. § 58-56-26.
e. Notwithstanding the contingency statement above, the Contractor shall do all of the following until such time that state law requires the BH I/DD Tailored Plan to be licensed as a Prepaid Health Plan (PHP) as set forth by the North Carolina Department of insurance:
    i. Have a written agreement with the TPA that at a minimum includes a statement of the duties the TPA is expected to perform on behalf of the Contractor; and
    ii. Include specific provisions in Contractor's written agreement with the TPA outlining Contractor's requirements for claims payment, in accordance with the requirements of this Contract.

l. *Section III. D. General Terms and Conditions,* ***50. WAIVER*** is revised and restated in its entirety as follows:

50. WAIVER: The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance. The Department reserves the right to waive any of the requirements in this Contract by providing written notice of such waiver to Contractor. In order to constitute a waiver, said waiver must be entitled "Waiver of Contract Requirements," list the specific requirement(s) being waived, the timeframe for such waiver, and be signed and dated

by the Deputy Secretary for the Division of Health Benefits. For avoidance of doubt or dispute, there shall be no tacit, de facto, verbal, informal, or written waivers signed by anyone other than a Deputy Secretary of the Department. Without such explicit written and signed "Waiver of Contract Requirements" document, the waiver is not effective.

m. *Section III. E. Confidentiality, Privacy and Security Protections, 2. Confidential Information* is revised and restated in its entirety as follows:

2. Confidential Information
   a. The Contractor, its agents, and its Subcontractors shall maintain the privacy, security and confidentiality of all data information, working papers, and other documents related to the performance of the Contract, including information obtained through its performance under the Contract, that meets the conditions for confidentiality under NCGS 132-1.2, is otherwise protected by law or applicable policy as confidential, or is identified by the Department as confidential, or not for release; i.e. confidential information. Any use, sale, or offer of confidential information associated with the performance of the Contract except as contemplated under the Contract or approved in writing by the Department shall be a violation of the Contract. Any such violation will be considered a material breach of the Contract. Contractor specifically warrants that it, its officers, directors, principals, employees, any Subcontractors, and approved third-party contractors shall hold confidential information received from the Department during performance of the Contract in the strictest confidence and shall not disclose the same to any third party except as contemplated under the Contract or approved in writing by the Department.
   b. Contractor warrants that all its employees, Subcontractors, and any approved third-party Contractors are subject to a non-disclosure and/or confidentiality agreement or provisions that is/are enforceable in North Carolina and sufficient in breadth to include and protect confidential information related to the Contract. The Contractor shall, upon request by the Department, verify and produce true copies of any such agreements/provisions. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C. Gen. Stat. § 132-1 et. Seq. The Department may provide a lawful, reasonable non-disclosure and confidentiality agreement for the Contractor's execution. The Department may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including but not limited to 26 U.S.C. 6103, SSA, and IRS Publication 1075 (Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities), HIPAA, and implementing regulation in the Code of Federal Regulations and any future regulations imposed upon the Department of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.
   c. The Department, State auditors, State Attorney General, federal officials as authorized by federal law or regulations, and State officials as authorized by State law or regulations, as well as the authorized representatives of the foregoing, shall have access to confidential information in accordance with the requirements of State and federal laws and regulations. No other person or entity shall be granted access to confidential information unless State and federal laws and regulations allow such access. The Department has the sole authority to determine if and when any other person or entity has properly obtained the right to have access to any confidential information and whether such access may be granted. Use or

disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.

d. The Contractor warrants that without prior written approval of the Department, the Contractor shall not incorporate confidential or proprietary information of any person or entity not a Party to the Contract into any materials furnished to the Department, nor without such approval shall the Contractor disclose to the Department or induce the Department to use any confidential or proprietary information of any person or entity not a Party to the Contract.

e. The foregoing confidentiality provisions do not prevent the Contractor from disclosing information that (i) at the time of disclosure by the Department is already known by the Contractor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Contractor other than an act that is authorized by the Department or applicable law, (iii) is rightfully received by Contractor from a third party and Contractor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the Department, (iv) is independently developed by the Contractor without use of the Department's confidential information, (v) is disclosed without similar restrictions to a third party by the Department, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Contractor, to the extent possible provides the Department with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

n. *Section III. E. Confidentiality, Privacy and Security Protections, 10. Privacy and Security Incidents and Breaches, b.* is revised and restated its entirety as follows:

b. Contractor shall report privacy and significant cybersecurity incidents as defined by N.C.G.S. § 143B-1320(a)(16a) (whether confirmed or suspected) to the Department's PSO Incident Website at the following link, accurate as of May 30, 2023: https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security within twenty-four (24) hours after the incident is first discovered. If a Social Security number has been compromised, the incident must be reported to the Department's PSO within sixty (60) minutes after the incident is discovered.

o. *Section III. G. Dispute Resolution for Contract Compliance, 5.* is revised and restated as follows:

5. If the unresolved dispute appears to impact more than one BH I/DD Tailored Plan, the Department Contract Administrator shall notify Department leadership, who will develop a plan of action with multiple BH I/DD Tailored Plans for resolving the dispute. The goal of the resolution process shall be to resolve all problems before they escalate to the next level. The Department and BH I/DD Tailored Plan Contract Administrators shall schedule telephone or face to face meetings as necessary in order to achieve resolution without conflict where possible.

II. Modifications to Section V. Scope of Services, A. Unified

Specific subsections are modified as stated herein.

a. *Section V. Scope of Services, A. Unified, 1. Administration and Management, i. Medicaid Program and State-funded Services Administration* revised and restated in its entirety as follows:

i. Medicaid Program and State-funded Services Administration

(i) In the State of North Carolina, the Department 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 and the single state authority for the SAMHSA Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant. The Division of Health Benefits (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) program. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the Medicaid program. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is designated with the administration of State-funded mental health, developmental disability, TBI and substance use services.

(ii) In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland and SAMHSA monitors North Carolina's block grant-funded activities.

(iii) The Department has the authority to administer the program in the way outlined in this RFA under the terms of the State's waiver under Section 1115 of the Social Security Act, the 1915(c) Innovations and TBI waivers, and various Medicaid State Plan Amendments.

(iv) The Department will remain responsible for all aspects of the North Carolina Medicaid and State-funded Services system, and will delegate the direct management of certain health services, including physical health, BH, I/DD, pharmacy, LTSS, and TBI services, and financial risks to the BH I/DD Tailored Plan as defined in the Contract. Certain functions delegated to the BH I/DD Tailored Plan pursuant to this Contract are the duty and responsibility of the Department as the grantee of federal grant funds. Nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Department to perform any of the duties assigned to the Department or its Secretary by the North Carolina General Statutes, the terms and conditions of the federal funds and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by the Department to reimburse the BH I/DD Tailored Plan for any of its duties under this Contract. The BH I/DD Tailored Plan will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the BH I/DD Tailored Plan has an adequate Network, delivers high quality care, and operates a successful Medicaid Managed Care program and State-funded Services system.

(v) The BH I/DD Tailored Plan shall work cooperatively with the Department to be good stewards of funds and to ensure effective administration of the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.

(vi) In partnership with the Department, the BH I/DD Tailored Plan shall develop processes and procedures to ensure the BH I/DD Tailored Plan is soliciting stakeholder input, including, but not limited to, input from members and recipients, as applicable, and providers, to drive policy development and continual improvement in the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.

(vii) The BH I/DD Tailored Plan shall provide certification by the Contractor's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting to either the CEO or CFO duly authorized to submit the certification concurrently with the submission of all data, documentation, or information requiring such certification under federal and state law and under this Contract to the Department that such information is accurate, complete and truthful. For Medicaid Managed Care, the BH I/DD Tailored Plan shall provide such certification in accordance with 42 C.F.R. § 438.606.

(viii) The BH I/DD Tailored Plan shall cooperate with the Department in the administration of North Carolina's federal Medicaid waivers (e.g., Section 1115, 1915(c), and other active waivers)

including providing reporting and data, engaging with the Department's External Evaluators, and supporting waiver-required stakeholder engagement.

(ix) The BH I/DD Tailored Plan shall comply with the following Department policies and any other Department policy as directed. The Department may amend policies and shall provide updated versions to the BH I/DD Tailored Plan at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The BH I/DD Tailored Plan shall have the opportunity to review and provide feedback prior to finalization. The following is a non-exhaustive list of policies for which the Department will provide a notice and comment period as described in this subsection:

(a) North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy;
(b) Advanced Medical Home Program Policy for Medicaid Members;
(c) AMH+ Practice and CMA Certification Policy;
(d) Pregnancy Management Program Policy for Medicaid Members;
(e) Care Management for High-Risk Pregnancy Policy for Medicaid Members;
(f) Care Management for At-Risk Children Policy for Medicaid Members;
(g) Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers;
(h) Management of Inborn Errors of Metabolism Policy for Medicaid Members;
(i) Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients Policy;
(j) NC Non-Emergency Medical Transportation Managed Care Policy;
(k) PCP Assignment Requirements Policy;
(l) Tribal Payment Policy;
(m) BH I/DD Tailored Plan Member Advisory Committee Guidance;
(n) Managed Care Clinical Supplemental Guidance; and
(o) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions.

(x) When reasonable, under these unified provisions, State-funded Services for which federal regulations do not apply, Contract reference to such regulation sets a requirement standard for State-funded services that must be met by the Contractor regardless of regulatory applicability.

b. *Section V. Scope of Services, A. Unified, 1. Administration and Management, iv. Third Party (Subcontractor) Contractual Relationships, (ii), (g)* is revised and restated in its entirety as follows:

(g) The BH I/DD Tailored Plan is required to have a single Medicaid Provider Network directory, encompassing all providers regardless of service type, available in both electronic and paper versions. See *Section V.B.4.ii. Provider Network Management* and *Section V.B.8.v. Provider Directory* for more information.

c. *Section V. Scope of Services, A. Unified, 1. Administration and Management, vi. Readiness Review Requirements, (vi), (e)* is revised and restated in its entirety as follows:

(e) Terminate this Contract in accordance with *Section III, D.46.* ***TERMINATION***.

d. *Section V. Scope of Services, A. Unified, 1. Administration and Management, ix. Staffing and Facilities for Medicaid and State-funded Services, (xiii) Organization Roles and Positions, (g)* is revised and restated as follows:

(g) BH I/DD Tailored Plan staff with prior professional experience providing diversion, in-reach or transition services under TCL who do not meet the minimum credentials for "Transition Coordinator" or "Diversion Specialist" as defined in *Section VII. Third Revised and Restated Attachment A. Second Revised and Restated Table 1: BH I/DD Tailored Plan Organization Roles and Positions* shall be permitted to fill the "Transition Coordinator" or "Diversion Specialist" role**.**

e. *Section V. Scope of Services, A. Unified, 1. Administration and Management, ix. Staffing and Facilities, (xiv) Physical Presence in North Carolina, (e)* is revised and restated to add (31) as follows:

(29) Liaison to the DSS;
(30) Waiver Contract Manager; and
(31) Olmstead Manager.

f. *Section V. Scope of Services, A. Unified, 1. Administration and Management, ix. Staffing and Facilities, (xv) Conflict of Interest, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall undertake reasonable actions to verify that employees or Subcontractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the North Carolina Medicaid program~~s~~, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.

g. *Section V. Scope of Services, A. Unified, 1. Administration and Management* revised to add the following:

x. COVID-19 Public Health Emergency Response and Unwinding
   (i) During the ongoing response to the Coronavirus-19 (COVID-19) pandemic, it is critical that the Department work with Contractor to institute efforts to keep Members healthy by taking steps to protect Members from infectious disease, providing access to testing, treatment and vaccine administration for COVID-19, ensuring care for ongoing chronic or acute conditions, and supporting Members and providers through the COVID-19 Public Health Emergency Unwinding.
   (ii) The BH I/DD Tailored Plan shall comply with all Department COVID-19 Policy Flexibilities, including modifications to NC Medicaid Clinical Coverage Policies and other modifications under State authority, and modifications under Federal authority as approved by the Centers for Medicare and Medicaid Services (CMS) and implemented by the Department and as communicated through applicable Special COVID-19 Bulletins and Letters to Managed Care CEOs issued by the Department.
   (iii) The BH I/DD Tailored Plan shall be responsible for ensuring that all guidance, trainings and technical assistance it provides to Members and providers are consistent with Federal and/or State guidance.
   (iv) The BH I/DD Tailored Plan shall comply with *Section VII. Attachment M.14. COVID-19 Public Health Emergency Managed Care Policy.*

h. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (iv)* and *Section V.A.2.a. First Revised and Restated Table 1: Member, Recipient, and Provider Support Call Center Operations* are revised and restated in its entirety as follows:

(iv) The BH I/DD Tailored Plan shall adhere to the Department's hours of operations, location, and staffing and member ID requirements for each service line as described in *Section V.A.2.a. Second Revised and Restated Table 1: Member, Recipient and Provider Support Call Center Operations*. The BH I/DD Tailored Plan shall adhere to hours of operations regardless of holidays.

Section V.A.2.a. Second Revised and Restated Table 1: Member, Recipient, and Provider Support Call Center Operations				
Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
1. Member and Recipient Service Line for Medicaid and State-funded Services	a. Non-emergency member and recipient issues: Monday – Saturday: 7AM – 6PM ET, including State holidays for member and recipient questions and additional hours as required by the Department during times of expected high volume (e.g., BH I/DD Tailored Plan launch) b. Emergency member and recipient issues: open twenty-four (24) hours per day/seven (7) days per week	Yes	Yes	At the beginning of Tailored Plan Marketing
2. Provider Support Service Line for Medicaid and State-funded Services	a. Monday – Saturday: 7AM – 6PM ET, including State holidays	Yes	Yes	At the beginning of Tailored Plan Marketing
3. Behavioral Health Crisis Line for Medicaid and State-funded Services	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	Yes (except for bilingual agents providing services to Members)	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
4. Pharmacy Service Line for Medicaid Program	a. Monday – Saturday: 7AM – 6PM ET, including State holidays b. Prescriber prior authorization services available to meet 24-hour review requirements as defined in *Section V.B.2.iii. Pharmacy Benefits*	Yes (except for pharmacists performing UM functions, such as prior authorization)	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan Pharmacy POS launch
5. Nurse Line for Medicaid Program	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	No	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch

Section V.A.2.a. Second Revised and Restated Table 1: Member, Recipient, and Provider Support Call Center Operations				
Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
6. Non-Emergency Medical Transportation (NEMT) Member Service Line for Medicaid Program	a. Monday – Saturday: 7AM – 6PM ET, including State holidays	No	No	At least forty-five (45) Calendar Days prior to BH I/DD Tailored Plan Launch
7. Non-Emergency Medical Transportation (NEMT) Provider Service Line for Medicaid Program	a. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	No	No	At least forty-five (45) Calendar Days prior to BH I/DD Tailored Plan Launch

i. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xii)* is revised and restated in its entirety as follows:

(xii) The BH I/DD Tailored Plan shall ensure the service lines are staffed with professionals who have sufficient training and knowledge, as defined in *Section V.A.2.iii. Staff Training for Medicaid and State-funded Services*, on North Carolina Medicaid and State-funded Services as defined within this Contract.

j. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xiv), (b), (1)* is revised and restated in its entirety as follows:

(1) Member Medicaid Managed Care resources, education and assistance to understand Medicaid benefits;

k. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xv), (b)* is revised and restated in its entirety as follows:

(b) Medicaid/State-funded Services identification number (preferred);

l. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xx) Behavioral Health Crisis Line* is revised and restated in its entirety as follows:

(xx) Behavioral Crisis Line:

(a) Must be staffed with licensed BH professionals.
(b) Must be able to address mental health, SUD, I/DD, and TBI-related crisis events.
(c) Must immediately connect to the crisis response systems.
(d) Must have patch capabilities to 911 and any other crisis emergency services lines. In instances where there is immediate danger to self or others, the BH I/DD Tailored Plan shall have procedures for immediate contact with local emergency responders. These

procedures should include monitoring the individual's status until emergency responders arrive on the scene.

(e) Must follow up with the member's care manager or organization providing Tailored Care Management to share relevant clinical and follow up information.

(f) The BH I/DD Tailored Plan Behavioral Health Crisis Line may use Interpretation services for no more than twenty percent (20%) of Behavioral Health Crisis Line calls received from Members who prefer to speak in Spanish, but these interpreters must be Healthcare or Medically Certified.

(1) Interpreters must have at least one of the following certifications:

i. Certified Medical Interpreter from NBCMI;

ii. Certified Healthcare Interpreter from CCHI;

iii. Core Certification Healthcare Interpreter from CCHI; or

iv. Internal Medical/Healthcare Medical Certification from Language/Interpreter Vendor.

(g) When providing services to Members, Behavioral Health Crisis Line bi-lingual agents may be located outside of North Carolina.

(h) Must not:

(1) Allow members or recipients to receive a busy signal;

(2) Allow Member or recipient calls to be answered by an automated response;

(3) Allow Members or recipients to leave messages and receive a call back;

(4) Shift calls to an overflow system during high volume call times; or

(5) Allow maximum call duration limits.

m. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xxii)* is revised and restated in its entirety as follows**:**

(xxii) The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers. The BH I/DD Tailored Plan is required to submit a request to the Department for review and approval for a call center used by the BH I/DD Tailored Plan, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract.

n. *Section V. Scope of Services, A. Unified, 2. Program Operations, i. Service Lines for Medicaid and State-funded Services* is revised to add the following**:**

(xxv) Secondary call centers are defined as any activities where Subcontractors or Vendors are performing duties directly related to Members or providers beyond the six (6) service lines specified in the Contract.

o. *Section V. Scope of Services, A. Unified, 3. Compliance, ii. Program Integrity (PI) for Medicaid and State-funded Services, (iii), (a) i*s revised and restated in its entirety as follows**:**

(a) Validation of Exclusion List Status for Medicaid and State-Funded Services

(1) Reserved.

(2) The BH I/DD Tailored Plan shall disclose to the Department within thirty (30) Calendar Days of BH I/DD Tailored Plan's knowledge any disciplinary actions or exclusions that have not been communicated on the Provider Enrollment File as a Termination to the BH I/DD Tailored Plan imposed on any licensed physician, physician assistant, nurse practitioner,

psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.

(3) The BH I/DD Tailored Plan shall check, at least every month, the exclusion status of persons, agents, or managing employees of a delegated entity or subcontractor against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal or state funds to Excluded Person(s) or entities. The BH I/DD Tailored Plan shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).

(4) The BH I/DD Tailored Plan shall take appropriate action upon identification that a person, agent, managing employee, delegated entity or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.

(5) The BH I/DD Tailored Plan shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:

i. The name(s) of the Excluded Person(s); and

ii. The amounts paid to the Excluded Person(s) over the previous twelve (12) months.

p. *Section V. Scope of Services, A. Unified, 3. Compliance, iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services, (iii) Investigation Coordination, (h)* is revised and restated in its entirety as follows:

(h) The BH I/DD Tailored Plan cannot take action, termination of provider, suspension of payment, or withhold of payment, related to potential findings of fraud without approval of the Department. Any such action taken after BH I/DD Tailored Plan has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.

q. *Section V. Scope of Services, A. Unified, 3. Compliance, iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services, (iii) Investigation Coordination* revised to add the following:

(k) Any cases that are being actively investigated by the LME/MCO at the time of BH I/DD Tailored Plan launch shall continue after launch.

r. *Section V. Scope of Services, A. Unified, 3. Compliance, iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services, (v.) Fraud Prevention Plan, (d), (16)* is revised and restated as follows:

(16) Description of criminal background and Exclusion List screen processes for its owners, agents, delegated entities, employees, and subcontractors; and

s. *Section V. Scope of Services, A. Unified, iv. Third Party Liability (TPL) for Medicaid, (ii) Cost Avoidance, (a), (6)* is revised and restated in its entirety as follows:

(6) Member Medicaid ID;

t. *Section V. Scope of Services, A. Unified, 3. Compliance, iv. Third Party Liability (TPL) for Medicaid, (ix) Identification of Other Forms of Insurance, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall load and submit to the Department updates and additions on other forms of insurance into its system within five (5) Business Days of matching and verification. The BH I/DD Tailored Plan shall review State TPL data prior to denying any claim for TPL or other insurance.

u. *Section V. Scope of Services, A. Unified, 3. Compliance, iv. Third Party Liability (TPL) for Medicaid* is revised to add the following:

(xii) The BH I/DD Tailored Plan shall pay and then chase for the following services:

(a) Medical Support Enforcement: The BH I/DD Tailored Plan shall pay and chase if the claim is for a service provided to a Member on whose behalf child support enforcement is being carried out if:

(1) The third-party coverage is through an absent parent; and

(2) The provider certifies that, if the provider has billed a third party, the provider has waited one hundred (100) Calendar Days from the date of service without receiving payment before billing the BH I/DD Tailored Plan.

(b) Preventive Pediatric Services: The BH I/DD Tailored Plan shall pay and chase for claims for preventive pediatric services, including EPSDT.

(c) In addition to medical support enforcement and preventative pediatric services, *Section V. A. 3. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits* lists programs and services that are an exception to the general rule that NC Medicaid is the payer of last resort. When a Member of the BH/IDD Tailored Plan is entitled to one or more of the following programs or services, then the BH/IDD Tailored Plan shall pay and chase the claim.

Section V. A. 3. Table 1: Program and Service Exceptions for TPL and Coordination of Benefits		
Program or Service	Federal	State
1. Crime Victims Compensation Fund	X	
2. Part B and C of Individuals with Disabilities Education Act (IDEA)	X	
3. Ryan White Program	X	
4. Indian Health Services	X	
5. Veteran's Benefits for state nursing home per diem payments	X	
6. Veteran's Benefits for emergency treatment provider to certain veterans in a non-VA facility	X	
7. Women, Infants and Children Program	X	
8. Older American Act Programs	X	
9. World Trade Center Health Program	X	
10. Grantees under the Title V of the Social Security Act	X	
11. Division of Service for the Blind		X
12. Division of Public Health "Purchase of Care" Program		X
13. Vocational Rehabilitation Services		X

14. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)		X

v. *Section V. Scope of Services, A. Unified, 3. Compliance, vi. Medicaid Service Recipient Explanation of Medicaid Benefits (REOMB) for Medicaid, (iii)* is revised and restated in its entirety as follows:

(iii) The BH I/DD Tailored Plan shall exclude those claims that include sensitive information–and Medicare crossover claims when creating the REOMB. Sensitive information shall be defined as any procedures for allergies, newborn treatment and care, substance use disorder information protected by 42 C.F.R. Part 2, and any treatment for a member's reproductive health including but not limited to pregnancy, sterilization, and screening and treatment for communicable diseases.

w. *Section V. Scope of Services, A. Unified, 3. Compliance, vi. Medicaid Service Recipient Explanation of Medicaid Benefits (REOMB) for Medicaid, (v)* is revised and restated in its entirety as follows:

(v) The BH I/DD Tailored Plan shall send a REOMB for at least ten percent (10%) of all claims or 335 claims for the month, whichever is less. (Excluded claims include those in referenced in this Section).

x. *Section V. Scope of Services, A. Unified, 4. Stakeholder Engagement and Community Partnerships, iv. Development of Housing Opportunities for Medicaid Members and State-funded Services Recipients, (iii)* is revised and restated in its entirety as follows:

(iii) The BH I/DD Tailored Plan shall develop and annually update a BH I/DD Tailored Plan Regional Housing Plan for its members and recipients that reflects the unique aspects of each Region, is parallel to the goals that will be outlined within the Statewide Housing Plan to reduce homelessness, and divert individuals from institutional settings, increase entry into and sustained supportive housing, promote independence for people with disabilities, promote housing as a key social determinant of health, provide a stable site for recovery activities, and proximity to employment and education. The plan will be due to the Department as determined upon the adoption of the Statewide Housing Plan. As long as the Regional Housing Plan clearly states it applies to the BH I/DD Tailored Plan the Regional Housing Plan may apply to other LME/ MCO operations, including without limitation the PIHP.

(a) The Department is in the process of developing a Statewide Housing Plan for the broader North Carolina population that will inform the BH I/DD Tailored Plan's Regional Housing Plan.

y. *Section V. Scope of Services, A. Unified, 4. Stakeholder Engagement and Community Partnerships, iv. Development of Housing Opportunities for Medicaid Members and State-funded Services Recipients, (iv), (b)* is revised and restated in its entirety as follows:

(b) Include strategies for implementation of housing objectives, milestones/goals, including to: reduce homelessness, and divert individuals from institutional settings, increase entry into and sustain supportive housing, promote independence for members and recipients with disabilities, improve members' and recipients' health, help members and recipients retain employment, increase landlord engagement to increase available units for Members;

z. *Section V. Scope of Services, A. Unified, 4. Stakeholder Engagement and Community Partnerships, iv. Development of Housing Opportunities for Medicaid Members and State-funded Services Recipients, (vii) Education and Outreach* is revised to add the following:

(e) Improve the capacity and performance of service providers to sustain supportive housing and improve retention rates in accordance with TCL Housing Guidelines issued by the Department.

aa. *Section V. Scope of Services, A. Unified, 4. Stakeholder Engagement and Community Partnerships, v. Community Crisis Services Plan for Medicaid and State-funded Services* is revised and restated in its entirety as follows:

v. Community Crisis Services Plan for Medicaid and State-funded Services

(i) The BH I/DD Tailored Plan shall implement the community crisis services plan as defined in N.C. General Statutes § 122C-202.2.

(ii) The community crisis services plan defined in the statute, shall cover the BH I/DD Tailored Plan's entire Region and shall be comprised of one or more community crisis services plans.

(iii) The BH I/DD Tailored Plan shall submit an updated community crisis services plan to the Department at least every two (2) years and when there are Significant Changes as defined by the Department.

(iv) The BH I/DD Tailored Plan shall include in the Crisis Planning Committee all affected agencies, including all Standard Plans that cover any of the counties covered in the community crisis services plan when updating the community crisis services plan.

(v) The BH I/DD Tailored Plan shall coordinate with Standard Plans and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each community crisis services plan and alternatives to involving law enforcement in behavioral health crisis response.

(vi) The BH I/DD Tailored Plan shall participate in local or regional crisis collaboratives with local magistrates, law enforcement, county commissioners, crisis providers, and hospitals, to meet and regularly share information on improvements to the crisis continuum.

bb. *Section V. Scope of Services, A. Unified, 4. Stakeholder Engagement and Community Partnerships* is revised to add the following:

vi. The BH I/DD Tailored Plan shall:

a. Accomplish the milestones required under TCL related to supportive housing for individuals participating in TCL. A designated single point of contact (Housing Coordinator) at the BH I/DD Tailored Plan shall be identified to coordinate all housing efforts and work closely with the Department's TCL team members.

b. Meet BH I/DD Tailored Plan-specific housing goals as established annually by the Department on or before July 1 of each State fiscal year. The Department and the BH I/DD Tailored Plan will determine the number of slots the Plan will fill for each year of the Settlement Agreement in accordance with N.C.G.S. § 122C-20.10.

c. Oversee annual Housing Quality Inspections (HQS) to ensure that each permanent supportive housing unit is safe, fully functional, and sanitary.

III. Modifications to Section V. Scope of Services, B. Medicaid

Specific subsections are modified as stated herein.

a. *Section V. Scope of Services, B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (i) Department Roles and Responsibilities, (a)* is revised and restated in its entirety as follows:

(a) Pursuant to Article 4. of Chapter 108D of the N.C. General Statutes, the Department was directed to transition certain North Carolina Medicaid populations, including populations eligible for BH I/DD Tailored Plans from a Medicaid Fee for Service structure to a Medicaid Managed Care structure. The Department shall maintain authority in determining North Carolina Medicaid eligibility and defining populations to be transitioned into Medicaid Managed Care consistent with Article 4. of Chapter 108D of the N.C. General Statutes.

b. *Section V. Scope of Services, B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (i) Department Roles and Responsibilities, (f)* is revised and restated in its entirety as follows:

(f) The Department shall be responsible for transmitting to the BH I/DD Tailored Plan all information related to North Carolina Medicaid eligibility and cost sharing via the Medicaid Managed Care eligibility file format.

c. *Section V. Scope of Services, B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (i) Department Roles and Responsibilities* is revised to add the following:

(h) The Department may contract with a third-party vendor to develop and implement an independent evaluation to determine if requests to enroll a non-eligible beneficiary into a BH I/DD Tailored Plan can be accepted based on medical necessity.

d. *Section V. Scope of Services, B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (ii) BH I/DD Tailored Plan Eligible Populations, (a), (3), i.* is revised and restated in its entirety as follows:

i. Individuals with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living (TCL) settlement agreement.

e. *Section V. Scope of Services, B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (v) Medicaid Managed Care Enrollment and Disenrollment, (a), (3)–(5)* is revised and restated in its entirety as follows:

(3) The BH I/DD Tailored Plan shall have staff with sufficient knowledge about the North Carolina Medicaid program and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.

(4) The BH I/DD Tailored Plan shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect the member's Medicaid eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).

(5) The BH I/DD Tailored Plan shall ensure automatic reenrollment of a member who is disenrolled solely because he or she loses North Carolina Medicaid eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g). From September 27, 2022 through seventeen (17) months after the end of the COVID-19 Public Health Emergency, the BH I/DD Tailored Plan shall ensure

automatic reenrollment of a Member who is disenrolled solely because he or she loses North Carolina Medicaid eligibility for a period of ninety (90) Calendar Days as allowed in under the Department's CMS approved waiver of Automatic Reenrollment into Medicaid Managed Care Plans as defined in section 1902(e)(14)(A) of the Social Security Act.

f. *Section V. Scope of Services, B. Medicaid, 1. Members, ii. Transition of Care, (ii) Crossover Population, (g)* is revised and restated in its entirety as follows:

(g) The BH I/DD Tailored Plan must honor existing and active medical prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the first ninety (90) Calendar Days after BH I/DD Tailored Plan implementation or until the end of the authorization period, whichever occurs first–to ensure continuity of care for members. For service authorizations managed by an LME/MCO and impacted by 42 C.F.R. Part 2, the BH I/DD Tailored Plan shall deem authorizations submitted directly by impacted Providers as covered under this requirement.- For the first ninety (90) Calendar Days after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network Providers equal to that of in network Providers until end of episode of care or the ninety (90) Calendar Days after BH I/DD Tailored Plan launch, whichever is less.

(1) To ensure that Providers fully understand each BH I/DD Tailored Plan's prior authorization requirements during the transition the BH I/DD Tailored Plan will still process and pay for services rendered during this Crossover transition period if:

i. A Provider fails to submit prior authorization prior to the services being provided and submits prior authorization after the date of service, or

ii. A provider submits for retroactive prior authorizations.

(2) Retroactive prior authorization does not apply to concurrent reviews for inpatient hospitalizations which should still occur during this time period. If a transitioning beneficiary is under an Ongoing Course of Treatment covered under N.C. Gen. Stat., § 58-67-88, the BH I/DD Tailored Plan shall pay claims and authorize services to the beneficiary's out-of-network Providers on par with in-network Providers for the duration of the applicable transitional period defined in statute .

g. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (vii) Member Services Website, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall develop and maintain a dedicated, interactive North Carolina Medicaid member services website that, at a minimum, has the functionality to allow the member to search for in-network providers and search the drug formulary. The website may be shared across and inclusive of this product and the BH I/DD Tailored Plan, which links to dedicated webpages for the Medicaid Direct health plan and the BH I/DD Tailored Plan.

h. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (viii) Communications with Members and Potential Members* is revised to add the following:

(h) The BH I/DD Tailored Plan shall also include on its Member Portal the ability for Members, at a minimum to:

(1) Request a change in their PCP.

(2) Request a change to their Tailored Care Management Entity or Provider.

(3) Update their contact Information, including opting into or out of text and/or email communications.

(4) Find forms or request a new Medicaid Card.

(5) Check the status of a claim.
(6) Find information about their benefits or coverage category.
(7) Submit grievances.
(8) Request appeals for Medicaid services.

i. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (xiii) Member Identification Cards, (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan is required to generate an identification card for each Member enrolled in the BH I/DD Tailored Plan with the following printed information:
(1) The Member's North Carolina Medicaid identification number
i. The Member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and
ii. The Member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the BH I/DD Tailored Plan.
(2) The BH I/DD Tailored Plan's name, mailing address and Member Portal.
(3) The Member's PCP name, physical address and phone number.
(4) The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
(5) Indicator if Member is NC Medicaid.
(6) The MID, fraud, waste and abuse hotline with the following language:
i. If you suspect a doctor, clinic, hospital, home health service or any other kind of health provider is committing Medicaid fraud, report it. Call (919) 881-2320.

j. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (xiv) Member Handbook, Innovations Member and Family Handbook, and TBI Handbook, (e), (2)* is revised and restated as follows:

(2) For BH I/DD Tailored Plans in selected Pilot regions—Information on the Healthy Opportunities Pilot program, as applicable, and how to access its services, including through Tailored Care Management.

k. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (xiv) Member Handbook, Innovations Member and Family Handbook, and TBI Handbook, (e), (12)* is revised and restated as follows:

(12) Cost sharing, if any, imposed on North Carolina Medicaid beneficiaries.

l. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (xv) Member Education and Outreach, (e)-(f)* is revised and restated as follows*:*

(e) Any outreach or education related to the proposed Member Incentive Program as described in *Section V.B.1.iii.(xx) Member Incentive Program* must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not require approval.
(f) In support of the Department's health equity goals, the BH I/DD Tailored Plan shall develop a Member Engagement and Marketing Plan for historically marginalized populations for review by the Department. The plan shall include the BH I/DD Tailored Plan's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. As long as the Member Engagement and Marketing Plan for

Historically Marginalized Populations clearly states that it applies to the BH I/DD Tailored Plan, the Member Engagement and Marketing Plan for Historically Marginalized Populations may apply to other LME/MCO operations, including, without limitation, the PIHP. The plan shall be submitted to the Department no later than January 6, 2023, and annually thereafter.

m. *Section V. Scope of Services, B. Medicaid, 1. Members, iii. Member Engagement, (xvii) Engagement with Beneficiaries Utilizing Long Term Services and Supports* is revised to add the following:

(l) The BH I/DD Tailored Plan shall adhere to the Department's BH I/DD Tailored Plan Member Advisory Committee Guidance.

(m) The BH I/DD Tailored Plan shall develop a LTSS Member Advisory Committee Charter in accordance with the Department's BH I/DD Tailored Plan Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Charter.

(n) The BH I/DD Tailored Plan shall develop a LTSS Member Advisory Committee Recruitment Plan in accordance with Department's Member Advisory Guidance and submit to the Department for approval annually and sixty (60) Calendar Days prior to any significant changes to the Plan.

n. *Section V. Scope of Services, B. Medicaid, 1. Members, v. Member Rights and Responsibilities, (ix)* is revised and restated in its entirety as follows:

(ix) Reserved.

o. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (iv) Notice of Adverse Benefit Determination, (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan shall give the Member timely and adequate notice of an Adverse Benefit Determination in writing consistent with the notice content and timing requirements below and in 42 C.F.R. § 438.10 and 42 C.F.R. § 438.404(a). The BH I/DD Tailored Plan shall give the provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.210(c).

p. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (iv) Notice of Adverse Benefit Determination, (f) Timing of the Notice of Adverse Benefit Determination, (4)-(5)* is revised and restated in its entirety as follows:

(4) For denial of payment of a Clean Claim, the BH I/DD Tailored Plan shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 C.F.R. 438.404(c)(2). A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an adverse benefit determination.

(5) For termination from or denial of participation in the Innovations Waiver program or TBI waiver program, the BH I/DD Tailored Plan shall give written notice to the member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date that the adverse decision is to take effect. Removal from the Registry of Unmet Needs is considered a denial of participation in the Innovations Waiver program or TBI waiver program.

q. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (iv) Notice of Adverse Benefit Determination, (h) Expeditated Resolution of Appeals, (4)* is revised and restated in its entirety as follows:

(4) In accordance with NC.G.S. § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited appeal requests made by a network provider acting as an authorized representative of the Member on behalf of a Member, the BH I/DD Tailored Plan shall presume an expedited appeal resolution is necessary. The BH I/DD Tailored Plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).

r. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (vi) State Fair Heating Process* is revised to add the following:

(h) The BH I/DD Tailored Plan will designate an email address for receipt of Department communications regarding State Fair Hearings. The BH I/DD Tailored plan will have a process in place to ensure that Department communications regarding expedited State Fair Hearings requests made pursuant to N.C. Gen. Stat. § 108D-15.1 are responded to as soon as possible and in no event later than nine (9) Work Hours from the timestamp of the Department's email communication. The BH I/DD Tailored Plan will respond to Department communications about standard State Fair Hearing requests per the requirement in *Section III.D.* ***38. RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION***. The Department shall notify the BH I/DD Tailored Plan as expeditiously as possible, but no later than nine (9) Work Hours of any expedited State Fair Hearing request involving the BH I/DD Tailored Plan.

(i) The BH I/DD Tailored Plan will have a process in place to upload to the Department all documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal. For expedited State Fair Hearing requests made pursuant to N.C. Gen. Stat. § 108D-15.1, the BH I/DD Tailored Plan will upload documentation as soon as possible and in no event later than nine (9) Work Hours from the timestamp on the Department communication requesting the documentation. For standard State Fair Hearing requests, the BH I/DD Tailored Plan will upload the requested documentation per the requirements laid out in *Section III.D.* ***38. RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION***.

s. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (viii)* is revised and restated in its entirety as follows:

(viii) Reserved.

t. *Section V. Scope of Services, B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (x)* is revised to add the following:

(g) 1915(i) services:

(1) If the BH I/DD Tailored Plan authorizes a requested 1915(i) service for a duration less than the duration requested in the Care Plan/ISP, the BH I/DD Tailored Plan shall provide written notice with Appeal rights and clinical or administrative reasons for the decision at the time of the limited authorization.

(2) If the BH I/DD Tailored Plan denies a request for authorization of 1915(i) services by a member, in whole or in part, or authorizes a requested 1915(i) service in a limited manner, including the type, level, or duration of service, BH I/DD Tailored Plan shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 C.F.R. § 438.404:

i. An Appeal filed by a member must not prevent any authorized 1915(i) services from being provided pending the outcome of the Appeal. BH I/DD Tailored Plan must not prevent the member from making a new request for 1915(i) services during a pending Appeal.

(3) The BH I/DD Tailored Plan shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all members from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to Appeal the denial, reduction, or termination of a service. The BH I/DD Tailored Plan shall not attempt to influence, limit, or interfere with a member's right or decision to file or pursue a Grievance or request an Appeal.

(4) Care Plan/ISP: The BH I/DD Tailored Plan shall ensure that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member.

(5) The BH I/DD Tailored Plan shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to 1915(i) services and other trainings relevant to due process procedures, whether related to 1915(i) services or otherwise.

u. *Section V. Scope of Services, B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advanced Medical Home Contracting, (a) Background and General Requirements, (4)* is revised and restated in its entirety as follows:

(4) The BH I/DD Tailored Plan shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices as described in *Section VII. Second Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid Members*.

v. *Section V. Scope of Services, B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advanced Medical Home Contracting, (b) Advanced Medical Home Quality Metrics, (3)* is revised and restated in its entirety as follows:

(3) The Department will provide the BH I/DD Tailored Plan with the AMH measure set and reporting schedule prior to implementation as described in *Section VII. Second Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid Members*.

w. *Section V. Scope of Services, B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advanced Medical Home Contracting, (c)* is revised and restated in its entirety as follows:

(c) The BH I/DD Tailored Plan shall offer AMH Performance Incentive Payments that utilize the AMH metrics to AMH Tier 3 practices, including AMH+ practices. These incentives are optional for AMH Tiers 1 and 2 as described in *Section V.B.4.v.(xvi) Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management.*

x. *Section V. Scope of Services, B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advanced Medical Home Contracting, (e) Required Data and Information Sharing to Support Care Management, (5)-(6)* is revised and restated in its entirety as follows:

(5) In order to support care management activities, the BH I/DD Tailored Plans shall provide the following data to CMHRP technology vendor for Local Health Departments (LHDs) providing care management of high-risk pregnancy:

i. Member assignment data applicable to their populations using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department and published on the Department's website.

ii. Claims and Encounter data: current and historical Medical and Pharmacy claims and encounter data applicable to their populations, using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department.

iii. Risk Stratification information:

a) BH I/DD Tailored Plan furnished risk scoring results,

b) Notification when Members fall into required Department priority population categories.

c) The BH I/DD Tailored Plan is encouraged to explain the types or categories of inputs to its risk stratification model with LHDs (e.g. frequent hospital utilization) that can inform specific actions by the LHD.

d) Quality measure performance information at the LHD level. The B/H Tailored Plans shall provide feedback on quality scoring results to each LHD on both an annual and an interim basis as specified by the Department.

(6) The BH I/DD Tailored Plan shall successfully implement all mandatory LHD program integrations with state selected CMHRP technology vendor. Successful integration completion requires both the BH I/DD Tailored Plan and LHD platform vendor to fully complete design, development, testing and deployment activities aligned with all the requirements and respective interface specifications specified by the Department and published on the Department's website.

y. *Section V. Scope of Services, B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (ii) PCP Choice and Assignment, (g)* is revised and restated in its entirety as follows:

(g) Members can change their PCP without cause twice per year. Members shall be given thirty (30) Calendar Days from receipt of notification of their PCP assignment each year to change their PCP without cause (1st instance) and shall be allowed to change their PCP without cause up to one (1) time per year thereafter (2nd instance). Members of federally recognized tribes may change their PCP without cause at any time.

(1) For Contract Year 1, Members can change their PCP without cause for the first one hundred eighty-one (181) Calendar Days after the BH I/DD Tailored Plan Launch.

z. *Section V. Scope of Services, B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (ii), (a)* is revised and restated in its entirety as follows:

(a) Cover all services in the North Carolina Medicaid State Plans with the exception of services carved out of Medicaid Managed Care under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract;

aa. *Section V. Scope of Services, B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (ii)* is revised to add the following:

(i) Ensure all services are person-centered, recovery focused, individualized, meet requirements for intensity and duration, and include supports based on need, choice, goals, wellness and health care, personal care, employment, daily living, and community supports.

(j) Ensure services available match the needs of individuals receiving ACT, CST, or TMS, including without limitation:

(1) Effective implementation of Community Support Team;
(2) Evidenced based peer support, focused on individuals in the current and future TCL target population; and
(3) Expanding capacity of health providers who are knowledgeable regarding wellness, recovery, and managing and preventing deterioration of chronic health conditions.

bb. *Section V. Scope of Services, B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid and NC Health Choice Services* is revised and restated in its entirety as follows:

(iii) Covered Medicaid and NC Health Choice Services

(a) The BH I/DD Tailored Plan shall cover all services as defined in the Medicaid State Plans with the exception of services carved out under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid State Plan covered services are described in *Section VII. Second Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid and NC Health Care State Plan); the BH I/DD Tailored Plan shall not be responsible for providing carved out services to members as defined in *Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care.*

(b) Consistent with N.C. Gen. Stat. §§ 108D-60 and 108D-35, the BH I/DD Tailored Plan shall be responsible for covering BH, I/DD and TBI services that are defined as *Section V.B.2. First Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans*, including 1915(c) Innovations and TBI waiver services and 1915(i) services, as well as any services that the Department obtains authority through a SPA or waiver to cover and adds to the BH I/DD Tailored Plan benefit package (e.g., supported employment).

(1) A crosswalk of the SUD services covered under the Medicaid State Plans to national clinical standards is provided in *Section V.B.2 First Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*.

(c) The BH I/DD Tailored Plan shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.

Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care[6]
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program

[6] N.C. Gen. Stat. § 108D-35.

Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract)[7]
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Section V.B.2. First Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	**BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)**
Enhanced BH services are *italicized*	
State Plan BH and I/DD Services • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment*[8] • *Ambulatory withdrawal management, without extended on-site monitoring* • *Ambulatory withdrawal management, with extended on-site monitoring* • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment • Clinically managed residential withdrawal services • *Medically monitored inpatient withdrawal services* • *Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization* • Early and periodic screening, diagnostic and treatment (EPSDT) services	**State Plan BH and I/DD Services** • Residential treatment facility services • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • Psychiatric residential treatment facilities (PRTFs) • *Assertive community treatment (ACT)* • *Community support team (CST)*[9] • *Psychosocial rehabilitation* • *Clinically managed low-intensity residential treatment* • *Clinically managed population-specific high intensity residential program* • *Clinically managed residential services* • *Medically monitored intensive inpatient services* • *Substance use intensive outpatient program (SAIOP)* • *Substance use comprehensive outpatient treatment program (SACOT)* • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **Waiver Services** • Innovations waiver services • TBI waiver services **1915(i) SPA services (BH I/DD Tailored Plan and PIHP)** • Community Transition • Respite • Supported Employment/Individual Placement Supports • Community Living and Supports • Individual and Transitional Supports

[7] The Department is considering pursuing legislative authority to carve these services into managed care.
[8] BH I/DD Tailored Plans will also be required to cover OBOT services as detailed in *Section VII. Second Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies.*
[9] CST includes tenancy supports.

Section V.B.2. First Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
1	Outpatient services	
2.1	Intensive outpatient services	Substance use intensive outpatient program
2.5	Partial hospitalization services	Substance use comprehensive outpatient treatment
3.1	Clinically Managed Low-Intensity Residential Treatment Services	Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house)
3.3	Clinically managed population-specific high-intensity residential services	Clinically managed population-specific high-intensity residential services
3.5	Clinically managed high-intensity residential services	Clinically managed residential services (substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Medically managed intensive inpatient service (Inpatient BH services)
Office-based opioid treatment	Office-based opioid treatment[10]	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification)
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory withdrawal management, with extended on-site monitoring
3.2WM	Clinically managed residential withdrawal services	Clinically managed residential withdrawal services (social setting detoxification)

[10] BH I/DD Tailored Plans will be required to cover OBOT services as detailed in *Section VII. Second Revised and Restated Attachment B. Summary of Covered Services & Clinical Coverage Policies.*

Section V.B.2. First Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	**ASAM Service Title**	**North Carolina Medicaid Service Title**
3.7-WM	Medically monitored inpatient withdrawal management	Medically monitored inpatient withdrawal management (non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal	Medically managed intensive inpatient withdrawal management (Inpatient BH services)

(d) The Department will allocate a specific number of Innovations and TBI waiver slots to each BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall manage access to its allotted waiver slots, including reserved capacity slots except for Military Transfers, and maintain a Registry of Unmet Needs (waiting list) for members who are determined eligible for waiver funding but for whom funding is not available at the time of their waiver eligibility determination. The BH I/DD Tailored Plan shall report on the status of the use of waiver slots and reserved capacity as required by the Department.

(e) The BH I/DD Tailored Plan shall cover Innovations and TBI waiver services for beneficiaries enrolled in the waivers as defined in *Section V.B.2. Table 4: Innovations Waiver Services* and *Section V.B.2. Table 5: TBI Waiver Services* (as applicable) pending CMS approval of the 1915(c) waiver renewals and authorization of funding by the General Assembly.

Section V.B.2. Table 4: Innovations Waiver Services[11]	
• Assistive Technology Equipment and Supplies • Community Living and Support • Community Navigator[12] • Community Networking • Community Transition • Crisis Services • Day Supports • Financial Support Services • Home Modifications • Individual Goods and Services	• Natural Supports Education • Residential Supports • Respite • Supported Employment • Specialized Consultation • Supported Living • Supported Living - Periodic • Supported Living – Transition • Vehicle Adaptations

[11] Only BH I/DD Tailored Plan members who are enrolled in the Innovations waiver will have access to these services.

[12] The Department plans to remove community navigator from the Innovations service array prior to BH I/DD Tailored Plan launch because it is duplicative with Tailored Care Management. Self-directed functions that are currently provided under the community navigator service definition will be incorporated into the financial support services definition.

Section V.B.2. Table 5: TBI Waiver Services[13]	
• Adult Day Health • Assistive Technology • Cognitive Rehabilitation • Community Networking • Community Transition • Crisis Support Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education	• Occupational Therapy • Personal Care • Physical Therapy • Remote Supports • Residential Supports • Respite • Resource Facilitation • Speech Language Therapy • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

(f) The Department currently covers a subset of BH services under its 1915(b)(3) waiver, which will sunset upon BH I/DD Tailored Plan launch. The Department plans to seek authority to cover most of the current 1915(b)(3) services through 1915(i) authority. Individuals receiving 1915(b)(3) services at BH I/DD Tailored Plan launch may receive those services until their eligibility for (i) services is evaluated no later than six (6) months after Tailored Plan launch.

(g) The BH I/DD Tailored Plan shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.

(h) The BH I/DD Tailored Plan shall, in accordance with the federal Women's Health and Cancer Rights Act of 1998 (WHCRA), provide protections to members who choose to have breast reconstruction relating to a mastectomy, including coverage of:
   (1) All stages of reconstruction of the breast on which the mastectomy has been performed;
   (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   (3) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

(i) The BH I/DD Tailored Plan shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).

(j) The BH I/DD Tailored Plan shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a member enrolling in the BH I/DD Tailored Plan.

(k) The BH I/DD Tailored Plan shall encourage primary care providers who serve members under age nineteen (19) to participate in the Vaccines for Children (VFC) program, which allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
   (1) The BH I/DD Tailored Plan shall require that primary care providers administer vaccines consistent with the American Academy of Pediatrics (AAP)/Bright Future periodicity schedule.
   (2) For Medical Benefits, the BH I/DD Tailored Plan shall reimburse the Provider for only the administration fee for VFC eligible beneficiaries.
   (3) Vaccines provided for children enrolled in Medicaid should go through the VFC, when the VFC program includes the vaccine.
   (4) Reserved.

[13] Only BH I/DD Tailored Plan members who are enrolled in the TBI waiver will have access to these services.

(5) The BH I/DD Tailored Plan shall adhere to additional VFC requirements as defined in *Section V.B.3.ix. Prevention and Population Health Programs*.

(l) Reserved.

(m) Changes to Covered Benefits

(1) The BH I/DD Tailored Plan shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid State Plans and consistent with any approved Medicaid waivers, except to the extent the service is carved out of Medicaid Managed Care.

(n) Institutions for mental disease (IMD) SUD Services

(1) Under North Carolina's 1115 waiver authority, the BH I/DD Tailored Plan shall provide coverage for substance use disorder services for members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.

(2) The BH I/DD Tailored Plan shall provide the Department with a weekly report on members who are residing or have resided in an IMD for SUD treatment as defined in *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.

(o) For members newly enrolled in the BH I/DD Tailored Plan with no immediately prior period of Medicaid Managed Care enrollment or NC Medicaid Direct enrollment with inpatient coverage, the BH I/DD Tailored Plan shall be responsible for any diagnosis-related group based inpatient facility claims if the member's first day of BH I/DD Tailored Plan enrollment is during the hospital stay.

cc. *Section V. Scope of Services, B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (b) UM Program Policy, (3)* is revised and restated in its entirety as follows:

(3) The BH I/DD Tailored Plan shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the BH I/DD Tailored Plan shall submit the attestation required by this Section annually, unless otherwise directed by the Department. The Department will conduct ad hoc reviews of the BH I/DD Tailored Plan's adherence to the attestation of compliance with UM and clinical coverage requirements on an ongoing basis. The BH I/DD Tailored Plan shall provide an analysis of their compliance with the attestation upon request as follows:

i. Within thirty (30) Business Days for routine requests;

ii. Within seven (7) Business Days for expedited requests; and

iii. Nothing in this Section shall be construed to limit or interfere with the Department's right to individually review and approve any BHI/DD Tailored Plan UM or clinical coverage policy to ensure compliance with the Contract.

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

(g) A chart of all North Carolina Medicaid clinical coverage policies is found in *Section VII. Second Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies*.

(h) For a limited number of services, the BH I/DD Tailored Plan shall incorporate existing NC Medicaid Direct, and State-funded clinical coverage policies into the UM Program to maintain

services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.B.2. Table 6: Required Clinical Coverage Policies.*

ee. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management* is revised to add the following:

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

(u) UM Policy for 1915(i) Services

(1) For 1915(i) services only:

i. The BH I/DD Tailored Plan shall submit the Department designated 1915(i) assessment tool and necessary information to the Department or the Department's specified vendor for the purposes of completing the independent evaluation to determine eligibility for 1915(i) services in alignment with requirements at 42 C.F.R. § 441.715(d). The BH I/DD Tailored Plan shall comply with any additional guidance released by the Department on the process for supporting the independent evaluation.

ii. The BH I/DD Tailored Plan shall ensure that the independent assessment is used to guide the development of the Care Plan/ISP, and that the results of the independent assessment are not the sole basis for limiting the services requested or approved. The BH I/DD Tailored Plan may use the independent assessment in conjunction with other information to reduce or deny requested services.

(2) The BH I/DD Tailored Plan shall ensure that any request for authorization of 1915(i) services is consistent with and incorporates the desires of the member and that such desires are reflected in the member's Care Plan/ISP as required by 42 C.F.R. § 441.725(b),including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section V.B.3.xii. Additional Tailored Care Management Requirements for Members Obtaining 1915(i) Services* for additional details.

i. The member's care manager based at a BH I/DD Tailored Plan, AMH+ or CMA shall discuss with the member the duration of the services desired by the member and shall ensure that the Care Plan/ISP requests authorization for each service at the duration requested by the member during the contract year.

ii. The member's care manager based at a BH I/DD Tailored Plan, AMH+ or CMA shall assist the member in developing a Care Plan/ISP and shall explain options regarding the 1915(i) services available to the member.

(3) The BH I/DD Tailored Plan shall inform members that they may make a new request for 1915(i) services at any time by requesting an updated Care Plan/ISP.

(4) Care managers based at a BH I/DD Tailored Plan, AMH+ or CMA may not exercise prior authorization authority over the Care Plan/ISP.

(5) The BH I/DD Tailored Plan shall issue prior authorizations for all BH, I/DD, and TBI services covered under the 1915(i) SPA according to the requirements set forth in the service definitions that will be established by the Department.

(6) During the transition period ending at BH I/DD Tailored Plan Launch or another timeframe as determined by the Department, the BH I/DD Tailored Plan shall submit a monthly report of completed 1915(i) assessments for members currently receiving 1915(b)(3) services and outstanding 1915(i) assessments until all assessments are completed.

(7) The BH I/DD Tailored Plan shall provide any additional information or reports requested by the Department as required by CMS for the 1915(i).

ff. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vi) Telehealth, Virtual Patient Communications and Remote Patient Monitoring, (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid beneficiaries as an alternative service delivery model where clinically appropriate in compliance with all state and federal laws, including HIPAA and record retention requirements.

gg. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vi) Telehealth, Virtual Patient Communications and Remote Patient Monitoring, (e)* is revised and restated in its entirety as follows:

(e) The BH I/DD Tailored Plan shall develop and submit a Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department. As long as the Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy clearly states that it applies to the BH I/DD Tailored Plan, the Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP. The Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy shall include:

(1) Eligible providers who may perform Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
(2) Modalities covered by the BH I/DD Tailored Plan;
(3) Modalities not covered by the BH I/DD Tailored Plan;
(4) Requirements for and limitations on coverage;
(5) Description of each covered modality, including:
    i. Compliance with local, state and federal laws, including HIPAA; and
    ii. Process to ensure security of protected health information.
(6) Reimbursement mechanism (i.e. flow of funds from BH I/DD Tailored Plan to all relevant providers and facilities) for each covered modality; and
(7) Billing guidance for providers.

hh. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vii) In Lieu of Services (ILOS), (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan may use ILOS, services or settings that are not covered under the North Carolina Medicaid State Plans, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)(2)i-iv.

ii. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (ix) Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall ensure the provision of Specialized Services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this contract as listed in *Section V.B.2.i.(iii) Covered Medicaid Services*.

(1) The BH I/DD Tailored Plan shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.

jj. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan shall impose the same cost sharing amounts as specified in North Carolina's Medicaid State Plans which are displayed in *Section V.B.2. Second Revised and Restated Table 7 Medicaid Managed Care Cost Sharing* below.

kk. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, (e) Exceptions for Cost Sharing* is revised and restated in its entirety as follows:

(e) Exceptions for Cost Sharing:

(1) Reserved.

(2) Consistent with 42 C.F.R. § 447.56, Medicaid cost sharing does not apply to a subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, 1915(c) waiver beneficiaries, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

(3) The BH I/DD Tailored Plan shall not impose cost sharing on Medicaid BH I/DD and TBI services, as defined by the Department.

ll. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, Section V.B.2. First Revised and Restated Table 7: Medicaid Managed Care Cost Sharing* is revised and restated in its entirety as follows:

Section V.B.2. Second Revised and Restated Table 7: Medicaid Managed Care Cost Sharing			
Income Level	***Annual Enrollment Fee***	***Service***	***Copay***
Medicaid			
All Medicaid beneficiaries	*None*	Physician services	$4/visit
		Outpatient services	$4/visit
		Podiatrists	$4/visit
		Generic and brand prescriptions	$4/script
		Chiropractic services	$4/visit
		Optical services/supplies	$4/visit
		Optometrists	$4/visit
		Non-emergency ER visit	$4/visit

mm. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, (f) Cost Sharing Noticing Requirements, (1)* is revised and restated in its entirety as follows:

(1) BH I/DD Tailored Plan shall provide written notice to members using the Department developed standardized template of any Department-initiated changes to the Medicaid benefits package or cost sharing requirements. Notification to members shall be provided at least thirty (30) Calendar Days in advance of the effective date of such change.

nn. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, (g) Electronic Verification System Requirements* revised and restated in its entirety as follows:

(g) Reserved.

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

(xi) Electronic Verification System Requirements

(a) The BH I/DD Tailored Plan and its Providers must utilize an Electronic Visit Verification (EVV) system to verify personal care services, including Medicaid State Plan and all waiver services that provide assistance with ADLs that are provided in the member's home and are not provided as a per diem service, prior to releasing payment.

(b) The BH I/DD Tailored Plan must utilize an EVV system to collect the following data from Providers as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:

(1) Type of service performed;
(2) Individual receiving the service;
(3) Date of the service;
(4) Time that the service begins;
(5) Location of service delivery;
(6) Individual providing the service; and
(7) Time that service ends

(c) If the BH I/DD Tailored Plan utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.

(d) The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for State Plan Personal Care Services, the 1915(i) Community Living and Supports services, Innovations waiver services, and TBI waiver services is in effect by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for Home Health Care Services is in effect by January 1, 2023.

(e) At time of BH I/DD Tailored Plan implementation, the BH I/DD Tailored Plan shall deliver the EVV data elements to the Encounter Processing System (EPS) for personal Care Services or services that provide support with activities of daily living in a member's home that are not daily rate services.

(f) The BH I/DD Tailored Plan shall permit providers to continue using their existing EVV system provided that the system is compliant with state and federal regulations.

(xii) Hysterectomy Statement and Sterilization Consent

(a) The BH I/DD Tailored Plan shall provide hospitals the ability to check the status of the hysterectomy statement and sterilization consent forms online.

(b) The BH I/DD Tailored Plan shall provide the capability to capture the NPI of the facility where a sterilization procedure was performed and to display that information in the consent form record for the Member.

(c) The BH I/DD Tailored Plan shall provide the web-based capability for the rendering provider and service facility provider, including providers associated with the facility, to inquire on the status of the consent by searching with the NPI and Member Medicaid ID.

(d) The BH I/DD Tailored Plan shall provide an operational timeline to the Department for review and approval on how the BH I/DD Tailored Plan will meet the requirements of this section no later than February 1, 2023.

pp. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits , (iii) Drug Formulary and PDL, (c), (1)* is revised and restated in its entirety as follows:

(1) All drugs included the North Carolina Medicaid PDL as posted on the Department's website. The BH I/DD Tailored Plan shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid PDL.

qq. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits , (iii) Drug Formulary and PDL, (g) Drug Formulary Updates, (1)* is revised and restated in its entirety as follows:

(1) The BH I/DD Tailored Plan will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file designating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid PDL. The BH I/DD Tailored Plan shall update their pharmacy claim system within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.

rr. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (iv) Pharmacy Utilization Management, (b)* is revised and restated in its entirety as follows:

(b) For pharmacy services, the BH I/DD Tailored Plan shall follow the existing NC Medicaid Direct Fee-for-Service clinical coverage policies and prior authorization (PA) criteria and clinical criteria into the UM program as described in:

(1) Clinical Coverage Policies: *Section V.B.2. Table 8: Required Pharmacy Clinical Coverage Policies* below. The BH I/DD Tailored Plan shall not implement any clinical or prior authorization criteria beyond those included in the policies.

(2) Prior authorization Criteria: Drugs and/or drug classes requiring prior approval are available at the following link, accurate as of February 14, 2023: https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html.

(3) Clinical Criteria: Drugs and/or drug classes subject to clinical criteria are available at the following link, accurate as of February 14, 2023: https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.

ss. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits , (iv) Pharmacy Utilization Management, (d), (10)* is revised and restated in its entirety as follows:

(10) The BH I/DD Tailored Plan shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program, a Standard Plan or another BH I/DD Tailored Plan through the expiration date of the active service authorization.

tt. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (a) Dispensing Fees, (2)-(3)* is revised and restated in its entirety as follows:

(2) The BH I/DD Tailored Plan shall reimburse based on a flat dispensing fee defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).

(3) The Department shall perform a cost of dispensing study every five (5) years to inform the NC Medicaid Direct Fee-for-Service dispensing rate and notify the BH I/DD Tailored Plan of any changes to the pharmacy dispensing fee.

uu. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs* is revised and restated in its entirety as follows:

(b) Ingredient Costs

(1) The BH I/DD Tailored Plan shall reimburse pharmacies' ingredient costs at the same rate at the NC Medicaid Direct Fee-for-Service rate.

(2) The BH I/DD Tailored Plan shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.

(3) Beginning July 1, 2026, and subject to Department review and approval, the BH I/DD Tailored Plan may develop its own pharmacy contracting for ingredient reimbursement if the BH I/DD Tailored Plan can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the BH I/DD Tailored Plan must also submit a pharmacy network access monitoring plan.

(4) The BH I/DD Tailored Plan shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the BH I/DD Tailored Plan.

(5) Reimbursement Inquiries. The BH I/DD Tailored Plan shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.

(6) Ingredient Costs for Non-340B

i. The BH I/DD Tailored Plan shall reimburse pharmacy ingredient costs using the same reimbursement methodologies as defined in the State Plan and applied to Medicaid Fee-for-Service programs.

a) Fee-for-Service rates are based on the National Average Drug Acquisition Cost (NADAC). If there is no NADAC, the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), or other financial arrangements established by the Department, as defined in the State Plan.

b) For traditional ingredient costs, reimbursement is based on the lesser of logic methodology, such that the pharmacy is reimbursed at the lesser of usual and customary (U&C), gross amount due (GAD) or the calculated allowed amount derived from NADAC, plus a professional dispensing fee. If not NADAC, then the lesser of WAC or SMAC (plus a professional dispensing fee), U&C or GAD.

ii. Non-340B hemophilia drugs shall be reimbursed by the BH I/DD Tailored Plan based on the Hemophilia reimbursement methodology defined in the State Plan.

a) Under the State Plan non-340B hemophilia drugs are reimbursed at the lesser of the following:

i. Non-340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee;

ii. Providers' usual and customary charge reported in the usual and customary Charge (U&C) field, plus a per unit professional dispensing fee; or

iii. Providers' Gross Amount Due (GAD).

b) Under the State Plan, the dispensing fee is paid based on the quantity of units dispensed. The per unit professional dispensing fee is $0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is $0.025/unit for all other non-hemophilia treatment center pharmacies.

(7) Ingredient Costs for 340B

i. Traditional 340B drugs purchased through the 340B program shall be reimbursed by the BH I/DD Tailored Plan based on the Fee for Service reimbursement methodology

for 340B drugs as defined in the State Plan and applied to Medicaid Fee-for-Service programs.

a) Under the State Plan, reimbursement rates are based on the provider's actual acquisition cost (purchase price) plus a professional dispensing fee. Reimbursement is based on actual acquisition cost when it is the lesser of National Average Drug Acquisition Cost (NADAC) or the gross amount due; if there is no NADAC, the lesser of the Wholesale Acquisition Cost (WAC), State Maximum Allowable Cost (SMAC), usual and customary, gross amount due, or other financial arrangements established by the Department.

b) The BH I/DD Tailored Plan shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B program. The BH I/DD Tailored Plan shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission clarification field 420-DK at the POS.

ii. Hemophilia drugs purchased through the 340B program shall be reimbursed by the BH I/DD Tailored Plan based on the Hemophilia reimbursement methodology as defined in the State Plan.

a) Under the State Plan, 340B hemophilia drugs are reimbursed at the lesser of the following:

i. 340B State Maximum Allowable Cost (SMAC), plus a per unit professional dispensing fee. SMAC rates are based on the providers' acquisition cost (purchase price);

ii. Provider's acquisition cost (purchase price) reported in the usual and customary charge (U&C) field, plus a per unit professional dispensing fee; or

iii. Provider's Gross Amount Due (GAD).

b) Under the State Plan, the dispensing fee is paid based on the quantity of units dispensed, reimbursement is applicable to pharmacy. The per unit professional dispensing fee is $0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is $0.025/unit for all other non-hemophilia treatment center pharmacies.

c) The BH I/DD Tailored Plan shall require the provider to only bill acquisition costs or purchase price in the U&C field.

(8) Reimbursement for Drugs in Indian Health Services

i. The BH I/DD Tailored Plan shall reimburse the Indian Health Services, or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of Indian Health Care Improvement Act (25 U.S.C § 1603 and authorized by Public Law 93-638 Agreement).

a) For drugs with calculated allowable amounts of less than $1,000 utilizing the Office of Management and Budget (OMB) encounter reimbursement methodology, which will pay a maximum of two (2) prescription drugs per Member, per day, per pharmacy provider under the OMB encounter payments, and for any additional prescription drugs (3 and up) same Member, same day, same pharmacy provider, the BH I/DD Tailored Plan shall reimburse at zero.

b) For drugs with a calculated allowable amount equal to or greater than $1,000, the BH I/DD Tailored Plan shall reimburse the I/T/U utilizing the current Fee-for-Services reimbursement methodology as defined by the State Plan. The

following is a list of exclusions to the I/T/U OMB encounter/ All Inclusive Rate (AIR):

i. Drugs and vaccines procured free of charge,
ii. Emergency supply dispensation,
iii. Eyeglasses,
iv. Prosthetic devices and hearing aids,
v. Diabetic testing supplies and continuous glucose monitors,
vi. Drug counseling or medication therapy management,
vii. 340B drugs,
viii. Medicare Part-B drugs,
ix. Medication assisted treatment (MAT) drugs,
x. Professional dispensing fees,
xi. Collection of rebates,
xii. Drug delivery or mailing, and
xiii. Drugs dispensed to Members assigned to Family Planning Waiver benefit plans.

(9) Blood Glucose Diabetes Testing Supplies (BGDTS) and Continuous Glucose Monitors (CGM)

i. The BH I/DD Tailored Plan shall reimburse BGDTS and CGMs at the lesser of State Maximum Allowable Cost (SMAC) rates or the provider's billable charges reported by the provider in the Usual and Customary Charge field.
ii. The BH I/DD Tailored Plan shall reimburse BGDTS based on the per unit basis (Example: one (1) box contains hundred (100) strips and only forty (40) will be dispensed; provider should bill the BH I/DD Tailored Plan for forty (40) units).
iii. The BH I/DD Tailored Plan shall not pay professional dispensing fees (PDF) for pharmacy BGDTS or CGM.
iv. The BH I/DD Tailored Plan shall only cover BGDTS listed on the PDL at pharmacy point-of-sale (POS).
v. The BH I/DD Tailored Plan shall only cover therapeutic CGMs listed on the PDL at pharmacy POS.
vi. The BH I/DD Tailored Plan shall only cover BGDTS and CGMs within the quantity limits defined in the NC Medicaid Pharmacy DTS CMG Fee Schedule
vii. The BH I/DD Tailored Plan shall require PA for a therapeutic CGM dispensed through pharmacy POS.
viii. The BH I/DD Tailored Plan shall cover non-therapeutic CGMs under DME. The BH I/DD Tailored Plan shall ensure the provider submits a non-therapeutic CGM as a medical claim.
ix. The BH I/DD Tailored Plan shall not cover therapeutic CGMs under the DME program.

(10) Medical Professional Drug Claims

i. Hospital Outpatient Drug Claims
   a) The BH I/DD Tailored Plan shall ensure drugs utilized in the Outpatient Hospital setting are billed to the BH I/DD Tailored Plan at their usual and customary charge, including those drugs used from the 340B inventory (rebates are collected on non 340B drugs in this setting).
   b) The BH I/DD Tailored Plan shall ensure providers bill transactions of outpatient hospital services to the BH I/DD Tailored Plan on a UB-04 or 837i transaction. The drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp RCC).

c) The requirements in this section apply to physician practices that are part of a hospital-based clinic (e.g., the clinic is a department of a hospital). Drugs are included in the outpatient hospital reimbursement methodology (Total Allowable billable charges x Hosp) RCC).

ii. Hospital Inpatient Drug Claims

a) The BH I/DD Tailored Plan shall reimburse the cost of drugs in the inpatient hospital setting utilizing the inpatient hospital reimbursement methodology, based on diagnosis-related group (DRG) (rebates are not collected for 340B drugs in this setting).

iii. Physician Administered Drug Program (PADP)

a) The BH I/DD Tailored Plan shall reimburse procedure coded drugs covered under the PADP and shall require providers to bill the BH I/DD Tailored Plan utilizing the CMS form 1500/837p.

b) The BH I/DD Tailored Plan shall require claims to be billed by providers utilizing the HCPCS and NDC combination per the NDC: HCPS Crosswalk file.

c) The BH I/DD Tailored Plan shall ensure drugs used in the PADP program are eligible for rebate (rebates are collected for drugs under this program, except for 340B drugs, radiopharmaceuticals, vaccines, and Crofab).

d) The BH I/DD Tailored Plan shall ensure 340B Drugs listed under the PADP are billed by the provider to the BH I/DD Tailored Plan at Acquisition Cost.

e) The BH I/DD Tailored Plan shall ensure the provider bills 340B drugs under CMS form 1500/837p with UD Modifiers, at 340B acquisition cost (purchase price) in the usual and customary Charge (U&C) field (rebates are not collected for 340B claims in this setting).

iv. Federally Qualified Health Centers/Rural Health Clinics

a) The BH I/DD Tailored Plan shall reimburse Federally Qualified Health Centers and Rural Health Clinic facilities for medical professional drugs eligible for reimbursement by the respective provider taxonomy at no less than one hundred percent (100%) of the NC Medicaid Physician Administered Drug Program (PADP) fee schedule.

b) The BH I/DD Tailored Plan shall require FQHC/RHC facilities to bill 340B drugs at 340B actual acquisition cost.

c) The BH I/DD Tailored Plan shall reimburse FQHC/RHC facilities for 340B drugs at the 340B acquisition cost plus a professional dispensing fee for point of sale (POS) claims. The BH I/DD Tailored Plan shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit National Council for Prescription Drug Programs (NCPDP) codes to identify claims for drugs, which were purchased through the 340B program. The BH I/DD Tailored Plan shall require the covered entity to submit claims using the NCPDP code "8" in the Basis of Cost Determinations field 423-DN and "20" in the submission clarification field 420-DK at the POS.

d) The BH I/DD Tailored Plan shall reimburse FQHC/RHC facilities for 340B drugs submitted as professional claims at the 340B acquisition cost. The BH I/DD Tailored Plan shall require the FQHC/RHC to submit professional claims utilizing the UD modifiers.

e) The BH I/DD Tailored Plan shall reimburse FQHC/RHC facilities in compliance with ingredient costs as prescribed in *Section V.C.3.h.ii a) – f).*

(11) The NC Medicaid Direct Fee-for-Service rates includes the National Average Drug Acquisition Cost (NADAC). If there is no NADAC: Wholesale Acquisition Cost (WAC), or

State Maximum Allowable Cost (SMAC) list, and other financial arrangements established by the Department.

(12) Based on lesser of logic methodology, such that the pharmacy is reimbursed the usual and customary cost or GAD if it is less than the NADAC, WAC or SMAC.

(13) 340B hemophilia purchased drugs are reimbursed based on the Hemophilia reimbursement methodology which reimburses 340B ingredient drugs at the lesser of Ceiling Prices (CP), Usual and Customary Charges (U&C)+Professional Dispensing Fess or the Gross Amount Due (GA).

(14) Non-340 hemophilia drugs are reimbursed based on the Hemophilia reimbursement methodology which reimburses Non-340B ingredient drugs at the lesser of Actual Acquisition Costs (AC), Usual and Customary Charges (U&C) or the Gross Amount Due (GAD).

(15) The BH I/DD Tailored Plan shall reimburse the Indian Health Services or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/TU) as defined in section 4 of Indian Health Care Improvement Act (25 U.S.C 1603 and authorized by Public Law 93-638 Agreement) for drugs with calculated allowable amount of less than $1,000 at the OMB encounter reimbursement methodology, which will pay a maximum of two (2) OMB encounter payments. Any additional drugs (3 and up) calculated at OMB encounter rate will pay zero. For drugs with calculated allowable amount equal or greater than $1,000 the I/T/U will continue to reimburse at current Fee-for-Services rates. The following is a list of exclusion to the I/T/U OMB encounter (AIR) POS Pharmacy reimbursement methodology:

i. Drugs and vaccines free of charge,
ii. Emergency supply dispensation,
iii. Eyeglasses,
iv. Prosthetic devices and hearing aids,
v. Diabetic testing supplies and continuous glucose monitors,
vi. Drug counseling or medication therapy management,
vii. 340B drugs,
viii. Medicare Part-B drugs,
ix. Medication assisted treatment (MAT) drugs,
x. Professional dispensing fees,
xi. Collection of rebates,
xii. Drug delivery or mailing, and
xiii. Drugs dispensed to beneficiaries assigned to Family Planning Waiver benefit plans.

(c) The BH I/DD Tailored Plan shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.

(d) Subject to Department review and approval, in Contract Year 2, or per NC G.S. Section 9D.19A. (a) whichever is later, the BH I/DD Tailored Plan may develop its own pharmacy contracting for ingredient reimbursement if the BH I/DD Tailored Plan can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the BH I/DD Tailored Plan must also submit a pharmacy network access monitoring plan.

(e) The BH I/DD Tailored Plan shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the BH I/DD Tailored Plan.

(f) Reimbursement Inquiries. The BH I/DD Tailored Plan shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.

vv. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (ix) Drug Rebates, (a) Ingredient Costs* is revised and restated in its entirety as follows:

(a) The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid to a BH I/DD Tailored Plan. The BH I/DD Tailored Plan or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid program. If the BH I/DD Tailored Plan or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.

ww. *Section V. Scope of Services, B. Medicaid, 2. Benefits, iv. Non-Emergency Medical Transportation, (viii)* is revised and restated in its entirety as follows:

(viii) The individuals included in *Section V.B.2. First Revised and Restated Table 9: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the BH I/DD Tailored Plan.

Section V.B.2. First Revised and Restated Table 9: Individuals Not Eligible to Receive NEMT Services	
Population	**Additional Detail**
Members in a nursing home	The facility is responsible for providing transportation to their patients.
Members in a long-term care facility	The facility is responsible for providing transportation to their patients.
Members during an inpatient hospital stays	Not a covered benefit
Members in the Innovations waiver obtaining Day Supports, Respite, Community Living and Support, or Supported Employment services	Transportation is included in the Medicaid provider's payment; members can use NEMT for transportation to other services
Members in the TBI waiver obtaining Supported Employment, Day Supports, Cognitive Rehabilitation or Community Networking	Transportation is included in the Medicaid provider's payment; members can use NEMT for transportation to other services

xx. *Section V. Scope of Services, B. Medicaid, 3. Care Management, i. Overview* is revised to add the following:

(vii) The BH I/DD Tailored Plan will ensure that all Tailored Care Management and care coordination are implemented with the goal that people with disabilities have a right under the Rehabilitation Act, Americans with Disabilities Act, and the US Supreme Court decision in Olmstead v LC (1999), to receive community-based services that meet their needs in the most integrated setting possible. The BH I/DD Tailored Plan will appoint an Olmstead manager who will work in connection with the State Olmstead Committees. In addition, the BH I/DD Tailored Plan will create an Olmstead Plan that aligns with the State Olmstead plan.

yy. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (i) Model Overview and Objectives, (a)-(c)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan must ensure that care managers delivering Tailored Care Management coordinate across a member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.

(b) Reserved.

(c) The BH I/DD Tailored Plan should make Tailored Care Management available to all BH I/DD Tailored Plan members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services as defined in *Section V.B.3.ii.(xix)(g) Duplication of Care Management*.

zz. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ii) Delivery of Tailored Care Management, (a), (2)* is revised and restated in its entirety as follows:

(2) Care Management Agency (CMA): To be eligible to become a CMA, an organization must, at the time of certification, have as its primary purpose the delivery of NC Medicaid or State-funded Services, other than Care Management, to the BH I/DD Tailored Plan eligible population in North Carolina. Provider organizations must be certified as a CMA to provide Tailored Care Management as defined in *Section V.B.3ii.(xviii) Certification of AMH+ Practices and CMA*s.

aaa. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ii) Delivery of Tailored Care Management, (b) Provider-based Tailored Care Management, (3)* is revised and restated in its entirety as follows:

(3) The BH I/DD Tailored Plan shall meet annual requirements established by the Department for the percentage of Members actively engaged in Provider-based Tailored Care Management approaches, meaning Members who are receiving at least one (1) of the following six (6) core Health Home services in that month:

i. Comprehensive care management: a team-based, person centered approach to effectively manage Members' medical, social and behavioral conditions;

ii. Care coordination: the act of organizing Member care activities and sharing information among all the participants involved with a Member's care to achieve safer and more effective care. Through organized care coordination, Members' needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care;

iii. Health promotion: education and engagement of a Member in making decisions that promote achievement of good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems;

iv. Comprehensive transitional care/follow-up: the process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions);

v. Individual and family supports: the coordinating of information and services to support Health Home members (or their caretakers/guardian) to maintain and promote the quality of life, with particular focus on community living options; or

vi. Referral to community and social support services: providing information and assistance for the purpose of referring Health Home members to resources that address their unmet-health resource needs identified in the care plan/ISP.

vii. Reserved.

viii. The percentage shall be calculated as:

a) Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department.
b) Denominator: Total number of eligible members actively engaged in Tailored Care Management.

ix. CMS guidance on the core Health Home service definitions and related activities can be found at the following website: https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf.

bbb. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ii) Delivery of Tailored Care Management, (b) Provider-based Tailored Care Management, (4)* is revised and restated in its entirety as follows:

(4) Each year, the Department will divide the amount of Tailored Care Management that was delivered by AMH+s and CMAs (and Clinically Integrated Networks (CINs) or Other Partners on their behalf) to Members of both the PIHP and BH I/DD Tailored Plan by the amount of all Tailored Care Management delivered to members of the PIHP and BH I/DD Tailored Plan. The annual required percentages for Provider-based Care Management delivered to the PIHP and BH I/DD Tailored Plan members are as follows:

i. Contract Year 1: thirty-five percent (35%);
ii. Contract Year 2: forty-five percent (45%);
iii. Contract Year 3: sixty percent (60%); and
iv. Contract Year 4: eighty percent (80%).

ccc. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (iii) Eligibility for Tailored Care Management* is revised and restated in its entirety as follows:

(iii) Eligibility for Tailored Care Management

(a) All members, including those enrolled in North Carolina's 1915(c) Innovations and TBI waivers and those using 1915(i) services, are eligible for Tailored Care Management, with the following exceptions for members participating in services that are duplicative of Tailored Care Management:

(1) Members obtaining Assertive Community Treatment (ACT);
(2) Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
(3) Reserved;
(4) Members participating in the High-Fidelity Wraparound program as described in *Section V.B.3.v.(v) High-Fidelity Wraparound*;
(5) Members obtaining Child Assertive Community Treatment (Child ACT);
(6) Members obtaining Critical Time Intervention;
(7) Members receiving services through SNFs for more than ninety (90) Calendar Days; and
(8) Members receiving any approved ILOS that are deemed duplicative through the Department's ILOS approval process.

ddd. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (iv) Enrollment in Tailored Care Management, (b), (3)* is revised and restated in its entirety as follows:

(3) The BH I/DD Tailored Plan shall provide care coordination and manage care transitions for members who opt-out of Tailored Care Management as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*.

i. In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver.

ii. In cases where a member obtaining 1915(i) services opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the care coordination services as stipulated by *Section V.B.3. xiii. Additional Care Coordination Functions for Members Obtaining 1915(i) Services*.

eee. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (v) Tailored Care Management Assignment* is revised and restated in its entirety as follows:

(v) Tailored Care Management Assignment and Re-Assignment

(a) The BH I/DD Tailored Plan shall ensure that all members, including those enrolled in the Innovations or TBI waiver, have a choice of care management approach (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management)*. To facilitate timely engagement in Tailored Care Management, the Department shall make initial Tailored Care Management assignments as described in the Technical Specifications for Tailored Care Management Provider Assignment. The BH I/DD Tailored Plan shall make Tailored Care Management assignments for Medicaid Members enrolled in the BH I/DD Tailored Plan after November 30, 2022, using a methodology, consistent with the requirements in this Section, that has been reviewed and approved by the Department. The assignment process for Tailored Care Management shall be distinct from the Primary Care Provider (PCP) assignment process described in *Section V.B.1.vii.(ii) PCP Choice and Assignment*.

(b) The BH I/DD Tailored Plan must submit to the Department its methodology for assigning and re-assigning eligible members to Tailored Care Management based at an AMH+ practice, a CMA or the BH I/DD Tailored Plan.

(1) The methodology shall include how a BH I/DD Tailored Plan will address re-assignment of a Member (e.g., when an AMH+ or CMA no longer participates in the Tailored Care Management program). The re-assignment methodology must be consistent with the requirements in this Section.

(c) The BH I/DD Tailored Plan must assign members to a mix of the three Tailored Care Management approaches (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*) according to the factors described in the Technical Specification for Tailored Care Management Provider Assignment.

(d) The BH I/DD Tailored Plan shall assign members to the most clinically appropriate care management approach as based on the factors described in herein . The BH I/DD Tailored Plan must assign each AMH+ and CMA providing Tailored Care Management a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the model.

(e) The BH I/DD Tailored Plan must ensure that Tailored Care Management assignment aligns with the annual requirements for Provider-based Care Management as described in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*.

(f) In addition to the factors outlined in the Technical Specifications for Tailored Care Management Provider Assignment, the BH I/DD Tailored Plan shall consider the following

factors when assigning each Member to care management at an AMH+ practice or a CMA, or at the BH I/DD Tailored Plan level:

(1) For Innovations and TBI waiver enrollees:

i. If the member enrolled in the Innovations or TBI waiver has an existing relationship with an LME/MCO care coordinator who meets the Tailored Care Management qualifications and training requirements as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements* and is employed by the member's BH I/DD Tailored Plan or in the BH I/DD Tailored Plan's network, the BH I/DD Tailored Plan must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.

ii. The BH I/DD Tailored Plan shall assign members enrolled in the Innovations or TBI waiver to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) waiver enrollees. 42 C.F.R. § 431.301(c)(1)(vi). The BH I/DD Tailored Plan shall ensure that members do not obtain both 1915(c) waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.

iii. BH I/DD Tailored Plan RN/OT teams are responsible for ensuring that the medical and functional needs of its TCL Members are identified and addressed. Duties include:

1. Conducting medical and functional assessments for Members who have complex needs prior to the transition from a facility to the community. The assessment must include a review of the medical records.
2. Developing a plan of care based on the medical and functional assessments, discussions with current staff and medical provider(s), and on the Member's goals and choices.
3. Seeking an FL2 from the medical provider for any physical health or personal care services that the Member will need to improve health status once in the community.
4. Evaluating the housing unit selected by the Member to ensure that it meets the functional needs identified in the assessment.
5. Ordering any adaptive equipment, durable medical equipment, assistive technology, or medical supplies that the Member will need once in housing.
6. Observing the Member during medication administration to determine the training needs, technology reminders, and level of confidence that the Member has to administer their own medication and what level of support that they will need.
7. Connecting the Member with primary care and/or specialty care as needed and in close proximity to the area the person chooses to live, as much as can be reasonably accomplished and/or ensuring that transportation is identified and made available to the member for Doctor's visits.
8. Training behavioral health providers on the plan of care.
9. Visiting the home on the first full day that the Member is in the home to ensure that all medical, adaptive, and assistive devices and supplies are in place. Vital signs should be taken at the home, when needed.
10. Working with Tailored Care Managers to understand and to monitor the medical and functional needs of the person and for ensuring that the requirements found in the plan of care are carried out. The RN/OT teams must continue engagement for the first ninety (90) Calendar Days that the member is in the community.

(g) The BH I/DD Tailored Plan shall permit members to change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause.

(h) The Department shall consider the following as appropriate cause for changes in care management approach, assigned organization providing Tailored Care Management, and care manager:

(1) The AMH+, CMA, BH I/DD Tailored Plan or care manager has, as determined by the Member or the BH I/DD Tailored Plan, failed to furnish accessible and appropriate services to which the member is entitled.

(2) The AMH+, CMA, BH I/DD Tailored Plan or care manager is not able to reasonably accommodate the member's needs.

(3) There is a change in the accessibility of the AMH+, CMA, BH I/DD Tailored Plan or care manager, including but not limited to the following:

i. The organization or care manager moves to a location that is not convenient for the member.

ii. There is a Significant Change in the hours the AMH+ practice or CMA is open and the member cannot reasonably meet during the new hours.

iii. There is a Significant Change in the hours the care manager is available and the member cannot reasonably meet during the new hours.

(4) The member determines that a change would be in the best interest of the member.

(5) The member's assigned AMH+ practice or CMA leaves the BH I/DD Tailored Plan's Network or is no longer certified by the Department.

(6) The member's assigned AMH+ practice or CMA becomes excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).

(7) The care manager is no longer employed by the AMH+, CMA, or BH I/DD Tailored Plan.

(i) The BH I/DD Tailored Plan shall have a Tailored Care Management reassignment process that provides guidance for the assignment of Members who have significant changes in their needs and may be better served by a different care management approach (CMA, AMH+ or plan based care management). Member choice must be honored in any reassignment algorithm designed by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall submit its policies and procedures for Care Management comprehensive assessments as part of its Care Management Policy.

(j) The BH I/DD Tailored Plan shall educate members on the three different care management approaches and provide unbiased counseling on selecting a care management Provider as part of the choice period prior to launch.

(k) The BH I/DD Tailored Plan shall send members information on Tailored Care Management, with information on their Tailored Care Management assignment and options for changing their assignment as part of the Member Welcome Packet.

(l) After the initial launch of the BH I/DD Tailored Plan, on an ongoing basis the BH I/DD Tailored Plan shall complete Tailored Care Management assignments and send Tailored Care Management assignment and information to new members as part of the Member Welcome Packet. In the event an existing member is re-assigned to a new Tailored Care Management Entity, the BH/IDD Tailored Plan shall send the Tailored Care Management insert with the member's new assignment information.

(m) Reserved.

(n) The BH I/DD Tailored Plan must share with each AMH+ practice and CMA, at least monthly, a roster of their assigned members and members' current contact and demographic information in a manner specified by the Department.

(o) The BH I/DD Tailored Plan must share each member's assignment to the organization providing Tailored Care Management with the member's PCP within fourteen (14) Calendar Days of assignment. Upon changes in the member's assigned PCP, the BH I/DD Tailored Plan must share the member's Tailored Care Management organization assignment with the member's new PCP within fourteen (14) Calendar Days of assignment to the new PCP.

(p) The BH I/DD Tailored Plan must share with each AMH+ and CMA all data elements specified in *Section V.B.3ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*

(q) The BH I/DD Tailored Plan must assign and must ensure that AMH+ practices and CMAs assign the member to a care manager with appropriate qualifications and experience according to the member's needs within thirty (30) Calendar Days of BH I/DD Tailored Plan enrollment.

(r) The BH I/DD Tailored Plan shall submit its policies and procedures for Tailored Care Management assignment as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

(s) After the initial launch of the BH I/DD Tailored Plan, on an ongoing basis BH I/DD Tailored Plan shall complete Tailored Care Management assignment and send the TCM insert within fourteen (14) Calendar Days of a member assignment being accepted by NC FAST. In the event an existing member is re-assigned to a new Tailored Care Management Entity, BH I/DD Tailored Plan shall send a notice containing at least the member's new assignment information.

fff. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (vi) Outreach and Engagement, (a), (1)* is revised and restated in its entirety as follows:

(1) For the purpose of starting the care management comprehensive assessment, contact or outreach may be telephonic, through two-way real time video and audio conferencing, or in-person.

ggg. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (vi) Outreach and Engagement* is revised to add the following:

(d) Beginning July 2024, the BH I/DD Tailored Plan shall provide an annual notice to medication management, including Tailored Care Management describing the program and the process for selecting an organization providing Tailored Care Management.

hhh. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (vii) Care Management Comprehensive Assessment* is revised and restated in its entirety as follows:

(vii) Care Management Comprehensive Assessment [17]

(a) The BH I/DD Tailored Plan must share the results of the care needs screening, as described in Section V.B.3.iii.(vi)(c) Care Needs Screening, with the assigned organization providing Tailored Care Management.

(b) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management is responsible for conducting the care management comprehensive assessment.

(c) The BH I/DD Tailored Plan shall ensure that the care management comprehensive assessment is conducted in a location that meets the member's needs.

[17] The care management comprehensive assessment is unrelated to the comprehensive clinical assessment and does not serve as a means to approve services.

(d) The BH I/DD Tailored Plan shall ensure that care managers make a best effort attempt to complete the care management comprehensive assessment in person, realizing that in limited instances it will be necessary to complete the care management comprehensive assessment via technology conferencing tools (e.g., audio and/or video tools).

(e) The BH I/DD Tailored Plan shall verify that care management comprehensive assessments are completed in a timely manner as part of routine monitoring.

(f) The assigned organization providing Tailored Care Management shall make its best effort to complete the care management comprehensive assessment within the following timeframes:

(1) Members identified as high acuity: Best efforts to complete it within forty-five (45) Calendar Days of BH I/DD Tailored Plan enrollment and no longer than sixty (60) Calendar Days of BH I/DD Tailored Plan enrollment. 42 C.F.R. § 438.208(b)(3).

(2) Members identified as medium/low acuity: Within ninety (90) Calendar Days of BH I/DD Tailored Plan enrollment. 42 C.F.R. § 438.208(b)(3).

(3) For purposes of provisions related to Tailored Care Management, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, to contact the member if the first attempt is unsuccessful.

(g) During Contract Years after Contract Year 1, the BH I/DD Tailored Plan shall ensure that care managers make best efforts to complete the care management comprehensive assessment for new members within ninety (90) Calendar Days of BH I/DD Tailored Plan enrollment. 42 C.F.R. § 438.208(b)(3).

(h) The BH I/DD Tailored Plan shall ensure that, as part of completing the care management comprehensive assessment, the assigned care manager at the organization providing Tailored Care management ask for the member's consent for participating in Tailored Care Management.

(1) As part of the consent process, the care manager must explain the Tailored Care Management program.

(2) Care managers should document in the care management data system that the member provided consent, including the date of consent in addition to any 'wet' or electronic signatures required on the ISP for members on the Innovations and TBI waivers.

(i) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management make available the results of the care management comprehensive assessment to the member's PCP, BH, I/DD, TBI and LTSS providers, and the BH I/DD Tailored Plan within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, provided that the member consents to making results available, if required by law. The BH I/DD Tailored Plan shall not withhold medically necessary services for members while awaiting completion of the care management comprehensive assessment.

(j) The BH I/DD Tailored Plan must attempt a care management comprehensive assessment at least annually for enrolled members who:

(1) Have neither opted out nor engaged in Tailored Care Management, and

(2) Are not receiving services duplicative of Tailored Care Management.

(k) The BH I/DD Tailored Plan shall ensure that a reassessment for members already engaged in Tailored Care Management is done:

(1) At least annually;

(2) When the member's circumstances, needs or health status changes significantly;

(3) Reserved;

(4) At the member's request;
(5) After triggering events, including:
i. Inpatient hospitalization for any reason ;
ii. Two (2) emergency department (ED) visits since the last care management comprehensive assessment (including reassessment);
iii. An involuntary treatment episode;
iv. Use of BH crisis services;
v. Arrest or other involvement with law enforcement/the criminal justice system, including Division of Juvenile Justice;
vi. Becoming pregnant and/or giving birth;
vii. A change in member circumstances that results in an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend/caretaker, or any other circumstance the plan deems to be a change in circumstance;
viii. Loss of housing;
ix. Reserved; and
x. Change in scores on Department-approved level-of-care determination and screening tools (e.g., ASAM, Child and Adolescents Needs and Strengths (CANS), Adult Needs and Strengths Assessment (ANSA), SIS®, and Rancho Los Amigos Levels of Cognitive Functioning Scale).

(l) When a member requests a reassessment; experiences a Significant Change in circumstances, needs or health status; experiences a significant change in level of care score; or experiences a triggering event, the BH I/DD Tailored Plan shall ensure that the member receives a reassessment within thirty (30) Calendar Days of when the BH I/DD Tailored Plan detects the change or event. Reassessments triggered by pregnancy or childbirth must address pregnancy-specific SUD and mental health screening covering the physical and BH needs of the infant and mother.

(m) In circumstances in which a care management comprehensive assessment may have been recently performed in the past six (6) months for MHSA IDD members (excluding innovations) or twelve (12) months for innovations or TBI members, reassessment may consist of an addendum or update to a previous care management comprehensive assessment.

(n) The BH I/DD Tailored Plan shall develop methodologies and tools for conducting the care management comprehensive assessment, as appropriate for differing member demographics and needs.

(o) The BH I/DD Tailored Plan shall incorporate the results of the care needs screening into the care management comprehensive assessment to the extent feasible.

(p) The care management comprehensive assessment shall address, at a minimum, the following:
(1) Immediate care needs;
(2) Current services and providers across all health needs;
(3) Functional needs, accessibility needs, strengths and goals;
(4) Other state or local services currently used;
(5) Physical health conditions, including dental conditions;
(6) Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
(7) Physical, intellectual and/or developmental disabilities;

(8) Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;
(9) Advanced directives, including advance instructions for mental health treatment;
(10) Available informal, caregiver or social supports;
(11) Standardized Unmet Health-Related Resource Needs questions to be provided by the Department covering four (4) priority domains:
  i. Housing;
  ii. Food;
  iii. Transportation; and
  iv. Interpersonal Violence/Toxic Stress;
(12) Any other ongoing conditions that require a course of treatment or regular care monitoring;
(13) For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;
(14) Risks to the health, well-being, and safety of the member and others (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols);
(15) Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
(16) Employment/community involvement;
(17) Education (including individualized education plan and lifelong learning activities) ;
(18) Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
(19) Risk factors that indicate an imminent need for LTSS;
(20) Caregiver's strengths and needs;
(21) Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.);
(22) Self-management and planning skills; and
(23) Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare.

(q) For members with an I/DD or TBI diagnosis, the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* plus the following:
  (1) Financial resources and money management; and
  (2) Alternative guardianship arrangements, as appropriate.

(r) For members ages zero (0) up to age three (3), the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* and incorporate questions related to Early Intervention (EI) services for children, including:
  (1) Whether the child is receiving EI services;
  (2) Member's current EI services;
  (3) Frequency of EI services provided;
  (4) Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and
  (5) Contact information for the CDSA service coordinator.

(s) For BH I/DD Tailored Plan members ages three (3) up to twenty-one (21) with a mental health disorder and/or SUD who are receiving BH or substance abuse services, including members with a dual I/DD and mental health or SUD diagnosis, the care management comprehensive assessment shall incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community.

(t) The BH I/DD Tailored Plan's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.

(u) For specific requirements related to care management comprehensive assessments for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.

(v) The BH I/DD Tailored Plan will be required to send a monthly report listing all members who received the Standardized Unmet Health-Related Resource Needs screening in the form and manner specified by the Department. See *Section VII. Second Revised and Restated Attachment J: Reporting Requirements* for more detail.

(w) The BH I/DD Tailored Plan shall submit its policies and procedures for Care Management comprehensive assessments as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

iii. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (a)* is revised and restated in its entirety as follows:

(a) Using the results of the care management comprehensive assessment, the assigned organization providing Tailored Care Management shall develop a Care Plan/ ISP. 42 C.F.R. § 441.725.

jjj. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (e)* is revised and restated in its entirety as follows:

(e) The BH I/DD Tailored Plan shall ensure the assigned care manager makes best efforts to complete an initial Care Plan or ISP within thirty (30) Calendar Days of the completion of the care management comprehensive assessment.

(1) For purposes of completing an Initial Care Plan, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, to contact the member if the first attempt is unsuccessful.

kkk. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (h)* is revised and restated in its entirety as follows:

(h) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP incorporates results of the care management comprehensive assessment (including Unmet Health-Related Resource Needs questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:

(1) CANS;
(2) ANSA;
(3) SNAP
(4) ASAM criteria;
(5) For Innovations waiver enrollees: SIS®;
(6) For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale; and
(7) For members obtaining or seeking to obtain 1915(i) services: independent assessment.

lll. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (j)* is revised and restated in its entirety as follows:

(j) For members with SED, I/DD, or TBI, the Care Plan/ISP should also include caregiver supports, including connection to respite services, as necessary.

mmm. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (o)* is revised and restated in its entirety as follows:

(o) For specific requirements related to Care Plan/ISPs for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.

nnn. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ix) Care Team Formation, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall ensure that the multidisciplinary care team consists of the following participants as applicable depending on member needs:
(1) The member;
(2) Caretaker(s)/legal guardians;
(3) The member's care manager;
(4) Supervising care manager;
(5) Care manager extenders (e.g., community navigators, community health workers, individuals with lived experience with an I/DD or a TBI, parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition);
(6) PCP;
(7) BH provider(s);
(8) I/DD and/or TBI providers;
(9) Other specialists;
(10) Nutritionists;
(11) Pharmacists and pharmacy techs;
(12) The member's obstetrician/gynecologist;
(13) Peer support specialist;
(14) In-reach and/or transition staff; and
(15) Other providers, as determined by the care manager and member.

ooo. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall ensure that each member who is actively engaged in Tailored Care Management receives care management in alignment with the goals outlined in their Care Plan or ISP.

ppp. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management, (c), (9)* is revised and restated in its entirety as follows:

(9) Conducting medication management, including regular medication reconciliation (conducted by appropriate care team member; a community pharmacist at the CIN level may assume this role,

in coordination with the AMH+ or CMA) support of medication adherence, and metabolic monitoring (for individuals prescribed antipsychotic medications.

qqq. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management, (l)* is revised and restated in its entirety as follows:

(l) The BH I/DD Tailored Plan must ensure that the assigned organization providing Tailored Care Management meet the minimum contact requirements for members according to their acuity tier as outlined below, unless the member expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP and reviewed with the supervising care manager, or if the member is enrolled in the Innovations waiver (as described in *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver*). Contacts may be delivered by the care manager, or care manager extenders, or staff supervised by the care manager, including but not limited to peer support specialists; provided, however, that only contacts delivered by the care manager or care manager extender shall count towards meeting contact requirements. In-person contact requirements must be met as described below. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing, If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The Department intends to release additional guidance on circumstances in which a member's acuity tier may change.

(1) Care manager contacts for members with BH needs
    i. High Acuity: At least four (4) care manager-to-member contacts per month, including at least one (1) in-person contact with the member
    ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    iii. Low Acuity: At least two (2) care manager-to-member contacts per month and at least two (2) in-person contacts member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person)

(2) Care manager contacts for members with an I/DD or TBI
    i. High Acuity: At least three (3) care manager-to-member contacts per month, including at least two (2) in-person contacts.
    ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
    iii. Low Acuity: At least one (1) telephonic or two-way real time video and audio conferencing, contact per month and at least two (2) in-person care manager-to-member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).

(3) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.

(4) For members with I/DD or TBI who have a guardian, telephonic or two-way real time video and audio conferencing contact may be with a Legally Responsible Person in lieu of the member, where appropriate or necessary. In-person contacts must involve the member.
(5) In the event that a care manager or care manager extender delivers multiple contacts to a member in one day, only one contact will count towards meeting the contact requirements.

rrr. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management* is revised to add the following:

(o) Care management extenders may support care managers in delivering Tailored Care Management by performing activities that fall within the below categories.
(1) When an extender performs one of the functions listed below, it may count as a Tailored Care Management contact if phone, video and audio, or in-person contact with the member is made:
i. Performing general outreach, engagement, and follow-up with members;
ii. Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation);
iii. Engaging in health promotion activities (as defined in the Tailored Care Management Provider Manual) and knowledge sharing;
iv. Sharing information with the care manager and other members of the care team on the member's circumstances;
v. Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services;
vi. Participating in case conferences; or
vii. Support the care manager in assessing and addressing unmet health-related resource needs.
(2) A care manager shall be solely responsible for:
i. Completing the care management comprehensive assessment;
ii. Developing the Care Plan/ISP;
iii. Facilitation of case conferences;
iv. Ensuring that medication monitoring and reconciliation occur;
v. Continuous monitoring of progress toward the goals identified in the Care Plan/ISP; and
vi. Managing care transitions, including creating 90-day transition plans.

sss. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xi) Transitional Care management, (b)-(c)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period for their assigned RN and OT care managers.
(c) The BH I/DD Tailored Plan shall ensure that CMAs and AMH+s providing Tailored Care Management carry out the following transitional care management functions.
(1) Ensure that a care manager is assigned to manage the transition.
(2) Have a care manager assume coordination responsibility for transition planning.
(3) Begin discharge planning no later than seven (7) Calendar Days after the member's admission, including convening a discharge team to assist the member in developing a plan to achieve outcomes that promote the member's growth, well-being and independence, based on the member's strengths, needs, goals and preferences, in the

most integrated setting appropriate in all domains of the member's life (including community living, activities, employment, education, recreation, and healthcare).

(4) Have a care manager or care team member make best efforts to contact the member during their stay in an institution (e.g., acute, subacute and long–term stay facilities) and contact them on the day of discharge.

(5) For individuals in TCL with RN and OT care management, ensure that RN/OT conduct medical and functional assessments, and pre-transition housing walk-through prior to discharge for TCL participants.

(6) Conduct outreach to the member's providers.

(7) Ensure development of a written discharge plan through a person-centered planning process in which the member.

(8) Review the discharge plan with the member and facility staff.

(9) Facilitate clinical handoffs.

(10) Make best efforts to have all services and supports included in discharge plan will be in place and available to the member on the day of discharge, confirm that the member can be safely discharged without such supports or else seek to postpone the discharge until ~~all~~ such services and supports required for safe discharge, in the sole discretion of the discharge and transition team are in place.

(11) Ensure effective implementation of the written discharge plan, including without limitation, the provision of all services and supports at the frequency, duration, intensity, and type agreed upon by the member and the transition team in the member's Care Plan/ISP.

(12) For member with a history of re-admission or crises, the factors that led to re-admission or crises and the services, supports, and recovery-oriented interventions shall be identified and addressed in the crisis plan section of the member's Care Plan/ISP.

(13) Refer and actively assist members in accessing and obtaining needed social services and supports identified as part of the transitional care management process, including housing in their written discharge plan.

(14) Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.

(15) Develop a ninety (90) day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff and the member's care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.

i. The ninety (90) day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP.

ii. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) day post-discharge transition plan.

iii. The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.

iv. Development of a ninety (90) day post-discharge transition plan is *not* required for all ED visits, but may be developed according to the care manager's discretion.

v. The assigned organization providing Tailored Care Management shall communicate with and provide education to the member and the member's caregivers and providers to promote understanding and implementation of the ninety (90) day post-discharge transition plan.

(16) Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.
(17) Ensure that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.
(18) Arrange to visit the member in the new care setting after discharge/transition.
(19) Conduct a care management comprehensive assessment within thirty (30) Calendar Days of the discharge/transition or update the current assessment.
(20) Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) Calendar Days of the discharge/transition based on the results of the care management comprehensive assessment.

ttt. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xiv) Staffing and Training Requirements* is revised and restated in its entirety as follows:

(xiv) Staffing and Training Requirements
(a) The BH I/DD Tailored Plan shall ensure that each care manager is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers with exceptions for extenuating circumstances for no longer than three (3) months.
(b) Supervisors cannot have a caseload, but will provide coverage for vacation, sick leave, or unforeseen staffing shortages. They will be responsible for reviewing all Tailored Care Management care plans and Individual Support Plans (ISPs) are complete, reviewing them for quality control, and will provide guidance to care managers on how to meet members' needs.
(c) The BH I/DD Tailored Plan shall ensure that the organizations providing Tailored Care Management (AMH+ practices, CMAs, or Plan Based have access to clinical consultants in order to access expert support appropriate for the needs of the panel under Tailored Care Management. Clinical consultants are not part of the care team for any given member; rather, the role of clinical consultants is to provide subject matter expert advice to the care team. The AMH+ or CMA may employ or contract with consultants or do so through a CIN or Other Partner, and the consultant should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.
(1) While different member needs will require different expertise, the AMH+ or CMA must ensure that it has access to at least the following experts:
i. A general psychiatrist or child and adolescent psychiatrist;
ii. A neuropsychologist or psychologist; and
iii. For CMAs, a primary care physician (PCP) to the extent the beneficiary's PCP is not available for consultation.
(2) AMH+ practices and CMAs may demonstrate that they have access to clinical consultants themselves or can contract with other provider organizations to arrange access. The per member per month (PMPM) rate for Tailored Care Management will take these costs into consideration.
(d) Care Management Staff Qualifications
(1) The BH I/DD Tailored Plan shall ensure that all care managers, supervising care managers and care manager extenders providing Tailored Care Management meet the following minimum qualification requirements, whether they are employed by the organization itself or employed at the CIN or Other Partner level:
i. Care managers serving all enrollees must have the following minimum qualifications:
a) Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 Waiver

Rules 10A NCAC 27G.0104 and 10A NCAC 28A.0102 related to the experience requirement for Qualified Professionals; and

b) For care managers serving members with LTSS needs: two years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. (This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.)

(2) The BH I/DD Tailored Plan shall ensure that all supervising care managers overseeing care managers performing Tailored Care Management have the following minimum qualifications:

i. Supervising care managers serving members with behavioral health conditions must have the following minimum qualifications:

a) A license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN); and

b) Three years of experience providing care management, case management, or care coordination to the population being served.

ii. Supervising care managers serving members with an I/DD or a TBI must have one of the following minimum qualifications:

a) A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI, or

b) A masters degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI, or

c) A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.

iii. If a member is dually diagnosed with a behavioral health condition and an I/DD or a TBI, the Tailored Plan and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the member's care manager.

iv. The Department will grant a one-time staff exception ('grandfathering') for specified BH I/DD Tailored Plan staff that:

a) Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan contract award (July 26, 2021).

b) This exception is based on the staff member possessing the required number of years of experience, but not the required degree, degree type or licensure type.

(3) To bolster the care management workforce, the Department will allow BH I/DD Tailored Plans AMH+ practices and CMAs to use care manager extenders, such as community navigators, community health workers, and certified peer support specialists, to support certain Tailored Care Management functions. The purpose of using care manager extenders is to help AMH+ practices, CMAs, and Tailored Plans best meet the needs of members, build efficient care teams by creating additional workforce capacity, and allow care managers and supervisors to focus on key tasks for assigned members as well as permit them additional time for members with intensive or complex needs.

i. Care manager extenders must have the following qualifications:

a) At least 18 years of age; and

b) A high school diploma or equivalent; and

c) Meet one of the following requirements:
    1. Be a person with lived experience with an I/DD or a TBI with demonstrated knowledge of and direct personal experience navigating the North Carolina Medicaid delivery system, or
    2. Be a person with lived experience with a behavioral health condition who is a Certified Peer Support Specialist, or
    3. A parent or guardian of an individual with an I/DD or a TBI or a behavioral health condition and has at least two years of direct experience providing care for and navigating the Medicaid delivery system on behalf of that individual (note that a parent/guardian cannot serve as an extender for their family member), or
    4. Has two years of paid experience performing the types of functions described in the "Extender Functions" section below, with at least one year of paid experience working directly with the Tailored Care Management eligible population.

ii. The care management functions of extenders must be directed by the care manager at an AMH+ practice, CMA, or Tailored Plan. The care manager and the care management supervisor must be able to direct all care management supports for members in order to ensure that all services are well coordinated. The Extender cannot work for the same organization where they receive services. The Department expects that a range of individuals will be able to meet these qualifications, including, but not limited to:
    a) Certified Peer Support Specialists;
    b) Community health workers (CHW), defined as individuals who have completed the NC Community Health Worker Standardized Core Competency Training (NC CHW SCCT);
    c) Individuals who served as Community Navigators prior to the implementation of Tailored Plans;
    d) Family Navigators;
    e) Parents or guardians of an individual with an I/DD or a TBI or a behavioral health condition (parent/guardian cannot serve as an extender for their own family member); and
    f) A person with lived experience with an I/DD or a TBI or a behavioral health condition.

(e) The BH I/DD Tailored Plan shall ensure all care managers and supervising care managers, care manager extenders serving its members, whether based at the BH I/DD Tailored Plan, AMH+ or CMA, are trained on all the topics described in this Section.

(f) The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes the following domains at a minimum in addition to any training requirements specified in N.C. G.S. § 122c-115.4:

(1) BH I/DD Tailored Plan eligibility and services:
    i. BH I/DD Tailored Plan eligibility criteria, services available through BH I/DD Tailored Plans, and differences between Standard Plan and BH I/DD Tailored Plan benefit packages;
    ii. Principles of integrated and coordinated physical and BH care and I/DD and TBI services;
    iii. BH crisis response;
    iv. Knowledge of Innovations and TBI waiver eligibility criteria;
    v. Understanding HCBS and available services; and

vi. Eligibility, assessment, and coordination of 1915(i) service including:
a) Process for conducting the state-designated assessment for individuals whose physical, cognitive, or mental conditions trigger a potential need for 1915(i) home and community-based services and supports,
b) Knowledge of available resources, service options, providers,
c) Requirements for ongoing coordination and monitoring of 1915(i) services, and
c) Best practices to improve health and quality of life outcomes (42 C.F.R. § 441.730(c).

(2) Whole-person health and unmet health-related resource needs
   i. Understanding and addressing ACEs, trauma, and trauma-informed care.
   ii. Understanding and addressing unmet health-related resource needs, including identifying, utilizing, and helping the member navigate available social supports and resources at the member's local level.
   iii. Cultural and Linguistic Competency, including member ability, considerations for tribal populations, nonwhite populations, and forms of bias that may affect BH I/DD Tailored Plan members.

(3) Community integration
   i. Independent living skills.
   ii. Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities.
   iii. Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community.
   iv. Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.

(4) Components of Health Home care management
   i. Health Home overview, including but not limited to Health Homes' purpose, target population, and services, in addition to members and their families' role in care planning.
   ii. Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas and facilitating meetings.

(5) Health promotion
   i. Providing education on members' chronic conditions.
   ii. Teaching self-management skills and sharing self-help recovery resources.
   iii. Conducting medication reviews and regimen compliance.
   iv. Promoting wellness and prevention programs.

(6) Other care management skills
   i. Transitional care management best practices.
   ii. Supporting health behavior change, including motivational interviewing.
   iii. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs.
   iv. Preparing members for and assisting them during emergencies and natural disasters.
   v. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings.
   vi. General understanding of virtual (e.g., Telehealth) applications in order to assist members in using the tools.

vii. Understanding needs of the justice-involved population.
viii. Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible members, such as PACE.
ix. Ethics, boundaries, and personal safety, including confidentiality, informed consent, mandated reporting, protected health information, HIPAA, and ensuring personal safety when entering someone's home.
x. Building a trusting relationship, including member relations and communication and conflict resolution.

(7) Additional trainings for care managers, care manager extenders and supervisors serving members with I/DD or TBI
i. Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers.
ii. Understanding HCBS, related planning, and 1915(c) services and requirements.
iii. Accessing and using assistive technologies to support individuals with I/DD and TBI
iv. Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services.
v. Educating members with I/DD and TBI about consenting to physical contact and sex

(8) Additional trainings for care managers, care manager extenders, and supervisors serving children
i. Child- and family-centered teams,
ii. Understanding of the "System of Care" approach (see *Section V.B.3.vii. System of Care*), including knowledge of child welfare, school, and juvenile justice systems, and
iii. Methods for effectively coordinating with school-related programming and transition-planning activities;

(9) Additional training for care managers, care manager extenders, and supervisors serving the children with complex needs
i. Specialized training in addressing co-occurring mental health disorders and I/DDs;

(10) Additional trainings for care managers, care manager extenders, and supervisors serving pregnant and postpartum women with SUD or with SUD history
i. Best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal;

(11) Additional trainings for care managers, care manager extenders, and supervisors serving members with LTSS needs
i. Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission;

(12) Reserved;

(13) Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications); and

(14) The State "System of Care" training curriculum (for care managers with assigned Members age three (3) up to age eighteen (18) with BH needs).

(15) To ensure care manager extenders are sufficiently prepared and capable to perform their duties, care manager extenders' training must include practical training modalities and evaluation, which may include role play, use of call scripts, and practice sessions.

(g) As a best practice, the BH I/DD Tailored Plan may collaborate with other BH I/DD Tailored Plans, PIHPs and any Tailored Care Management organization it sees appropriate on Tailored Care Management curriculum development.

(h) The BH I/DD Tailored Plan shall allow care managers, care manager extenders, and supervisors, regardless of the organization in which they provide care management, to waive components of the required training if the care manager or supervisor can verify that they have previously completed and demonstrated competency in a specific training domain.

(1) The BH I/DD Tailored Plan must document and get approval for their approach to waiving components of the required training in their Care Management Policy. (*Section V.B.3.vi. Care Management Policy*).

(i) The BH I/DD Tailored Plan must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.

(j) The BH I/DD Tailored Plan shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.

(k) The BH I/DD Tailored Plan shall ensure that care managers complete the identified core training modules before being deployed to serve members; care managers must complete the remaining training modules as identified in the TCM Provider Manual.

(l) Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.

(m) The BH I/DD Tailored Plan or designated vendor shall provide training to its Network providers about Tailored Care Management.

(n) The BH I/DD Tailored Plan shall not require care managers, care manager extenders, and supervisors working in multiple BH I/DD Tailored Plan regions to complete and pass each required domain of the Tailored Care Management training curriculum more than once. Care managers and supervisors should complete and pass the training in the region where they serve the most members.

(1) The BH I/DD Tailored Plan may require care managers and supervisors to complete additional training, beyond the required domains, specific to their region or the populations they serve.

(2) The Department will provide guidance in the TCM Provider Manual on care management training requirements, including refresher courses.

(o) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit to the Department its Tailored Care Management training plan for approval:

(1) Policies and procedures for training and qualification of care managers, supervising care managers, care manager extenders and other multidisciplinary team members;

(2) Training modalities (e.g., in-person versus online);

(3) Approach to tracking and verifying that care managers have completed trainings;

(4) Process for addressing noncompliance with trainings;

(5) Timing/frequency of trainings;

(6) Summary of curriculum;

(7) Approach for assessing competencies;

(8) Approach for annual refreshers and ongoing continuing education; and

(9) Approach for waiving specific training domains for care managers and supervisors.

uuu. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (a) Tailored Care management Data System Requirements* is revised and restated in its entirety as follows:

(a) Tailored Care Management Data System Requirements

(1) The BH I/DD Tailored Plan shall have IT infrastructure and data analytic capabilities to support the care management requirements of this Contract, including the capabilities to:

i. Consume and use physical health, BH, I/DD and TBI claims, pharmacy and encounter data, clinical data, ADT data, risk stratification information and/or Unmet Health-Related Resource Needs data; and

ii. Share and transmit data with AMH+ practices and CMAs.

(2) The BH I/DD Tailored Plan shall have a single care management data system across Medicaid and State-funded Services.

(3) The BH I/DD Tailored Plan shall ensure all organizations providing Tailored Care Management have care management data systems that have the ability to:

i. Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers.

ii. Electronically document, store, and make available the care management comprehensive assessment and re-assessment.

iii. Electronically document store and make available Care Plans and ISPs.

iv. Consume and analyze claims and encounter data to generate member clinical insights.

v. Provide access to – and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements.

vi. Reserved.

vii. Reserved.

viii. Track referrals.

ix. Allow care managers to:

a) Identify risk factors for individual members;

b) Develop actionable Care Plans and ISPs;

c) Monitor and quickly respond to changes in a member's health status;

d) Track a beneficiary's referrals and provide alerts where care gaps occur;

e) Monitor a beneficiary's medication adherence;

f) Transmit and share reports and summary of care records with care team members; and

g) Support data analytics and performance.

x. Helping schedule and prepare members (via, e.g., reminders and transportation) for appointments.

xi. The BH I/DD Tailored Plan shall submit a description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

vvv. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (b) Data Sharing in Support of Tailored Care Management, (1)* is revised and restated in its entirety as follows:

(1) The BH I/DD Tailored Plan shall provide data to AMH+ practices and CMAs to support Tailored Care Management. The BH I/DD Tailored Plan shall follow NCDHHS requirements for data

sharing outlined in the AMH+ and CMA Program Technical & Data Requirements document. This document has been posted in the Prepaid Health Plan Data Utility (PCDU) tool.

www. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (b) Data Sharing in Support of Tailored Care Management, (3)* is revised and restated in its entirety as follows:

(3) In cases where the Department establishes additional standard file formats for data-sharing reports, the BH I/DD Tailored Plan shall utilize the file format, timing, and frequency specified by the Department.

xxx. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (b) Data Sharing in Support of Tailored Care Management, (8)* is revised and restated in its entirety as follows:

(8) The BH I/DD Tailored Plan shall make best effort to adopt standardized data-sharing formats and protocols as they are developed by the Advisory Committee.

yyy. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (b) Data Sharing in Support of Tailored Care Management, (10)* is revised and restated in its entirety as follows:

(10) The BH I/DD Tailored Plan shall setup an onboarding process for AMH+ and CMA practices and will work with them to ensure they clearly understand the technical requirements they need to follow to develop all the data interfaces specified in the AMH+ and CMA data sharing requirements.

zzz. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (b) Data Sharing in Support of Tailored Care Management* is revised to add the following:

(11) The BH I/DD Tailored Plan will work with the AMH+ and CMA practices to guide the AMH+ and CMA practices through the development phase, share any test files and perform integration testing prior to start sharing and receiving production data with the AMH+ and CMA practices.

aaaa. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xv) Data System Requirements, Data Sharing, and Risk Stratification, (c) Risk Stratification, (2), xv.* is revised and restated in its entirety as follows:

xv. Results/scores of level-of-care determination and screening tools (e.g., ASAM, CANS, ANSA, Rancho *Los* Amigos Levels of Cognitive Functioning Scale, and SIS®, to the extent available), and other tools, as recommended by the Department.

bbbb. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xviii) Certification of AMH+ Practices and CMAs, (c), (2)* is revised and restated in its entirety as follows:

(2) During Readiness Review, if the BH I/DD Tailored Plan or a designated Department contracted vendor determines that the AMH+ practice or CMA (or CIN or Other Partner on behalf of such organizations) is not ready to meet the requirements of the Tailored Care Management model. In this situation, the BH I/DD Tailored Plan shall provide reasons to the Department why it proposes to decline to contract with that AMH+ practice, CMA or CIN or Other Partner, inclusive

of technical assistance provided and why the AMH+ practice, CMA or CIN or Other Partner is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation, if it deems the BH I/DD Tailored Plan's reasons for not contracting to be unsatisfactory.

cccc. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xviii) Certification of AMH+ Practices and CMAs, (d)-(e)* is revised and restated in its entirety as follows:

(d) AMH practices other than those certified as AMH+ practices are not required to meet the Tailored Care Management requirements within this Section; however, in their capacity as assigned PCPs for BH I/DD Tailored Plan members, they shall meet the requirements for AMH practices contained in *Section VII. Second Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid*.

(e) Reserved.

dddd. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight, (f)-(g) i*s revised and restated in its entirety as follows:

(f) For Innovations waiver members, TBI waiver members, and members obtaining 1915(i) services who are engaged in Tailored Care Management, the BH I/DD Tailored Plan must ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) waiver as described further in *Section V.B.3ii.(v) Tailored Care Management Assignment*. 42 C.F.R. § 431.301(c)(1)(vi) and 42 C.F.R. § 441.730.(b).

(1) The BH I/DD Tailored Plan shall submit its policies and procedures for ensuring conflict-free care management as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

(2) The BH I/DD Tailored Plan shall provide written notification to members regarding requirements for conflict-free case management, including that:

i. Members are entitled to choice in the organization where they obtain Tailored Care Management;

ii. Members are entitled to choice in their 1915(c) or 1915(i) service providers; and

iii. Members cannot obtain both Tailored Care Management and 1915(i) services or both Tailored Care Management and 1915(c) services, as applicable to the member, through the same provider organization .

(3) The BH I/DD Tailored Plan must submit a draft of this notice to the Department for approval.

(g) Duplication of Care Management

(1) The BH I/DD Tailored Plan shall ensure that a member does not receive duplicative care management services and Providers do not receive payment for duplicative services.

(2) The Department has determined that case management provided through ACT and ICF-IIDs and care management provided through the High-Fidelity Wraparound program, Child ACT, Critical Time Intervention, care management provided through long stay SNFs, PACE, are duplicative of Tailored Care Management.

(3) The Department will review In Lieu of Services (ILOS) submissions to determine whether the service is duplicative of Tailored Care Management. Service duplication determination will be reported to the BH I/DD Tailored Plan by the Department upon approval or rejection of the ILOS request submission.

(4) If a member is receiving a duplicative service, the Tailored Plan is responsible to ensure aspects of Tailored Care Management that are not covered by the duplicative service are provided by the BH I/DD Tailored Plan.
(5) When a member is receiving a service besides one listed in *Section V.B.3.ii.(iii)(a*) that has potential for duplication with Tailored Care Management, the BH I/DD Tailored Plan and the provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
(6) If a Member receives a duplicative service, the BH I/DD Tailored Plan must deny claims submitted by Providers for Tailored Care Management.
(7) The BH I/DD Tailored Plan shall submit its policies and procedures for ensuring members do not receive duplicative care management from multiple sources as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

eeee. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight, (o)* is revised and restated in its entirety as follows:

(o) In the event of continued underperformance by an AMH+ practice, a CMA or a CIN or Other Partner that is not corrected after the time limit set forth on the CAP, and the BH I/DD Tailored Plan terminates its contract with the AMH+ practice, CMA, CIN, or other entity, then the BH I/DD Tailored Plan shall notify the Department within seven (7) Calendar Days of initiating contract termination that it will no longer be contracting with the AMH+ practice, CMA or CIN or Other Partner for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.

ffff. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight* is revised to add the following:

(r) In Contract Year 1, the BH I/DD Tailored Plan should not condition Tailored Care Management contracts on audits/other monitoring activities that go beyond what is necessary for a practice to meet Tailored Care Management requirements. BH I/DD Tailored Plans are able to work with Tailored Care Management providers by mutual agreement to prepare for NCQA pre-delegation auditing or to otherwise build care management capacity.

gggg. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management i*s revised to add the following:

(xx) Additional Tailored Care Management Requirements for Members Participating or Eligible to Participate in Transitions to Community Living
(a) Tailored Care Management shall incorporate all care coordination activities, as required in the TCL settlement agreement.
(b) For members participating or eligible to participate in TCL, referrals shall be made to the Department's designated tool or system (currently the Referral Screening and Verification Process (RSVP) tool) and then shall be screened by an independent screener who is employed by or on behalf of the responsible BH I/DD Tailored Plan to determine whether the individual meets eligibility requirements for diversion and TCL. Eligibility requirements include Medicaid or Medicaid eligible due to income being equal to or less than the established income threshold, verified SMI/SPMI, unstable housing, and at risk of entering an ACH with accompanying evidence, such as an FL2 or application to a specific ACH.

(c) The BH I/DD Tailored Plan's outreach team shall provide TCL members education about housing options and the choice to remain in the community and services and supports in the community. The BH I/DD Tailored Plan also shall initiate community integration planning and inform the member of available rental subsidies.

hhhh. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members, (iv) i*s revised and restated in its entirety as follows:

(iv) The BH I/DD Tailored Plan shall employ a sufficient number of dedicated housing specialist(s) with knowledge, expertise and experience to engage public housing authorities, private landlords, state and federal housing agencies entities to develop, gain access to, rehabilitate , and otherwise generate housing stock and access with priority for members, and to act as advisors on affordable and supportive housing programs for care managers and all members, consistent with the Department's expectation that BH I/DD Tailored Plans will play an integral role in the State's supportive housing approach utilizing a Housing First model; community integration initiatives for individuals with mental illness, I/DD and/or substance use disorders; and requirements as outlined in *Section V.A.4. Stakeholder Engagemen*t *and Community Partnerships.*

iiii. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members, (vii), (e)* is revised and restated in its entirety as follows:

(e) Connect Members to programs and resources that can assist in securing competitive integrated employment, supported employment (such as through the Individual Placement and Support-Supported Employment (IPS-SE) program), education apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.

jjjj. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members, (vii)* is revised to add the following:

(f) For members with special health care needs who opt out or are not engaged in Tailored Care Management, the BH I/DD Tailored Plan shall perform care coordination functions as required by 42 C.F.R. § 438.208(c), which are described in *Section V.B.3.iii.(viii) Care Coordination for Members with Special Health Care Needs*.

kkkk. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members, (viii) Care Transitions, (c), (1)* is revised and restated as follows:

(1) Permit transition staff (as described further in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*), including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process. The BH I/DD Tailored Plan will make best efforts to ensure facilities within its network will allow access onsite and electronically to members, facility electronic medical records, and team meetings. The members and the tailored care manager will lead the discharge and transition team meetings. The tailored care manager will actively connect member to all community-based services and supports with the assistance of the facility staff assigned to discharge and transition.

llll. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members,* is revised to add the following:

(x) Care Coordination for Members with Special Health Care Needs

(a) Overview

(1) The BH I/DD Tailored Plan is required by 42 C.F.R. § 438.208(c) to perform care coordination functions for members with special health care needs, as defined by the Department in Section III.A. Definitions, if the member is not engaged in Tailored Care Management.

(b) Assessment and Engagement

(1) The BH I/DD Tailored Plan shall implement mechanisms to assess each member with special health care needs who is not engaged in Tailored Care Management to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. Assessment mechanisms must use appropriately qualified health care professionals, as defined by the Department. The BH I/DD Tailored Plan shall connect the member to any services identified by the assessment. 42 C.F.R. § 438.208(c)(2).

(2) The BH I/DD Tailored Plan shall develop engagement strategies for the member, including identification of barriers to treatment and referral and efforts to engage the member in Tailored Care Management, unless the member is receiving a duplicative service as defined in Section V.B.3.ii.(iii)(a) Eligibility for Tailored Care Management.

(3) The BH I/DD Tailored Plan shall answer any questions that the enrollee or legally responsible person (LRP) may have regarding available services.

(4) The BH I/DD Tailored Plan shall provide information to members about their rights, protections, and responsibilities, including the right to change providers, the grievance and complaint resolution process, and the reconsideration and Fair Hearing process.

(5) The BH I/DD Tailored Plan shall permit members with special health care needs to directly access specialists as appropriate for the member's condition and identified needs. 42 C.F.R. 438.208(c)(4).

mmmm. *Section V. Scope of Services, B. Medicaid, 3. Care Management, iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver, (ii), (a)* is revised and restated in its entirety as follows:

(a) Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:

(1) The BH I/DD Tailored Plan shall ensure that the member's care manager convenes a person-centered planning meeting and completes the ISP. This is done after the member is administered the SIS® and the level of care determination for initial plans of care.

(2) If applicable, the BH I/DD Tailored Plan shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the BH I/DD Tailored Plan.

(3) The BH I/DD Tailored Plan shall review ISP for waiver compliance, medical necessity, and the member's health and safety needs.

(4) The BH I/DD Tailored Plan shall approve or deny the ISP within standard service authorization periods except for in the case of initial plans which must be received within sixty (60) Calendar Days of level of care determination. In the case where services are needed more immediately, an interim plan of care may be completed so that services may be approved with the full ISP being completed afterwards and within sixty (60) Calendar Days of level of care determination.

(5) The BH I/DD Tailored Plan shall ensure that waiver services begin within forty-five (45) Calendar Days of ISP approval.

(6) The BH I/DD Tailored Plan shall ensure that the Member provides a signature (wet or electronic) on the ISP to indicate informed consent, in addition to ensuring that the ISP includes signatures from all individuals and providers responsible for its implementation. As part of the consent process, members must consent to the following:

i. By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
ii. My care manager helped me know what services are available.
iii. I was informed of a range of providers in my community qualified to provide the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
iv. The plan includes the services/supports I need.
v. I participated in the development of this plan.
vi. I understand that my care manager will be coordinating my care with the [Tailored Plan] network providers listed in this plan.
vii. I understand that all services under the Innovations Waiver, including Residential Supports and Supported living, should be requested to the full extent of the individual's level of medical necessity; regardless of the individual's budgeting category.
viii. I understand that services may be authorized in excess of the Individualized Budget.

nnnn. *Section V. Scope of Services, B. Medicaid, 3. Care Management, v. Other Care Management Programs, (ii), (b), (8)-(9)* is revised and restated in its entirety as follows:

(8) The BH I/DD Tailored Plan shall incorporate all Department-defined care management practice standards for CMHRP into each of its contracts with LHDs, as noted in *Section VII. Attachment M.4. Care Management for High-Risk Pregnancy Policy for Medicaid Members*.

(9) At the conclusion of Contract Year 2, the BH I/DD Tailored Plan shall have the option to continue to contract with LHDs for CMHRP; or to include CMHRP services within Tailored Care Management for members experiencing high risk pregnancy (whether provided by the organization responsible for Tailored Care Management or by another organization under contract with the BH I/DD Tailored Plan).

oooo. *Section V. Scope of Services, B. Medicaid, 3. Care Management, v. Other Care Management Programs, (ii), (d)-(e)* is revised and restated in its entirety as follows:

(d) The BH I/DD Tailored Plan must participate in Department-led meetings involving the CMHRP program~~s~~, including requiring attendance by appropriate clinical and operational leadership at meetings.

(e) The BH I/DD Tailored Plan must incorporate new guidance, policy, operational manuals and other program-specific requirements regarding CMHRP into BH I/DD Tailored Plan operations and LHD contracts, as applicable, and within Department-specified timelines.

pppp. *Section V. Scope of Services, B. Medicaid, 3. Care Management, v. Other Care Management Programs, (v), (b), (1)* is revised and restated in its entirety as follows:

(1) Reserved.

qqqq. *Section V. Scope of Services, B. Medicaid, 3. Care Management, vi. Care Management Policy, (ii), (f)-(g)* is revised and restated in its entirety as follows:

(f) Policies and procedures for care management comprehensive assessments, including but not limited to:
  (1) Reserved;
  (2) Assessment tools/questions used;
  (3) Variation in care management comprehensive assessment based on population, including:
    i. For members obtaining State Plan LTSS besides 1915(i) services, and
    ii. For members obtaining 1915(i) services, the approach to incorporating information from the independent assessment with the member's care management comprehensive assessment.
  (4) Expected volume of care management comprehensive assessments monthly and annually;
  (5) Method of conducting the care management comprehensive assessment based on member needs or other factors; and
  (6) Audits of care management comprehensive assessments to ensure they meet quality expectations.

(g) Policies and procedures for Care Plan/ISP development with members, including:
  (1) Approach for involving multidisciplinary care team;
  (2) Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved;
  (3) Process for and frequency of Care Plan/ISP updates;
  (4) Approach for ISP development for members enrolled in the Innovations or TBI waivers;
  (5) Approach for Care Plan/ISP development for members obtaining 1915(i) services as required by 42 C.F.R. § 441.725; and
  (6) Audits of care plan/ISP to ensure they meet quality expectations.

rrrr. *Section V. Scope of Services, B. Medicaid, 3. Care Management, vi. Care Management Policy, (ii), (m), (1)* is revised and restated in its entirety as follows:

(1) Policies and procedures for training and qualification of care managers, supervising care managers, care manager extenders and other multidisciplinary team members;

ssss. *Section V. Scope of Services, B. Medicaid, 3. Care Management, vi. Care Management Policy, (ii), (s)* is revised and restated in its entirety as follows:

(s) Reserved.

tttt. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iii), (d)* is revised and restated in its entirety as follows:

(d) Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing. The BH I/DD Tailored Plan will maintain a monthly Local Barriers Committee (LBC) that is cross-functional and includes Departmental standing representation along with their Local Ombudsman to report and solve any barriers to transition in individual member situations and/or systemic barriers affecting transition. The BH I/DD Tailored Plan will submit a quarterly local barriers report to the Department within thirty (30) Calendar Days after the close of each quarter. Emergent need for barriers help between LBC meetings will be made

with the Department's State Barriers Committee point of contact. If BH I/DD Tailored Plan's LBC cannot resolve identified barriers at the local level, those barriers will be referred promptly to the Department's monthly State Barriers Committee. If the State Barriers Committee cannot resolve the barrier, it will be submitted promptly with recommendations for resolution to the Transition Oversight Committee that is chaired by the Deputy Director of Medicaid.

uuuu. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iii), (e), (1), ii.* is revised and restated in its entirety as follows:

ii. Clearly document in the Informed Decision Making Tool (IDM) that the member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the member of available community services, including supportive housing.

vvvv. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iii), (i)* is revised and restated in its entirety as follows:

(i) For members residing in an ACH or state developmental center, and members age 18 and over residing in a state psychiatric hospital and who have been identified for transition, refer the member to a BH I/DD Tailored Plan transition coordinator, the member's care manager in the Tailored Care Management model, and DSOHF Admission Through Discharge Manager for transition services (see *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*) and ensure a timely, Warm Handoff to the transition staff or care manager in the Tailored Care Management model that the BH I/DD Tailored Plan assigns to the member.

wwww. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iii)* is revised to add the following:

(l) Engage with the member and the member's family and/or guardians through frequent face to face meetings. Frequency of such face to face meetings should be determined on a case by case basis, but shall occur no less than twice every ninety (90) Calendar Days.

xxxx. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iv), (b)* is revised and restated in its entirety as follows:

(b) Collaborate with the following individuals, specialists, and provider types as applicable depending on the member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
(1) The member and/or the member's family or guardian;
(2) Facility providers;
(3) Facility discharge planners;
(4) The member's care manager;
(5) The member's community-based PCP once selected;
(6) Peer support specialist or other individuals determined to have appropriate shared lived experience;
(7) Educational specialists;
(8) The RN and OT who have assessed the medical and functional needs of the member being transitioned into housing; and
(9) Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.

yyyy. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iv), (k), (1)* is revised and restated in its entirety as follows:

(1) Assess settings that the member is transitioning to, using the IDM Tool approved by the Department as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.

zzzz. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (iv), (n)* is revised and restated in its entirety as follows:

(n) For members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with the Department and the county DSS to ensure Medicaid eligibility is active upon or soon after discharge.

aaaaa. *Section V. Scope of Services, B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (vii) In-Reach and Transition Staff Training, (b)* is revised to add the following:

(6) Documenting the preferences of the Member in the Informed Decision-Making Tool (IDM).

bbbbb. *Section V. Scope of Services, B. Medicaid, 3. Care Management, ix. Prevention and Population Health Programs, (iv) Additional Prevention and Population Heath Programs, (a), (2) Newborn Screening Programs, ii.* is revised and restated in its entirety as follows:

ii. The BH I/DD Tailored Plan shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Section VII. Second Revised and Restated Attachment M.8. Management of Inborn Errors of Metabolism Policy for Medicaid Members.*

ccccc. *Section V. Scope of Services, B. Medicaid, 3. Care Management, x. Healthy Opportunities, (iv), (b) NCCARE360, (5) Other care management entities under contract with Tailored Plans, ii.-iii.* is revised and restated in its entirety as follows:

ii. The Department intends to work with Unite USA, Inc. to facilitate NCCARE360 licensing and training for assigned organizations providing Tailored Care Management that choose to use NCCARE360 and organizations participating in the Healthy Opportunities Pilot (as applicable).

iii. The Department will ensure that an assigned organization providing Tailored Care Management that is required or chooses to use NCCARE360 for the functions outlined in *Section V.B.3.ix.(iv)(b) NCCARE360,(1)* for Medicaid members gains and maintains access to the Unite USA, Inc. NCCARE360 Base Package and Base Support, as outlined in *Section V.B.3.ix.(iv)(b) NCCARE360,(2)(i)* and *Section V.B.3.ix.(iv)(b) NCCARE360,(2)(ii)* to use NCCARE360 for Medicaid members at no cost to the assigned organization providing Tailored Care Management. All requirements outlined in *Section V.B.3.ix.(iv)(b) NCCARE360,(1)* are available through the NCCARE360 Base Package and Base Support will be funded by the Department. Any additional NCCARE360 functionality that is not necessary to support the requirements of the Department will not be funded by the Department.

ddddd. *Section V. Scope of Services, B. Medicaid, 3. Care Management, x. Healthy Opportunities, (v) Contributions to Health-Related Resources, (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Department-defined Medical Loss Ratio (MLR), as described in *Section V.B.7.ii. Medical Loss Ratio*, subject to Department review and approval.

eeeee. *Section V. Scope of Services, B. Medicaid, 3. Care Management, x. Healthy Opportunities, (vi) Healthy Opportunities Pilots to Address Unmet Health-Related Resource Needs, also known as Healthy Opportunities Pilots* is revised and restated in its entirety as follows:

(vi) Enhanced Care Management Pilots to Address Unmet Health-Related Resource Needs, also known as Healthy Opportunities Pilots

(a) Background

(1) CMS has authorized an Enhanced Case Management and Other Services Pilot, the "Healthy Opportunities Pilot program," for a five (5)-year period, from November 1, 2019, through October 31, 2024, as a part of North Carolina's Section 1115 Medicaid Demonstration waiver.

(2) Through the Healthy Opportunities Pilot program, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) Healthy Opportunities priority domains (housing, food, transportation, and interpersonal violence/toxic stress) can be delivered effectively to Medicaid members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the Pilot program is to learn which evidence-based interventions and processes are most effective to improve health, lower health care costs for specific populations, and to inform health care delivery statewide.

(3) Through a competitive procurement process, the Department established Healthy Opportunities Pilots in three (3) areas of the State to provide a subset of high-need, high-risk, and emerging risk Medicaid members with information, services, and benefits targeted to measurably improve health and lower costs. The Pilot will employ evidence-based interventions addressing members' needs in housing, food, transportation, and interpersonal safety/toxic stress. The BH I/DD Tailored Plan shall play a key role in executing the Pilot in accordance with the roles and responsibilities enumerated below.

(4) Reserved.

(5) Each Pilot region will have one Healthy Opportunities Network Lead. The Network Lead's role is to develop, contract with and manage a network of Pilot Service providers called Human Service Organizations (HSOs) that can deliver the evidence-based Pilot interventions across each of the four (4) Healthy Opportunities priority domains within the Pilot Regions. Each Network Lead determines the counties that constitute its local Pilot region as defined in its DHHS-Network Lead contract.

(6) Pilot regions are distinct from Tailored Plan regions, and as a result, only a subset of counties in a BH I/DD Tailored Plan region may be participating in the Pilots. Any BH I/DD Tailored Plan operating in a Pilot Region shall implement the Pilot program for its Pilot-eligible members in accordance with the roles and responsibilities enumerated in this Section and in any additional requirements and guidance issued by the Department.

fffff. *Section V. Scope of Services, B. Medicaid, 3. Care Management* is revised to add the following:

xii. Additional Tailored Care Management Requirements for Members Obtaining 1915(i) Services

(i) Tailored Care Management shall incorporate all 1915(i) care coordination activities, namely requirements for an independent assessment and development of a person-centered Care Plan/ISP, as required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.

(ii) The BH I/DD Tailored Plan shall notify an organization providing Tailored Care Management when one of its assigned members requests or would benefit from 1915(i) services so that the organization can commence the independent assessment.

(iii) The BH I/DD Tailored Plan shall share the results of the independent evaluation for 1915(i) services with the assigned organization providing Tailored Care Management in an electronic format.

(a) The BH I/DD Tailored Plan shall ensure that the assigned organization performing Tailored Care Management incorporates the results of the independent assessment into the Care Plan/ISP.

(b) The completion of the independent assessment does not trigger a full care management comprehensive assessment and may be an addendum or an update to a previous care management comprehensive assessment.

(c) The BH I/DD Tailored Plan shall ensure that at a member's annual reassessment, as described in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment***,** the independent assessment for 1915(i) services is included as part of the broader care management comprehensive assessment.

xiii. Additional Care Coordination Functions for Members Obtaining 1915(i) Services

(i) For members who are not engaged in Tailored Care Management when it is determined they may benefit from 1915(i) services, the BH I/DD Tailored Plan shall:

(a) Conduct outreach to the member to inform the member that to obtain 1915(i) services, they have the choice of engaging in Tailored Care Management or obtaining care coordination services through the BH I/DD Tailored Plan.

(1) For members who have not opted out of Tailored Care Management, the BH I/DD Tailored Plan shall make best efforts to engage the member in Tailored Care Management encompassing 1915(i) care coordination.

(b) In cases where a member obtaining 1915(i) services opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide care coordination for the 1915(i) services, including meeting requirements for conducting the independent assessment and development of Care Plans/ISPs required by 42 C.F.R. § 441.720 and 42 C.F.R. § 441.725.

(1) The BH I/DD Tailored Plan shall ensure that care coordination for 1915(i) services is performed by a care manager meeting the qualifications described in *Section V.B.3.ii.(xiv)(c) Care Manager Qualifications.*

(2) The Department will not make a Tailored Care Management payment to the BH I/DD Tailored Plan for members who opt out of Tailored Care Management.

(ii) For all members obtaining 1915(i) services, regardless of whether they engage in Tailored Care Management, the BH I/DD Tailored Plan shall ensure that care coordination includes:

(a) Conducting the independent assessment using a Department-designated tool to determine need for specific 1915(i) services. The BH I/DD Tailored Plan shall comply with any additional guidance released by the Department on the Department-designated tool to conduct the independent assessment.

(b) Guiding the development and submission of the Care Plan/ISP, based on assessed need and living arrangements, at least annually:

(1) The BH I/DD Tailored Plan shall ensure that the member's care manager convenes a person-centered planning meeting and completes the Care Plan/ISP in line with federal requirements 42 C.F.R. § 441.725. This is done after the member is administered the independent assessment for initial plans of care.
(2) If applicable, the BH I/DD Tailored Plan shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the Care Plan/ISP to the BH I/DD Tailored Plan.
(3) The BH I/DD Tailored Plan shall review Care Plan/ISP for compliance with 1915(i) SPA requirements, medical necessity, and the member's health and safety needs.
(4) The BH I/DD Tailored Plan shall approve or deny the Care Plan/ISP within standard service authorization periods except for in the case of initial plans, which must be received within sixty (60) Calendar Days of 1915(i) eligibility determination.
(5) In the case where services are immediately needed, an interim plan of care may be completed so that services may be approved with the full Care Plan/ISP being completed afterwards and within the sixty (60) Calendar Days of eligibility determination for 1915(i) services. Immediately needed 1915(i) services may include, but are not limited to, 1915(i) services that a member needs in order to:
    i. Facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting;
    ii. Prevent imminent placement outside the person's current living arrangement;
    iii. Address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm; or
    iv. Prevent imminent loss of competitive integrated employment or an offer of such employment.
(6) The BH I/DD Tailored Plan shall ensure that 1915(i) services begin within forty-five (45) Calendar Days of Care Plan/ISP approval.

(c) Monitoring requirements found in the 1915(i) SPA.
(d) Explaining the service authorization process.
(e) Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP, including providing a list of available providers and arranging provider interviews.
(f) Monitoring Care Plan/ISP goals at a minimum frequency based on the target date assigned to each goal.
(g) Maintaining close contact with the member/LRP (if applicable), providers and other members of the Care Plan/ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
(h) Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the member as required by 42 C.F.R. § 441.710(a)(1)(i).
(i) Completing the independent assessment prior to the development of the Care Plan/ISP and updating at least annually or as significant changes occur with the member as required by 42 C.F.R. § 441.720(b).
(j) Providing timely notification to BH I/DD Tailored Plan utilization management of updates to eligibility for 1915(i) services and timely processing of updates to the Care Plan/ISP.

(k) Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan.

(l) Monitoring of service delivery to verify that:

(1) At least one (1) 1915(i) service is utilized at a frequency determined by the Department in the 1915(i) SPA as required by 42 C.F.R. § 441.710(c).

(2) Services are furnished in accordance with the Care Plan/ISP.

(3) Member is offered a choice of 1915(i) service providers.

(4) Member has access to services and supports that meet the member's needs.

(5) Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-1915(i) service needs (medical care) are addressed and documented as appropriate.

(6) 1915(i) services utilized do not exceed authorization.

(7) Member is satisfied with the services being rendered.

(iii) The BH I/DD Tailored Plan shall monitor service utilization to remain within service authorizations.

(iv) The BH I/DD Tailored Plan shall notify the member's provider and AMH+ practice or CMA (if applicable) of utilization decisions.

ggggg. *Section V. Scope of Services, B. Medicaid, 4 Providers, i. Provider Network, (i)* is revised and restated in its entirety as follows:

(i) Providers are the backbone of North Carolina's Medicaid Program and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks BH I/DD Tailored Plans that share and support that tradition.

hhhhh. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (iii) Availability of Services (42 C.F.R. § 438.206), (e) Pharmacy Services, (4), ii.* is revised and restated in its entirety as follows:

ii. The BH I/DD Tailored Plan must submit any significant changes to its mail order program to Department for approval at least ninety (90) Calendar Days before implementation target date of the change.

iiiii. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (iii) Availability of Services (42 C.F.R. § 438.206), (h) SUD Residential Treatment Services, (1)* is revised and restated in its entirety as follows:

(1) BH I/DD Tailored Plans shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VII. Third Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid.*

jjjjj. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (iii) Availability of Services (42 C.F.R. § 438.206)* is revised to add the following:

(i) 1915(i) Services

(1) The BH I/DD Tailored Plan shall ensure that 1915(i) service providers comply with HCBS standards as set forth in 42 C.F.R. § 441.730 and requirements set forth by the Department.

(2) Provider agencies shall comply with the applicable provider specifications for services set forth in the 1915(i) SPA.

(3) National accreditation is required of most providers of 1915(i) services per the 1915(i) SPA. Upon contracting with the BH I/DD Tailored Plan, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the waiver(s). The organization must be established as a legally constituted entity capable of meeting all of the requirements of the BH I/DD Tailored Plan.

kkkkk. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (iv) Furnishing of Services (42 C.F.R. § 438.206(c)), (c)* is revised and restated in its entirety as follows:

(c) The BH I/DD Tailored Plan shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service, if the provider serves only Medicaid.

(1) The Department may require after hours and weekend hours to address the needs of the member.

lllll. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (vii) Assurance of Adequate Capacity and Services (42 C.F.R. § 438.207), iv. (a), (2), iv*. revised and restated in its entirety as follows:

iv. Within thirty (30) Calendar Days of a significant change, including merger or county disengagement.

mmmmm. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (vii) Assurance of Adequate Capacity and Services (42 C.F.R. § 438.207), iv. (a), (5)* is revised and restated in its entirety as follows:

(5) The Department shall supply to the BH I/DD Tailored Plan member eligibility information, including county of residence and zip codes for each Medicaid beneficiary that is in the BH I/DD Tailored Plan-eligible population as of the date of the Department's report. The information will be provided to the BH I/DD Tailored Plan, at a date to be defined by the Department for purposes of demonstrating compliance with the time or distance standards found in *Section VII. Second Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid* during the Readiness Review, and as other times as needed as part of the network adequacy oversight.

nnnnn. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (vii) Assurance of Adequate Capacity and Services (42 C.F.R. § 438.207), iv. (c)* is revised and restated in its entirety as follows:

(c) The BH I/DD Tailored Plan shall provide the Department with Network data files quarterly and anytime there is significant change that impacts network adequacy and the ability to provide services. The Department shall prescribe the standardized file format and content. The standardized detailed file layout must include, but is not limited to, the following data elements:

(1) Provider names (first, middle, last);
(2) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
(3) Street address(as) of service location(s);
(4) County(ies) of service location(s);
(5) Telephone number(s) at each location;
(6) Provider specialty;
(7) Provider NPI or API;
(8) NPI type (individual or organization/facility providers);
(9) Taxonomy(ies);
(10) Whether provider is accepting new members and the conditions if applicable;
(11) Identification as an IHCP;

(12) Identification as an Essential Provider;
(13) Identification as an Advanced Medical Home/Primary Care Provider;
(14) Identification of limitations on age of members seen by provider;
(15) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
(16) Whether provider has completed Cultural and Linguistic Competency training; and
(17) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.

ooooo. *Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (vii) Assurance of Adequate Capacity and Services (42 C.F.R. § 438.207), iv. (d), (1)* is revised and restated in its entirety as follows:

(1) At least once a calendar quarter, the BH I/DD Tailored Plan shall monitor its Provider Network for a significant change that would affect the adequacy capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *Section VII. Second Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards*.

ppppp. *Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (c), (1)* is revised and restated in its entirety as follows:

(1) The BH I/DD Tailored Plan shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done monthly thereafter.
   i. If the BH I/DD Tailored Plan is made aware of providers included in their network file that are not actively enrolled in NC Medicaid, the BH I/DD Tailored Plan shall remove the provider from the BH I/DD Tailored Plan network File within one (1) Business Day of notification. The BH I/DD Tailored Plan shall remove any provider from the BH I/DD Tailored Plan Network File and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider.

qqqqq. *Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (y)* is revised and restated in its entirety as follows:

(y) For any provider subject to a rate floor as outlined in *Section V.B.4.iv. Provider Payments,* a BH I/DD Tailored Plan may include a provision in the provider's contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of the Durable Medical Equipment and the Physician Administered Drug Program rate floors. A BH I/DD Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

rrrrr. *Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (e) Network Contracting Decisions, (2)* is revised and restated in its entirety as follows:

(2) Reserved.

sssss. *Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (h) Provider Directory, (5), iii.* is revised and restated in its entirety as follows:

iii. Any time there has been a significant change in BH I/DD Tailored Plan operations that impacts the content of the directory.

ttttt. *Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (h) Provider Directory, (6), xiv.* is revised and restated in its entirety as follows:

xiv. Whether provider serves Medicaid beneficiaries;

uuuuu. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (v) Hospital Payments (Excluding BH Claims), (c)* is revised and restated in its entirety as follows:

(c) The applicable rate floor and methodology for outpatient hospital services (excluding hospital outpatient laboratory services), including Emergency Department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.

(1) The applicable rate floor and methodology for in-network hospital outpatient laboratory services shall be 146.38% of the Medicaid Fee-for-Service Laboratory fee schedule rate in effect on July 1, 2021, unless the BH I/DD Tailored Plan and hospital have mutually agreed to an alternative reimbursement amount or methodology.

(2) The BH I/DD Tailored Plan shall apply the following exceptions to the rate floor and methodology for in network hospital outpatient laboratory services:

i. If the services are not part of the NC Medicaid Laboratory Fee schedule, outpatient hospital reimbursement shall be one hundred percent (100%) of billed charges multiplied by the Ratio of Cost to Charges (RCC) when calculating the reimbursement rate.

ii. COVID-19 Vaccine Administration and COVID-19 Testing reimbursement shall be based on the NC Medicaid Direct rates.

vvvvv. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (v) Hospital Payments (Excluding BH Claims)* is revised to add the following:

(h) The BH I/DD Tailored Plan shall not use the Outpatient Prospective Payment System (OPPS) to reimburse institutional hospital outpatient claims including lab and drug claims.

wwwww. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (vii) Federally-Qualified health Centers (FQHCs)/Rural Health Cares (RHCs) Payments, (a), (1)* is revised and restated in its entirety as follows:

(1) All ancillary services (i.e. radiology, etc.) shall be based on the applicable codes included on the FQHC/RHC fee schedules.

xxxxx. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (x) Public Ambulance Provider Payments* is revised and restated in its entirety as follows:

(x) Public Ambulance Provider Payments

(a) The BH I/DD Tailored Plan shall reimburse in-network public ambulance providers no less than 100% of base rates specified in the North Carolina Medicaid Managed Care Public

Ambulance Provider Cost-Based Fee Schedule for Medicaid members (as allowed under 42 C.F.R. § 438.6(c)(iii)(B)), unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

yyyyy. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))* is revised and restated in its entirety as follows:

(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))

(a) The BH I/DD Tailored Plan shall make additional directed payments as prescribed by the Department and approved by CMS, to certain in-network providers described in this section.

(b) The BH I/DD Tailored Plan shall include the Department defined additional directed payments in its contracts with applicable providers.

(c) The BH I/DD Tailored Plan shall determine a due date for providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.

(d) The BH I/DD Tailored Plan shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) Business Days of receiving the payment from the State.

(e) The BH I/DD Tailored Plan shall submit the data to substantiate additional directed payments to the Department and each applicable provider quarterly in a format to be defined by the Department.

(f) The Department shall reconcile the data to the BH I/DD Tailored Plan's encounter submissions. The BH I/DD Tailored Plan shall support the reconciliation process upon request from the Department.

(g) The BH I/DD Tailored Plan shall adhere to the directed payment service unit encounter requirements as described in *Section V. H. 2. Encounters.*

(h) For Directed Payments for Local Health Departments (LHDs):

(1) The Department will establish a cost-to-charge ratio for each LHD that will be used to determine a minimum fee schedule.

(2) The Department will adjust each LHD's cost-to-charge ratio annually by Medicare Economic Index (MEI) and any change to the LHD's chargemaster to assure that annual per-unit payment growth rate does not exceed the MEI.

(3) The Department will use LHD submitted charges and the established cost-to-charge ratio to develop the uniform dollar or percentage increase.

(4) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the difference between the rate paid to the LHDs by the Standard Plan BH I/DD Tailored Plans and the minimum fee schedule amount determined by the State multiplied by the LHD claims for each BH I/DD Tailored Plan.

(5) The Department will perform an annual verification of the LHD directed payments based on BH I/DD Tailored Plan encounter data submitted to the State to assure all claims data has been properly captured and calculated for directed payments.

(i) For Directed Payment for Faculty Physicians Affiliated with the Teaching Hospitals for each University of North Carolina Medical School, and Hospitals Owned by UNC Health Care or Vidant Medical Center:

(1) The Department will establish a uniform dollar increase annually at the average commercial rate for certain eligible medical professionals as defined in the Medicaid State Plan, Attachment 4.19-B, Section 5, Page 2, Subsection (c)(2).

(2) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the difference between the rate paid to the eligible medical professionals by the Standard Plan BH I/DD Tailored Plans and the minimum fee schedule amount determined by the State multiplied by the actual utilization for the eligible professionals.

(3) The Department will establish an annual aggregate cap for total eligible medical professional directed payments pursuant to State Law.[21]

(4) The Department will perform an annual verification of the eligible medical professional directed payments based on BH I/DD Tailored Plan encounter data submitted to the State to assure all claims data has been properly captured and calculated for directed payments and to assure compliance with aggregate annual payment cap.

(j) For Directed Payments to Vidant Medical Center:

(1) The Department will establish a uniform dollar increase for each managed care discharge (inpatient), initially determined by dividing the projected inpatient quality pool amount by the number of projected inpatient managed care discharges.

(2) The Department will establish a uniform increase per billed charge (outpatient), initially determined by dividing the total outpatient pool amount by the projected managed care outpatient charges.

(3) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the actual number of managed care discharges multiplied by the uniform per discharge amount (inpatient) plus the actual managed care billed charges multiplied by the uniform per charge amount (outpatient).

(k) For Directed Payments to University of North Carolina Health Care System Hospitals:

(1) The Department will establish a uniform dollar increase for each managed care discharge (inpatient), initially determined by dividing the projected inpatient quality pool amount by the number of projected inpatient managed care discharges.

(2) The Department will establish a uniform percentage increase per billed charge (outpatient), initially determined by dividing the total outpatient pool amount by the projected managed care outpatient charges.

(3) The Department will calculate the directed payment amount to the BH I/DD Tailored Plans on a quarterly basis as the actual number of managed care discharges multiplied by the uniform per discharge amount (inpatient) plus the actual managed care billed charges multiplied by the uniform per charge amount (outpatient).

(l) Interest and Penalties

(1) The BH I/DD Tailored Plan shall pay interest on late directed payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid as specified in the Contract.

(2) In addition to the interest on late directed payments required by this Section, the BH I/DD Tailored Plan shall pay the provider a penalty equal to one percent (1%) of the directed payment for each calendar day following the date that the directed payment should have been paid as specified in the Contract.

[21] North Carolina S.L. 2020-88, Section 13(b)

zzzzz. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xiii) Nursing Facility Payments* is revised and restated in its entirety as follows:

(xiii) Nursing Facility Payments

(a) The BH I/DD Tailored Plan shall reimburse in-network nursing facilities (excluding those owned and operated by the State) no less than ninety-five percent (95%) of the facilities' adjusted Medicare rate for the first twenty (20) Calendar Days of a Member's nursing facility stay and eighty percent (80%) of the facility's adjusted Medicare rate for the remainder of a Member's nursing facility stay, unless the PHP and provider have mutually agreed to an alternative reimbursement arrangement.

aaaaaa. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xvi) Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management* is revised and restated in its entirety as follows:

(xvi) Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management

(a) For Tailored Care Management, the BH I/DD Tailored Plan shall pay AMH+ practices and CMAs:

(1) Tailored Care Management payment for each month in which the AMH+ practice or CMA performed Tailored Care Management for each Medicaid member. For Medicaid Members, the Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. This Tailored Care Management payment shall not be placed at risk. The BH I/DD Tailored Plan shall pay AMH+ practices or CMAs the Tailored Care Management payment for any month in which the Medicaid member is assigned to the AMH+/CMA the AMH+/CMA delivers at least one (1) care management contact. The BH I/DD Tailored Plan shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact, even if the AMH+/CMA has not delivered the minimum number of contacts during the month based on the member's acuity tier, as described in *Section V.B.3.ii.(x)(l)*.

(2) Performance incentive payment, if earned by the AMH+ or CMA. The performance incentive payment shall be based on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual, once released.

(3) Prior to the release of AMH+ and CMA metrics in the Department's Technical Specifications Manual, the BH I/DD Tailored Plan may, but is not required to make, performance incentive payments to AMH+ or CMAs for Tailored Care Management. The Department encourages the BH I/DD Tailored Plan to base any performance incentive payment on the Tailored Plan measure set and Medicaid Quality Strategy. Following the release of AMH+ and CMA metrics, the BH I/DD Tailored Plan must offer performance incentives payments to AMH+ and CMAs and base these performance incentive payment on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual.

(b) Only contacts delivered by the assigned care manager or care manager extender shall count towards meeting the contact requirements described in *Section V.B.3.ii.(x)(m)* and be eligible for payment. In the event that the supervising care manager is providing coverage for a care manager (e.g., sick leave, vacation, staff turnovers) and delivers a contact to a member, the contact shall count towards meeting contact requirements and be eligible for payment.

bbbbbb. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xvii) Payments of Medical Home Fees to Advanced Medical Homes* is revised and restated in its entirety as follows:

(xvii) Payments of Medical Home Fees to Advanced Medical Homes

(a) In addition to the payment for services provided, the BH I/DD Tailored Plan shall pay all AMH practices a Medical Home Fee. "AMH practices" means all practices participating in the AMH program for the purposes of contracting with Standard Plans and BH I/DD Tailored Plans, including, but not limited to, AMH practices also certified as AMH+ practices for the purposes of Tailored Care Management.

(b) The BH I/DD Tailored Plan shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 1 –3 practices may be prorated for partial months and shall be no less than the following amounts:

i. For April 1, 2023 through June 30, 2023, $20.00 medical home PMPM for all BH I/DD Tailored Plan members regardless of Age, Blind, and Disabled (ABD) status;

ii. Starting July 1, 2023, $5.00 PMPM for all BH I/DD Tailored Plan members regardless of Age, Blind, and Disabled (ABD) status.

(c) The BH I/DD Tailored Plan shall pay medical home fees and care management fees, that includes AMH, AMH+, CMHRP and Healthy Opportunities (as applicable) payments, by no later than the last day of each month however, payment for each month shall be based upon Member's enrollment with the BH I/DD Tailored Plan at the beginning of the same month.

cccccc. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xix) Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services), (b)* is revised and restated in its entirety as follows:

(b) The BH I/DD Tailored Plan shall develop Good Faith Provider Contracting Policy that includes a description of how the BH I/DD Tailored Plan will conclude that a "good faith" contracting effort has been made. The BH I/DD Tailored Plan shall submit the policy to the Department for review ninety (90) Calendar Days after Contract Award.

(1) The BH I/DD Tailored Plan shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.

(2) The BH I/DD Tailored Plan shall include in its Good Faith Contracting Policy a description of the outreach program to providers that the BH I/DD Tailored Plan, and its subcontractors as applicable, will utilize when leveraging one of the BH I/DD Tailored Plan's existing Medicaid program's Networks to build a new program's Network. The BH I/DD Tailored Plan's outreach program shall be added to the BH I/DD Tailored Plan's Good Faith Contracting Policy no later than March 15, 2023. The BH I/DD Tailored Plan shall update the Policy whenever there are significant changes to the outreach program.

dddddd. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xxv) Payment for Durable Medical Equipment* is revised and restated in its entirety as follows:

(xxv) Payment for Durable Medical Equipment

(a) During the initial contract term of the BH I/DD Tailored Plan, the reimbursement for durable medical equipment, supplies, orthotics and prosthetics shall be set at one hundred percent (100%) of the lesser of the supplier's usual and customary rate or the maximum allowable

Medicaid fee-for-service rates for durable medical equipment and supplies, orthotics and prosthetics.

eeeeee. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments, (xxvii) Provider Hardship Payments* is revised and restated in its entirety as follows:

(xxvii) Provider Hardship Payments

(a) The BH I/DD Tailored Plan shall ~~h~~ process Hardship Payment requests from a provider within seven (7) Business Days of receipt of a hardship request or three (3) Business Days of receipt of an urgent hardship request.

(b) The BH I/DD Tailored Plan shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval prior to no later than March 15, 2023. The BH I/DD Tailored Plan may submit a consolidated Provider Hardship Payment Policy applicable for both Medicaid Direct and BH I/DD Tailored Plan programs. The Provider Hardship Payment Policy shall include:

(1) Method for providers to submit hardship payment requests,

(2) Description of timeline for payment for standard and urgent requests, including integration into check write schedule,

(3) Criteria for requests to be reviewed and approved by the BH I/DD, and

(4) Description of how providers and Department will be notified of status of the request and payment, if applicable.

(c) The BH I/IDD Tailored Plan shall recoup Hardship Payments by offsetting the provider's future claim payments or through a one-time repayment by the provider.

ffffff. *Section V. Scope of Services, B. Medicaid, 4. Providers, v. Provider Payments* is revised to add the following:

(xxviii) Payment for Opioid Treatment Program Providers

(a) Beginning April 1, 2023, the BH I/DD Tailored Plan shall reimburse Opioid Treatment Programs no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

(xxix) ICF/IDD Provider Payments

(a) Beginning April 1, 2023, the BH I/DD Tailored Plan shall increase reimbursement rates to eligible community based ICF/IDD providers by amounts prescribed by the Department. The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements of *Section V.B.6.i.(iv). Prompt Payment Standards* For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess.

(1) The Department shall maintain and share with the BH I/DD Tailored Plan a list of eligible providers, the applicable increase for each provider, and the time period (by dates of service) for which each provider is eligible for the enhanced reimbursement amount in the PCDU. Enhanced reimbursement amounts may vary by provider.

(2) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to certain providers for dates of service specified by the Department to account for any changes to provider eligibility for all or a portion of the enhanced reimbursement.

(3) The BH I/DD Tailored Plan shall communicate to contracted providers that enhanced reimbursement amount is contingent on eligibility for ICF/IDD Direct Care Worker wage-related reimbursement increases maintained by the Department.

(xxx) HCBS Direct Care Worker Wage Increases

(a) Beginning April 1, 2023, the BH I/DD Tailored Plan shall increase reimbursement rates to eligible HCBS providers for eligible services by amounts no less than the amounts prescribed by the Department. The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements of Section V.B.6.i.iv.4). For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of Section V.B.6.i.iv).

(1) Reimbursement increases for State Plan services shall be no less than the per unit reimbursement increases in the North Carolina Medicaid Fee-For-Service Fee Schedule.

(2) Reimbursement increases for approved in-lieu of services shall be no less than the per unit reimbursement increases communicated through Medicaid provider bulletins.

(b) The Department shall maintain and share with the PHP a list of HCBS services and codes that the rate increase will apply to through the PCDU and the DHHS Website.

(c) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to provider eligibility for enhanced reimbursement.

(d) The BH I/DD Tailored Plan shall communicate to contracted providers that the reimbursement increase is contingent on eligibility for HCBS Direct Care Worker wage-related reimbursement increases maintained by the Department.

(xxxi) Payments for COVID-19 Vaccines Administration and Testing

(a) The PHP shall reimburse providers based on Department's NC Medicaid Direct rates for COVID-19 Vaccine Administration and COVID-19 testing.

(xxxii) Payment for Behavioral Health Services provided to Members awaiting hospital discharge

(a) Upon CMS approval, the BH I/DD Tailored Plan shall reimburse in-network providers for Behavioral Health Services provided to Members awaiting hospital discharge as defined in the NC Medicaid State Plan and in Clinical Coverage Policy 2A-1 at no less than 100% of the Medicaid Direct Fee schedule unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.

gggggg. *Section V. Scope of Services, B. Medicaid, 4. Providers, vi. Provider Grievances and Appeals, (vi) Appeals, (a)* is revised and restated in its entirety as follows:

i. The BH I/DD Tailored Plan shall offer providers Appeal rights as described in *Section VII. Third Revised and Restated Attachment I. Provider Appeals for Medicaid and State-funded Providers.*

hhhhhh. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, i. Quality Management and Quality Improvement, (v), (a), (1)* is revised and restated in its entirety as follows:

(1) The BH I/DD Tailored Plan shall submit an annual combined QAPI Plan for Medicaid and State-funded services, delineating the BH I/DD Tailored Plan's plans for performance improvement projects and other quality improvement efforts as part of the QAPI Plan. As long as the QAPI clearly states that it applies to the BH I/DD Tailored Plan, the QAPI Plan may apply to other LME/MCO operations, including, without limitation, the PIHP.

iiiiii. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, i. Quality Management and Quality Improvement, (ix) Quality Measures, (a)* is revised and restated in its entirety as follows:

(a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website, that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and financial accountability for a select set of measures to be specified by the Department.

jjjjjj. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (ii), (a)* is revised and restated in its entirety as follows:

i. Payments to AMH+ and CMA providers will be considered VBP only when these contracts include a performance incentive payment, as described in *Section V.B.4.v. Provider Payments*.

kkkkkk. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (ii), (c)* is revised and restated in its entirety as follows:

(c) The BH I/DD Tailored Plan shall re-submit contract templates to the Department for review at least ninety (90) Calendar Days before use in the market when any new VBP arrangements (excluding AMH+s, which is covered in *Section V.B.4.v. Provider Payments*) or changes to VBP arrangements are added.

llllll. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (iii)* is revised and restated in its entirety as follows:

(iii) The Department may set minimum targets for VBP contracting starting in Contract Year 2, and implement withholds associated with these targets. Targets will be published at least six (6) months prior to the Contract Year in which they take effect.

mmmmmm. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (v)* is revised and restated in its entirety as follows:

(v) Following the end of Contract Year 1, the BH I/DD Tailored Plan shall complete a VBP Assessment, in a format to be determined by the Department, based on the categories based on the categories developed by HCP-LAN.

(a) The Department shall use the VBP Assessment to demonstrate details about VBP contracts and compare documented progress to the BH I/DD Tailored Plan's final VBP Strategy on an annual basis.

(b) The BH I/DD Tailored Plan shall report the initial results of its VBP Assessment focused on VBP contracts in place to date following ninety (90) Calendar Days after the end of Contract Year 1.

(c) The BH I/DD Tailored Plan shall update the VBP Assessment on an annual basis, following ninety (90) Calendar Days after the end of each contract year.

nnnnnn. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (vi), (c), (1), iv.* is revised and restated in its entirety as follows:

iv. The BH I/DD Tailored Plan's plan for measurement of outcomes and results related to VBP by year.

oooooo. *Section V. Scope of Services, B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (vi), (c), (2)* is revised and restated in its entirety as follows:

(2) The BH I/DD Tailored Plan's projected annual targets for VBP contracts with providers in HCP-LAN Levels 1 through 4 in a format to be determined by the Department.

pppppp. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (i)* is revised and restated in its entirety as follows:

(i) In order to incentivize successful Medicaid Managed Care and increase provider participation, the BH I/DD Tailored Plan shall pay all providers on a timely basis upon receipt of any Clean Claims for covered services rendered to members who are enrolled with the BH I/DD Tailored Plan in accordance with State and Federal statutes. To maximize Federal match and ensure accurate reporting, the BH I/DD Tailored Plan shall comply with the Department's Managed Care Billing Guidance to Prepaid Health Plans (commonly known as the PHP Billing Guide) or as otherwise directed by the Department.

(a) When the Department releases revisions to the Managed Care Billing Guide, BH I/DD Tailored Plan shall update their systems to process new claims received within forty-five (45) Calendar Days of the Managed Care Billing Guide publish date, and reprocess impacted claims within seventy-five (75) Calendar Days of publication of this new guidance. If the BH I/DD Tailored Plan is unable to update their system and reprocess claims within the seventy-five (75) Calendar Days timeline, interest and penalties shall be paid on those claims according to requirements in *Section V.B.6.i.(iv)(d) Interest and Penalties*.

qqqqqq. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards, (c), (2)* is revised and restated in its entirety as follows:

(2) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid programs, are subject to an out-of-state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.

rrrrrr. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards, (d)* is revised to add the following:

(4) The BH I/DD Tailored Plan shall have a no cost option for providers to select for claims submitted by electronic funds transfer (EFT) for transmission of claims through switch companies and/or clearinghouses. Requiring transaction fees, including but not limited to clearinghouse fees and electronic funds transfer (EFT) fees, are in violation of contractual obligation to follow the rate floor for pharmacy. The BH I/DD Tailored Plan shall provide a no-cost option for processing all claim types.

ssssss. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards, (f)* is revised and restated in its entirety as follows:

(f) Remittance Advice

(1) The BH I/DD Tailored Plan shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.

(2) The BH I/DD Tailored Plan shall provide a Remittance Advice to every Local Health Department each month explaining their CMHRP payments including number of members, rates, and total payment for each program individually.
(3) The BH I/DD Tailored Plan shall provide a Remittance Advice to every Advanced Medical Home or its payment delegate each month explaining their medical home payments including number of members, rates, and total payment.
(4) The BH I/DD Tailored Plan shall work with the LHD and AMH on an agreed upon format for the monthly Remittance Advice.

tttttt. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards* is revised to add the following:

(h) The BH I/DD Tailored Plan shall process and pay claims based on the codes submitted by the provider. The BH I/DD Tailored Plan shall not change any data elements submitted by the provider on a claim. Nothing in this section is intended to prohibit or otherwise limit BH I/DD Tailored Plan's right to deny claims for missing data elements or for lack of medical necessity.
(i) Claims Processing for Child Medical Evaluation (CME)
(1) When a Member is referred for an exam for suspected maltreatment by Child Welfare Services or DSS, the BH I/DD Tailored Plan shall require the rostered CMEP providers to follow the Child Medical Evaluation and Medical Team Conference for Child Maltreatment Policy (Clinical Coverage Policy 1A-5) and bill according to Clinical Coverage Policy 1A-5 Attachment A, requiring the CME claim to be submitted with the Child Medical Evaluation Checklist (Attachment B).
(2) When processing CME claims referred through law enforcement, the BH I/DD Tailored Plan shall process these claims as any other claim for services rendered and not follow Clinical Coverage Policy 1A-5.
(j) Claims Provider Validation
(1) The BH I/DD Tailored Plan shall validate the taxonomy code submitted on the claim against the Taxonomy Code field(s) sent for the provider on the provider enrollment file. The additional taxonomy level information provided for information purposes only on the provider enrollment file should not be used during the claim submission process.
(2) The BH I/DD Tailored Plan shall validate the claim's date of service against the enrolled provider's taxonomy effective dates. In the case of inpatient stays, if a provider's taxonomy status changes during a Member's stay, taxonomy effective date validation should be based on the date of discharge for DRG based claims and should be based on the date of service for per diem claims.
(3) Once validated, the PHP shall price claims based on the taxonomy code submitted on the claim.
(k) The BH I/DD Tailored Plan shall use the same grouper version as the Department. Grouper updates at the Department occur annually in October, and the BH I/DD Tailored Plan shall use the Managed Care Billing Guide to identify the current grouper version number.

uuuuuu. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (c)* is revised and restated in its entirety as follows:

(c) Pursuant to N.C. Gen. Stat. § 58-3-225(f), the BH I/DD Tailored Plan may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the Member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be

submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the BH I/DD Tailored Plan and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

(1) The BH I/DD Tailored Plan may require that claims be submitted within three hundred sixty-five (365) Calendar days after the date of the provision of care to the Member for pharmacy point of sale claims and may not limit the time to fewer to three hundred sixty-five (365) days.

(2) When a member is retroactively enrolled, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date of enrollment for health care provider and health care provider facility claims and three hundred sixty-five (365) Calendar Days for pharmacy point of sale claims.

vvvvvv. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (d) Interest and Penalties, (4)* is revised and restated in its entirety as follows:

(4) The BH I/DD Tailored Plan shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. The BH I/DD Tailored Plan shall reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates within seventy-five (75) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section.

wwwwww. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards,* is revised to add the following:

(h) The BH I/DD Tailored Plan is presumed to have received a written claim in accordance with N.C. Gen. Stat. § 58-3-225(b).

xxxxxx. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims, (vi) System Standards* is revised to add the following:

(c) BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports. The mutually agreed upon solution for electronic claim attachments must, at a minimum, allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard HIPAA transaction (ASC X12, 275 claim attachment format or attachment indication in an 837 with the attachment sent separately). BH I/DD Tailored Plan shall implement this capability for provider use no later than September 1, 2023. If an extension is needed, BH I/DD Tailored Plan may submit a request to the Contract Administrator for Day-to-Day Activities.

yyyyyy. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, i. Claims* is revised to add the following:

(viii) National Correct Coding Initiative (NCCI)

(a) The Department has opted to use the Compatible Medicaid NCCI Methodologies in the Medicaid Managed Care program and share the Non-public Medicaid NCCI Edit Files with the BH I/DD Tailored Plans for processing claims that are paid by the BH I/DD Tailored Plan on a Fee-for-Service basis.

(b) The BH I/DD Tailored Plan shall follow NCCI policies to control improper coding that may lead to inappropriate payments to providers by the BH I/DD Tailored Plan.

(1) The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with the BH I/DD Tailored Plan on a quarterly basis, when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.

i. Within three (3) Calendar Days of receipt of the edit files, the BH I/DD Tailored Plan shall provide written notice to the Department confirming receipt of the files.

(2) The BH I/DD Tailored Plan shall incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the PHP pays on a Fee-for-Service basis. The NCCI editing shall occur prior to current procedure code review and any other editing by the BH I/DD Tailored Plan's claims payment systems.

(3) The BH I/DD Tailored Plan shall load the Non-public Medicaid NCCI Edit Files into its claims payment systems upon receipt of the edit files from the Department.

i. The edit files shall be loaded and ready for use by the BH I/DD Tailored Plan by no later than 12:00 am on the first day of the calendar quarter in which the edit files are effective.

ii. If the BH I/DD Tailored Plan experiences issues loading the edit files into its claims payment systems or any other issues with the edit files that prevents the BH I/DD Tailored Plan from properly loading the files into its systems, the BH I/DD Tailored Plan shall notify the Department within twenty-four (24) hours of identifying the issue.

iii. The BH I/DD Tailored Plan shall provide written notice to the Department no later than two (2) Calendar Days after the start of each calendar quarter acknowledging that the new Non-public Medicaid NCCI Edit Files in effect for that quarter were properly loaded into its claims payment systems.

iv. If the edit files are not properly loaded and ready for use by 12:00 am on the first day of the calendar quarter, the BH I/DD Tailored Plan shall reprocess any claim processed without using the Non-public Medicaid NCCI Edits in effect for that quarter. All reprocessed claims are subject to the prompt pay standards, including interest and penalties, specified in the Contract.

v. The BH I/DD Tailored Plan shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.

vi. The BH I/DD Tailored Plan shall only apply Outpatient Hospital NCCI edits to outpatient lab, drugs, and radiology claims.

(c) The BH I/DD Tailored Plan and its Subcontractors are subject to the terms and conditions of *Section VII. Attachment M.11. National Correct Coding Initiative Confidentiality Agreement*.

(ix) Known System Issues

(a) The BH I/DD Tailored Plan shall develop, maintain, and share a Known System Issues Tracker with providers through newsletters, provider portal, and/or health plan website on a weekly

basis to keep providers informed on all known health plan system issues with provider impact.

(b) The Known System Issues tracker shall include the following information, at a minimum:
  (1) Provider Type: type of provider(s) impacted by the system issue (e.g., hospital, pediatrics);
  (2) Number of Impacted Providers: number of known providers impacted by the system issue;
  (3) Category: type of system issue (e.g., claims, eligibility, provider, prior approval);
  (4) Issue: detailed description of the system issue and implications. If claims related, include the estimated number of claims impacted and the estimated total billed amount;
  (5) Date Issue Found: month, day, and year the BH I/DD Tailored Plan identified the system issue;
  (6) Number of Days Outstanding: number of days this issue has been open;
  (7) Estimated Fix Date: month, day, and year the BH I/DD Tailored Plan plans to have this system issue resolved;
  (8) Status: status of the issue (open, ongoing, or closed);
  (9) Resolution: description of the actions taken to resolve the system issue. If applicable, include claims adjustment/reprocessing timeline and make a note of resolved issues with pending adjustments/pending reprocessing. For pending adjustments, include estimated date of completion;
  (10) Interest/Penalties Owed: whether interest and penalties will be applied (Yes or No); and
  (11) Date Resolved: month, day, and year the BH I/DD Tailored Plan resolved this system issue.

(c) The BH I/DD Tailored Plan shall maintain each item on the Known Issues Tracker for at least ninety (90) Calendar Days after resolution of the issue.

(d) The BH I/DD Tailored Plan shall include the link to the Known Issues Tracker in the Provider Manual and submit the updated deliverable to the Department no later than December 1, 2022.

(x) Payer Initiated Claim Adjustment

(a) The BH I/DD Tailored Plan shall have the capability to complete payer initiated claim adjustments of adjudicated claims by provider types, claim types, and time period.

(b) The BH I/DD Tailored Plan shall comply with the Departments policies and procedures on claim adjustments/reprocessing.

(c) The BH I/DD Tailored Plan shall have the capability to complete a report of adjudicated claims and provide all relevant claim data including claim number, member Medicaid number, provider NPI, and date of service.

(d) The BH I/DD Tailored Plan shall complete the adjustment report as requested by the department when a previously processed claim by the payer has been adjusted/reprocessed. There is no minimum number of claims required for the report. If an issue has been identified, all claims impacted should be corrected and included in the report.

zzzzzz. *Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Stands and Frequency* is revised and restated in its entirety as follows:

(v) Submission Standards and Frequency

(a) The BH I/DD Tailored Plan shall submit all claims processed as encounters, as defined in this Section, and each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

(1) Timeliness

i. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract and monthly medical home and care management fees, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.

ii. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the claim payment date.

iii. The BH I/DD Tailored Plan encounter data submissions shall meet or exceed a timely submission standard of ninety-eight percent (98%) within thirty (30) Calendar Days after payment whether paid or denied for medical claims and within seven (7) Calendar Days after payment whether paid or denied for pharmacy claims.

a) Medical: for purposes of determining if the BH I/DD Tailored Plan has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters.

b) Pharmacy: for purposes of determining if the BH I/DD Tailored Plan has met the timeliness encounter submission standards, 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters will be counted by the Department as pharmacy encounters.

iv. Encounter data timeliness shall be defined as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.

(2) Accuracy

i. BH I/DD Tailored Plan encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.

a) Medical: for purposes of determining if the BH I/DD Tailored Plan has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters.

b) Pharmacy: for purposes of determining if the BH I/DD Tailored Plan has met the accuracy encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.

c) Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.

(3) Reconciliation

i. BH I/DD Tailored Plan encounter submissions shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim

amounts reported on financial reports within one hundred twenty (120) Calendar Days.

a) Medical: For purposes of determining if the BH I/DD Tailored Plan has met the reconciliation encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters.
b) Pharmacy: For purposes of determining if the BH I/DD Tailored Plan has met the reconciliation encounter submission standards, only NCPDP encounters will be counted by the Department as pharmacy encounters.

ii. Encounter data reconciliation shall be defined as the paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.

(b) Initial Encounter Data at Medicaid Managed Care Launch
(1) The BH I/DD Tailored Plan shall include encounter data for medical claims which have a date of service on or after the Medicaid Managed Care launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.
(2) The BH I/DD Tailored Plan shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.

(c) To support the Department achieving efficient encounter data processing, the BH I/DD Tailored Plan shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.

(d) In the event the BH I/DD Tailored Plan enters into a sub-capitated or other VBP reimbursement arrangement with a provider, the BH I/DD Tailored Plan shall be responsible for submitting all encounters to the Department, containing all the required data fields.

(e) The BH I/DD Tailored Plan shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.

(f) The BH I/DD Tailored Plan shall submit to NC Tracks, within thirty (30) Calendar Days of claim payment, an electronic Tailored Care Management Payment claim for the first Tailored Care Management contact service paid by the BH/DD Tailored Plan.

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

(vii) The Department has established a separate payment outside of the capitation rate for Tailored Care Management for members enrolled in Medicaid. This payment will be made to the BH I/DD Tailored Plan for any month in which the member is engaged in Tailored Care Management.

bbbbbbb. *Section V. Scope of Services, B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (ii)* is revised and restated in its entirety as follows:

(ii) The BH I/DD Tailored Plan shall calculate and report aggregate MLR for the rating period on two (2) bases as follows:

(a) The BH I/DD Tailored Plan shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
(1) For the April 1, 2023 through June 30, 2024 rating period, the BH I/DD Tailored plan shall report the CMS-defined MLR separately for April 1, 2023 through June 30, 2023 and July 1, 2023 through June 30, 2024 time periods to align with the MLR reporting year as defined in 42 C.F.R. § 438.8(b).

(2) The numerator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the BH I/DD Tailored Plan's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).

(3) The denominator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall equal the BH I/DD Tailored Plan's adjusted premium revenue. The adjusted premium revenue shall be defined as the BH I/DD Tailored Plan's premium revenue minus the BH I/DD Tailored Plan's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).

(b) The BH I/DD Tailored Plan shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.

(1) The BH/IDD Tailored plan shall report the Department-defined MLR for the entire April 1, 2023 through June 30, 2024 rating period.

(2) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:

i. The BH I/DD Tailored Plan is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:

a) Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.

b) Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

ii. The BH I/DD Tailored Plan is prohibited from including in the Department-defined MLR numerator any of the following expenditures:

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), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

b) Payments to related providers that violate the Payment Limitations as required in the Contract.

iii. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:

a) Payments from the Department to reimburse for required additional directed payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

ccccccc. *Section V. Scope of Services, B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (iii), (d)* is revised and restated in its entirety as follows:

(d) The BH I/DD Tailored Plan shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting period.

ddddddd. *Section V. Scope of Services, B. Medicaid, 7. Financial Requirements, iii. Financial Management, (vii) Financial Viability, (f)* is revised and restated in its entirety as follows:

(f) LME-MCO must be licensed as a BH I/DD Tailored Plan as set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-25 if required by legislation and in accordance with such.

eeeeeee. *Section V. Scope of Services, B. Medicaid, 7. Financial Requirements, iv. Tailored Care Management Capacity Building Performance Incentive Program, (v) Capacity Building Milestones* is revised to add the following:

(c) The BH I/DD Tailored Plan shall not make the distribution of funds contingent on any milestone or requirement for providers that is not already defined in this Contract.

fffffff. *Section V. Scope of Services, B. Medicaid, 7. Financial Requirements* is revised to add the following:

v. Risk Corridor

(i) A risk corridor arrangement between the BH I/DD Tailored Plan and the Department will apply to share in gains and losses of the BH I/DD Tailored Plan as defined in this section. The Risk Corridor payments to and recoupments from the BH I/DD Tailored Plan will be based on a comparison of the BH I/DD Tailored Plan's reported Risk Corridor Services Ratio ("Reported Serves Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Tailored Plan Rate Book ("Target Services Ratio").

(a) The Risk Corridor Measurement Period is defined as April 1, 2023 to June 30, 2024~~3~~.

(b) The risk corridor payments and recoupments will be based on a comparison of the BH I/DD Tailored Plan's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the BH I/DD Tailored Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

(c) The BH I/DD Tailored Plan Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the BH I/DD Tailored Plan Rate Book and weighted by the BH I/DD Tailored Plan's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).

(d) The Reported Services Ratio numerator shall be the BH I/DD Tailored Plan's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care programs. The numerator shall be defined as the sum of:

i. Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments and COVID-19 vaccine and testing costs.

ii. Advanced Medical Home Fees as defined in *Section V.B.4.v. Provider Payments* including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department.

iii. Performance Incentive Payments to Advanced Medical Homes as defined in *Section V.B.4.v. Provider Payments.*

iv. Other quality-related incentive payments to NC Medicaid providers

v. Non-claims based provider stabilization payments to support provider sustainability and beneficiary access.
vi. Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.

(e) The BH I/DD Tailored Plan is prohibited from including in the Reported Services Ratio numerator the following expenditures:
i. Payments to providers and Tailored Plan expenses for Tailored Care Management.
ii. Payments to providers for delegated Care Management.
iii. Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department.
iv. Interest or penalty payments to providers for failure to meet prompt payment standards.
v. Payments to related providers that violate the Payment Limitations as required in the Contract.
vi. COVID-19 vaccine administration and testing costs included in any non-risk arrangement.
vii. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

(f) The Reported Services Ratio denominator represents the Medicaid managed care revenue received by the BH I/DD Tailored Plan for enrollments effective during the Risk Corridor Measurement Period excluding the separate Tailored Care Management revenue. The denominator shall be equal to the Department-defined MLR denominator.

(g) BH I/DD Tailored Plan shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

(h) The BH I/DD Tailored Plan must provide an attestation of the accuracy of the information provided in its submitted risk corridor calculations, as specified in 42 C.F.R. § 438.606.

(i) Terms of the Risk Corridor
i. If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the BH I/DD Tailored Plan shall pay the Department eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus three percent (3%) and the Reported Services Ratio.
ii. If the Reported Services Ratio is greater than the Target Services Ratio plus three percent (3%), the Department shall pay the BH I/DD Tailored Plan eight percent (80%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).

(j) Risk Corridor Settlement and Payments
i. The Department will complete a settlement determination for the Risk Corridor Measurement Period.
ii. The BH IDD Tailored Plan shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.
iii. The BH I/DD Tailored Plan shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

iv. The BH I/DD Tailored Plan shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.

v. The Department may choose to review or audit any information submitted by the BH I/DD Tailored Plan.

vi. The Department will complete a Risk Corridor Settlement determination for the Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.

vii. The Department will provide the BH I/DD Tailored Plan with written notification and corresponding documentation of the final Risk Corridor Settlement determination prior to initiating a payment or remittance. The Risk Corridor Settlement shall become final if dispute resolution is not requested pursuant to *Section VI. G. Dispute Resolution for Contract Performance.*

viii. If the final Risk Corridor Settlement requires the BH I/DD Tailored Plan to remit funds to the Department, the BH I/DD Tailored Plan must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final Risk Corridor settlement.

ix. At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to contribute all or a part of the amount otherwise to be remitted to:

1. Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
2. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.

x. To be considered for the in lieu of remittance option, the BH I/DD Tailored Plan must submit a proposal to the Department for review and approval concurrent with or prior to submission of the BH I/DD Tailored Plan's interim Risk Corridor Services Ratio report.

xi. If the BH I/DD Tailored Plan has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the Tailored Plan by offsetting a subsequent monthly capitation payment.

xii. If the final Risk Corridor Settlement requires the Department to make additional payment to the BH I/DD Tailored Plan, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final Risk Corridor settlement. If the BH I/DD Tailored Plan initiates a dispute as described in accordance with *Section VI. G. Dispute Resolution for Contract Performance,* the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

gggggggg. *Section V. Scope of Services, B. Medicaid, 8. Technical Specifications, iii. Enrollment and Reconciliation, (iii) Provider Enrollment and Credentialing, (a)* is revised and restated in its entirety as follows:

(a) The Department or a designated vendor will provide to the BH I/DD Tailored Plan a daily, full file including all North Carolina Medicaid enrolled providers, including relevant enrollment and credentialing information.

(1) During the Provider Credentialing Transition Period, the information will be provided daily, in a format and transmission protocol to be defined by the Department.

(2) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the BH I/DD Tailored Plan a notice of change to the frequency and format not less than one hundred twenty (120) Calendar Days prior to implementation.

hhhhhhh. *Section V. Scope of Services, B. Medicaid, 8. Technical Specifications, iii. Enrollment and Reconciliation, (iii) Provider Enrollment and Credentialing, (e)* is revised and restated in its entirety as follows:

(e) The BH I/DD Tailored Plan shall integrate the daily provider enrollment file sent by the department and apply any provider updates to their database.

iiiiiii. *Section V. Scope of Services, B. Medicaid, 8. Technical Specifications, v. Provider Directory, (i), (c)* is revised and restated in its entirety as follows:

(c) The BH I/DD Tailored Plans shall verify that all providers included in the Provider Directory are actively enrolled in NC Medicaid.

jjjjjjj. *Section V. Scope of Services, B. Medicaid, 8. Technical Specifications, vi. Technology Documents* is revised to add the following:

(vi) SOC 2 Type II Report

(a) The BH I/DD Tailored Plan must submit a completed Soc 2 Type II report per the schedule outlined below. If the technology platform used to deliver the services under this contract has not been used in a production setting prior to the go live of the BH I/DD Tailored Plan, a Self-Assessment must be performed on the technology platform and submitted to the Department prior to go live, in lieu of the Soc 2 Type II.

(1) The following cycle will be used to allow all BH I/DD Tailored Plans the time needed to complete the required operations observation period, and the review and reporting period prior to submission to the Department:

i. December 2023 – September 2024 - Audit Operations Period – 6-10 Months – During this period it is anticipated the PHPs are working with their auditors to gather the appropriate information and evidence to generate the final report.

ii. October 2024 – November 2024 - Report and Review Period – 2 Months – During this period it is anticipated that the PHP is working with its auditor to review the final findings and document, and provide any additional evidence or other feedback needed to complete the report.

iii. December 1, 2024 – The finalized document is due to the Department. If BH I/DD Tailored Plan completes the audit with a shorter Audit Operations period, BH I/DD Tailored Plan can submit the document early.

(2) The cycle outlined above will be repeated for each scheduled submission of the SOC 2 Type II report. In addition, BH I/DD Tailored Plan use the same cycle for their Subcontractors. The BH I/DD Tailored Plan shall collect and review the final reports of all Subcontracts in compliance with the requirements in the Contract. The BH I/DD Tailored Plan shall follow all Department, State, and federal security rules, regulations, policy and statutes and to flow down the relevant contractual requirements to their Subcontractors.

IV. Modifications to Section V. Scope of Services, C. State-funded Services

Specific subsections are modified as stated herein.

a. *Section V. Scope of Services, C. State-funded Services, 1. Recipients, a. Eligibility for State-funded Services, iii.* is revised and restated in its entirety as follows:

iii. NC Medicaid beneficiaries who are members of Standard Plans are ineligible to obtain State-funded Services.

b. *Section V. Scope of Services, C. State-funded Services, 1. Recipients, a. Eligibility for State-funded Services, viii.* is revised and restated in its entirety as follows:

viii. The BH I/DD Tailored Plan shall not impose eligibility criteria on State-funded behavioral health crisis services funded with State dollars, including detoxification services listed in *Section V.C.2 Table 1: Required State-funded BH, I/DD, and TBI Services.*

c. *Section V. Scope of Services, C. State-funded Services, 1. Recipients, b. Recipient Engagement, vi. Recipient Services Website* is revised to add the following:

h) The BH I/DD Tailored Plan shall also include on its Recipient Portal the ability for recipients, at a minimum to:
1. Request a change to their Provider.
2. Update their Contact Information, including opting into or out of text and/ or email communications.
3. Find Forms.
4. Check the Status of a Claim.
5. Find information about their benefits or coverage category.
6. Submit Complaints.
7. Request Appeals for State- Funded Services.
8. Find information about their State Funded Services.

d. *Section V. Scope of Services, C. State-funded Services, 2. Services, a. State-funded BH, I/DD and TBI Services, iv. Covered Services, Section V.C.2. First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services* is revised and restated in its entirety as follows:

Section V.C.2. Second Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
All–Disability	1. Diagnostic assessment [22] 2. Facility based crisis for adults [23] 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services [24]	1. BH urgent care 2. Facility based crisis for children and adolescents

[22] Diagnostic assessment may be provided through Telehealth.

[23] This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

[24] The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

Section V.C.2. Second Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
Adult Mental Health	1. Assertive community treatment (ACT) [25] 2. Assertive engagement 3. Case management[26] 4. Community support team (CST) Peer Support Services[27] 6. Psychosocial rehabilitation 7. Mental health recovery residential services [28] 8. Individual placement and support-supported employment (IPS-SE)[29] 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management	1. Partial hospitalization
Child Mental Health	1. High fidelity wraparound (HFW)[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI [32]	1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment[31] 6. Respite 7. Adult Day Vocational Programs (ADVP)	1. TBI long term residential rehabilitation services
Substance Use Disorder - Adult	1. Ambulatory detoxification 2. Assertive engagement 3. Case management[32] 4. Clinically managed population specific high intensity residential services[33] 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports[34]	1. Social setting detoxification services

[25] The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

[26] This service may include critical time intervention, case management, and resource intensive case management (RICM).

[27] Peer supports include individual and group services.

[28] This category of services may include group living and supervised living among other services.

[29] The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364

[30] The Department intends allocate funding for slots for HFW services.

[31] I/DD and TBI care management will be only be provided by the BH I/DD Tailored Plan.

[32] This service may include critical time intervention, case management, and RICCM.

[33] The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.

[34] Peer supports include individual and group services.

Section V.C.2. Second Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	8. Substance use residential services and supports[35] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment) 15. Community Support Team 16. BH Comprehensive Case Management	
Substance Use Disorder - Child	1. Multi-systemic therapy 2. SAIOP 3. Substance use residential services and supports 4. High fidelity wraparound (HFW) 5. Assertive Engagement	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

e. *Section V. Scope of Services, C. State-funded Services, 3. Care Management and Prevention, d. Diversion from Institutional Settings, iii. Staff Requirements, b), 3.* is revised and restated in its entirety as follows:

3. Individuals with relevant and direct experience providing diversion services under TCL may continue to provide diversion services without meeting the minimum qualifications for Diversion Specialists described in this Section.

f. *Section V. Scope of Services, C. State-funded Services, 3. Care Management and Prevention, e. In-Reach and Transition from Institutional Settings, ii. Eligibility for In-Reach and Transition Services, a)* is revised and restated in its entirety as follows:

a) All non-Medicaid covered potential recipients with SMI residing in an ACH or state psychiatric hospital who meet the TCL eligibility criteria set forth in the Settlement Agreement and LME-MCO Communication Bulleting #J281 dated March 14, 2018, subject to the availability of State funds, shall be eligible for state-funded in-reach and transition activities.
   1. The Department retains the right to modify eligibility criteria for state-funded in-reach and transition activities.

[35] This category of services will be covered an interim basis until the Department completes its implementation of the 1115 SUD waiver and updates to the service definitions for SUD services to completely align with the ASAM criteria.

g. *Section V. Scope of Services, C. State-funded Services, 4. Providers, b. Provider Network Management, ix. Provider Directory, f), 13.* is revised and restated in its entirety as follows:

13. Whether a provider serves Medicaid beneficiaries;

h. *Section V. Scope of Services, C. State-funded Services, 4. Providers, e. Provider Grievances and Appeals, vi. Appeals, a)* is revised and restated in its entirety as follows:

a) The BH I/DD Tailored Plan shall offer providers appeal rights as described in *Section VII. Third Revised and Restated Attachment I. Provider Appeals for Medicaid and State-funded Providers*.

i. *Section V. Scope of Services, C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, v., a) QAPI Plan, 1.* is revised and restated in its entirety as follows:

1. The BH I/DD Tailored Plan shall submit an annual combined QAPI Plan for Medicaid and State-funded services, delineating the BH I/DD Tailored Plan's plans for performance improvement projects and other quality improvement efforts as part of the QAPI Plan. The Department expects the BH I/DD Tailored Plan to submit a combined QAPI Plan for Medicaid and State-funded services.

j. *Section V. Scope of Services, C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, v., a) QAPI Plan* is revised to add the following:

9. Mechanisms to assess and address health equity including access to culturally and linguistically appropriate services and a diverse provider pool.
10. As part of its QAPI Plan submissions, the BH I/DD Tailored Plan shall include Member Advisory Committee (MAC) and Consumer and Family Advisory Committee (CFAC) activity, result summaries, and program assessments of the following:
    i. Mechanisms to collect and assess feedback from the BH I/DD Tailored Plan Member Advisory Committee and Consumer and Family Advisory Committee;
    ii. The BH I/DD Tailored Plan's actions/initiative taken based on Member Advisory Committee and Consumer and Family Advisory Committee feedback in alignment with improvement and appropriateness of care provided to Members;
    iii. Mechanisms to review member satisfaction and feedback on the member experience with BH I/DD Tailored Plan responsiveness to member issues/comments/concerns;
    iv. The BH I/DD Tailored Plan shall submit an updated MAC and CFAC roster of committee members when there are modifications made to the MAC and CFAC representatives (reference BH I/DD Tailored Plan MAC Guidance for MAC and CFAC statutory requirements for member composition requirements and responsibilities). This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUS), etc.

k. *Section V. Scope of Services, C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, x. Public Health Reporting and Tracking, a), 1.* is revised and restated in its entirety as follows:

1. Performance Improvement Projects (PIPs)
    i. For Medicaid, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI Plan. See *Section V.B.5.i. (xiii) Performance Improvement Projects;*
    ii. For State Funded Services, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI Plan, these PIPs not required to be conducted separate from

Medicaid, data related to State Funded Services must be separated from Medicaid when the same PIP is conducted; and

iii. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in the document. Remove barriers (e.g., services coverage, implementation challenges, recipient education).

l. *Section V. Scope of Services, C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, xi. Performance Improvement Projects (PIPs), a)-b)* is revised and restated in its entirety as follows:

a) For Medicaid, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI Plan. See *Section V.B.5.i. (xiii) Performance Improvement Projects*. For State Funded Services, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI Plan, these PIPs not required to be conducted separate from Medicaid, data related to State Funded Services must be separated from Medicaid when the same PIP is conducted. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in the document.

b) To the extent that the BH I/DD Tailored Plan's Medicaid PIPs apply to non-clinical and clinical areas relevant to State-funded services, the BH I/DD Tailored Plan shall include State-funded services and recipients in the PIP. The BH I/DD Tailored Plan shall ensure the PIP:

1. Is designed to achieve significant improvement in health outcomes as part of the annual BH I/DD Tailored Plan QAPI Plan review; and
2. Includes measurement of performance using quality indicators as part of the annual BH I/DD Tailored Plan QAPI Plan review.

m. *Section V. Scope of Services, C. State-funded Services, 6. Claims Management, a. Provider Claims, i. Claims Processing and Reprocessing Standards, c)* is revised and restated in its entirety as follows:

c) The BH I/DD Tailored Plan Shall require claims to be submitted within ninety (90) Calendar Days.

n. *Section V. Scope of Services, C. State-funded Services, 7. Financial Requirements, c. Administrative Funding, i.* is revised and restated in its entirety as follows:

i. The BH I/DD Tailored Plan shall be allowed to expend up to ten percent (10%) of the amount of SSF expended in the prior year, each fiscal year on administrative expenses.

V. <u>Modifications to Section VI. Contract Performance for Medicaid and State-funded Services</u>

Specific subsections are modified as stated herein.

a. *Section VI. Contract Performance for Medicaid and State-funded Services, F. Payment of Liquidated Damages and other Monetary Sanctions, 1.* is revised and restated in its entirety as follows:

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

b. *Section VI. Contract Performance for Medicaid and State-funded Services, G. Dispute Resolution for Contract Performance, 2.* is revised and restated in its entirety as follows:

2. The Contractor shall have the right to dispute certain contract performance actions by the Department, including the imposition of C~~A~~MPs, intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the Contractor shall not have the right to dispute the Department's decision to require the Contractor to perform a remedial action.

c. *Section VI. Contract Performance for Medicaid and State-funded Services, G. Dispute Resolution for Contract Performance, 3. Dispute Resolution Procedures, a.* is revised and restated in its entirety as follows:

a. To initiate a dispute, the Contractor shall submit a written request for a dispute resolution within thirty (30) Calendar Days of the date of the Notice of Deficiency imposing the Department's intended action. The Department may extend the Contractor's deadline to request dispute resolution for good cause if the Contractor requests an extension within ten (10) Calendar Days of the date on the written notice.

VI. Modifications to Section VII. RFA Attachments

Specific attachments are modified as stated herein.

a. *Section VII. Second Revised and Restated Attachment A. BH I/DD Tailored Plan Organizational Roles and Positions for Medicaid and State-funded Services* is revised and restated in its entirety as *Section VII. Third Revised and Restated Attachment A. BH I/DD Tailored Plan Organizational Roles and Positions for Medicaid and State-funded Services* and attached to this Amendment.

b. *Section VII. First Revised and Restated Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Cover Policies* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Cover Policies* and attached to this Amendment.

c. *Section VII. First Revised and Restated Attachment C. Approved Behavioral Health In Lieu of Services for Medicaid* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment C. Reserved*.

d. *Section VII. First Revised and Restated Attachment D. Anticipated Contract Implementation Schedule* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment D. Anticipated Contract Implementation Schedule* and attached to this Amendment.

e. *Section VII. First Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics* and attached to this Amendment.

f. *Section VII. First Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards* and attached to this Amendment.

g. *Section VII. Second Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* is revised and restated in its entirety as *Section VII. Third Revised*

and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts and attached to this Amendment.

h. *Section VII. Second Revised and Restated Attachment H. Addendum for Indian Health Care Providers* is revised and restated in its entirety as *Section VII. Third Revised and Restated Attachment H. Addendum for Indian Health Care Providers* and attached to this Amendment.

i. *Section VII. Second Revised and Restated Attachment I. Provider Appeals for Medicaid and State-Funded Services Providers* is revised and restated in its entirety as *Section VII. Third Revised and Restated Attachment I. Provider Appeals for Medicaid and State-Funded Services Providers* and attached to this Amendment.

j. *Section VII. First Revised and Restated Attachment J. Reporting Requirements* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* and attached to this Amendment.

k. *Section VII. First Revised and Restated Attachment L. Managed Care Terminology Provided to the BH I/DD Tailored Plan for Use with Members Pursuant to 42 C.F.R. § 438.10* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment L. Managed Care Terminology Provided to the BH I/DD Tailored Plan for Use with Members Pursuant to 42 C.F.R. § 438.10* and attached to this Amendment.

l. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and attached to this Amendment.

m. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid and NC Health Choice Members* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid Members* and attached to this Amendment.

n. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy* and attached to this Amendment.

o. *Section VII. Attachment M. Policies, Attachment M. 4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members* is renamed to *Section VII. Attachment M. 4. Pregnancy Management Program Policy for Medicaid*. There are no other changes to this *Section VII. Attachment M., Attachment M. 4*.

p. *Section VII. Attachment M. Policies, Attachment M. 5. Case Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members* is renamed to *Section VII. Attachment M. 5. Case Management for High-Risk Pregnancy Policy for Medicaid*. There are no other changes to this *Section VII. Attachment M. Policies, Attachment M. 5*.

q. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers* is renamed to *Section VII. Second Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers* and attached to this Amendment.

r. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 8. Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members* is renamed to *Section VII.*

Second Revised and Restated Attachment M. 8. Management of Inborn Errors of Metabolism Policy for Medicaid Members and attached to this Amendment.

s. *Section VII. Attachment M. Policies, First Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients* is renamed to *Section VII. Second Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients* and attached to this Amendment.

t. *Section VII. Attachment M. Policies* is revised to add *Section VII. Attachment M. Policies, Attachment M. 13. Approved <TP NAME> In Lieu of Services,* which attached to this Amendment.

u. *Section VII. Attachment M. Policies* is revised to add *Section VII. Attachment M. Policies, Attachment M. 14. COVID-19 Public Health Emergency Managed Care Policy* which attached to this Amendment.

v. *Section VII. First Revised and Restated Attachment P. Performance Metrics, Services Level Agreements and Liquidated Damages* is revised and restated in its entirety as *Section VII. Second Revised and Restated Attachment P. Performance Metrics, Services Level Agreements and Liquidated Damages* and attached to this Amendment.

VII. **Effective Date:** This Amendment is effective June 1, 2023, unless otherwise explicitly stated herein, subject to approval by CMS.

VIII. **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.

North Carolina Department of Health and Human Services

_____ Date: _____

Jay Ludlam, Deputy Secretary
NC Medicaid

TP Name

_____ Date: _____

TP Authorized Signature

Third Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services

The Department requires that the BH I/DD Tailored Plan staff the following roles to fulfill the requirements of the North Carolina Medicaid Managed Care Program and/or State-funded Services.

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for overseeing assigned care managers. For Medicaid and State-funded Services, these individuals are responsible for reviewing all Care Plans (Medicaid only) and ISPs for quality control and providing guidance to care managers on how to address members' complex health and social needs. For Medicaid, these individuals are responsible for ensuring fidelity to the Tailored Care Management model. For State-funded Services, this position only services recipients with I/DD and TBI.	• Must meet North Carolina Residency requirements • If serving Members with BH conditions, must hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD or a TBI must have one (1) of the following minimum qualifications: ○ A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; OR ○ A master's degree in a human service field

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR ○ A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI. • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, BH I/DD Tailored Plan and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the enrollee's care manager. • The Department will grant a one-time staff exception ('grandfathering') for specified BH I/DD Tailored Plan staff that: ○ Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan Contract Award (July 26, 2021). ○ This exception is based on the staff enrollee possession the required number of years of experience,

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		but not the required degree, degree type or licensure type.
3. State-funded BH Care Management Coordinator	This individual is responsible for developing policies, practices and systems that support the provision of case management services for State-funded Services recipients with BH conditions. In accordance with applicable provisions of N.C.G.S. 122C-115.4(g)(1), this individual shall serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated BH System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Juvenile Justice Section of the Division of Adult Correction and Juvenile Justice, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.	• Must meet North Carolina Residency requirements • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or RN • Must have three (3) years of supervisory experience working directly with complex individuals with a BH condition
4. Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	For Medicaid, these individuals shall be responsible for providing integrated whole-person care management under the Tailored Care Management model, including coordinating across physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs. For State-funded Services, these individuals are responsible for providing care management for recipients with I/DD and TBI needs, including coordination across BH, I/DD, TBI and Unmet Health Resource Needs.	• Must meet North Carolina Residency requirements • Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 waiver of experience requirement for Qualified Professionals. • For care managers serving enrollees with LTSS needs: ○ Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. ○ This experience may be concurrent with the

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).	• Must meet North Carolina Residency requirements
6. Full-Time Transition Supervisor(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	• Must meet North Carolina Residency requirements • Must meet the care manager supervisor qualifications described above and outlined in *Section V.B.3.ii.(xiv)(c)Care Manager Qualifications.* • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
7. Full-Time Transition Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for: • individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting.	• Must meet North Carolina Residency requirements Transition Coordinators serving individuals with SMI: • Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or • Must hold a Bachelor's degree in a human

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. Transition Coordinators serving individuals with I/DD or TBI: • Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD or TBI; or • Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
8. Full-Time Peer Support Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members and recipients with BH diagnoses residing in a state psychiatric hospital or an ACH.	• Must meet North Carolina Residency requirements • Must have NC Certified Peer Support Specialist Program Certification
9. Full-Time In-Reach Specialist(s) for North Carolina Medicaid Managed Care Program	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	• Must meet North Carolina Residency requirements

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		• Must hold a Bachelor's degree in a human services field • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians. • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
10. Diversion Specialist(s) for State-Funded Services	These individuals are responsible for performing diversion functions and activities described in *Section V.C.3.d.iv. Diversion Activities* for recipients eligible to receive diversion services as described in *Section.V.C.3.d.ii. Eligibility for Diversion.*	• Must meet North Carolina Residency requirements • Must: a. Be a Master's level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or licensed as a RN plus one (1) year of relevant experience working directly with individuals with SMI; **or** b. Have one (1) year prior relevant and direct experience providing diversion services under TCL~~I~~.
11. System of Care Family Partner(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	• Must meet North Carolina Residency requirements • Must hold high school diploma or GED • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid or State-funded BH services

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
12. System of Care Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	• Must meet North Carolina Residency requirements • Must hold: a. A Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; **or** b. A Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems
13. DSOHF Admission Through Discharge Manager for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for: • Coordinating and/or performing transition functions and activities described in *Section V.B.3.viii.(iv)* and *Section V.C.3.e.iv* for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. • Coordinating and/or performing discharge planning functions for BH I/DD Tailored Plan members and state-funded recipients who are not receiving transition functions and activities described in *Section V.B.3.viii.(iv)* and *Section V.C.3.e.iv* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as the BH I/DD Tailored Plan liaison to ADATCs in the BH I/DD Tailored Plan's region.	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must meet North Carolina Residency requirements • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: • Must meet North Carolina Residency requirements • Must hold: a. A Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; **or** b. A Bachelor's degree in a human services

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		field plus five (5) years of relevant experience working directly with individuals with I/DD; **or** c. A Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
14. Member and Recipient Appeal Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates member and recipient appeals in a timely manner.	• Must meet North Carolina Residency requirements
15. Member and Recipient Complaint and Grievance Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates member and recipient complaints and grievances in a timely manner.	• Must meet North Carolina Residency requirements
16. Full-Time Member and Recipient Complaint and Grievance Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient complaints and grievances in accordance with state and federal laws and this Contract.	• For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing complaints and grievances
17. Full-Time Peer Review and/or Member and Recipient Appeal Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient appeals in accordance with state and federal laws and this Contract.	• Peer reviewers must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing appeals
18. Full-Time Member and Recipient Services and Service Line Staff for North Carolina Medicaid	These individuals coordinate communication with members and recipients.	• Must meet North Carolina Residency requirements

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
Managed Care Program and State-funded Services		
19. Provider Relations and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communications between the BH I/DD Tailored Plan and providers.	• Must meet North Carolina Residency requirements
20. Provider Network Relations Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals support the Provider Network Director in network development and management.	• Must meet North Carolina Residency requirements
21. Provider Complaint, Grievance, and Appeal Coordinator for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must meet North Carolina Residency requirements
22. Pharmacy Director for the Pharmacy Service Line for the North Carolina Medicaid Managed Care Program	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract.	• Must meet North Carolina Residency requirements • Must be a North Carolina registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
23. Full-Time Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing • Pharmacists shall be registered, with current NC Pharmacist license.
24. Full-Time I/DD and TBI Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must meet North Carolina Residency requirements • Must be a Qualified Professional in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
25. PBM Liaison for the North Carolina Medicaid Managed Care Program	If the BH I/DD Tailored Plan partners with a third-party PBM, this individual serves as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	N/A
26. Tribal Provider Contracting Specialist (If applicable) for the North Carolina Medicaid Managed Care Program	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must meet North Carolina Residency requirements
27. Reserved.		
28. Liaison between the Department and the North Carolina Attorney General's MID for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must meet North Carolina Residency requirements
29. Special Investigations Unit (SIU) Lead for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, or pre-law, or have at least five (5) years of relevant experience • Must complete CLEAR training or provide a timeframe as to when it will be complete
30. Special Investigations Unit (SIU) Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law, or criminal justice, **or** have at least three (3) years of relevant experience
31. Liaison to the Division of Social Services for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serves as a primary contact to triage and escalate member specific or BH I/DD Tailored Plan questions.	• Must meet North Carolina Residency requirements

Section VII. Third Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
32. Waiver Contract Manager for the North Carolina Medicaid Managed Care Program	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1115 Waiver and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	• Must meet North Carolina Residency requirements Minimum of seven (7) years of management experience, preferably in human services
33. Olmstead Manager	Provide coordination across BH I/DD Tailored Plan program areas to assist the BH I/DD Tailored Plan in putting in place an array of policies, procedures or practices that support the ADA/Olmstead integration mandate within the BH I/DD Tailored Plan and its provider network.	• Must meet North Carolina Residency requirements • Must hold: a. A Bachelor's degree in an area specific to the program from an appropriately accredited institution and three years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience; **or** b. Master's degree in an area specific to the program from an appropriately accredited institution and two years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience.

Second Revised and Restated Attachment B: Summary of Medicaid Covered Services and Clinical Coverage Policies

Second Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies documents the list of Clinical Coverage Policies the Department maintains currently for its NC Medicaid Direct program for Medicaid benefits that will be covered by the BH I/DD Tailored Plans. Full details on the policies are available at: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

North Carolina's Medicaid State Plan is available here: https://medicaid.ncdhhs.gov/document/state-plan-under-title-xix-social-security-act-medical-assistance-program. The Department reserves the right to update the clinical coverage policies for covered benefits.

Section VII. Second Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11

	NC Clinical Coverage Policy 1-F, Chiropractic Services
Clinic services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Durable medical equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members*
Family planning services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Federally qualified health center (FQHC) services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions

Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management
Home health services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.l, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A
Home infusion therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy
Hospice services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services
ICF-IID services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Innovations waiver services	8P: North Carolina Innovations (*Innovations waiver enrollees only)
Inpatient hospital services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services
Inpatient psychiatric services for individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services
Inpatient substance use services	NC Clinical Coverage Policy 8B, Inpatient BH Services Medically managed intensive inpatient withdrawal services Medically managed intensive inpatient services
Inpatient and Outpatient BH services	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:

	Mobile Crisis Management Intensive-In-Home Services Multisystemic Therapy Psychosocial Rehabilitation Child and Adolescent Day Treatment Partial Hospitalization Professional Treatment Services in a Facility Based Crisis System Substance Use Intensive Outpatient Program Substance Use Comprehensive Outpatient Program Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment) Clinically Managed Residential Services (substance abuse non-medical community residential treatment) NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-5 Diagnostic Assessment NC Clinical Coverage Policy 8A-6: Community Support Team (CST) NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification) NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-9 Opioid Treatment Program NC Clinical Coverage Policy 8A-10: Clinically Managed Residential Withdrawal Services (social setting detoxification) NC Clinical Coverage Policy 8A-11: Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification) North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services NC Clinical Coverage Policy 8D-4: Clinically Managed Population-Specific High Intensity Residential Program NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders NC Clinical Coverage Policy 8G – Peer Supports

	NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH)
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Non-emergent transportation to medical care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 Non-Emergency Medical Transportation Managed Care Policy
Nursing facility services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40 42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures

	NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home
Occupational therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Optometry services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient hospital services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the- Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	SSA, Title XIX, Section 1905(a)(11)

	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Physician services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.I, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27,Electrodiagnostic Studies

	NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty
Podiatry services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Prescription drugs and medication management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The- Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters *Section V.B.2.iii. Pharmacy Benefits* of the Contract

Private duty nursing services (PDN)	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age
Prosthetics, orthotics and supplies	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
Respiratory care services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Rural health clinic services (RHC)	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Services for individuals age 65 or older in an institution for mental disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services
Speech, hearing and language disorder services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Telehealth, Virtual Patient Communications and	42 C.F.R. § 410.78

Remote Patient Monitoring	NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring
Tobacco cessation counseling for pregnant women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant

	NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older

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Second Revised and Restated Attachment D. Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of BH I/DD Tailored Plan services beginning on April 1, 2023. The Department may make adjustments after Contract Award but in no event will a Key Milestone or Deliverable be due earlier than provided for below.

Section VII. Second Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
1	Contract Award	The date the Department will award the Managed Care Contract for BH I/DD Tailored Plans	6/11/2021
2	Commencement of BH I/DD Tailored Plan Implementation Planning	The date the BH I/DD Tailored Plan Implementation Team must be ready to commence Implementation Planning activities	6/11/2021
3	Draft Implementation Plan	The date the BH I/DD Tailored Plan's Implementation Plan Draft must be submitted to the Department	Contract Award + fourteen (14) days
4	Identification of additional resources for Implementation Team	The date the BH I/DD Tailored Plan must identify any additional resources needed to support the implementation activities	Contract Award + twenty (20) days
5	Submission of BH I/DD Tailored Plan Operating Plan	The date the BH I/DD Tailored Plan's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
6	Submission of key technology deliverables	The date the BH I/DD Tailored Plan submits to the Department: • Security Compliance Plan • Encounter and Claims Implementation Approach • System Interface Design	Contract Award + thirty (30) days
7	Submission of Business Continuity Plan	The date the BH I/DD Tailored Plan's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
8	Submission of key Medicaid and State-funded provider materials	The date the BH I/DD Tailored Plan submits to the Department: • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual	Contract Award + thirty (30) days
9	Submission of member and recipient education efforts	The date the BH I/DD Tailored Plan submits its planned member and recipient education efforts to the Department	Contract Award + sixty (60) days
10	Acquisition of service line phone numbers	The date the BH I/DD Tailored Plan must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days

Section VII. Second Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
11	Submission of Tobacco Cessation Plan	The date the BH I/DD Tailored Plan must submit a Tobacco Cessation Plan to the Department	Contract Award + ninety (90) days
12	Submission of Fraud Prevention Plan	The date the BH I/DD Tailored Plan must submit a Fraud Prevention Plan to the Department for review and approval	Contract Award + ninety (90) days
13	Establishment of BH I/DD Tailored Plan Office and Call Center(s) in NC	The date the BH I/DD Tailored Plan must begin implementing call center(s) and staff in North Carolina	Contract Award + ninety (90) days
14	Submission of Locum Tenens Policy	The date the BH I/DD Tailored Plan submits to the Department the Locum Tenens Policy	Contract Award + ninety (90) days
15	Tribal Engagement Strategy (as applicable)	The date the BH I/DD Tailored Plan's Tribal Engagement Strategy Medicaid must be submitted to the Department for review	Contract Award + ninety (90) days
16	Pharmacy Provider Network Audit Program	The date the BH I/DD Tailored Plan's Pharmacy Provider Network Audit Program Medicaid must be submitted to the Department	Contract Award + ninety (90) days
17	Mail Order Program Policy	The date the BH I/DD Tailored Plan's Mail Order Program Policy Medicaid, including a sample of all member mail order-related correspondence, must be submitted to the Department	Contract Award + ninety (90) days
18	Good Faith Provider Contracting Policy	The date the BH I/DD Tailored Plan shall develop and submit Good Faith Provider Contracting Policy that includes a description of how the BH I/DD Tailored Plan will conclude that a "good faith" contracting effort has been made and/or refused and the Objective Quality Standards used in contracting decisions	Contract Award + ninety (90) days
19	Submission of Third Party Liability Policy	The date the BH I/DD Tailored Plan submits to the Department the Third Party Liability Policy	Contract Award + ninety (90) days
20	Whistleblower Policy	The date the BH I/DD Tailored Plan shall develop and submit a Whistleblower Policy related to whistleblower protections	Contract Award + ninety (90) days
21	Submission of key member and recipient materials	The date the BH I/DD Tailored Plan submits to the Department: • Member Enrollment and Disenrollment Policy • Member ID Card • Member Welcome Packet • Recipient Welcome Packet • Member and Recipient Mailing Policy	Contract Award + ninety (90) days

Section VII. Second Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
		• Member and Recipient Rights and Responsibilities Policy	
22	Opioid Misuse Prevention and Treatment Program Policy	The date the BH I/DD Tailored Plan shall develop and submit an Opioid Misuse Prevention Program Policy for Medicaid	Contract Award + ninety (90) days
23	Submission of Training Program	The date the BH I/DD Tailored Plan's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
24	Submission of Transition of Care Policy	The date the BH I/DD Tailored Plan shall submit the Medicaid Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
25	Provider Grievances and Appeals Policies	The date the BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policies for both Medicaid and State-funded services	Contract Award + one hundred twenty (120) days
26	State-funded Recipient Eligibility Policy	The date the BH I/DD Tailored Plan must submit the recipient eligibility policy to the Department for review and approval	Contract Award + one hundred fifty (150) days
27	Submission of key clinical and care management materials	The date the BH I/DD Tailored Plan submits to the Department • Medicaid and State-funded Care Management Policies • Medicaid and State-funded UM Program Policies • Medicaid EPSDT Policy • Medicaid NEMT Policy • System of Care Policy • In-Reach and Transition Policy	Contract Award + one hundred fifty (150) days
28	Submission of Local Community Collaboratives Strategy	The date the BH I/DD Tailored Plan must submit the Local Community Collaboratives Strategy to the Department for review and approval	Contract Award + one hundred fifty (150) days
29	Submission of VBP Assessment and VBP Strategy for Medicaid	The date the BH I/DD Tailored Plan's first retrospective VBP Assessment and prospective VBP Strategy must be submitted to the Department	Contract Award + six (6) months
30	BH I/DD Tailored Plan marketing materials	Marketing Materials should be submitted to the Department for approval eight (8) weeks prior to use.	Ad-hoc
31	Contracting with AMH+ and CMAs for Tailored Care Management	The date the contracts must be finalized with certified AMH+ practices and CMAs for Tailored Care Management	Ninety (90) days before BH I/DD Tailored Plan launch
32	Contracting with PCPs	The date the contracts must be finalized with providers to allow for PCP assignment	Ninety (90) days before BH I/DD Tailored Plan launch

Section VII. Second Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
33	PCP Auto Assignment	The date that PCP auto assignment must be completed for members enrolling in BH I/DD Tailored Plans at launch	Forty-five(45) days before BH I/DD Tailored Plan launch
34	TCM Auto Assignment	The date that TCM auto assignment must be completed for members enrolling in BH I/DD Tailored Plans at launch	Forty-five(45) days before BH I/DD Tailored Plan launch
35	Commencement of Marketing Activities	The date the BH I/DD Tailored Plan is allowed to begin marketing activities	Eight (8) weeks prior to open enrollment
36	BH I/DD Tailored Plan Launch	The date the BH I/DD Tailored Plan must begin delivering health care services to members and recipients	April 1, 2023
37	Funding of Risk Reserves	The BH I/DD Tailored Plan must meet the capital requirements as outlined in *Section V.B.7.iii.(vii) Financial Viability* and *Section V.C.7.i. Financial Viability*	April 1, 2023
38	BH I/DD Tailored Plan Marketing Plan	The date the BH I/DD Tailored Plan shall submit their Marketing Plan to the Department	July 1, 2023
39	Member Engagement and Marketing Plan for Historically Marginalized Populations	The date the BH I/DD Tailored Plan submits the Member Engagement and Marketing Plan for Historically Marginalized Populations to the Department.	January 6, 2023

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Second Revised and Restated Attachment E: BH I/DD Tailored Plan Quality Metrics

1. BH I/DD Tailored Plan Quality Metrics for Medicaid

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be provided no later than six (6) months prior to BH I/DD Tailored Plans launch, or when the Department releases the data required for such reports, whichever is later.

Updates to BH I/DD Tailored Plan Quality Metrics

a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website, as necessary, to align with the annual January update.
b. The BH I/DD Tailored Plan shall begin to track the updated measures when posted annually in January.
c. The BH I/DD Tailored Plan shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with Second Revised and Restated *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the BH I/DD Tailored Plan would report the results in June 2024).
d. An asterisk (*) indicates that the measure is calculated by the Department.

The BH I/DD Tailored Plan will also be required to report the Innovations and TBI waiver measures listed *in Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measurers* and *Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with BH I/DD Tailored Plans around these performance measures.

The BH I/DD Tailored Plan will also be required to report the 1915(i) measures listed *in Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915 (i) Performance Measurers*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with BH I/DD Tailored Plans around these performance measures.

Section VII. Second Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric

Ref #	NQF #	Measure Name	Steward
1.	1516	Child and Adolescent Well-Care Visit	NCQA
2.	Reserved		
3.	0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA
4.	0108	Follow Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	NCQA
5.	Reserved		
6.	1407	Immunizations for Adolescents (Combo 2) (IMA)	NCQA
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA
8.	1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
9.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
10.	Reserved		

Section VII. Second Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric			
Ref #	**NQF #**	**Measure Name**	**Steward**
11.	1800	Asthma Medication Ratio (AMR) – Ages 5 to 18 Years	NCQA
12.	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Ages 3 Months to 17 Years	NCQA
13.	0033	Chlamydia Screening in Women (CHL) – Ages 16 to 20	NCQA
14.	0576	Follow-Up After Hospitalization for Mental Illness (FUH) – Ages 6 to 17	NCQA
15.	0418/0418e	Screening for Depression and Follow-Up Plan (CDF) – Ages 12 to 17	CMS

Section VII. Second Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult (Age 18 or Older Unless Otherwise Noted)			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0105	Antidepressant Medication Management (AMM)	NCQA
2.	0032	Cervical Cancer Screening (CCS) – Ages 21 to 64	NCQA
3.	0033	Chlamydia Screening in Women (CHL) – Ages 21 to 24	NCQA
4.	0059 / 0575	Hemoglobin A1c Control for Patients with Diabetes (HBD)[1]	NCQA
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
6.	3175	Continuity of Pharmacotherapy for Opioid Use Disorder	USC
7.	0018	Controlling High Blood Pressure (CBP)	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	NCQA
9.	0039	Flu Vaccinations for Adults (FVA)*	NCQA
10.	0576	Follow-up After Hospitalization for Mental Illness (FUH)	NCQA
11.	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
12.	1768	Plan All Cause Readmissions (PCR)-[Observed versus expected ratio]	NCQA
13.	0418/ 0418e[1]	Screening for Depression and Follow-up Plan (CDF)	CMS
14.	Reserved	[redacted]	
15.	Reserved		
16.	NA	Rate of Screening for Unmet Resource Needs*[2]	NC DHHS
17.	NA	Total Cost of Care*	Health Partners

[1] Plans must report to the Department whether they are using the standard or electronic measure.

[2] The Department is exploring potential adoption of HEDIS' new Social Needs Screening and Intervention (SNS-E) measure. In the interim, the PHPs will submit a quarterly operational report that includes beneficiary screening results that will be used to calculate this measure.

Section VII. Second Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult (Age 18 or Older Unless Otherwise Noted)			
Ref #	**NQF #**	**Measure Name**	**Steward**
18.	NA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
19.	1800	Asthma Medication Ratio (AMR) – Ages 19 to 64	NCQA
20.	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA
21.	0034	Colorectal Cancer Screening (COL)	NCQA
22.	NA	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU)	NCQA

Section VII. Second Revised and Restated Attachment E.1. Table 3: Survey Measures and General Measures: Maternal					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	NA	Low Birth Weight*[3]	NC DHHS	Annually Calendar Year	June 1
2.	1517	Prenatal and Postpartum Care (PPC)	NCQA	Annually Calendar Year	June 1
3.	NA	Rate of Screening for Pregnancy Risk*[4]	NC DHHS	**N/A**	**N/A**

Section VII. Second Revised and Restated Attachment E.1. Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0006	CAHPS Survey	AHRQ

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

[3] The PHPs will submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure.
[4] The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
14.	Percentage of beneficiaries reporting that their ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
17.	Proportion of individuals whose annual ISP was revised or updated	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
18.	Proportion of individuals for whom an annual ISP took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
19.	Number and percentage of waiver participants whose ISPs were revised, as applicable, by the Care Coordinator to address their changing needs	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
20.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
27.	Percentage of Innovations waiver beneficiaries who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
28.	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
30.	Percentage of BH I/DD TP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
32.	Number and percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
34.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
37.	The proportion of claims paid by the BH I/DD TP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
38.	The consistency of NC Innovations capitated rates (The proportion of the BH I/DD TP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM)	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
40.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
42.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
3.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
6.	Proportion of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
7.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of Individual Support Plans that address identified health and safety risk factors	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
17.	Proportion of new waiver beneficiaries receiving services according to their ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
23.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
24.	Number and Percentage of deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Percentage of medication errors resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
26.	Percentage of beneficiaries who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
27.	Percentage of level 2 and 3 incidents reported within required time frames	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
28.	Percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
30.	Percentage of restrictive interventions resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percent of restrictive interventions used by a trained staff member.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
33.	Percent of restrictive interventions that are documented according to state policy.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
34.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	The percentage of waiver beneficiaries age 22 and older who had a primary care or preventative care visit during the waiver year	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
36.	The proportion of claims paid by the PIHP for NC TBI wavier services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new BH I/DD Tailored Plan members who have an independent evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of BH I/DD Tailored Plan members who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
3.	Number of BH I/DD Tailored Plan members with SMI/SED who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
4.	Number of BH I/DD Tailored Plan members with SUD who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
5.	Number of BH I/DD Tailored Plan members with I/DD who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
6.	Number of BH I/DD Tailored Plan members with TBI who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
7.	Number of BH I/DD Tailored Plan members on the Innovations waitlist who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of independent re-evaluations completed at least annually for BH I/DD Tailored Plan members using 1915(i) services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
9.	Proportion of new independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
18.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
19.	Percentage of beneficiaries reporting that their Care Plan/ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of Care Plan/ISPs that address identified health and safety risk factors	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
21.	Proportion of Care Plans/ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
22.	Proportion of individuals whose annual Care Plan/ISP was revised or updated	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
23.	Proportion of individuals for whom an annual Care Plan/ISP took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 11
24.	Number and percentage of BH I/DD Tailored Plan members using 1915(i) services whose Care Plans/ISPs were revised, as applicable, by the Care Manager to address their changing needs	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Proportion of beneficiaries who are using 1915(i) services in the type, scope, amount, and frequency as specified in the Care Plan/ISP.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
27.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
28.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
30.	Number and percentage of beneficiary deaths of BH I/DD Tailored Plan members using 1915(i) services where required BH I/DD Tailored Plan follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
31.	Number and percent of actions taken to protect the beneficiary using 1915(i) services, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
32.	Percentage of BH I/DD Tailored Plan members using 1915(i) services who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percentage of medication errors resulting in medical treatment for BH I/DD Tailored Plan members using 1915(i) services	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	Percentage of BH I/DD Tailored Plan Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
37.	Number and percentage of level 2 or 3 incidents where required BH I/DD Tailored Plan follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
38.	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
44.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Second Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
46.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

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2. BH I/DD Tailored Plan Quality Metrics for State-funded Services

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be released no later than six (6) months prior to BH I/DD Tailored Plan launch. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance measures.

Measures that the BH I/DD Tailored Plan will be expected to calculate and report with associated liquidated damages are indicated with an asterisk (*). The full list of performance measures, service level agreements and associated liquidated damages are listed in *Section VII. Second Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*.

Section VII. Second Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
1.	Initiation of Services	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
2.	Engagement in Services	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
3.	Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment & Substance use disorder treatment	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
4.	State Psychiatric Hospital Readmissions within thirty (30) Calendar Days and one hundred eighty (180) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
5.	ADATC Readmissions within thirty (30) Calendar Days and one hundred eighty (180) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15

Section VII. Second Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
6.	Community MH Inpatient Readmissions within thirty (30) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
7.	Community SUD Inpatient Readmission within thirty (30) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15

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3. BH I/DD Tailored Plan Combined Quality Metrics for Medicaid and State-funded Services

The measures below that are not in the first release of the Technical Specifications may be calculated by The Department. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance measures.

Section VII. Second Revised and Restated Attachment E.2. Table 3: Combined Survey Measures and General Measures for Medicaid and State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
1.	Net Increase in Members Served in TCL Supportive Housing	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
2.	Members Served in TCL Supportive Housing	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
3.	TCL Supportive Housing Retention	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15

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Second Revised and Restated Attachment F: BH I/DD Tailored Plan Network Adequacy Standards

1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid

At a minimum, BH I/DD Tailored Plans's Medicaid network shall consist of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, I/DD and TBI providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section V.B.4.i. Provider Network.*

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

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

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

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

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

The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time/distance standards found in *Distance Standards* for BH service types in *Section VII. Second Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid* and *Section VII. Second Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid.*

Section VII. Second Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Primary Care[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics[2]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members *Research-based BH treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	Research--*based BH treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8	Location-Based Services	P*sychosocial rehabilitation, Substance Use Comprehensive Outpatient Treatment, Substance Use Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members *Child and Adolescent Day Treatment Services:* Not subject to standard	*Child and Adolescent Day Treatment Services:* Not subject to standard
9	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* ≥ 1 provider within each BH I/DD Tailored Plan Region • *Medically monitored inpatient withdrawal services:(non-hospital medical detoxification)* ≥ 2 provider within each BH I/DD Tailored Plan Region	

[1] Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.
[2] Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Second Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Ambulatory withdrawal management without extended on-site monitoring (ambulatory detoxification), Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal(social setting detoxification):* ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities and 1915(i) services)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	

15	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region,
		• *Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment):* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region *(refer to 10A NCAC 27G.3400)*
		• *Clinically managed residential services (substance abuse non-medical community residential treatment)*:
		  ○ *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until 90 calendar days after licensure requirements are established
		  ○ *Adolescent:* Contract with all designated CASPs statewide
		  ○ *Women & Children:* Contract with all designated CASPs statewide
		• Clinically managed population-specific high-intensity residential program: contract with all designated CASPs
		• *Clinically managed low-intensity residential treatment services (substance abuse halfway house)*:
		  ○ *Adult:* Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[3]
		  ○ *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)
		• *Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	

[3] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. Second Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
16	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:* ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification*: Not subject to standard	
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• *Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:* ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports:* ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification*: N/A	
18.	Employment and Housing Services	• *Individual Placement and Supports (IPS) – Supported Employment (Adult MH):* Eligible individuals shall have the choice of at least 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients.	
19.	1915(i) Services	• *Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD):* ≥ 2 providers of each 1915(i) service within each BH I/DD Tailored Plan Region. • *In-Home Respite:* ≥ 2 providers within 45 minutes of the member's residence. • *Community Transition:* Not subject to standard	

Section VII. Second Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services

Section VII. Second Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification) • Ambulatory withdrawal management with extended on-site monitoring • *Clinically managed residential withdrawal services (social setting detoxification)* • *Medically monitored inpatient withdrawal services (non-hospital medical detoxification)* • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Medically Managed Intensive Inpatient Service (Inpatient Behavioral Health) • Medically Managed Intensive Inpatient Withdrawal Management (Inpatient Behavioral Health) *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Medically managed intensive inpatient Service (Acute care hospitals with adolescent inpatient substance use beds) • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment facility services • Clinically managed low-intensity residential treatment services (substance abuse halfway house) • Clinically managed population-specific high-intensity residential program • Clinically managed residential services (substance abuse non-medical community residential treatment) • Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment) • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:

Section VII. Second Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
7.	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment
8.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
9.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Remote supports • Residential Supports • Resource Facilitation • Respite

Section VII. Second Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
		• Specialized Consultation • Speech and Language Therapy • Supported Employment • Supported living • Vehicle Modifications
10.	Employment and Housing Services	• Individual Placement and Support-Supported Employment (Adult MH)
11.	1915(i) Services	• Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

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BH I/DD Tailored Plans is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:

Section VII. Second Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) calendar days for member less than six (6) months of age Within thirty (30) calendar days for members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) calendar days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) calendar days
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours

Section VII. Second Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) calendar days
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within two (2) hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Emergency Services available immediately available twenty-four (24) hours a day, 7 days a week.
11	Emergency Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, 7 days a week.
12	Emergency Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, 7 days a week.
13	Urgent Care Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
14	Urgent Care Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards*	Within twenty-four (24) hours

Section VII. Second Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
		for Medicaid Members and State-funded Recipients	
15	Routine Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within fourteen (14) calendar days
16	Routine Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within forty-eight (48) hours

The BH I/DD Tailored Plan is required to use the following provider types as "specialty care" providers for purposes of *Section VII. Second Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time or Distance Standards for Medicaid* and *Section VII. Second Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid* as found in this attachment.

Section VII. Second Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
1	Allergy/Immunology
2	Anesthesiology
3	Cardiology
4	Dermatology
5	Endocrinology
6	ENT/Otolaryngology
7	Gastroenterology
8	General Surgery
9	Gynecology
10	Infectious Disease
11	Hematology
12	Nephrology
13	Neurology
14	Oncology
15	Ophthalmology

Section VII. Second Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
16	Optometry
17	Orthopedic Surgery
18	Pain Management (Board Certified)
19	Psychiatry
20	Pulmonology
21	Radiology
22	Rheumatology
23	Urology

2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services

At a minimum, BH I/DD Tailored Plans's State-funded Services network shall consist of mental health, SUD, I/DD and TBI providers and Three-Way Contract inpatient care providers, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section V.C.4.a. Provider Network.*

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

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

In order to ensure that all members have timely access to all covered health care services, BH I/DD Tailored Plans shall ensure its network meets, at a minimum, the following time or distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Offeror should reference *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients* for service types marked with a (^). The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time or distance standards found in distance standards for BH service types in *Section VII. Second Revised and Restated Attachment F.2. Table 2 Classifications of Service Category for Behavioral Health Time or Distance Standards.*

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

Section VII. Second Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[4]	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services^	*Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients *Child and Adolescent Day Treatment Services*: Not subject to standard	*Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients *Child and Adolescent Day Treatment Services*: Not subject to standard
3	Crisis Services^	• *Facility based crisis for adults:* The greater of: o 2+ facilities within each BH I/DD Tailored Plan Region, OR o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available). • *Non-Hospital Medical Detoxification:* ≥ 2 provider within each BH I/DD Tailored Plan Region • *Ambulatory Detoxification :* ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region	
4	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5.	Reserved		
6	Community/Mobile Services^	Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. High Fidelity Wraparound ≥ 2 provider within one hour	
		Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[5]	*Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients*
7	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region • *Substance Abuse Halfway House*: o *Adult:* Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[6] o *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • *Substance Abuse Medically Monitored Community Residential Treatment*: Access to ≥1 licensed provider • *Substance Abuse Non-Medical Community Residential Treatment*:	

[4] The Department defines recipients for the purposes of network adequacy as those who received State-funded Services in the previous year.

[5] The Department defines recipients for the purposes of network adequacy as those who received State-funded Services in the previous year.

[6] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. Second Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		○ *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until 90 calendar days after licensure requirements are established) ○ *Adolescent:* Contract with all designated CASPs statewide ○ *Women & Children:* Contract with all designated CASPs statewide • *Substance Use Residential Supports & Mental Health Recovery Residential Services:* To be determined	
8	Employment and Housing Services	• *Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use).* Eligible individuals shall have the choice of at least 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *Individual Placement and Support-Supported Employment (Adult MH):* 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services,* IDD Supported Employment: 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • *Clinically Managed Population-specific High Intensity Residential Programs*: To be determined • *TBI long-term residential rehabilitation services:* To be Determined	

The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time or distance standards found in *Distance Standards* for BH service types in *Section VII. Second Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards and Section VII. Second Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards.*

Section VII. Second Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
1	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
2	Location-Based Services^	Psychosocial Rehabilitation		Y			
		Substance Abuse Comprehensive Outpatient				Y	
		Substance Abuse Intensive Outpatient Program				Y	Y
		Outpatient Opioid Therapy				Y	

Section VII. Second Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
3	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y	
		Ambulatory Detoxification				Y	
4	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y	Y
5.	Reserved						
6	Residential Treatment Services	Substance Abuse Halfway House				Y	Y
		Substance Abuse Medically Monitored Residential Treatment				Y	
		Substance Abuse Non-Medical Community Residential Treatment				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			
		Clinically managed population specific high intensity residential services				Y	
7	Community/Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	
		Transition Management Service		Y			
		High Fidelity Wraparound			Y		Y

Section VII. Second Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
		Intensive In-home			Y		Y
		Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y
8	Employment and Housing Services	I/DD & TBI Day Supports	Y				
		Community Living & Support	Y				
		I/DD & TBI Residential Services	Y				
		Supported Employment	Y				
		Residential Supports	Y	Y			
		Respite Services	Y		Y		Y
		Individual Placement and Supports (IPS)-Supported Employment		Y		Y	
		TBI Long-term Residential Rehabilitation Services	Y				
		Clinically Managed Population-specific High Intensity Residential Programs				Y	

BH I/DD Tailored Plans is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service.

Section VII. Second Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
BH Care/I/DD			
1	Mobile Crisis Management Services	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

Section VII. Second Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
3	Emergency Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
4	Emergency Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
5	Urgent Care Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
6	Urgent Care Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
7	Routine Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within fourteen (14) calendar days
8	Routine Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within forty-eight (48) hours

Third Revised and Restated Attachment G: Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts

1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts

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

1. **Contracts between the BH I/DD Tailored Plan and providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored plan utilizes the definition as found in *Section II.A.* of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.
    c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the State includes an extension option.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination.
    e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
        i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
            1. Transition of administrative duties and records; and
            2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
    f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and the timeframe within which the provider must notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
        i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.

ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
    1. During the provider credentialing transition period, no less frequently than every five (5) years.
    2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost, and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.
h. Member Billing: The contract must address the following:
    i. That the provider shall not bill any member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the member requests to receive the service; and
    ii. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
i. Provider Accessibility: The contract must address provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
    i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
    ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
    iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the provider.
j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the BH I/DD Tailored Plan, before rendering health care services.
k. Medical Records: The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
    i. Maintain confidentiality of member medical records and personal information and other health records as required by law;
    ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
    iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
l. Member Appeals and Grievances: The contract must address the provider's obligation to cooperate with the member in regard to member appeals and grievance procedures.
m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.

n. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
o. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the BH I/DD Tailored Plan's web-based billing process.
p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
    i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
    ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
    iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.
q. Utilization Management (UM): The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.
s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in Section V.B.4.v. Provider Grievances and Appeals.
u. Assignment: Provisions on assignment of the contract must include that:
    i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
    ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
w. Interpreting and Translation Services: The contract must have provisions that indicate:
    i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
    ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
    iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
x. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management

Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

y. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.

z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

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

bb. Chapter 58 requirements: Pursuant to 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, the contract must include provisions that address the following statutes and subsections:

i. G. S. 58-3-200(c).
ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
iii. G.S. 58-50-270(1), (2), and (3a).
iv. G.S. 58-50-275 (a) and (b).
v. G.S. 58-50-280 (a) through (d).
vi. G.S. 58-50-285 (a) and (b).
vii. G.S. 58-51-37 (d) and (e).

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

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

ee. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH/IDD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard

ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).

ff. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

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

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

a. AMH Provider Manual
b. *Section VII. Second Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid Members*
c. *Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid Members*
d. *Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid Members*

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

a. Compliance with state and federal laws
   The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
b. Hold Member Harmless
   The [Provider] agrees to hold the member harmless for charges for any covered service. The [Provider] agrees not to bill a member for medically necessary services covered by the Company so long as the member is eligible for coverage.
c. Liability
   The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

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

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

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

g. G.S. 58-3-225, Prompt claim payments under health benefit plans.
1. 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, BH I/DD Tailored Plan shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

2. The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) Calendar Days from the date of covered service and, in the case of health care provider facility claims, within one-hundred-eighty (180) Calendar Days after the date of the Member's discharge from the facility. The [Provider} shall submit all pharmacy point of sale claims within three hundred- sixty-five (365) Calendar Days after the date of the provision of care to the Member. However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
    i. For Medical claims (including BH):
        1. The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
        2. The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
        3. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
    ii. For Pharmacy Claims:
        1. The [Company] shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
        2. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.
    iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).
    iv. The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
    v. If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and penalties. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.
    vi. Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] penalties equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.
    vii. The [Company] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to requests the interest or the liquidated damages.

h. Contract Effective Date.
    1. The contract shall at a minimum include the following in relation to the effective date of the contract.
    2. The effective date of any [Provider] added under this [Agreement] shall be the later of the effective date of this [AGREEMENT] or the date by which the [Provider's] enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).

i. Tobacco-free Policy.

1. The contract with a provider shall at a minimum include the following in relation to the implementation of a tobacco-free policy unless the provider is a residential provider facility described below.
2. [Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting [Provider] from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients [Provider] serves.
3. Contracts with facilities that are owned or controlled by the provider and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required:
4. [Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:
   (1) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].
   (2) For outdoor areas of campus, [PROVIDER] shall:
      i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
      ii. Prohibit staff/employees from using tobacco products anywhere on campus.

2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services

The BH I/DD Tailored Plan shall develop and implement contracts with providers to meet the requirements of the Contract. The BH I/DD Tailored Plan's provider contracts shall, at a minimum, comply with the terms of the Contract, state law, and include required standard contracts clauses.

1. Contracts between the BH I/DD Tailored Plan and Providers, must, at a minimum, include provisions addressing the following:

a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices that constitute the entire contract between the parties.

b. Definitions: The contract must define technical State-funded Services terms used in the contract, and if those definitions are referenced in other documents distributed to providers and recipients, ensure that definitions are consistent.

   i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section III.A*. of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.

c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the state includes an extension option.

d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract

upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a network contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division.

e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
   i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
      1. Transition of administrative duties and records; and
      2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.

f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and to notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
   i. The provider's obligations to be an enrolled State-funded Services provider, and the grounds for termination if the provider does not maintain enrollment.
   ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
      1. During the provider credentialing transition period, no less frequently than every five (5) years.
      2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.

h. Recipient Billing: The contract must address the following that the provider shall not bill any State-funded Services recipient for covered services. This provision shall not prohibit a provider and recipient from agreeing to continue non-covered services at the recipient's own expense, as long as the provider has notified the recipient in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the recipient requests to receive the service.

i. Provider Accessibility: The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
   i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
   ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
   iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A Provider's competency to meet

individual referral needs will be negotiated between the BH I/DD Tailored Plan and the Provider.

j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility before rendering health care services and reporting of eligibility information to the BH I/DD Tailored Plan.

k. Medical Records: The contract must require that providers:
   i. Maintain confidentiality of recipient medical records and personal information and other health records as required by law;
   ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
   iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Recipient Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the recipient in regard to recipient appeals and grievance procedures.

m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.

n. Provider Network: The contract must include a provider network provision that ensures that LGBTQ recipients who obtain covered services are not subject to treatment or bias that does not affirm their orientation.

o. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider must be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in BH I/DD Tailored Plan's web-based billing process.

p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
   i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
   ii. Information on benefit exclusions; administrative and UM requirements; credential verification programs; quality assessment programs; and provider sanction policies.
   iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.

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

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

s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.

t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines

on Provider Complaint and Appeals as found in *Section V.C.4.e. Provider Grievances and Appeals.*

u. Assignment: Provisions on assignment of the contract must include that:
   i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
   ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

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

w. Interpreting and Translation Services: The contract must have provisions that indicate:
   i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
   ii. The provider must ensure the provider's staff is trained to appropriately communicate with recipients with various types of hearing loss.
   iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

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

y. Chapter 58 requirements: The contract must include provisions that address the following statutes and subsections:
   i. G. S. 58-3-200(c).
   ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
   iii. G.S. 58-50-270(1), (2), and (3a).
   iv. G.S. 58-50-275 (a) and (b).
   v. G.S. 58-50-280 (a) through (d).
   vi. G.S. 58-50-285 (a) and (b).
   vii. G.S. 58-51-37 (d) and (e).

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

aa. Providers Subject to Other Payment Directives: For all contracts with providers subject to specific payment provisions as found in *Section V.C.4.iv. Provider Payments*, a provision that indicates the terms and conditions of each applicable payment methodology/requirement.

bb. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.

cc. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

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

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

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

b. Hold Recipient Harmless
The [Provider] agrees to hold the recipient harmless for charges for any covered service. The [Provider] agrees not to bill a recipient for medically necessary services covered by the Company so long as the recipient is eligible for coverage.

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

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

e. Access to provider records
The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
   i. NC DHHS, its State-funded Services personnel, or its designee;
   ii. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
   iii. The North Carolina Office of State Auditor, or its designee;
   iv. A state law enforcement agency; and

v. Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

g. Provider ownership disclosure
The [Provider] agrees to notify, in writing, the [Company] and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction.

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Third Revised and Restated Attachment H: Addendum for Indian Health Care Providers

The BH I/DD Tailored Plan shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. Purpose of Addendum; Supersession.

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

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.

b. 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.

c. "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).).

d. "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.

e. "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.

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

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

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

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

3. Description of IHCP.

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

□ IHS.

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

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

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

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

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

a. The BH I/DD Tailored 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.

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

5. Member Option to Select the IHCP as Primary Health Care IHCP.

The BH I/DD Tailored 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 BH I/DD Tailored Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14(b)(3) and 457.1209.

6. Agreement to Pay IHCP.

a. The BH I/DD Tailored 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.

b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the BH I/DD Tailored Plan pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the BH I/DD Tailored Plan is less than the amount they would have received under FFS or the applicable encounter rate.

7. Persons Eligible for Items and Services from IHCP.

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

b. No term or condition of the BH I/DD Tailored Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The BH I/DD Tailored 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 BH I/DD Tailored Plan members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a BH I/DD Tailored 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 BH I/DD Tailored Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

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

c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the BH I/DD Tailored Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC §§ 1621t and 1647a, the BH I/DD Tailored Plan shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the BH I/DD Tailored Plan 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 BH I/DD Tailored 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 BH I/DD Tailored Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The BH I/DD Tailored 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 BH I/DD Tailored 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 BH I/DD Tailored 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 BH I/DD Tailored 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 BH I/DD Tailored 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 Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.

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

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the BH I/DD Tailored Plan.

19. Sovereign Immunity.

Nothing in the BH I/DD Tailored 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 BH I/DD Tailored Plan.

APPROVALS

For the BH I/DD Tailored Plan:	**For the IHCP:**
*Date:*_____	*Date:* _____
*Signature:*_____	*Signature:*_____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(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;
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(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;
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

Third Revised and Restated Attachment I: Provider Appeals for Medicaid and State-funded Services Providers

The following are the reasons for which the BH I/DD Tailored Plan must allow a provider to appeal an adverse decision made by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall provide an appeals process to providers in accordance with *Section V.B.4.v. Provider Grievances and Appeals for Medicaid and Section V.C.4.e. Provider Grievances and Appeals for State-funded Services.*

Section VII. *Third Revised and Restated* Attachment I. 1. Table 1: Provider Appeals for Medicaid Providers, and State-funded Services Providers	
Reference Number	**Appeal Criteria**
For Participating Providers	
1	A Participating Provider has the right to appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a Participating provider for the following reasons: • Finding of or recovery of an overpayment by the BH I/DD Tailored Plan; • Withhold or suspension of a payment related to waste or abuse concerns; • Contract termination for cause or finding of contract violation • Corrective action by the BH I/DD Tailored Plan; and • Determination to de-certify an AMH+ or CMA (applicable to Medicaid providers only).
For Non-Participating Providers	
2	A Non-Participating provider may appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a Participating Provider for the following reasons: • Disputes regarding an out-of-network payment arrangement, such as a single-case agreement; • Finding of waste or abuse by the BH I/DD Tailored Plan; and • Finding of or recovery of an overpayment by the BH I/DD Tailored Plan.

Second 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 *Second Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State -funded Services* and *Second 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 *Second Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *Second Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *Second 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 *Second Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services*.

1. Although the State has indicated the reports that are required, the BH I/DD Tailored Plan may suggest additional reports.
2. As part of Readiness Review, the 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. The 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 the 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 the BH I/DD Tailored Plan.
    b. For State-funded Services only, the BH I/DD Tailored Plan shall cross-reference all State-funded Services recipients in the Department's Common Name Data Services.
4. The BH I/DD Tailored Plan shall submit all data on a schedule provided by the Department.
5. The 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. The 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. Second Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
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. Monthly TCL	Monthly report containing the names and member Medicaid ID numbers of the Transitions to Community Living in the BH I/DD Tailored Plan's Region.	Monthly
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

8. SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly
9. TBI In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
10. I/DD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
C. Community Inclusion		
1. Daily Reporting on Community Integration Services and Supports	Data entry to document activities and updates related to TCL member personal and demographic information, program status, diversion attempts, in-reach and transition, housing and separations, and services for individuals with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) 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	Data entry to document rental subsidy and leasing information and updates for individuals including, but not limited to, members with Serious Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI) residing in or at risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) platform or other systems determined by the State.	Daily
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
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
8. Suspended and Terminated Providers Report**	Monthly report on suspended/terminated providers and provider payments.	Monthly
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. QAPI Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
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
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

Section VII. Second Revised and Restated Attachment J. Table 2: BH I/DD Tailored Plan Data Extracts for Medicaid and State-funded Services		
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. *Second Revised and Restated* Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
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
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[1]
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	Alternate-week report providing the prior two calendar weeks' summary of members who are receiving SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provide NPI, facility admission date and facility discharge date.	Bi-Weekly

[1] *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. *Second Revised and Restated* Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
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 Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
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[2]
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		
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. 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

[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. *Second Revised and Restated* Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. TCM Provider Status Change Report	Monthly report on tracking TCM Provider status changes and the associated decision reasoning.	Monthly
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. High Needs Member Follow Up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
8. 1915(i) Service Tailored Care Management Report	Quarterly report providing the number of members obtaining 1915(i) services actively engaged in Tailored Care Management and the number of members obtaining 1915(i) services at each CMA that is also a 1915(i) service provider.	Quarterly
D. Reserved		
1. Reserved	[redacted]	
E. Providers		
1. Reserved	[redacted]	
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. FQHC/RHC Summary Remittance Advice Report	Quarterly report to support additional directed payments to certain providers including FQHC/RHCs. BH I/DD Tailored Plans will leverage template to enable Wrap Payments for FQHCs and RHCs. Report includes a payment summary section and a detailed section, broken out by month, that shows Encounter, MID, Patient ID, Last Name, MEG, Procedure Code, Modifier, DOS, Amount Paid, and Payment Date. Different payments are broken out by service category. Report is broken out by each applicable NPI for FQHCs. Report excludes denied claims and Medicare Primary Claims, including Medicare Part C (Medicare Advantage).	Quarterly

Section VII. *Second Revised and Restated* Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
6. Local Health Department Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: local health departments. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each Local Health Department the amounts in accordance with the invoice summary.	Quarterly
7. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: public ambulance providers. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each Public Ambulance Provider the amounts in accordance with the invoice summary.	Quarterly
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. Summary UNC_ECU Physician Claims Report	Quarterly report. BH I/DD Tailored Plans will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
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

Section VII. *Second Revised and Restated* Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
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.	Monthly
2. UNC Vidant Directed Payment Report Data - Outpatient	Quarterly report to support additional directed payments for outpatient services to certain providers: UNC Health Care System hospitals and Vidant Medical Center. BH I/DD Tailored Plans will be required to populate the template with detailed claims data necessary to support DHB calculation of a directed payment. NC Medicaid will furnish to the BH I/DD Tailored Plan the directed payment amount with formal instructions to pay each provider their directed payment amount.	Quarterly
3. UNC Vidant Directed Payment Report Data - Inpatient	Quarterly report to support additional directed payments for inpatient services to certain providers: UNC Health Care System hospitals and Vidant Medical Center. BH I/DD Tailored Plans will be required to populate the template with detailed claims data necessary to support DHB calculation of a directed payment. NC Medicaid will furnish to the BH I/DD Tailored Plan the directed payment amount with formal instructions to pay each provider their directed payment amount.	Quarterly
4. Claims Monitoring Report	Weekly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	Weekly
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

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Section VII. *Second Revised and Restated* Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid		
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. Eligible Mothers for Low Birth Weight Extract	Eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.	Quarterly

Section VII. Second Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Medicaid Alerts and Notifications for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. Reserved		

Section VII. Second Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Eligibility		
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. 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

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 Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators since 20061. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities. 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.	Quarterly

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. Block Grant Report	Monthly report submitted to the State's Consumer Data Warehouse (CDW) on demographics, outcomes measures, and other record types not available through claims (e.g., recipient living situation, consumer surveys, services and utilization, readmissions, social connectedness, and employment), as determined by the Department.	Monthly
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.

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Section VII. Second 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)		
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, Ad Hoc
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. Healthy Opportunities Pilot Care Management Payment Report	Monthly report of BH I/DD Tailored Plan spending on care management payments. The Department will provide the BH I/DD Tailored Plan with at least 60 days' notice before this report is due, which will be determined when the first AMH+(s)/CMA(s) begin participating in the Healthy Opportunities Pilot.	Monthly
6. Healthy Opportunities Pilot Enrollment of High-Priority Populations Report	Quarterly report beginning in Pilot Service Delivery Period 2 on Pilot enrollment of high-priority populations.	Quarterly

Second Revised and Restated Attachment L: Managed Care Terminology Provided to the BH I/DD Tailored Plan for Use with Members Pursuant to 42 C.F.R. § 438.10

Key terms below are defined as they are intended to be used with Members and do not conflict with the definitions in *Section II. Definitions and Abbreviations* of this contract.

1. Appeal: If NC Medicaid Direct makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an appeal when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask NC Medicaid Direct for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." Appeals and grievances are different.
2. Co-Payment (Copay): An amount you pay when you get certain health care services or a prescription.
3. Durable Medical Equipment (DME): Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.
4. Emergency Medical Condition: A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.
5. Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
6. Emergency Department Care (or Emergency Room Care): Care you receive in a hospital if you are experiencing an emergency medical condition.
7. Emergency Services: Services you receive to treat your emergency medical condition.
8. Excluded Services: Services that are not covered by the BH I/DD Tailored Plan.
9. Grievance: A complaint about your provider, care or services. Contact NC Medicaid Direct and tell them you have a "grievance" about your services. Grievances and appeals are different.
10. Habilitation Services and Devices: Health care services that help you keep, learn or improve skills and functioning for daily living.
11. Health Insurance: A type of insurance coverage that helps pay for your health and medical costs. Your Medicaid coverage is a type of health insurance.
12. Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.
13. Hospice Services: Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.
14. Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.
15. Hospital Outpatient Care: Services you receive from a hospital or other medical setting that do not require hospitalization.
16. Medically Necessary: Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
17. Network (or Provider Network): A group of doctors, hospitals, pharmacies and other health professionals who have a contract with the BH I/DD Tailored Planto provide health care services for members.
18. Out-of-Network (or Non-participating Provider): A provider that is not in NC Medicaid Direct's provider network.

19. Network Provider (or Participating Provider): A provider that is in NC Medicaid Direct's provider network.
20. Physician Services: Health care services you receive from a physician, nurse practitioner or physician assistant.
21. Health Plan (or Plan): Organization providing you with health insurance.
22. Prior Authorization (or Preauthorization): Approval you must have from NC Medicaid Direct before you can get or continue getting certain health care services or medicines.
23. Premium: The amount you pay for your health insurance every month. Most Medicaid beneficiaries do not have a premium.
24. Prescription Drug Coverage: Refers to how BH I/DD Tailored Plan helps pay for its Members' prescription drugs and medications.
25. Prescription Drugs: A drug that, by law, requires a provider to order it before a beneficiary can receive it.
26. Primary Care Provider (or Primary Care Physician): The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes.) Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.
27. Provider: A health care professional or a facility that delivers health care services, like a doctor, clinician hospital or pharmacy.
28. Rehabilitation Services and Devices: Health care services and equipment that help you recover from an illness, accident, injury or surgery. These services can include physical or speech therapy.
29. Skilled Nursing Care: Health care services that require the skill of a licensed nurse.
30. Specialist: A provider who is trained and practices in a specific area of medicine.
31. Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury.

Attachment M. Policies

Second Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy

a. Background

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

b. Scope

The North Carolina BH I/DD Tailored Plan and Medicaid Managed Care Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the BH I/DD Tailored Plan in the enrollment of beneficiaries into BH I/DD Tailored Plans. The intent of this Policy is not to replace any existing enrollment processes related to NC Medicaid Direct.

c. Identification of Beneficiaries Eligible for a BH I/DD Tailored Plan

a. In accordance with Section 4.(5). of Session Law 2015-245, as amended,[1] the Department will conduct regular data reviews to identify beneficiaries who meet one or more of the following criteria for enrollment in a BH I/DD Tailored Plan:

b. Beneficiaries being served by the Innovations waiver;[2]

c. Beneficiaries being served by the TBI waiver;[3]

d. Beneficiaries being served by Transitions to Community Living (TCL);

e. Beneficiaries on the waiting list for the Innovations waiver;

f. Beneficiaries on the waiting list for the TBI waiver;

g. Beneficiaries who have used a Medicaid service that will only be available through a BH I/DD Tailored Plan as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;

h. Beneficiaries who have used a BH, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;

i. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina;

j. Beneficiaries who have a qualifying I/DD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations;*

[1] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

[2] All Medicaid beneficiaries who are enrolled in the Innovations waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.

[3] All Medicaid beneficiaries who are enrolled in the TBI waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.

k. Beneficiaries who have a qualifying mental health diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;[4,5]

l. Beneficiaries who have a qualifying SUD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;[6]

m. Beneficiaries who have had two (2) or more psychiatric hospitalizations or readmissions within eighteen (18) months;

n. Beneficiaries who have had an admission to a State psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode(s) in a State-owned facility;

o. Beneficiaries who have had two (2) or more visits to the emergency department for a psychiatric problem within eighteen (18) months; and

p. Beneficiaries who have had two (2) or more episodes using BH crisis services within eighteen (18) months.

q. The Department will employ the processes described below to identify existing Medicaid beneficiaries as eligible for a BH I/DD Tailored Plan.

r. In the period prior to Standard Plan launch:
   i. The Department will conduct data reviews to identify beneficiaries meeting BH I/DD Tailored Plan data-based eligibility criteria using dates of service to be determined by the Department.
   ii. Beneficiaries identified by the Department as meeting the BH I/DD Tailored Plan eligibility criteria based on available data or through the request to enroll in a BH I/DD Tailored Plan process will remain in their delivery system at Standard Plan launch.

s. In the period between Standard Plan and BH I/DD Tailored Plan launch:
   i. The Department will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet BH I/DD Tailored Plan data-based eligibility criteria.
   ii. The Department will send beneficiaries identified as BH I/DD Tailored Plan eligible a notice informing them of their BH I/DD Tailored Plan eligibility and auto-enroll them in NC Medicaid Direct/the LME/MCO in their Region.

t. Beneficiaries who are not identified and auto-enrolled through the Department's data review will have the option to request to enroll in NC Medicaid Direct/LME/MCO by submitting a request for to the Department for review.

[4] The list of Medicaid-covered enhanced BH services can be found in NC Medicaid Clinical Coverage Policy 8-A.
[5] Beneficiaries who meet the following criteria for SMI or SED are determined BH I/DD Tailored Plan eligible: (1) beneficiaries under 18 years of age with a claim or encounter with a date of service since the lookback period that includes a schizophrenia or schizoaffective disorder, regardless of service utilization; (2) beneficiaries with a claim/encounter demonstrating use of electroconvulsive therapy since January 1, 2018, regardless of diagnosis; and (3) beneficiaries who have used clozapine or long acting injectable anti-psychotics since January 1, 2018, regardless of diagnosis.
[6] The list of Medicaid-covered enhanced BH services can be found in NC Medicaid Clinical Coverage Policy 8-A.

u. Prior to BH I/DD Tailored Plan launch, the Department will reassess BH I/DD Tailored Plan eligibility for beneficiaries who were previously identified as meeting the BH I/DD Tailored Plan eligibility criteria who receive Medicaid services through NC Medicaid Direct/LME/MCOs based on a more recent lookback period.

v. Beneficiaries who no longer meet the BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in Standard Plans at BH I/DD Tailored Plan launch unless they are excluded from Standard Plan enrollment, in which case, they will be auto-enrolled in NC Medicaid Direct.

w. The Department will send beneficiaries who continue to meet the BH I/DD Tailored Plan eligibility criteria based on data reviews or the request to enroll in a BH I/DD Tailored Plan process at the point of the reassessment a notice indicating that they will be enrolled in a BH I/DD Tailored Plan and can elect to enroll in a Standard Plan at any point during the coverage year unless they are excluded from Standard Plans, in which case they can enroll in NC Medicaid Direct at any point during the coverage year.

x. The Department will transmit BH I/DD Tailored Plan assignment to the BH I/DD Tailored Plan through an 834 eligibility file.

y. If a beneficiary selects a Standard Plan prior to the scheduled transition date to BH I/DD Tailored Plans, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit Standard Plan selection to the Standard Plan through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary chooses to enroll in a Standard Plan, the beneficiary will not have access to services only covered by BH I/DD Tailored Plans (unless the beneficiary is under age 21 and the service is covered through EPSDT).

z. If the beneficiary is excluded from Standard Plan enrollment and elects to enroll in NC Medicaid Direct prior to the scheduled transition to BH I/DD Tailored Plans, the Enrollment Broker will transmit the NC Medicaid Direct selection to the Department through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary who is excluded from Standard Plan enrollment chooses to enroll in NC Medicaid, the beneficiary will not have access to non-State Plan services only covered by BH I/DD Tailored Plans (e.g., waiver services, in lieu of services, and value-added services).

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

bb. Period after BH I/DD Tailored Plan implementation (ongoing enrollment)

cc. Standard Plan members
    i. The Department will regularly review encounter, claims and other relevant and available data to identify Standard Plan members who newly meet BH I/DD Tailored Plan data-based eligibility criteria.
    ii. The Department will send a notice to Standard Plan members identified as eligible for a BH I/DD Tailored Plan.
    iii. Beneficiaries enrolled in a Standard Plan who are identified by the Department's data review as meeting BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in a BH I/DD Tailored Plan the first of the month following identification, unless the member calls prior to the end of the month to request to continue enrollment in the Standard Plan. Beneficiaries who are auto-enrolled in the BH I/DD Tailored Plan will have the option to re-enroll in a Standard Plan.
    iv. Beneficiaries who are not identified through the Department's data review will have the option to request a review for BH I/DD Tailored Plan enrollment as described below. In cases where the

Department approves a beneficiary's request, the beneficiary will be enrolled in a BH I/DD Tailored Plan on the first day of the following month.

dd. If a Medicaid applicant is determined eligible for Medicaid, Medicaid Managed Care mandatory and BH I/DD Tailored Plan eligible based upon available data or an approved request for BH I/DD Tailored Plan enrollment, the Department will auto-assign the applicant to the regional BH I/DD Tailored Plan through an 834 eligibility file.

ee. Coverage by the BH I/DD Tailored Plan begins on the first day of the month in which Medicaid eligibility is determined. The Department is considering seeking legislative change to make BH I/DD Tailored Plan coverage effective prior to the date of the Medicaid eligibility determination. New Medicaid beneficiaries will have an opportunity to select a Standard Plan at any point during the coverage year unless the beneficiary is excluded from Standard Plan enrollment. If the beneficiary is excluded from Standard Plan enrollment, the beneficiary can elect to enroll in NC Medicaid Direct at any point during the coverage year.

d. Request for Enrollment in a BH I/DD Tailored Plan

a. The Department will allow a beneficiary who is enrolled in a Standard Plan, the Statewide Specialized Foster Care Plan, or NC Medicaid Direct (and not part of an excluded group) to request to enroll in a BH I/DD Tailored Plan if the beneficiary is not otherwise identified through available data.

b. The Enrollment Broker will provide information to beneficiaries via phone, chat, website, and mail on how to request to enroll in a BH I/DD Tailored Plan.

c. Beneficiaries may request to enroll in a BH I/DD Tailored Plan using one of the following forms:
   i. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form
   ii. Request to Enroll in a BH I/DD Tailored Plan: Provider Form
   iii. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form

d. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form, the beneficiary (or guardian/legally responsible person) submits a form that indicates whether the beneficiary meets at least one of the eligibility criteria for a BH I/DD Tailored Plan as outlined in Section 4.(5) of Session Law 2015-245, as amended.[7]

e. The beneficiary's care manager may assist the beneficiary to complete the form. If the care manager assists the beneficiary to complete the form, the care manager must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.

f. The beneficiary must provide either documentation of their needs or contact information for their provider with permission for the Department to contact the provider.

g. The beneficiary (or authorized representative[8]) must sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.

h. Request to Enroll in a BH I/DD Tailored Plan: Provider Form
   i. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, the beneficiary (or guardian/legally responsible person) may work with their provider to complete a form indicating the reason(s) the beneficiary is believed to be eligible for the BH I/DD Tailored Plan.

[7] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

[8] Authorized representative refers to the beneficiary's legal guardian.

ii. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
iii. The beneficiary (or authorized representative) must also sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.
iv. The beneficiary or authorized representative or provider transmits the completed form.
v. The Enrollment Broker will transmit the request to the Department for review within twenty-four (24) hours of receipt.
vi. The Department will review the form and determine whether the beneficiary is eligible for a BH I/DD Tailored Plan according to the following timeframes:
(a) Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form will be reviewed in eight (8) Calendar Days
(b) Request to Enroll in a BH I/DD Tailored Plan: Provider Form will be reviewed in five (5) Calendar Days

i. The Department will transmit the beneficiary's transfer to a BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the transfer, unless there is a service need as outlined in the next section.

j. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Only Available in the BH I/DD Tailored Plans

k. Beneficiaries enrolled in Standard Plans who have a need for a service only available in BH I/DD Tailored Plans (i.e., a service-related request) will be able to transfer to a BH I/DD Tailored Plan through the following process.

l. The provider must submit the service authorization request and the Request to Enroll in a BH I/DD Tailored Plan: Provider Form to the Department on behalf of the Standard Plan member.

m. The Standard Plan member or legal guardian must sign the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, which acknowledges the request and that approval will lead to immediate disenrollment from Standard Plan and enrollment in a BH I/DD Tailored Plan.

n. The Department will review and enroll the Standard Plan member in a BH I/DD Tailored Plan effective within one (1) business day retroactive to the date of the request.[9]

e. Beneficiaries Part of Excluded or Delayed groups who Become Eligible for Limited Medicaid Managed Care on the Basis of BH I/DD Tailored Plan Eligibility, as Described in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans*

a. The Department believes that certain members of groups that are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The Department is exploring a legislative change to allow certain groups of beneficiaries that are otherwise excluded or delayed from Medicaid Managed Care to become eligible for a limited set of benefits from Medicaid Managed Care on the basis of BH I/DD Tailored Plan eligibility.

[9] For Standard Plan Members transferring to the Behavioral Health I/DD Tailored Plan in order to obtain a service only available through the Behavioral Health I/DD Tailored Plan, the timeline for processing the service authorization period—both for standard and expedited requests—will begin when the Department receives the request to transfer to a Behavioral Health I/DD Tailored Plan.

b. Pending legislative change, beneficiaries who are enrolled in both full Medicare and Medicaid and are determined to be BH I/DD Tailored Plan eligible will be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for coverage of BH, I/DD, and TBI benefits (limited Medicaid Managed Care).

c. The Department is also considering a similar approach for beneficiaries who are medically needy, participate in the NC HIPP program, or served through CAP/C or CAP/DA and determined to be BH I/DD Tailored Plan eligible to be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI benefits (limited Medicaid Managed Care).

d. The Department will transmit the auto-assignment to the assigned BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the date the beneficiary is determined to meet BH I/DD Tailored Plan eligibility. Because the beneficiary is otherwise excluded or delayed from Medicaid Managed Care, the beneficiary will not be permitted to choose a Standard Plan during the coverage year; however, the beneficiary will have the option to move back to NC Medicaid Direct.

f. Ongoing Review of Enrollment in a Behavioral Health I/DD Tailored Plan

a. On an ongoing basis, the Department will review the service utilization of BH I/DD Tailored Plan members as well as Standard Plan members who had been flagged in the past as BH I/DD Tailored Plan eligible but chose to enroll in a Standard Plan, to determine whether they should continue to be enrolled, or eligible to enroll, in BH I/DD Tailored Plans.

b. Behavioral Health I/DD Tailored Plan-eligible individuals, whether they are enrolled in a Standard Plan or BH I/DD Tailored Plan, will continue to be eligible for a BH I/DD Tailored Plan if they either have a qualifying I/DD diagnosis, have TBI needs as described in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans* or have used a Medicaid or State-funded BH service other than outpatient therapy and medication management in the past twenty-four (24) months prior to their annual redetermination date.

c. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan at renewal and noticed as part of the annual redetermination notice. Beneficiaries who do not meet one of the criteria above and are excluded from Standard Plan enrollment will be enrolled in NC Medicaid Direct.

g. Medicaid Eligibility Redeterminations

a. At a member's annual Medicaid renewal, if a member is redetermined eligible for Medicaid, continues to be eligible for a BH I/DD Tailored Plan, and has not elected to enroll in a Standard Plan, the Department will auto-assign the member into the same BH I/DD Tailored Plan from the prior eligibility year, provided that the member's Medicaid county of eligibility remains in the same BH I/DD Tailored Plan Region.

b. If the member's eligibility has moved to a county that is part of a different BH I/DD Tailored Plan Region, the Department will auto-assign the member into the BH I/DD Tailored Plan in the member's new county of eligibility.

c. The member will continue to have the opportunity to elect to enroll in a Standard Plan at any point during the coverage year. Members who are excluded from Standard Plan enrollment have the opportunity to elect to enroll in NC Medicaid Direct at any point during the coverage year.

d. The member may select a Standard Plan at his or her Medicaid redetermination if he or she is not excluded from Standard Plans. If the member selects a Standard Plan, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit the Standard Plan selection to the Standard Plan through an 834 eligibility file. Coverage of the member by the

Standard Plan will begin on the first day of the next month in which the member selected the Standard Plan. Members who are excluded from Standard Plan enrollment may elect to enroll in NC Medicaid Direct at their Medicaid redetermination.

e. If a member is determined based on data reviews to no longer be eligible for BH I/DD Tailored Plan but still eligible for Medicaid and the member believes that they are still eligible, the member will have the opportunity to submit a Request to Enroll in a BH I/DD Tailored Plan.

f. If a member is determined to no longer be eligible for Medicaid, the member will be notified and disenrolled from the BH I/DD Tailored Plan by the Department.

h. Special Enrollment Cases

Exempt populations

a. Exempt populations as defined in *Section V.B.1.i.(iii)(a)* that are BH I/DD Tailored Plan eligible will be able to enroll in BH I/DD Tailored Plans.

b. The Enrollment Broker will provide choice counseling to exempt populations and support BH I/DD Tailored Plan, Standard Plan, NC Medicaid Direct, EBCI Tribal Option (as applicable), and PCP selection throughout the beneficiary's eligibility year.

c. If a beneficiary in an exempt population selects a BH I/DD Tailored Plan, the Enrollment Broker will transmit the BH I/DD Tailored Plan selection to the Department. The Department will transmit BH I/DD Tailored Plan selection to the BH I/DD Tailored Plan through an 834 eligibility file.

d. If a beneficiary in an exempt population elects to move from a BH I/DD Tailored Plan to a Standard Plan or other delivery system (such as NC Medicaid Direct or EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan or delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan or delivery system.[10]

e. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system at redetermination and at any point during the year,

f. Deemed newborns

g. The Department shall enroll deemed newborns in a Standard Plan or Tribal Option (as eligible) regardless of the mother's enrollment in a BH I/DD Tailored Plan. To enroll in a BH I/DD Tailored Plan the beneficiary must meet Tailored Plan eligibility criteria.

i. Disenrollment from BH I/DD Tailored Plans and Medicaid Managed Care

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

b. Member requested disenrollment

i. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the BH I/DD Tailored Plan to the Enrollment Broker by phone, mail, in-person, or electronically.

[10] There may be instances (e.g., an urgent medical need), as determined by the Department and based on the beneficiary's needs, in which enrollment in the new PHP or the new delivery system may become effective sooner, including mid-month.

ii. A member who is not excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if applicable) any time during the coverage year.[11]
iii. A member who is excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to NC Medicaid Direct any time during the coverage year.
iv. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
v. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
vi. The Enrollment Broker will process disenrollment requests in accordance with the following:
vii. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
viii. The Enrollment Broker will notify the Department of its decision by the next business day following receipt of the request.

c. Notice of disenrollment determination
i. The Department will notify the member or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.[12]

d. Expedited review of member initiated requests for disenrollment
i. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the BH I/DD Tailored Plan could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
ii. The Enrollment Broker will process requests for expedited review in accordance with the following:
a) The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
b) The Department will evaluate and decide whether to approve or deny the request.

iii. The Department will notify the member, or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.

e. Disenrollment required by the Department
i. The Department may disenroll a member from Medicaid Managed Care for any of the following reasons:
a) Loss of eligibility
1. If the Department determines that a member is no longer eligible for Medicaid, the member will be notified by the Department and the member will be disenrolled from the BH I/DD Tailored Plan. The disenrollment effective date will be the last date of the member's Medicaid eligibility.

[11] Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan.
[12] 42 C.F.R. § 438.56(e).

2. If a member is disenrolled from a BH I/DD Tailored Plan solely because the member loses his or her eligibility for Medicaid for a period of two (2) months or less, the member will automatically be reenrolled in the BH I/DD Tailored Plan upon reenrollment in Medicaid.[13]

b) Change in Medicaid eligibility category
   1. If the Department determines that a member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.i.(iii)(*c) the member will be notified by the Department and the Department will disenroll the member from the BH I/DD Tailored Plan. The disenrollment effective date will be the date when the member's change in eligibility category was effective.

c) Nursing facility long-term stays
   1. A member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from the BH I/DD Tailored Plan on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[14]
   2. The BH I/DD Tailored Plan shall utilize the Department-developed standardized process for monitoring length of stay for members in nursing facilities to ensure members receive appropriate levels of care and to report to the Department members who need to be disenrolled due to stays that exceed ninety (90) calendar days.

f. To monitor and report a member's length of stay in a nursing facility the BH I/DD Tailored Plan must use the following process:
   i. Within thirty (30) days of admission to a nursing facility, the BH I/DD Tailored Plan will assess a member's health care needs and estimate the potential length of stay. If the member requires a stay for longer than ninety (90) calendar days, the BH I/DD Tailored Plan must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.
   ii. The BH I/DD Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.
   iii. The Department will send the BH I/DD Tailored Plan and the member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the member's disenrollment from the BH I/DD Tailored Plan.
   iv. The BH I/DD Tailored Plan must notify the Department with an attestation of any member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.

g. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.

h. Neuro-Medical Centers and Veterans Homes
   i. A beneficiary, otherwise eligible for enrollment in the BH I/DD Tailored Plan, residing in a state-owned Neuro-Medical Center[15] or a DMVA-operated Veterans Home[16] when the Department implements the BH I/DD Tailored Plan is excluded and will receive care in these facilities through NC Medicaid Direct.

[13] 42 C.F.R. § 438.56(g).
[14] Session Law 2015-245, as amended by Session Law 2018-49.
[15] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities
[16] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities

ii. A member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of BH I/DD Tailored Plans will be disenrolled from the BH I/DD Tailored Plan by the Department.
iii. The Neuro-Medical Center or Veterans Home will submit the member's information, including date of admission, to the Department within fourteen (14) calendar days of admission.
iv. The Department will notify the member and the BH I/DD Tailored Plan of the disenrollment and the disenrollment effective date.
v. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.
vi. In accordance with 42 C.F.R. § 438.56(f), members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department.

j. BH I/DD Tailored Plan and Managed Care Enrollment Policy Changes

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes. The Department shall provide written notice to each BH I/DD Tailored Plan of such change no later than sixty (60) days prior to the effective date of such change, unless shorter notice period is required by a federal or state law or regulatory change, with the Parties executing a Contract Amendment to incorporate such modifications.

Attachment M. Policies

Second Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid Members

a. Background

1) The Advanced Medical Home (AMH) program refers to an initiative under which a Standard Plan or BH I/DD Tailored Plan must pay Medical Home Fees to all participating primary care practices that act as PCPs. In the context of BH I/DD Tailored Plans, only AMH practices certified as AMH+ practices will play the lead role in providing Tailored Care Management. However, BH I/DD Tailored Plans must include the standard terms and conditions below in contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.B.4.iv.(xvii) Payments of Medical Home Fees to Advanced Medical Homes.*

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

b. Standard Terms and Conditions for BH I/DD Tailored Plan Contracts with All Advanced Medical Home Providers

1) Accept members and be listed as a PCP in the BH I/DD Tailored Plan's member-facing materials for the purpose of providing care to members and managing their healthcare needs.

2) Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.

3) 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) Provide direct patient care a minimum of thirty (30) office hours per week.

5) Provide preventive services, in accordance with *Section VII. Second Revised and Restated Attachment M.2. Table 1: Required Preventive Services*.

6) Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan's medical record documentation guidelines.

7) Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.

8) Transfer copies of the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.

9) Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan's network adequacy standards.

10) Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.

11) Review and use member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level UM and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.

12) Review and use the monthly enrollment report provided by the BH I/DD Tailored Plan for the purpose of participating in BH I/DD Tailored Plan or practice-based population health or care management activities.

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

Attachment M. Policies

Second Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy

a. Background

1) Prior to BH I/DD Tailored Plan launch, the Department will implement a direct process to certify provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs as described below and in the BH I/DD Tailored Plan Provider Manual for Tailored Care Management https://files.nc.gov/ncdma/DRAFT_Tailored-Care-Management-Provider-Manual_20191205.pdf. This certification process will require providers to apply to the Department and be assessed against the criteria in this policy.

2) AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department's vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.

3) CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid, or State-funded services, other than care management, to the BH I/DD Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

b. Eligibility

To become certified as an AMH+ practice or CMA, an organization must meet the requirements for an AMH+ practice or CMA, given at *Section V.B.3.ii.(ii)Delivery of Tailored Care Management*

c. Organizational Standing and Experience Criteria

1) The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the BH I/DD Tailored Plan population, specifically the subpopulation(s) for which it proposes to become a certified Tailored Care Management provider.

2) All organizations entering the certification process, including prospective AMH+ practices, will be required to indicate one or more of the following specialty designation type(s):
    i. Mental health and SUD
        a. Adult
        b. Child/adolescent
    ii. I/DD (not enrolled in the Innovations Waiver)
    iii. TBI (not enrolled in the TBI Waiver)
    iv. Innovations Waiver
    v. TBI Waiver

vi. Co-occurring I/DD and behavioral health
    a. Adult
    b. Child/adolescent

3) Organizations that specialize in BH must demonstrate their capacity to serve populations with both mental health and SUD needs. The organization must offer an array of services that are aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization will be able to show at least a two (2) year history of providing services to the BH I/DD Tailored Plan population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management as it rolls out.

4) The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.

5) The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.

6) Tailored Care Management must be recognized by the organization's leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.

7) The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.

8) The Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look for evidence of a strong governance structure.

9) Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

d. Staffing Criteria

1) AMH+ practices and CMAs must meet the same care management staffing requirements as the BH I/DD Tailored Plan. *See Section V.B.3.ii.(xiv) Staffing and Training Requirements.*

2) The evaluation of each provider organization's application for AMH+ or CMA certification will include gaining an understanding of the role of any CIN or Other Partner in supporting or facilitating Tailored Care Management.

3) Where the AMH+ practice or CMA proposes to rely on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look to ensure that care management is sufficiently integrated with the organization's practice team, as Tailored Care Management requires.

4) Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to:
    a. Approve hiring/placement of a care manager
    b. Require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.

5) CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support the Tailored Care Management model.

6) Arrangements with CINs or Other Partners must include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid and/or has supported similar efforts in other states.

7) Any subsidiaries of LME/MCOs, BH I/DD Tailored Plans or other health plans may not be considered CINs or Other Partners for the purposes of Tailored Care Management with the following exception:
   a. That AMH+ practice or CMA may decide to enter into arrangements with a BH I/DD Tailored Plan as an "Other Partner" for use of its IT products or platforms for care management, in order to meet the care management data system requirements.

8) AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section V.B.3.ii.(xiv)(b)*.

e. Population Health and HIT Criteria

1) The AMH+ or CMA must have implemented an EHR or an electronic clinical system of record that is in use by the AMH+ practice or CMA's providers that may electronically to record, store, and transmit their assigned members' clinical information, including medication adherence.

2) The AMH+ or CMA must use a single care management data system, whether or not integrated within the same system as the EHR or clinical system of record, which allows care managers to perform the following care management functions, at minimum:
   a. Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
   b. Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
   c. Electronically document and store the Care Plan or ISP;
   d. Incorporate claims and encounter data;
   e. Provide access to ; and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements
   f. Track referrals; and
   g. Allow care managers to:
      i. Identify risk factors for individual members
      ii. Develop actionable Care Plans and ISPs
      iii. Monitor and quickly respond to changes in a member's health status
      iv. Track a member's referrals and provide alerts where care gaps occur
      v. Monitor a member's medication adherence
      vi. Transmit and share reports and summary of care records with care team members
      vii. Support data analytics and performance and send quality measures (where applicable).

3) The AMH+ practice or CMA must receive and use enrollment data from the BH I/DD Tailored Plan to empanel the population in Tailored Care Management: To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner on its behalf) must be able to:
   a. Receive, in machine-readable format, and maintain up-to-date records of acuity tiers by member, as determined and shared by the BH I/DD Tailored Plan;
   b. Receive, in machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the BH I/DD Tailored Plan; and
   c. Electronically reconcile the Tailored Care Management assignment lists received from the BH I/DD Tailored Plan with its list of patients/clients for whom it provides Tailored Care Management.

4) The same requirements for use of ADT information apply at the BH I/DD Tailored Plan level and AMH+ or CMA level. See *Section V.B.3.ii.(xv)(d) ADT Feeds for Organizations Providing Tailored Care Management.*

5) The same requirements for use of "NCCARE360" apply at the BH I/DD Tailored Plan level and AMH+ or CMA level. See *Section V.B.3.ii.(x) Ongoing Care Management.*

6) The Department expects that during the first two contract years, BH I/DD Tailored Plans, AMH+ practices, and CMAs a will rely on the standardized acuity tiering methodology described above Section *V.B.3.ii.(x)(k)* as the primary method for segmenting and managing their populations.

7) As described in *V.B.3.ii.(xv)(c) Risk Stratification*, BH I/DD Tailored Plans will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs.

8) By Contract Year 3, as the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approach, refining the data and risk stratification scores they receive from BH I/DD Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs' use of patient registries to track patients by condition type/cohort is encouraged, but not required.

9) Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled beneficiaries and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

f. Quality Measurement Criteria

1) After the launch of BH I/DD Tailored Plans, AMH+ practices and CMAs will be required to gather, process, and share data with BH I/DD Tailored Plans for the purpose of quality measurement and reporting.

2) The Department will publish quality measure requirements each year. Elements of the list may be modified on a quarterly basis, but new measures will be added only during annual updates.

3) AMH+ practices and CMAs may need to perform tasks including:
   a. Abstracting data from patient charts;
   b. Performing quality assurance to validate the accuracy of data in patient charts that is used for quality measurement purposes;
   c. Using additional codes to fully document patient status and needs in order to improve the accuracy of quality measurement; and
   d. Explaining to patients the purpose of certain state-sponsored surveys, how the state and BH I/DD Tailored Plans will use survey results, and how their information will be kept confidential.

4) As covered in *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification,* BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

g. Other Tailored Care Management Criteria

1) AMH+ practices and CMAs must develop policies for communicating and sharing information with beneficiaries and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.

2) AMH+ practices and CMAs must meet the same contact requirements as the BH I/DD Tailored Plan*. See Section V.B.3.ii.(x) Ongoing Care Management.*

3) AMH+ practices and CMAs must meet the same requirements for Care Management Comprehensive Assessment that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(vii) Care Management Comprehensive Assessment.*

4) AMH+ practices and CMAs must meet the same requirements for Care Plans and ISPs that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(viii) Development of Care Plan/Individual Support Plan.*

5) AMH+ practices and CMAs must meet the same requirements for the composition of a care team that apply at the BH I/DD Tailored Plan level.

6) By BH I/DD Tailored Plan launch, the AMH+ practice or CMA must demonstrate the ability to electronically and securely transmit the Care Plan or ISP to each member of the multidisciplinary care team**.** *See Section V.B.3.ii.(ix).Care Team Formation.*

7) AMH+ practices and CMAs must meet the same requirements for ongoing care management that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(x) Ongoing Care Management.*

8) AMH+ practices and CMAs must meet the same requirements related to addressing Unmet Health-Related Resource Needs that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(x) Ongoing Care Management.*

9) AMH+ practices and CMAs must meet the same requirements for transitional care management that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(xi) Transitional Care Management*.

10) AMH+ practices and CMAs must meet the same requirements for care coordination for members obtaining 1915(c) Innovations and TBI waiver services that that apply at the BH I/DD Tailored Plan level. See *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver.*

11) AMH+ practices and CMAs must meet the same requirements for care coordination for members obtaining 1915(i) services that that apply at the BH I/DD Tailored Plan level. See *Section V.B.3. xiii. Additional Care Coordination Functions for Members Obtaining 1915(i) Services.*

12) Care managers based at AMH+s and CMAs, as well as any supporting CINs or Other Partners, will be required to undergo the same training requirements as care managers based at BH I/DD Tailored Plans. *See Section V.B.3.ii.(xiv) Staffing and Training Requirements.*

Attachment M. Policies

Second Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers

a. Background

This Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a BH I/DD Tailored Plan in determining whether to allow a provider to be included in the BH I/DD Tailored Plan's network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider. For network providers of Medicaid BH, I/DD, and TBI services, the BH I/DD Tailored Plan has the authority to maintain a closed network for these services as set forth in Section 4.(10)(a)(1)(IV) of Session Law 2018-48. The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the BH I/DD Tailored Plan in selection and retention of network providers for Medicaid BH, I/DD, and TBI services.

b. Scope

This Policy applies to the BH I/DD Tailored Plan and covers credentialing and re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to acute, primary, BH, SUD, and LTSS [42 C.F.R. § 438.214(b)(1)].

c. Policy Statement

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

d. Provider Enrollment and Credentialing

a. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

b. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid program or as a State-funded Services provider.

c. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider or State-funded Services Enrolled provider.

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

e. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid or State-funded Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

f. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan accrediting organization. The applicable data and processing standards shall be consistent with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.

g. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid or State-funded Services Enrolled provider, with the application serving for enrollment as a NC Medicaid Direct provider and a Medicaid Managed Care provider.

h. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the NC Medicaid Direct program or provide State-funded services.

i. Providers will be reverified and recredentialed as permitted by the Department in the Contract.

j. A BH I/DD Tailored Plan shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the BH I/DD Tailored Plan will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid or State-funded Services Enrolled provider in accordance with the standards contained in this Policy

k. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The BH I/DD Tailored Plan shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

e. Provider Credentialing and Re-credentialing Policy

a. The BH I/DD Tailored Plan shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:

b. Meet the requirements specified in 42 C.F.R. § 438.214;

c. Meet the requirements specified in this Contract;

d. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, mental health, substance use disorders, and long-term services and supports providers;

e. Establish that the BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.

f. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider or State-funded Services provider;

g. Prohibit BH I/DD Tailored Plan from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).

h. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

i. Prohibit BH I/DD Tailored Plan to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;

j. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers or State-funded Services providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and

k. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH, I/DD, and TBI services. At a minimum, these standards shall assess a provider's ability to deliver care.

l. Identify standards and establish a documented process for making network contracting decisions on State-funded Services providers.

m. Describe the information that providers will be requested to submit as part of the contracting process.

n. Describe the process by which the BH I/DD Tailored Plan will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).

o. If BH I/DD Tailored Plan requires a provider to submit additional information as part of its contracting process, the BH I/DD Tailored Plan's policy shall include a description of all such information.

p. BH I/DD Tailored Plan shall make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates BH I/DD Tailored Plan shall re-credential providers as follows:

q. The BH I/DD Tailored Plan shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.

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

s. BH I/DD Tailored Plan shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.

t. BH I/DD Tailored Plan shall have discretion to make network contracting decisions consistent with the Policy.

Attachment M. Policies

Second Revised and Restated Attachment M. 8. Management of Inborn Errors of Metabolism Policy for Medicaid Members

1. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.
2. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.
3. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that BH I/DD Tailored Plan cover the full cost of therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized Care Plan.
4. Once a client is established with a specialized treatment facility a nutrition Care Plan is developed and products prescribed. The current system of product coverage is four pronged:
    a) Clients with health insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers. Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) are required.
    b) Clients with Medicaid coverage are served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product.
    c) Clients participating in WIC are served through the Nutrition Services Branch (NSB). Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. WIC funds are used to pay the metabolic product invoices.
    d) Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the

manufacturer to the main office of the local WIC agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

5. The BH I/DD Tailored Plan will need to establish working relationships with each product provision entity or other entity to provide coverage of the prescribed metabolic formulas.

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

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

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

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

Attachment M. Policies

First Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients

a. Background

The BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients provides the BH I/DD Tailored Plans with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

b. Behavioral Health Services Definitions

1. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.
2. Adult Facility-Based Crisis Services: a state-funded crisis service for the purpose of network adequacy standards.
3. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.
4. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.
5. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.
6. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.
7. Clinically managed residential withdrawal services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.
8. Medically monitored inpatient withdrawal services (non-hospital medical detoxification) (adults only): a crisis service for the purpose of network adequacy standards.
9. Medically managed intensive inpatient withdrawal services (acute care hospitals with adult inpatient substance use beds): a Medicaid crisis service for the purpose of network adequacy standards.
10. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
11. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
12. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
13. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
14. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.

15. Medically managed intensive inpatient withdrawal services (Acute Care Hospitals with Adult Inpatient Substance Use Beds): inpatient BH services for the purpose of network adequacy standards.
16. Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.
17. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
18. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
19. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
20. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
21. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
22. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
23. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.
24. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.
25. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.
26. Urgent Care for Mental Health:
    a) Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
    b) Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.
27. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.
28. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable

to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

29. Urgent care for SUD:
    a) Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
    b) Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.
30. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.
31. Specialized Services: as partial hospitalization for children and adults for the purposes of the network adequacy standards.

Attachment M. Policies

Attachment M. 13. Approved <TP NAME> In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid State Plans or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.

The BH I/DD Tailored Plan may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows:

1. The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to the Department by the BH I/DD Tailored Plan demonstrating such cost effectiveness and clinical effectiveness;
2. Members shall not be required by the BH I/DD Tailored Plan to use the alternative service or setting;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the BH I/DD Tailored Plan; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise.

In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process. In accordance with *Section V.B.2. Benefits*, the following In Lieu of Services have been approved by the Department:

Attachment M.13 Approved <TP NAME> In Lieu of Services					
No.	Service Name	Revenue/ Procedure Code	Approved	End Date (Glidepath only)	Description

ILOS that have received conditional approval from the Department are effective through December 31, 2023. If the BH I/DD Tailored Plan wishes to continue offering the conditionally approved ILOS beyond December 31, 2023, the BH I/DD Tailored Plan shall resubmit the Department's standardized ILOS Service Request Form at least ninety (90) Calendar Days prior to December 31, 2023.

Attachment M. Policies

Attachment M. 14. COVID-19 Public Health Emergency Managed Care Policy

The Department's goal in implementing Medicaid Managed Care is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which purchases health while addressing both medical and non-medical drivers of health. During the ongoing response to the Coronavirus-19 (COVID-19) pandemic, it is critical that the Department work with Contractor to institute efforts to keep Members healthy by taking steps to protect Members from infectious disease, providing access to testing, treatment and vaccine administration for COVID-19, ensuring care for ongoing chronic or acute conditions, and supporting Members and providers through the Public Health Emergency Unwinding.

1. Member materials
    i. Within forty-five (45) Business Days of execution of this Amendment, the BH I/DD Tailored Plan shall begin including inserts in the Member Welcome Packet and handbooks that address COVID-19 and the COVID-19 Federal Public Health Emergency Unwinding (PHE Unwinding).
        a. The inserts must include links to Federal and State guidance and resources, including information on the PHE and impact of the PHE unwinding on Medicaid eligibility.
        b. The BH I/DD Tailored Plan may distribute COVID-19 inserts to Members without prior approval from the Department, however, the the BH I/DD Tailored Plan shall make changes to the inserts as requested by the Department after initial distribution.
    ii. The BH I/DD Tailored Plan may include informational materials on COVID-19 when sending other member communications, including but not limited to explanations of benefits and communications for appeals and grievances.
    iii. No later than January 1, 2023, the BH I/DD Tailored Plan shall make available within two clicks of the homepage of its member website information regarding changes to benefits, eligibility, and enrollment during the term of this Amendment.
        a. The BH I/DD Tailored Plan shall include within one click of the homepage information on what Members should do if they are experiencing symptoms of COVID-19.
        b. The BH I/DD Tailored Plan shall include link(s) on its member website to the State website on the COVID-19 response and the PHE Unwinding.
    iv. No later than January 1, 2023, the BH I/DD Tailored Plan shall update member smartphone apps to include information on benefit, eligibility and enrollment changes during the term of this Amendment, what the Member should do if they experience symptoms of COVID-19, and links to the State website on the COVID-19 response and the PHE Unwinding.
    v. All updates to Member materials will be subject to language and accessibility requirements in *Section V.B.1.iii* of the Contract.
    vi. The Department reserves the right to review and request changes to the BH I/DD Tailored Plan's COVID-19 updates to any required member materials or marketing materials defined in the Contract.

2. Advisory Committees
The BH I/DD Tailored Plan shall consult with its CFAC and LTSS Member Advisory Committee on the BH I/DD Tailored Plan's response to COVID-19 and the PHE Unwinding.

3. Call Centers
    i. No later than January 1, 2023, the BH I/DD Tailored Plan shall ensure all call center staff are aware of and are prepared to answer Member questions related to changes in eligibility, enrollment, benefits and provider networks related to COVID-19 and the PHE Unwinding.
    ii. The BH I/DD Tailored Plan shall ensure Member services call center nurse staff line and behavioral health crisis line staff:

a. Are aware of and can direct Members to further information on statewide programs and initiatives related to COVID-19, best practices for limiting disease spread, testing sites, vaccine administration, and policy changes stemming from COVID-19 and the PHE Unwinding;
b. Are able to refer Members to housing specialists, as needed;
c. Are able to assist Members in finding providers offering telehealth and other virtual care;
d. Are able to inform Members of resources to meet unmet health-related resource needs, such as food, housing and transportation, and direct Members to additional information on these resources; and
e. Are able to link to Member's Tailored Care Manager, as applicable.

iii. The the BH I/DD Tailored Plan shall ensure nurse staff lines are aware of and can refer Members to guidance for prevention, symptom monitoring, and testing, as well as refer members to other State resources related to the COVID-19 response.
iv. The the BH I/DD Tailored Plan shall update call center scripts to include the information required in this Section and submit to the Department as defined in the Contract.

4. Benefits
   a. The BH I/DD Tailored Plan shall cover COVID-19 testing according to guidance issued by the Department.
   b. During the COVID-19 Public Health Emergency, the BH I/DD Tailored Plan shall cover the testing, treatment, and vaccine administration for COVID-19 and comply with cost-sharing requirements as defined in the Department's approved CMS waivers, state plan amendments, and concurrence letters related to COVID-19.
   c. After the end of the COVID-19 Public Health Emergency, the Department reserves the right to require the BH I/DD Tailored Plan's to cover the testing, treatment, and vaccine administration for COVID-19 without cost-sharing for members.

5. Population Health
   i. No later than March 1, 2023, the BH I/DD Tailored Plan shall conduct outreach to Members under 18 years of age to encourage routine immunization and provide information on how to safely access routine immunizations.
   ii. The BH I/DD Tailored Plan shall develop and implement new health education programs to educate Members about symptoms, prevention guidance, and treatment for COVID-19.

6. Provider Communications
   i. The BH I/DD Tailored Plan shall post through appropriate channels provider-focused guidance developed by the Department in response to COVID-19 including changes to eligibility, benefits, new Federal and State flexibilities, payment processes, how to comply with Federal and/or State guidance and the PHE unwinding,

7. Provider Payments
   i. The BH I/DD Tailored Plan shall update providers reimbursements, consistent with rate floor requirements, to reflect Department defined COVID-19 related fee schedule changes as defined in the Contract.
   ii. For providers without a rate floor requirement, the BH I/DD Tailored Plan shall adjust negotiated provider reimbursement rates by an amount no less than the associated dollar change in the fee schedule made by the Department in the fee-for-service program in response to COVID-19.

Second Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

It is agreed by the Parties that no performance metric or SLA will be determined as unmet and no liquidated damages will be assessed or punitive action taken against Contractor where the fault of such purported non-compliance is significantly, materially or predominantly caused by a third-party, including by the Department. A subcontractor of the Contractor is not a third-party.

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$2,500 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section III.D.**15. DISCLOSURE OF CONFLICTS OF INTERESTS*** and *Section V.A.1.ix.(xiii) Conflicts of Interest.*	$5,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.D.**16. DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION***.	$500 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.D.**17. DISCLOSURE OF OWNERSHIP INTEREST***.	$1,250 per entity disclosure/attestation for each disclosure/attestation that is not received or is received and signed by an entity that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in *Section III.D.**46. SUBCONTRACTORS***.	Up to $25,000 per occurrence
B. Members		
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section V.B.1.iv. Marketing.*	$2,500 per occurrence
2.	Failure to comply with member enrollment and disenrollment processing timeframes as described in *Section V.B.1.i.(v) Medicaid Managed Care Enrollment and Disenrollment.*	$250 per occurrence per member
3.	Failure to comply with timeframes for providing member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section V.B.1.iii. Member Engagement.*	$125 per occurrence per member
4.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section V.B.1.iii.(xvi) Engagement with Consumers, Section V.B.1.c.xvii. Engagement with Beneficiaries Utilizing Long Term Services and Supports, and Section V.B.1.iii.(xviii) Engagement with Innovations and TBI Waiver Members.*	Up to $25,000 per occurrence

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
5.	Failure to comply with member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.1.vi. Member Grievances and Appeals.*	$250 per occurrence
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$2,500 per occurrence
7.	Failure to provide continuation or restoration of services where member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.1.vi. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. **AND** $500 per Calendar Day for each day the BH I/DD Tailored Plan fails to provide continuation or restoration as required by the Department.
8.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.1.vi. Member Grievances and Appeals.*	$500 for each mediation or hearing that the BH I/DD Tailored Plan fails to attend as required.
9.	Failure to comply with Transition of Care requirements as specified *Section V.B.1.ii. Transition of Care.*	$50 per Calendar Day, per member **AND** The value of the services the BH I/DD Tailored Plan failed to cover during the applicable transition of care period, as determined by the Department.
10.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal within the requirements in *Section III.D.* ***38. RESPONSE TO STATE INQUIRIES AND REQUEST FOR INFORMATION***.	$250 per occurrence.
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	$2,500 per occurrence per member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package and V.B.2.iii. Pharmacy Benefits.*	$2,500 per standard authorization request $3,750 per expedited authorization request

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section V.B.4.i. Provider Network.*	$500 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package.*	$1,250 per occurrence
5.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.B.2.iii. Pharmacy Benefits.*	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $1,250 per Calendar Day per occurrence
6.	Failure to ensure that a member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified *Section V.B.2.iv. Non-Emergency Transportation.*	$250 per occurrence per member
7.	Failure to comply with driver requirements as defined in the Department's NEMT Policy.	$750 per occurrence per driver
8.	Failure to comply with the assessment and scheduling requirements as defined in the Department's NEMT Policy.	$125 per occurrence per member
9.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	$750 per Calendar Day per vehicle
10.	Failure to timely notify the Department that the BH I/DD Tailored Plan lowered a provider's AMH Tier status.	$500 per Calendar Day
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management Policy as required by *Section V.B.3.ii. Tailored Care Management.*	$125 per Calendar Day
2.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in the *Section V.B.3.ii. Tailored Care Management* (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	$250 per deficient/missing care management comprehensive assessment or plan
3.	Failure for Plan to adhere to the quarterly minimum contact requirements for a member's acuity tier by panel as described in *Section V.B.3.ii.(x) Ongoing Care Management.*	$1000 per month where panel contact were less than 50% of contacts
4.	Reserved.	[redacted]
5.	Failure to notify the Department within fourteen (14) Calendar Days that the BH I/DD Tailored Plan determined that an AMH+ or CMA is not meeting Tailored Care Management requirements as set forth in *Section V.B.3.ii.(xix) Oversight.*	$250 per Calendar Day

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
6.	Failure to meet annual requirements established by the Department for the percentage of members actively engaged in Tailored Care Management who are obtaining Provider-based Care Management as set forth in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management* (liquidated damage to begin in second contract year).	Up to $50,000 per percentage below the requirement each Calendar Year
7.	Failure to comply with federal conflict-free case management requirements for members enrolled in the Innovations or TBI waiver.	$250 per occurrence per member
8.	Failure to timely notify the Department of a notice of underperformance sent to an LHD or the termination of a contract with an LHD.	$250 per Calendar Day
9.	Failure to implement and maintain an Opioid Misuse Prevention and Treatment Program and Member Lock-In Program as *described in Section V.B.3.i. Prevention and Population Health Programs.*	Beginning at BH I/DD Tailored Plan Launch: $1,000 per occurrence for Opioid Misuse and Prevention and Treatment Program Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $1,000 per occurrence for Member Lock-in Program
10.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the BH I/DD Tailored Plan in at least 98% of Pilot service authorizations, as required in *Section V.B.3.x. Healthy Opportunities*.	$50 per identified instance of duplicated service delivery **AND** Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service that was duplicated for each identified instance of duplication
11.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to use BH I/DD Tailored Plan capitation to cover member's benefits prior to use of Healthy Opportunities Pilot program funds or as otherwise required in *Section V.B.3.x. Healthy Opportunities*.	$125 per occurrence **AND** Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service in each identified instance
E. Providers		
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section V.B.4.ii. Provider Network Management.*	$500 per confirmed incident
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan's provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the affected members within the timeframes required by *Section V.B.4.ii. Provider Network Management.*	$50 per Calendar Day per member for failure to timely notify the affected member or Department
3.	Reserved.	[redacted]

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.B.4.i. Provider Network.*	$2,500 per Calendar Day
5.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section V.B.4.i. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$1,250 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	$125 per Calendar Day
7.	Reserved.	[redacted]
F. Quality and Value		
1.	Failure to submit all required quality measures including audited HEDIS results within the timeframes specified in *Section V.B.5.a. Quality Management and Quality Improvement.*	$2,500 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$500 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$500 per Calendar Day
4.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.*	$50,000 per month for every month beyond the month NCQA accreditation must be obtained until such time as the BH I/DD Tailored Plan is terminated in accordance with *Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.*
G. Claims and Encounter Management		
1.	Failure to timely submit monthly encounter data set certification.	$500 per Calendar Day
H. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day
3.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section V.B.7.ii. Medical Loss Ratio* and *Section VII Second Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$500 per Calendar Day
I. Compliance		
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services.*	$2,500 per Calendar Day that the Department determines the BH I/DD Tailored Plan is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.K.1. Compliance Program* and *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.A.3.iv. Third Party Liability (TPL) for Medicaid* and *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$125 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$1,250 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan's own conduct, a provider, or a member.	$125 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day
J. Technical Specifications		
1.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department member's PHI.	$250 per member per occurrence

Section VII. Second Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$250 per occurrence
3.	Failure by the BH I/DD Tailored Plan to timely report a HIPAA breach or a security incident or timely provide members a notification of breach or notification of provisional breach.	$250 per member per occurrence, not to exceed $5,000,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$250 per Calendar Day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$500 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$250 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g. prevention and population health management programs, drug utilization review program).	$ 10,000 per occurrence per plan or program
5.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	$250 per Calendar Day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved CAP
6.	Engaging in gross customer abuse of Members by Contractor service line agents as prohibited by *Section V.A.2.(xxiv) Gross Customer Abuse.*	$1,000 per occurrence
7.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.A.2.(xxiv) Gross Customer Abuse.*	$250 per Business Day the Contractor fails to timely report to the Department.
8.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$250 per occurrence.

Section VII. Second Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
A. Administration and Management		
1.	Failure to comply with conflict of interest requirements described in *Section III.D.**15. DISCLOSURE OF CONFLICTS OF INTERESTS** and Section V.A.1.ix.(xiii) CONFLICT OF INTEREST*.	$2,500 per occurrence
2.	Failure to timely provide conflict of interest or criminal conviction disclosures as required by *Section III.D.**15. DISCLOSURE OF CONFLICTS OF INTERESTS*** and *Section III.D.**16. DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION***.	$250 per Calendar Day
3.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.D.**17. DISCLOSURE OF OWNERSHIP***.	$625 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements.
4.	Failure to perform necessary oversight of Subcontractors as described in *Section III.D.**46. SUBCONTRACTORS***.	Up to $12,500 per occurrence
B. Providers		
1.	Failure to update online and printed provider directory as required by *Section V.C.4.b. Provider Network Management.*	$250 per confirmed incident
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan's provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the affected recipients within the timeframes required by *Section V.C.4.b. Provider Network Management.*	$50 per Calendar Day per recipient for failure to timely notify the affected recipient or Department
3.	Reserved.	[redacted]
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.C.4.a. Provider Network.*	$500 per Calendar Day
5.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in *Section V.C.4.a. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$625 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	$125 per Calendar Day
7.	Failure to maintain accurate provider directory information as required by *Section V.C.4.b. Provider Network Management.*	$50 per confirmed incident
C. Claims Management		
1.	Failure to timely submit monthly claims data set certification.	$250 per Calendar Day
D. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day

Section VII. Second Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
2.	Failure to timely and accurately submit monthly financial reports in accordance with *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per Calendar Day
E. Compliance		
1.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$625 per incident for failure to fully cooperate during an investigation
2.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan's own conduct, a provider, or a recipient.	$125 per Calendar Day
3.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Second Revised and Restated Attachment J. Reporting Requirements*.	$500 per Calendar Day
F. Technical Specifications		
1.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$125 per recipient per occurrence
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of recipient PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per recipient per occurrence
3.	Failure by the BH I/DD Tailored Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$125 per recipient per occurrence, not to exceed $2,500,000
G. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per Calendar Day that the Department determines the BH I/DD Tailored Plan is not in compliance
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee

Section VII. Second Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$5,000 per occurrence per plan or program
5.	Failure to provide a timely and acceptable corrective action plan or comply with a CAP as required by the Department.	$125 per Calendar Day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved corrective action

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
2.	Call Response Time/Call Answer Timeliness –Member and Recipient Service Line	The BH I/DD Tailored Plan shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
3.	Call Wait/Hold Times – Member and Recipient Service Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Call Abandonment Rate – Member and Recipient Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
5.	Call Wait/Hold Times – Behavioral Health Crisis Line	The BH I/DD Tailored Plan shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$15,000 per month
6.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
7.	Call Response Time/Call Answer Timeliness –Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
8.	Call Wait/Hold Times – Provider Support Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
9.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The BH I/DD Tailored Plan shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the BH I/DD Tailored Plan to its system to trigger enrollment and disenrollment processes.	Daily	$500 per twenty-four (24) hour period Note: Effective one (1) month prior to BH I/DD Tailored Plan launch
B. Member Grievances and Appeals					
1.	Member Appeals Resolution - Standard	The BH I/DD Tailored Plan shall resolve at least ninety-eight percent (98%) of BH I/DD Tailored Plan internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$5,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
2.	Member Appeals Resolution - Expedited	The BH I/DD Tailored Plan shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	$5,000 per month
3.	Member Grievance Resolution	The BH I/DD Tailored Plan shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	$2,500 per month
C. Pharmacy Benefits					
1.	Adherence to the Preferred Drug List	The BH I/DD Tailored Plan shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $50,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater.

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
D. Care Management					
1.	Contracting with AMH+ and CMAs	The BH I/DD Tailored Plan shall contract with 100 percent (100%) of the certified AMH+ practices and CMAs located in its Region, except for the exceptions cited in the contract (*Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*).	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the BH I/DD Tailored Plan divided by the total number of certified AMH+ practices and CMAs.	Monthly	$25,000 per month
E. In-Reach and Diversion					
1.	Reserved.				
F. Service Lines					
1.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
2.	Call Wait/Hold Times - Nurse Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
4.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month
5.	Call Wait/Hold Times - Pharmacy Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month
6.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than ten (10) seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
7.	Call Response Time/Call Answer Timeliness -NEMT Member Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
8.	Call Wait/Hold Times - NEMT Member Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
9.	Call Abandonment Rate – NEMT Member Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than ten (10) seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
10.	Call Response Time/Call Answer Timeliness -NEMT Provider Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
11.	Call Wait/Hold Times - NEMT Provider Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
12.	Call Abandonment Rate – NEMT Provider Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than ten (10) seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
13.	Reserved.				
14.	Encounter Data Timeliness – Medical	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of medical claims within thirty (30) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per claim per Calendar Day

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
15.	Encounter Data Timeliness – Pharmacy	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of pharmacy claims within seven (7) Calendar Days after payment whether paid or denied. For purposes of this standard, pharmacy encounters only include 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $100 per claim per Calendar Day
16.	Encounter Data Accuracy – Medical	The BH I/DD Tailored Plan shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims. For purposes of this standard, medical encounters include 837-P encounters and 837 I-encounters.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	$12,500 per month
17.	Encounter Data Accuracy – Pharmacy	The BH I/DD Tailored Plan shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. For purposes of this standard, pharmacy encounters only include NCPDP encounters.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $25,000 per week

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
18.	Encounter Data Reconciliation—Medical	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. For purposes of this standard, medical encounters only include 837-P encounters and 837-I encounters.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.	Monthly	$5,000 per month
19.	Encounter Data Reconciliation—Pharmacy	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within thirty (30) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within sixty (60) Calendar Days. For purposes of this standard, pharmacy encounters only include NCPDP encounters.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $5,000 per month

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
G.	**Website Functionality**				
1.	Website User Accessibility	The BH I/DD Tailored Plan's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.	Any occurrence during which the website is not accessible, except for those occurrences that have been Department approved and pre-announced.	Daily	$2,500 per occurrence
2.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month
3.	Timely response to electronic inquiries	The BH I/DD Tailored Plan shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) Business Days of receipt.	Electronic inquires include communications received via email, fax, web or other communications received electronically by the BH I/DD Tailored Plan (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence

Section VII. Second Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Access to Primary/ Preventive Care for Individuals under NC Innovations waiver	Ninety percent (90%) of Innovations waiver beneficiaries will have a primary care or preventative health service	The percentage of Medicaid enrollees continuously enrolled for the 12-month contract period under the 1915(c) NC Innovations waiver (ages 3 and older) who received at least one service under the NC Innovations waiver during the measurement period who also received a primary care or preventative health service. For persons ages three (3) to six (6) and ages twenty (20) and older, the person received a primary care or preventative health service during the measurement period. For persons ages seven (7) to nineteen (19), the person received a primary care or preventative health service during the previous two measurement periods.	Annually	$50,000 per year

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Section VII. Second Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility Based Crisis Services for Mental Health Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	$50,000 per quarter
2.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for Substance Use Disorder Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	$50,000 per quarter

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Section VII. Second Revised and Restated Attachment P. Table 6: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
1.	Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the BH I/DD Tailored Plan (i.e., other Medicaid or State-Funded BH I/DD Tailored Plan service) in at least ninety-five percent (95%) of Pilot service authorizations.	$25 per identified instance of duplicated service delivery **AND** Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service that was duplicated for each identified instance of duplication
2.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements in this Amendment.	$250 per Calendar Day that the Department determines the BH I/DD Tailored Plan is not in compliance
3.	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes.	$250 per Calendar Day
4.	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes.	$250 per Calendar Day
5.	Failure to comply with the following provisions enumerated in *Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* of to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that BH I/DD Tailored Plan workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data; • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials; and • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment.	$250 per occurrence