Amendment Number 7 (9)

Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

THIS Amendment to Contract #30-2020-052-DHB-# (Contract), as subsequently amended, 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.

Purpose:
The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract in the following Sections:

I. Section II. General Procurement Information and Notice to Applicants;
II. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
III. Section IV. First Revised and Restated Minimum Qualifications;
IV. Section V. Scope of Services; and
V. Section VII. Attachments.

The Parties agree as follows:

I. Modifications to Section II. General Procurement Information and Notice to Applicants

a. *Section II. General Procurement Information and Notice to Applicants* is revised and restated in its entirety as follows:

Section II. Reserved

II. Modifications to Section III. Definitions, Abbreviations, Contract Term, 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 in their entirety as identified herein:

49. **Closed Network:** Has the same meaning as "closed network" defined in N.C. Gen. Stat. § 108D-23(c).
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: July 1, 2024 through June 30, 2025
    b. Contract year 2: July 1, 2025 through June 30, 2026
    c. Contract year 3: July 1, 2026 through June 30, ~~2~~2027
    d. Contract year 4: July 1, 2027 through June 30, 2028
265. **System Security Plan (SSP)**: Serves as an overview of the security requirements for the system and its components by describing the security controls in place, or planned, for meetings those requirements, the rationale for security categorization, how individual controls are implemented within specific environments, and situational system usage restrictions. Additional information regarding the System Security Plan is available at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/document/security-manual/. The term Security Compliance Plan (SCP) may be used interchangeably with System Security Plan (SSP).

b. ***Section III. A. Definitions,*** **is revised to add the following newly defined terms:**

269. **Department of Adult Corrections (DAC) Priority Re-entry Program:** The DAC Priority Re-entry Program, formerly known as DAC-Serious Mental Illness program, supports incarcerated individuals with Severe Mental Illness (SMI) and a violent or aggressive charge or individuals prescribed Clozapine who are re-entering the community. The DAC Priority Re-entry Program provides coordination and connection to physical health providers, behavioral health providers, and other community resources.
270. **Health care Clearinghouse:** Has the same meaning as Health care Clearinghouse as defined in 45 C.F.R. § 160.103.
271. **Juvenile Justice Behavioral Health (JJBH):** JJBH refers to local teams comprised of stakeholders that support youth involved, or at risk of involvement, with the juvenile justice system. The JJBH teams are responsible for ensuring justice-involved youth and their families have access to treatment and natural community supports. The BH I/DD Tailored Plan supports the JJBH program through their JJBH liaison.
272. **High Priority Re-entry List:** A list provided by the Department of Adult Corrections to the BH I/DD Tailored Plans to support the identification of individuals for the DAC Priority Re-entry Program.
273. **Treatment Accountability for Safer Communities (TASC):** The TASC program provides services to people with substance use disorder or mental health problems who are involved in the justice system. After an individual's criminal case has been adjudicated to continue with treatment and recovery, TASC identifies services necessary to support ongoing treatment and recovery. Additionally, TASC providers can assist in identifying appropriate individuals for treatment and support services, facilitate entry into the recovery process and ensure community safety with partner agencies.

c. ***Section III. B. Abbreviations and Acronyms*** **is revised to add the following new acronyms:**

256. DAC: Department of Adult Corrections
257. IHS: Indian Health Services
258. JJBH: Juvenile Justice Behavioral Health
259. TASC: Treatment Accountability for Safer Communities

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

29. <u>MEDIA CONTACT APPROVAL AND DISCLOSURE:</u>

a. 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 practical. 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.
b. Media Interviews: Contractor shall not agree to participate in a media request for an interview related to the terms of this Contract prior to obtaining prior approval from the Department, which approval shall not be unreasonably withheld. Upon receipt of a request for an interview, Contractor shall provide the information outlined in the Health Plan Media Interview Request Instructions for Health Plans to the Department for review.

e. ***Section III. D. General Terms and Conditions, 33. PARTICIPATION IN REGIONAL SERVICE CONTINUITY:*** **is revised and restated in its entirety as follows:**

33. PARTICIPATION IN CATCHMENT AREA SERVICE CONTINUITY: In the event the Department terminates, suspends, or delays a BH I/DD Tailored Plan Contract in another Catchment Area, this Contractor agrees to meaningfully participate with the Department, all other active BH I/DD Tailored Plan Contractors, and any other entities as required by the Department in a collaborative process to identify solutions for ensuring service continuity in such a Catchment Area. Solutions identified under the process may include, but are not limited to, expanding the Contractor's service area, leveraging the Contractor's network building capabilities, and Contractor support for other operational activities, as needed.

f. ***Section III. D. General Terms and Conditions, 34. PAYMENT AND REIMBURSEMENT: d. Tailored Care Management Payments:*** **is revised to add the following:**

ii. If a BH I/DD Tailored Plan is notified by an AMH+ practice, CMA, or the Department and/or independently identifies a TCM Member who was reassigned to the BH I/DD Tailored Plan for TCM but should have remained assigned to the AMH+/CMA TCM Provider, the BH I/DD Tailored Plan should follow the process outlined in *Section V.B.3.ii.(v)(v)* of the Contract. During the time period that one or more Member(s) systematically show as being assigned to the BH I/DD Tailored Plan for receipt of TCM but should have been assigned to the AMH+/CMA TCM Provider, the BH I/DD Tailored Plan shall make the Tailored Care Management payment to the AMH+/CMA to which the Member should have been assigned in accordance with *Sections III.D.34.d*. and *V.B.4.v*. of this Contract.

g. ***Section III. D. General Terms and Conditions, 34. PAYMENT AND REIMBURSEMENT: f. Healthy Opportunities Pilot Program:, i. Capped Allocation, c., 1.*** **is revised and restated in its entirety as follows:**

1. Before adjusting Contractor's capped allocation, the Department will inform Contractor in writing at least thirty (30) Calendar Days prior to the adjustment or a mutually agreed upon timeline by the Department and Contractor, 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.

h. ***Section III. E. Confidentiality, Privacy and Security Protections, 5. Information Technology, a.-c.*** **is revised and restated in its entirety as follows:**

a. Contractor shall comply with and adhere to all applicable federal and North Carolina laws, regulations, policies, and guidelines, including but not limited to HIPAA, CMS and State IT Security Policy and Standards; Department Privacy and Security Policies; and the most recent Information Security and Privacy guidance shared by CMS. State and Department policies may be revised periodically, with at last thirty (30) Calendar Days' notice to Contractor and Contractor shall comply with any revisions following the notice period as soon as practicable upon written notification of such revision(s). The State Security Manual is available at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/document/security-manual/.

b. Contractor's information technology systems shall meet all State and federal statutes, rules and regulations governing information technology (including but not limited to 26 U.S.C. 6103, SSA, IRS Publication 1075, and HIPAA) and the policies of the NC Department of Information Technology, including NIST 800-53, as outlined in the State's Information Security Manual which can be found at the following links, accurate as of ~~A~~pril 25, 2025. *See e.g.* https://it.nc.gov/statewide-information-security-policies; https://it.nc.gov/documents/statewide-information-security-manual and https://it.nc.gov/document/statewide-data-classification-and-handling-policy.

c. Enterprise Architecture Standards: The North Carolina Statewide Technical Architecture standards are located at the following link, accurate as of April 25, 2025: https://it.nc.gov/resources/statewide-it-

procurement/vendor-engagement-resources. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems

i. *Section III. E. Confidentiality, Privacy and Security Protections, 5. Information Technology, f.* is revised and restated in its entirety as follows:

f. Patch Management: As soon as practicable upon receipt of written notification of the need to do so, the Contractor will apply patches based on State requirements on or to any Information Technology Systems or platforms that share information with (or interfaces with) the Department's Information Technology Systems or which may impact the delivery of services to the Department's members, provided that the patches do not disrupt Contractor operations. The State requirements are located at the following link, accurate as of April 25, 2025: https://it.nc.gov/documents/statewide-information-security-manual.The Contractor will coordinate patching activity with the Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with Contractor patching. The requirement to apply the patch may come from the Contractor, the Department, or an external organization such as https://www.us-cert.gov/.

j. *Section III. E. Confidentiality, Privacy and Security Protections, 9. Security, a. State of NC Security Standards and DHHS Privacy and Security Standards, i.* is revised and restated in its entirety as follows:

i. Contractor shall comply with all security standards including those published in the State of North Carolina Statewide Information Security Manual, the Department PSO Standards, and any federal regulations and requirements (found at the following link, accurate as of April 25, 2025: https://policies.ncdhhs.gov/document/security-manual/. The State of North Carolina Statewide Information Security Manual is available at the following URL, accurate as of August 9, 2022: https://it.nc.gov/statewide-information-security-policies. The Department will work with the Contractor to validate compliance with the PSO standards.

k. *Section III. E. Confidentiality, Privacy and Security Protections, 9. Security, c. State of NC Data Classification and Handling* is revised and restated in its entirety as follows:

c. State of NC Data Classification and Handling
The State of North Carolina Data Classifications as published in the North Carolina Department of Information Technology Data Classification and Handling Policy guide and the related handling procedures will apply to all data held in Contractor's IT systems on behalf of the Department, and in the execution of this Contract. The guide is available at the following URL, accurate as of April 25, 2025: https://it.nc.gov/document/statewide-data-classification-and-handling-policy.

III. Modifications to Section IV. First Revised and Restated Minimum Qualifications

a. *Section IV. First Revised and Restated Minimum Qualifications* is revised and restated in its entirety as follows:

Section IV. Reserved

IV. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

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

(hh) NCMT AMH/PCP AA Requirements Document;
(ii) NC Medicaid Managed Care Billing Guidance to Health Plans;

b. ***Section V. A. Unified, 1. Administration and Management, i. Medicaid Program and State-Funded Services Administration, (ix)*** **is revised to add the following:**

(jj) Direct Support Professional (DSP) Workforce Plan; and
(kk) Health Plan Media Interview Request Instructions for Health Plans.

c. ***Section V. A. Unified, 1. Administration and Management, v. Implementation for BH I/DD Tailored Plan Services, (v), (b)*** **is revised and restated in its entirety as follows:**

(b) End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting. The Department, if deemed necessary for the project execution, shall develop and provide an End-to-End test plan aligned with specific requirements for the program that includes all systems part of End-to-End testing. At a minimum, the End-to-End testing Plan shall include:
(1) High level description of the End-to-End Testing scope;
(2) High level overall End-to-End Testing duration;
(3) Applications or systems that are part of the End-to-End testing; and
(4) Integrations that are part of the End-to-End testing.

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

(b) Reserved.

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

(d) Must have warm transfer capabilities to crisis emergency services lines, including (but not necessarily limited to) 911, 988, and mobile crisis teams. 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.
(1) The BH I/DD Tailored Plan Behavioral Health Crisis must have warm transfer capabilities to the NC peer warm line (1- 855-PEERS NC).

f. ***Section V. A. 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xx) Behavioral Crisis Line:*** **is revised to add the following:**

(i) Shall have the capability to refer Members and Recipients to appointments for appropriate behavioral health services within the timeframes set forth in *Fourth Revised and Restated Attachment F: BH I/DD Tailored Plan Network Adequacy Standards.*

g. ***Section V. A. 3. Compliance, iv. Third Party Liability (TPL) for Medicaid, (xiv)*** **is revised and restated in its entirety as follows:**

(xiv) To support the insurance come-behind billing effort and protect the BH I/DD Tailored Plan's recovery rights on billed claims, the BH I/DD Tailored Plan shall submit to the Department a listing of the claims previously billed to insurance carriers or recovered by other means. This listing is referred to as a match-off file. After the initial match-off file is delivered, the subsequent frequency will be monthly. The BH I/DD Tailored Plan shall deliver the initial match-off file to reflect the claims billed to insurance carriers or recovered during the period of July 1, 2025 through September 30, 2025 to the Department by no later than October 15, 20254. The monthly match-off files shall be delivered by the fifteenth (15^{th}) day of each month and include the claims billed or recovered in the previous calendar month.

h. ***Section V. A. Unified, 4. Stakeholder Engagement and Community Partnerships, v. Community Crisis Services Plan for Medicaid and State-funded Services*** **is revised to add the following:**

(vii) To facilitate the Department's assessment of service utilization, funding sources, and financial sustainability of crisis providers, the BH I/DD Tailored Plan shall submit the Crisis Facility Utilization Report and Crisis Service Funding Report in accordance with the requirements in *Section VII. Fourth Revised and Restated Attachment J. Reporting Requirements.*

i. ***Section V. A. Unified, 5. Transitions to Community Living, iv. Behavioral Health Services, (i) Access to Array and Intensity of Behavioral Health Services, (b), (2)*** **is revised and restated in its entirety as follows:**

(2) If a TCL member residing in an Adult Care Home and/or State Psychiatric Hospital indicates to the BH I/DD Tailored Plan that they are not interested in community-based supportive housing, the BH/IDD Tailored Plan shall consult with the TCL member to complete the Informed Decision-Making Tool (IDM); and

j. ***Section V. A. Unified, 5. Transitions to Community Living, v. IPS Services, (iv) Integrated Supported Employment and Behavioral Health Services for TCL Members*** **is revised to add the following:**

(e) For Members and Recipients with SPMI receiving IPS services who may be at risk of placement in a congregate living facility, within thirty (30) Calendar Days of receiving the TCL member's IPS-Supported Employment Participant ACH In/At-Risk Checklist ("In/At-Risk Checklist") completed by the IPS provider, the BH I/DD Tailored Plan shall review the Member's In/At-Risk Checklist to determine whether the In/At-Risk criteria defined by the Department have been met. To demonstrate that the Member has met In/At-Risk criteria, the BH I/DD Tailored Plan shall submit to the Department the Member's In/At-Risk Checklist for each TCL and/or In/At-Risk Member or Recipient determined by the BH I/DD Tailored Plan to meet the In/At-Risk criteria defined by the Department.

k. ***Section V. A. Unified, 5. Transitions to Community Living, vi. Quality Assurance and Performance Improvement, (ii)*** **is revised and restated in its entirety as follows:**

(ii) In accordance with TCL QAPI guidance issued by the Department, the BH I/DD Tailored Plan shall integrate TCL QAPI Plan elements into its overall QAPI and QMIP by September 2, 2024. Beginning with the reports due August 14, 2024 and through May 31, 2025, the BH I/DD Tailored Plan shall submit to the Department within forty-five (45) Calendar Days following the end of each quarter a TCL QAPI Progress Report regarding implementation of the TCL component of its QAPI Plan in accordance with TCL QAPI Guidance issued by the Department. Effective September 1, 2025, TCL QAPI Plan and activity reporting will be required annually as part of the regular QAPI and QMIP cycle, and all TCL QAPI Plan components shall be included in the annual Quality submissions.

l. ***Section V. A. Unified, 5. Transitions to Community Living, vi. Quality Assurance and Performance Improvement*** **is revised to add the following:**

(iii) The BH I/DD Tailored Plan shall work cooperatively with the Department and the Department's designated contractor to participate in on-site interviews of individuals eligible for TCL and their providers, and desk reviews of TCL operations to evaluate compliance with the requirements of the TCL Settlement Agreement and this Contract, to include but not limited to, the following domains:

(a) Community Based Supported Housing;
(b) Community Based Mental Health Services;
(c) Supported Employment Services;
(d) Discharge and Transition Process;
(e) Pre-Admission In Reach and Diversion; and
(f) Quality Assurance and Performance Improvement.

(iv) In accordance with the terms of the TCL Settlement Agreement, the BH I/DD Tailored Plan shall attend monthly meetings of the Department Transition Oversight Committee monitoring implementation of the TCL Settlement Agreement. Upon the Department's request, the BH I/DD Tailored Plan shall provide information to the Transition Oversight Committee as necessary to supplement reporting regarding

(a) Discharge-related measures, including without limitation: housing vacancies, discharge planning and transition process, referral process and subsequent admissions, time between application for services to discharge destination, and actual admission date to community-based settings, and barriers.

m. ***Section V. A. Unified, 8. Clinically Appropriate Placement of Minors*** **is revised and restated in its entirety as follows:**

8. Clinically Appropriate Placement of All Minors

i. For Members not in DSS custody and for Members in DSS custody and enrolled with the BH I/DD Tailored Plan following the launch of the CFSP, the BH I/DD Tailored Plan shall take the following action upon receiving notification from DSS or from the hospital or Member's LRP that a Member under eighteen (18) years of age remains in the Emergency Department for longer than twenty-four (24) hours and is ready for discharge or transfer to another facility to receive Medicaid State Plan behavioral health, I/DD, and/or TBI service.

(i) Within one (1) Business Day of receiving notification described in *Section V.A.8.i.* of the Contract:

(a) If the Member is not in DSS custody, the BH I/DD Tailored Plan shall contact the Medicaid help center to open a case for the Member; or

(b) If the Member is in DSS custody, the BH I/DD Tailored Plan shall:

i) Confirm that the Member has an open case with the Department of Health and Humans Services' Rapid Response Team as defined in NCGS § 122C-142.2(g) ("Rapid Response Team");

ii) If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS open a Rapid Response Team case for the Member.

(ii) Within three (3) Business Days of receiving notification described in *Section V.A.8.i.* of the Contract, the BH I/DD Tailored Plan shall demonstrate best efforts to arrange for the Member to receive services in an appropriate placement with the approval of the Member's guardian or legally responsible person (LRP).

(iii) Within seven (7) Business Days of receiving notification described in *Section V.A.8.i.* of the Contract, the BH I/DD Tailored Plan shall develop a rapid response plan for the Member using the Department-developed *Rapid Response Plan* template and attach the completed *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case.

(a) Until the Member is discharged or transferred to a clinically appropriate setting for receipt of medically necessary services, the BH I/DD Tailored Plan shall update the Member's *Rapid Response Plan* on a weekly basis and shall attach the updated Rapid Response Plan to the Member's open

Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last submitted update.

(b) The BH I/DD Tailored Plan shall participate in all Department-led escalation calls to which the BH I/DD Tailored Plan is invited with~~in~~ advance notice related to arranging placement for the Member.

(iv) In the event that a Member is not placed within twenty-four (24) hours following the BH I/DD Tailored Plan's receipt of notification described in *Section V.A.8.i.* of the Contract, the BH I/DD shall include the Member on the BH I/DD Tailored Plan's next weekly submission of the BCM-073-M report.

ii. For Members in DSS custody and enrolled with the BH I/DD Tailored Plan following the launch of CFSP, the BH I/DD Tailored Plan shall take the following actions upon receipt of notification from DSS that a Member under eighteen (18) years of age has been taken into physical DSS custody; requires evaluation for or delivery of Medicaid State Plan behavioral health, I/DD, and/or TBI services, including residential placement in a licensed facility (i.e., residential treatment and/or PRTF service); and is staying overnight in a DSS office, hotel, or similar placement.

(i) Within one (1) Business Day of receiving notification described in *Section V.A.8.ii.* of the Contract, the BH I/DD Tailored Plan shall:

(a) Contact the Member's County DSS to confirm that the Member has an open Rapid Response Team case;

(b) If the Member does not have an open Rapid Response Team case, request on behalf of the Department that DSS opens a Rapid Response Team case for the Member.

(ii) Within three (3) Business Days of receiving the notification described in *Section V.A.8.ii.* of the Contract, the BH I/DD Tailored Plan shall demonstrate best efforts to arrange for the Member to be appropriately placed to receive medically necessary services. Unless the Member is in an emergency, automatic referral to a hospital emergency department for services does not satisfy this requirement.

(iii) Within seven (7) Business Days of receiving the notification described in *Section V.A.8.ii*. of the Contract, the BH I/DD Tailored Plan shall develop a rapid response plan using the Department-developed *Rapid Response Plan* template and attach the completed *Rapid Response Plan* to the Member's open Rapid Response Team case in the Medicaid help center.

(a) Until the Member is placed in a clinically appropriate setting to receive medically necessary services and is no longer staying overnight in a DSS office or similar placement, the BH I/DD Tailored Plan shall update the Member's *Rapid Response Plan* on a weekly basis and shall attach the updated Rapid Response Plan to the Member's open Rapid Response Team case in the Medicaid help center within seven (7) Calendar Days of last submitted update.

(b) The BH I/DD Tailored Plan shall participate in all Department-led escalation calls relating to arranging placement for the Member.

(iv) In the event that a Member is not placed in a clinically appropriate setting for receipt of medically necessary services within one (1) Business Day following the BH I/DD Tailored Plan's receipt of notification described in *Section V.A.8.ii*. of this Contract, the BH I/DD Tailored Plan shall include the Member on the BH I/DD Tailored Plan's next submission of the BCM-073-M report.

(v) The BH I/DD Tailored Plan shall work with the Member's DSS Office to update the crisis/ safety plan for each Member staying overnight in a DSS office, hotel or similar placement while awaiting clinically appropriate placement and shall reasonably work with the DSS Office to arrange for the Member to receive medically necessary assessments, services, and supports while staying overnight in a DSS office, hotel, or similar placement pending clinically appropriate placement.

iii. A Member's need for services shall be determined through a clinical evaluation, completed by a licensed professional, that is adequate to determine the appropriate level of care.

(i) Within three (3) Business Days of receiving notification described in *Sections V.A.8.i.* or *V.A.8.ii*. of the Contract, the BH I/DD Tailored Plan shall arrange for the Member to receive a clinical evaluation, completed by a licensed professional, that is adequate to determine the appropriate level of care.

(ii) If the Emergency Department where the Member is awaiting discharge, Member's guardian or LRP, contracted provider, or external TCM provider or other person/entity denies the BH I/DD Tailored Plan and/or its contracted Providers to have access to the Member to conduct and complete a clinical evaluation as described in *Section V.A.8.iii*, the BH I/DD Tailored Plan shall notify the Department within one (1) Business Day of being denied access to the Member.

iv. Nothing in this Section requires the BH I/DD Tailored Plan to arrange for placement outside the recommended level of care determined by the Member's clinical evaluation as described in *Section V.A.8.iii*, or outside of services covered under the Member's applicable State-funded or Medicaid benefit plan.

v. In the event that the parent, legal guardian or legal custodian of a Member under eighteen (18) years of age for whom the BH I/DD Tailored Plan has received notification described in *Sections V.A.8.i.* or *V.A.8.ii.* of this Contract rejects or refuses admission to an appropriate placement identified by the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall, within one (1) Business Day, identify a mutually agreeable placement within the recommended level of care identified by the clinical evaluation described in Section V.A.8.iii by, at minimum, addressing barriers to the Member's parent, legal guardian, or legal custodian accepting the appropriate placement, and shall continue efforts to identify a mutually agreeable placement until placement is achieved.

n. *Section V.B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care, (a), (8)* is revised and restated in its entirety as follows:

(8) Beneficiaries who are inmates of prisons, as provided in NCGS § 108D-40(a)(9);

o. *Section V.B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care, (11)-(12)* is revised and restated in its entirety as follows:

(11) Beneficiaries with services provided through the PACE[3];
(12) Beneficiaries enrolled in the Optional COVID-19 (MCV) Testing Program[4]; and

p. *Section V. B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care* is revised to add the following:

(13) Beneficiaries who are residing in carceral settings other than prisons and whose Medicaid eligibility has been suspended, as provided in NCGS § 108D-40(a)(9a).

q. *Section V. B. Medicaid, 1. Members, iii. Member Engagement, (ix) Written and Verbal Member Materials, (b), (4), i.* is revised and restated in its entirety as follows:

i. Taglines are required on materials that are critical for potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d). For all materials requiring a tagline, the BH I/DD Tailored Plan shall use the Department-developed Auxiliary Aids and Interpreter Services Taglines Template.

[3] The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to N.C. Gen. Stat. § 108D-35(3), which excludes all PACE program services from Medicaid Managed Care.
[4] The Department is seeking a change in State law to clarify that individuals enrolled in the Optional COVID-19 (MCV) Testing Program, authorized under Section 4.5 of S.L. 2020-4, are also excluded from Medicaid Managed Care, if the coverage is still available at the launch of Managed Care.

r. ***Section V. B. Medicaid, 1. Members, vii. Advance Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advance Medical Home Contracting, (a) Background and General Requirements, (2)-(3)*** **is revised and restated in its entirety as follows:**

(2) AMH practices will act as primary care providers (PCPs) for BH I/DD Tailored Plan Members. The BH I/DD Tailored Plan shall pay to the AMH practice serving as the PCP for Members the Medical Home Fee in accordance with *Section V.B.4.v.(xvii) Payments of Medical Home Fees to Advanced Medical Home*.

(3) AMH practices ready to take primary responsibility for care management under BH I/DD Tailored Plans must become certified as AMH+ practices as described in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMA*s. The Department will establish a fixed Tailored Care Management payment for AMH+ practices certified to provide Tailored Care Management as described in *Section III.D.36. Payment and Reimbursement.*

s. ***Section V. B. Medicaid, 1. Members, vii. Advance Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advance 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 Advance Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management*. The BH I/DD Tailored Plan shall exclusively base the calculation of all Performance Incentive Payments on the defined AMH quality measure set.

t. ***Section V. B. Medicaid, 1. Members, vii. Advance Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advance Medical Home Contracting*** **is revised to add the following:**

(f) The BH I/DD Tailored Plan shall provide to AMHs participating in AMH performance incentive arrangements access to data necessary to support their participation in AMH performance incentive arrangements. This should include at a minimum:

(1) Beneficiary Assignment Data;
(2) Beneficiary Claims Data;
(3) Quality Performance Data (including Care Gap Reports; and
(4) Access to Admission Discharge and Transfer (ADT) Data.

u. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid, (c), Section V.B.2. Table 1: Services Carved out of Medicaid Managed Care*** **is revised and restated in its entirety as follows:**

Section V.B.2. First Revised and Restated 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 documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by Children's Developmental Services Agency (CDSA) or by a provider contracted with a CDSA to provide those services

[6] N.C. Gen. Stat. § 108D-35.

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
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

v. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid, (c), Section V.B.2. Table 2: Second Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans*** **is revised and restated in its entirety as follows:**

[7] The Department is considering pursuing legislative authority to carve these services into managed care.

Section V.B.2. Third 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*[3] • *Ambulatory Withdrawal Management, without Extended On-Site Monitoring* (Ambulatory Detox) • *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* • Early and periodic screening, diagnostic and treatment (EPSDT) services • *Substance use intensive outpatient program (SAIOP)* • *Substance use comprehensive outpatient treatment program (SACOT)*	**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)*[4] • *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* • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **1915(i) Option Services** • Supported Employment *for IDD and TBI/* Individual Placement *and Support (IPS) Services* • *Individual and Transitional Support (ITS) Services* • Respite *Services* • Community Living and Supports *(CLS) Services* • Community Transition *Services* **Waiver Services** • Innovations waiver services • TBI waiver services

w. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid, (c), Section V.B.2. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*** **is revised and restated in its entirety as follows:**

Section V.B.2. Second 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)
4	Medically managed intensive inpatient services	Medically managed intensive inpatient service (Inpatient BH services)
Office-based opioid treatment	Office-based opioid treatment[8]	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) Ambulatory withdrawal management, with extended on-site monitoring
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.2WM	Clinically managed residential withdrawal services	Clinically managed residential withdrawal services (social setting detoxification)
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)

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

x. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iv) Medical Necessity*** **is revised to add the following:**

(h) Consistent with guidance from the American Academy of Pediatrics, the BH I/DD Tailored Plans shall apply the following professional standards in conducting an EPSDT medical necessity review:
(1) Traditional evidence grading (patient-centered or scientific evidence for children) with a hierarchy or algorithm of standards applied;
(2) Professional standards of care for children; or
(3) Consensus expert pediatric opinion**.**

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

(a) The BH I/DD Tailored Plan shall develop a single utilization management (UM) program for covered medical, BH, I/DD, LTSS, and pharmacy services that is applied to covered services offered under this Contract and to covered services offered under the PIHP Contract and is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in the required NC Medicaid clinical coverage policies set forth in *Section V.B.2.i. (v) (h) and the Section V.B Second Revised and Restated Table 6: Required Clinical Coverage Policies* of the Contract, subject to the following:
(1) The BH I/DD Tailored Plan shall incorporate NC Medicaid Direct clinical coverage policies into its UM Program in accordance with the *Section V.B. Second Revised and Restated Table 6: Required Clinical Coverage Policies* of this Contract.
(2) The BH I/DD Tailored Plan shall submit to the Department through the Prepaid Health Plan Data Utility (PCDU) for review and approval an updated parity analysis workbook that documents the policies and procedures, as written and in operation, and processes, evidentiary standards, strategies, or other factors used by the BH I/DD Tailored Plan in applying non-quantitative UM limits at the following times:
i. Department Initiated:
a) When covered benefits are to be added to, modified by, or removed from the Contract, the Department's Contract Administrators shall notify the BH I/DD Tailored Plan's Contract Administrators in writing of the revisions to be incorporated via a Contract Amendment;
b) The BH I/DD Tailored Plan shall submit to the Department information needed for the Department to conduct a parity analysis by submitting an updated parity analysis workbook no later than thirty (30) Calendar Days after the Department notifies the BH I/DD Tailored Plan of covered benefits intended to be added to, modified by, or removed from the Contract;
c) The Department shall allow the BH I/DD Tailored Plan sixty (60) Calendar Days after receipt of the Department's response to the updated parity analysis workbook, unless an earlier timeframe is mandated by CMS, to implement any revisions requested by the Department to be incorporated;
ii. BH I/DD Tailored Plan Initiated: The BH I/DD Tailored Plan shall submit to the Department an updated parity analysis workbook at least forty-five (45) Calendar Days before the BH I/DD Tailored Plan adds or changes a non-quantitative UM limit to one or more covered benefit(s).
iii. Irrespective of whether the updated parity analysis workbook is submitted following a Department-initiated or BH I/DD Tailored Plan-initiated request, the Department shall review and notify the BH I/DD Tailored Plan of its approval or request for more information within thirty (30) Calendar Days of receipt of the BH I/DD Tailored Plan's updated parity analysis workbook.

(3) At least forty-five (45) Calendar Days before the BH I/DD Tailored Plan adds or changes a quantitative limit applied to covered benefits, the BH I/DD Tailored Plan shall submit to the Department an updated parity analysis workbook to allow the Department to determine whether the proposed limit(s) is/are parity compliant. The BH I/DD Tailored Plan may submit one parity analysis workbook inclusive of both the PIHP and BH I/DD Tailored Plan program.

(4) Notwithstanding *Section V.B.2.i.(v)(h)* of the Contract, if the Department determines that one or more UM quantitative or non-quantitative limits applied by the BH I/DD Tailored Plan cause the BH I/DD Tailored Plan or the NC Managed Care program to be noncompliant with applicable mental health parity requirements, the BH I/DD Tailored Plan shall remove the UM limit(s) identified by the Department as being noncompliant from its PIHP and BH I/DD Tailored Plan UM Program within sixty (60) Calendar Days of the Department giving the BH I/DD Tailored Plan Notice of the non-compliant limit(s) to be removed.

(5) The BH I/DD Tailored Plan shall ensure the UM program aligns with the parameters laid out in *Section V.A.1.vi. Readiness Review Requirements*, to the degree a Subcontractor relationship applies.

z. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (b) UM Program Policy, (7)* is revised and restated as follows:

(7) The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. § 438.3(e)(1)(ii), 42 C.F.R. § 438.905, and 42 C.F.R. § 438.910.

i. In addition to the updated parity analysis workbook submissions required under *Section V.B.2.i.(v)(a)* of this Contract, the BH I/DD Tailored Plan shall submit a completed standardized parity analysis workbook, developed by the Department and provided upon award, to the Department annually and within thirty (30) Calendar Days of request by the Department to allow the Department to assess the BH I/DD Tailored Plan's parity compliance in accordance with 42 C.F.R. § 438.920.

aa. *Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (i), Section V.B First Revised and Restated Table 6: Required Clinical Coverage Policies* is revised and restated in its entirety as follows:

Section V.B.2. Second Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	***Scope***
BH and I/DD Services: *For these policies, BH I/DD Tailored Plans shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.*	
1915(c) Home and Community-Based Services (HCBS) Waivers	*8P: North Carolina Innovations*
Other Services	
Auditory Implant External Parts	*13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair* *13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair*
Obstetrics and Gynecology	*1E-7: Family Planning Services*
Physician Services	*1A-4: Cochlear and Auditory Brainstem Implants* *1A-23: Physician Fluoride Varnish Services*

Section V.B.2. Second Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	***Scope***
	1A-36: Implantable Bone Conduction Hearing Aids (BAHA) *1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions*
Pharmacy	As defined in *Section V.B.2.iii. Pharmacy Benefits*

bb. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (p), (5), i. Emergency services*** **is revised to add the following:**

g) Certain Local Health Department services: The BH I/DD Tailored Plans shall not require Members to obtain a referral or prior authorization for Sexually Transmitted Infection and/or Tuberculosis services rendered at a Local Health Department (LHD).

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

(8) The BH I/DD Tailored plan shall conduct or contract for the completion of the independent assessment required for receipt of Medicaid State Plan Personal Care Services.

dd. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (u) UM Policy for 1915(i) Services, (6)*** **is revised and restated in its entirety as follows:**

(6) The BH I/DD Tailored Plan shall submit to the Department a monthly report of Members for whom the transition from 1915(b)(3) services to 1915(i) services is in progress and the BH I/DD Tailored Plan's progress in completing the independent assessments for Members identified as in need of or requesting to receive 1915(i) services until all transitions are completed. The BH I/DD Tailored Plan shall submit to the Department upon its request information regarding Member transitions to 1915(i) services for reporting to CMS.

ee. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vii) In Lieu of Services (ILOS), (b)*** **is revised and restated in its entirety with no revisions to subsections (1)-(7) as follows:**

(b) Once each Contract Year, the BH I/DD Tailored Plan shall submit to the Department for review and approval the Department's standardized ILOS Service Request Form for each proposed new ILOS or revision to an existing ILOS offered under the Contract, except that the BH I/DD Tailored Plan may submit the standardized ILOS Service Request Form to the Department at any time to request termination or reduction of services offered as an ILOS.

ff. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (xi) Electronic Verification System Requirements, (e)*** **is revised and restated in its entirety as follows:**

(e) 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.

gg. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (xi) Electronic Verification System Requirements*** **is revised to add the following:**

(g) The BH I/DD Tailored Plan shall submit monthly reporting using the EVV Key Metrics Report for the EVV program.

hh. ***Section V. 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, prior authorization (PA) criteria, clinical criteria, and Preferred Drug List as described below in the UM program. The BH I/DD Tailored Plan shall align any of its clinical and prior authorization criteria with all of the requirements in the documents listed below:

(1) Clinical Coverage Policies: *Section V.B.2. Table 8: Required Pharmacy Clinical Coverage Policies* below.

(2) Prior authorization Drugs and Clinical Criteria: Forms for Drugs and/or drug classes requiring prior approval are available at the following link, accurate as of April 25, 2025: https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html. Policies and clinical criteria for Drugs and/or drug classes subject to clinical criteria are available at the following link, accurate as of April 25, 2025 https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html.

(3) Reserved.

(4) Preferred Drug List: Available at the following link, accurate as of April 25, 2025: https://medicaid.ncdhhs.gov/preferred-drug-list.

ii. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (iv) Pharmacy Utilization management, (d)*** **is revised to add the following:**

(11) Prior authorization policies and pharmacy point of service edits implemented by the BH I/DD Tailored Plan shall be consistent with the FDA label or medically accepted uses, as defined in Section 1927(k)(6) of the Social Security Act, as part of its UM program to ensure Member safety, to prevent overprescribing, and inappropriate prescribing of drugs.

jj. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (iv) Pharmacy Utilization management, (f)*** **is revised and restated in its entirety as follows:**

(f) The BH I/DD Tailored Plan may require utilization edits or PA for drugs based on the drug's FDA approved indication(s) and use(s) or medically acceptable uses, as defined in Section 1927(k)(6) of the Social Security Act, until the Department determines the need for and establishes clinical coverage and PA criteria or determines that clinical coverage criteria or prior authorization is not to be applied to a drug or drug class.

kk. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (a) Dispensing Fees, (4)-(6)*** **is revised and restated in its entirety as follows:**

(4) Reserved.

(5) Reserved.

(6) For 340B and Non-340B Hemophilia drugs, the dispensing fee is paid based on the submitted quantity of units dispensed, utilizing a multiplier at $0.04 for Hemophilia Treatment Center (HTC) pharmacies and $0.025 for all other Non-Hemophilia Treatment Center pharmacies.

ll. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii)Pharmacy Reimbursement, (b) Ingredient Costs, (1)*** **is revised and restated in its entirety as follows:**

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

mm. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (11)-(15)*** **is revised and restated in its entirety as follows:**

(11) Reserved.
(12) Reserved.
(13) Reserved.
(14) Reserved.
(15) Reserved.

nn. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (c)-(f)*** **is revised and restated in its entirety as follows:**

(c) Reserved.
(d) Reserved.
(e) Reserved.
(f) Reserved.

oo. ***Section V. 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) BH I/DD Tailored Plan shall meet the annual requirements established by the Department in *Section V.B.3.ii.(ii)(b)(4)* of this Contract for the percentage of Members actively assigned to an AMH+ or CMA for Provider-based Tailored Care Management. The AMH+/CMA Providers are responsible for delivering at least one (1) of the following six (6) core Health Home services:

i. Reserved;
ii. Reserved;
iii. Reserved;
iv. Reserved;
v. Reserved;
vi. Reserved;.
vii. Reserved;
viii. Reserved;
ix. Reserved;
x. Comprehensive care management;
xi. Care coordination;
xii. Health promotion;
xiii. Comprehensive transitional care/follow-up;
xiv. Individual and family supports; or
xv. Referral to community and social support services.
xvi. CMS guidance on the core Health Home core service definitions and related activities can be found at the following websites: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center and *Section V.4.2.* of the *Tailored Care Management Provider Manual*.

pp. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ii) Delivery of Tailored Care Management, (b) Provider-based Tailored Care Management, (5)*** **is revised and restated in its entirety as follows:**

(5) The Department will assess compliance with annual required percentages for each Contract Year during the first quarter of subsequent Contract Year, beginning in Contract Year 2. The percentage shall be calculated as:

i. Numerator: Number of Members assigned to provider-based Tailored Care Management provided by care managers based in entities (AMH+ practices or CMAs) certified by the Department as measured on the first day of the first quarter of a new Contract Year.

ii. Denominator: Total number of eligible Members assigned to any Tailored Care Management entity (AMH+ practices, CMAs, or Plan-based care management) as measured on the first day of the first quarter of a new Contract Year.

qq. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (iv) Enrollment in Tailored Care Management, (b), (1)*** **is revised to add the following:**

ii. If a Member opts out of Tailored Care Management, the BH I/DD Tailored Plan shall disenroll the Member from Tailored Care Management by the last day of the month in which the BH I/DD Tailored Plan received the Member's *Tailored Care Management Opt-out Form*. In the event that the BH I/DD Tailored Plan receives the Member's *Tailored Care Management Opt-out Form* within the last three (3) Calendar Days of the month and is unable to disenroll the Member prior to the end of the month, the BH I/DD Tailored Plan shall notify the assigned AMH+/CMA of the date on which the Member's opt out request will become effective in NC FAST.

rr. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (iv) Enrollment in Tailored Care Management, (b)*** **is revised to add the following:**

(5) At least once annually, the BH I/DD Tailored Plan shall attempt to reengage Members who have opted out of Tailored Care Management and Members who have not opted out and for whom no Tailored Care Management claim has been submitted within the prior twelve (12) months.

ss. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (v) Tailored Care Management Assignment and Re-Assignment, (d)*** **is revised to add the following:**

(1) The BH I/DD Tailored Plan shall assign the Member to a contracted AMH+ practice, CMA, or the BH I/DD Tailored Plan for Tailored Care Management within twenty-four (24) hours of the effectuation date of the Member's enrollment in the BH I/DD Tailored Plan.

tt. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (v) Tailored Care Management Assignment and Re-Assignment, (f), (1) For Innovations and TBI waiver enrollees:, ii.*** **is revised and restated in its entirety as follows:**

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. § 441.301(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.

uu. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (v) Tailored Care Management Assignment and Re-Assignment, (i)*** **is revised to add the following:**

(1) Member choice must be processed in the assignment cycle following the Member's request. In the event the BH I/DD Tailored Plan receives the Member's choice request with all information required

to process the reassignment request within the last three (3) Business Days of the month and is unable to complete the reassignment process, the BH I/DD Tailored Plan must notify the Member of the effective date of their choice.

vv. *Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (v) Tailored Care Management Assignment and Re-Assignment* is revised to add the following:

(t) To ensure continuity of care, prevent misassignments and allow for Warm handoffs, the BH I/DD Tailored Plan shall notify the Tailored Care Management entity from which the Member is being reassigned during each monthly reassignment cycle. By the end of the month, the BH I/DD Tailored Plan shall provide to the Tailored Care Management entity that the Member is leaving the following data:
  (1) The Member's Identification Number;
  (2) The name of the Tailored Care Management entity to which the Member is being reassigned; and
  (3) The reason that the Member is being reassigned.

(u) Notwithstanding the requirement at Section V.B.3.ii.(v)(v) of this Contract, the BH I/DD Tailored Plan shall reassign a Member within fifteen (15) Calendar Days of confirming that the Member requires reassignment.

(v) If a BH I/DD Tailored Plan is notified by an AMH+ practice, CMA, or the Department and/or independently identifies that a TCM Member who was reassigned to the BH I/DD Tailored Plan should have remained assigned to the AMH+/CMA TCM provider, the BH I/DD Tailored Plan shall do all of the following:
  (1) No more than sixty (60) Calendar Days after the BH I/DD Tailored Plan has been notified that the Member should have remained assigned to the AMH+ Practice or CMA and within thirty (30) Calendar Days of submitting the Reassignment Attestation Form as required by *Section V.B.3.ii.(v)(v)(2).* of this Contract, the BH I/DD Tailored Plan shall reassign the Member back to the AMH+ practice or CMA to which the Member should have remained assigned.
  (2) Within the first week of the month, the BH I/DD Tailored Plan shall submit to the Department through the PCDU a completed *Reassignment Attestation Form* to report:
    i. Each Member who was reassigned to the BH I/DD Tailored Plan for Tailored Care Management in the prior month when that Member should have remained assigned to an AMH+ practice or CMA; and
    ii. The AMH+ practice or CMA to which the BH I/DD Tailored Plan is working to reassign each Member.
  (3) In accordance with *Section III.D.34.d.* of the Contract, the BH I/DD Tailored Plan shall make the Tailored Care Management monthly payment to the AMH+ practice or CMA to which the Member should have remained assigned for each month in which the Member was reassigned to the BH I/DD Tailored Plan but should have remained assigned to the AMH+ practice or CMA for Tailored Care Management.

(w) Within five (5) Calendar Days of the effective date of a Member's reassignment, the BH/IDD Tailored Plan shall transmit the following data to the Member's assigned AMH+ practice or CMA:
  (1) Member assignment information, including demographic data and any clinically relevant and available eligibility information.
  (2) Pharmacy lock-in data including all mandatory fields and valid values noted in the data specification document.
  (3) Member claims/encounter data, including historical physical, behavioral health, and pharmacy claims/encounter data. The BH I/DD Tailored Plan shall transmit new physical and/or behavioral

health claims/ encounter data on a monthly cadence and new pharmacy claims/ encounters data on a weekly cadence.

(4) Acuity tiering and risk stratification data. The BH I/DD Tailored Plan receives the Member's acuity tier (e.g., low, medium, high) from the Department. The BH I/DD Tailored Plan is required to transmit the Member's acuity tier to the Member's assigned AMH+ practice or CMA along with the results and methods of any risk stratification conducted by the BH I/DD Tailored Plan.

(5) Other data to support a Member's reassignment to an AMH+ practice, CMA or BH I/DD Tailored Plan. The BH I/DD Tailored Plans shall transfer current care plans/ ISPs and care management assessments, ADT data, and historical Member clinical info to the Member's assigned AMH+ practices, CMAs or BH I/DD Tailored Plans.

ww. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (vii) Care Management Comprehensive Assessment, (f)*** **is revised and restated as follows:**

(f) The assigned organization providing Tailored Care Management shall make its best effort to complete the care management comprehensive assessment within ninety (90) Calendar Days of BH I/DD Tailored Plan enrollment. 42 CFR § 438.208(b)(3).

(1) Reserved.

(2) Reserved.

(3) For purposes of provisions related to Tailored Care Management, "Best efforts" 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.

xx. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management, (k)-(l)*** **is revised and restated in its entirety as follows:**

(k) The Department will establish a standardized methodology to assign each member to a Tailored Care Management acuity tier (e.g., high, medium, low).

(1) A Member's acuity tier represents the Department's estimate of the Member's care needs and necessary intensity of care management. This estimate does not supersede or otherwise override the clinical judgement of the assigned care manager.

(2) A Member's acuity tier is a combination of an alphabetical prefix followed by a numerical suffix that represents the Department's estimate of the Member's care needs and required intensity of care respectively.

i. The alphabetical prefix may be one of the following values:

a) "BH", representing the Department's estimate that the Member has primarily behavioral health care needs or co-occurring behavioral health and intellectual/development disability care needs.

b) "IDD", representing the Department's estimate that the Member has primarily intellectual/developmental disability care needs.

ii. The numerical prefix may be one of the following values:

a) "01", representing the Department's estimate that the Member requires a low intensity of care.

b) "02", representing the Department's estimate that the Member requires a moderate intensity of care.

c) "03", representing the Department's estimate that the Member requires a high intensity of care.

iii. The Department will assign the alphabetical prefix and numerical suffix of "UN01" to a Member if the Department has not yet calculated an estimate of the Member's care needs, or otherwise lacks sufficient historical data to do so.

(3) The Department assigns each Tailored Care Management eligible Member to an acuity tier and shares this information with the BH I/DD Tailored Plans, and to the Member's assigned AMH+ or CMA as a tool to inform decision-making related to Member needs (e.g., whom to prioritize for outreach, who may have significant immediate needs), care manager and supervising care manager assignments, and to inform risk stratification. Acuity tier information is a retrospective snapshot in time based on the Member's available medical history including historical claims data. A Member's care needs can change at any time and care managers are expected to use their clinical judgement on the intensity of care management necessary to support a Member.

(l) The assigned Tailored Care Management entity shall use its clinical judgment and the results of the Member's comprehensive care management assessment to determine the frequency and type of contacts to be made based on the Member's needs. Nothing in this Section shall preclude the BH I/DD Tailored Plan from reviewing the medical necessity of the frequency or format of Tailored Care Management contacts documented in the Member's care plan/ ISP and/or from requesting validation of the frequency or format of contacts delivered.

(1) For Members who have consented to and engaged in Tailored Care Management, an in-person contact shall be conducted between the Member's assigned care manager and the Member, or with a Member's legally responsible person or legal guardian in lieu of the Member, where appropriate or necessary. Care managers should tailor the number, frequency and type of contacts based on the Member's needs.

(2) For Members who request accommodations due to relevant health conditions, contacts can be delivered, at the discretion of the assigned Tailored Care Management entity, using clinically-appropriate assistive technologies (e.g., speech-to-text application, secure platforms for two-way instant messaging/texting).

(3) The BH I/DD Tailored Plan shall document, or shall review to confirm that the assigned AMH+ or CMA has documented, the Member's preferences for contact frequency and Member accommodation requests in the Member's Care Plan/ ISP reviewed with the Member's assigned care manager.

i. If any changes are made to the Member's Care Plan/ ISP, including changes to the frequency of contacts, intensity of care management needs, and/or accommodation requests, the BH I/DD Tailored Plan shall obtain, or shall review the Member's updated Care Plan/ ISP to verify that the assigned Tailored Care Manager has obtained, the signature of the Member or legally responsible person/ guardian on the updated Care Plan/ISP.

(4) The BH I/DD Tailored Plan shall conduct, and shall include in its contracts with AMH+ and CMA providers a term requiring that the assigned care manager/extender/supervising care manager conduct, care management contacts in manner that ensures the security of protected health information and complies with all state and federal laws, including HIPAA and requirements related to records retention.

(5) If the care manager/extender/supervising care manager utilizes two-way real time video and audio conferencing or assistive technologies to conduct the care management contact with a Member, the care manager/extender/supervising care manager shall enable applicable encryption and privacy modes. Public facing audio/video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used to conduct care management contact(s).

(6) If the care manager/ extender/ supervising care manager conduct the care management contact using two-way instant messaging or texting with a Member who requests accommodations due to relevant, specific health conditions as determined by the care manager and documented in the Member's signed Care Plan/ ISP, the care manager/extender/supervising care manager and

Member shall communicate using two-way instant messaging/texting via a secure portal that has met all Department-required security and privacy requirements.

yy. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver, (e)*** **is revised and restated in its entirety as follows:**

(e) If the member is enrolled in the Innovations or TBI waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall:

(1) Comply with the Individual Support Plan (ISP) requirements set forth in federal law and regulations, the Innovations Waiver, *Clinical Coverage Policy 8P: Innovations* and the TBI Waiver;

(2) Incorporate the *HCBS Monitoring Check Sheet* into care management contacts; and

(3) Furnish and document in the ISP contacts at the higher of the frequency and modality required under Innovations Waiver, *Clinical Coverage Policy 8P: Innovations*, the TBI Waiver, or *Section V.B.3.ii.(x) Ongoing Care Management*.

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

(k) The BH I/DD Tailored Plan shall ensure that care managers complete the training modules as set forth in the Tailored Care Management Provider Manual.

aaa. ***Section V. 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 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 or CMA inclusive of technical assistance provided and why the AMH+ practice or, CMA 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.

bbb. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight, (b), (2)*** **is revised and restated in its entirety as follows:**

(2) Reserved.

ccc. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight, (f)*** **is revised and restated in its entirety as follows with no revisions to subsections (1)-(3):**

(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. § 441.301(c)(1)(vi) and 42 C.F.R. § 441.730(b).

ddd. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xix) Oversight, (j)*** **is revised and restated as follows:**

(j) Reserved.

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

(s) The Department shall monitor the BH I/DD Tailored Plan's adherence to the Tailored Care Management model; compliance with Tailored Care Management requirements outlined in this Contract and relevant documents identified in *Section V.A.1.i.(ix)* of this Contract; and delivery of quality Tailored Care Management annually utilizing the TCM Statewide Monitoring Tool.

(1) For a period of one (1) year from initial monitoring review of the BH I/DD Tailored Plan by the Department's contracted vendor, the Department shall offer Technical Assistance to the BH I/DD Tailored Plan to remediate quality and/or compliance issues identified through use of the TCM Statewide Monitoring Tool.

(2) The BH I/DD Tailored Plan shall use the TCM Statewide Monitoring Tool to evaluate contracted AMH+ practices and CMAs' compliance with the *Tailored Care Management Provider Manual*; required Tailored Care Management terms in the BH I/DD Tailored Plan's Tailored Care Management provider contracts; and delivery of quality Tailored Care Management.

i. For monitoring and reviews conducted by the BH I/DD Tailored Plan prior to January 31, 2026, the BH I/DD Tailored Plan shall provide technical assistance to its contracted AMH+s and/or CMAs to remediate non-compliance or quality issues identified through the TCM Statewide Monitoring Tool.

ii. For services furnished on or before the end of the first monitoring review and technical assistance period, except as to egregious noncompliance issues as determined by the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall not withhold payments or recoup payments made to an AMH+ practice and/ or CMA based on noncompliance or quality issues identified by the BH I/DD Tailored Plan through use of the TCM Statewide Monitoring Tool.

(t) The BH I/DD Tailored Plan shall document Tailored Care Management services provided to its Members and shall verify that assigned organizations providing Tailored Care Management to the BH I/DD Tailored Plan's Members document Tailored Care Management service delivery in accordance with the *Tailored Care Management Provider Manual*.

(1) The BH I/DD Tailored Plan shall validate that_AMH+ practices and CMAs assigned to deliver Tailored Care Management to the BH I/DD Tailored Plan's Members are complying with *Tailored Care Management Provider Manual* standards for records management and documentation.

(2) The BH I/DD Tailored Plan shall take appropriate remedial action permitted under the terms of its contract with an AMH+ and/or CMA if the AMH+ and/or CMA practice is found by the BH I/DD Tailored Plan to be noncompliant with *Tailored Care Management Provider Manual* documentation requirements.

fff. ***Section V. B. Medicaid, 4. Providers, i. Provider Network, (vii) Assurances of Adequate Capacity Services (42 C.F.R.*** **§ 438.207)*** ***(a), (2), iv.*** **is revised and restated in its entirety as follows:**

iv. Within thirty (30) Calendar Days of a significant change, including merger, opening of Contractor's Network as to one or more services(s) in accordance with *Section V.B.4.ii.(i)* of the Contract, or county disengagement.

ggg. *Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (i)* is revised and restated in its entirety as follows:

(i) The BH I/DD Tailored Plan shall manage its Network to meet availability, accessibility, and quality goals and requirements.

(a) In developing its network for physical health and pharmacy services, the BH I/DD Tailored Plan shall negotiate with any willing provider in good faith regardless of provider or BH I/DD Tailored Plan affiliation.

(b) In developing its network for BH, I/DD, and TBI services, the Department expects the BH I/DD Tailored Plan to ensure network adequacy and the BH I/DD Tailored Plan has the authority to maintain a closed network for services as set forth in NCGS § 108D-23 and this Contract. Pending legislative change, the BH I/DD Tailored Plan shall include all essential providers for BH, I/DD, and TBI services located in the BH I/DD Tailored Plan's Region in its Network regardless of closed network requirements.

(c) The BH I/DD Tailored Plan shall accept all providers of services covered under this Contract who appear on the Provider Enrollment File (PEF) and accept Network rates, except as to services specified by the Department in *Section V.B.4.ii.(i) Table 1: Services Subject to Closed Network Authority under NCGS § 108D-23(c)*. If the BH I/DD Tailored Plan is made aware of a provider on the PEF that is on an Exclusion List, the BH I/DD Tailored Plan shall notify OCPI and may refuse to contract with the provider or terminate the provider in accordance with *Section V.A.3.ii.(iii)(a)* of this Contract.

(1) The Department shall give Contractor Notice of any proposed changes to, and a copy of, intended amendments to the list of services for which the BH I/DD Tailored Plan shall maintain a closed network ("Closed Network List") set forth in *Section V.B.4.ii.(i) Table 1: Services Subject to Closed Network Authority under NCGS § 108D-23(c)* at least sixty (60) Calendar Days before the intended effective date of changes to the Closed Network Services List memorialized in an amendment.

i. Within fourteen (14) Calendar Days of receiving Notice of proposed changes to the Closed Network Services List set forth in *Section V.B.4.ii.(i) Table 1: Services Subject to Closed Network Authority under NCGS § 108D-23(c)*, the BH I/DD Tailored Plan shall submit any feedback regarding changes to the Closed Network Services List to the Department for consideration.

(2) Pursuant to NCGS § 108D-23(c), the BH I/DD Tailored Plan shall maintain a closed network as to the services appearing in *Section V.B.4.ii.(i) Table 1: Services Subject to Closed Network Authority under NCGS § 108D-23(c)*.

Section V.B.4.ii.(i) Table 1: Services Subject to Closed Network Authority under NCGS § 108D-23(c)
• Assertive Community Treatment (ACT); • Multi-Systemic Therapy (MST); • Community Support Team (CST) • Intensive In-Home Services • Child and Adolescent Day Treatment; • SUD Residential Treatment Services (ASAM 3.1, 3.3, 3.5, 3.7) • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD) • All 1915(c) Home and Community Based Innovations Waiver services • All 1915(c) Home and Community Based TBI Waiver services • All 1915(i) Home and Community Based Waiver services • All 1915(b)(3) Waiver Services (Individual Support, Intensive Recovery Support, In-Home Skill Building, One-Time Transitional Costs, Respite, Supported Employment, and Transitional Living Skills).

(d) The Department shall make a determination as to whether each approved in lieu of service (ILOS) offered by the BH I/DD Tailored Plan shall be offered under a closed or open Network.

(1) To facilitate the Department's determination on whether an existing ILOS may be offered via an open or closed provider Network, the BH I/DD Tailored Plan shall submit to the Department by no later than October 1, 2025:

i. The BH I/DD Tailored Plan's parity-compliant recommendation for whether the existing ILOS shall be offered under a closed or open Network; and

ii. Rationale to support the BH I/DD Tailored Plan's parity-compliant recommendation where the BH I/DD Tailored Plan seeks approval to offer an ILOS under a Closed Network.

iii. Within forty-five (45) Calendar Days of receiving the BH I/DD Tailored Plan's parity-compliant recommendation and rationale required under this subsection, the Department shall give the BH I/DD Tailored Plan Notice of whether the existing ILOS shall be offered via a closed or open Network.

(2) To facilitate the Department's determination on whether a new or modified existing ILOS may be offered via an open or closed provider Network, the BH I/DD Tailored Plan shall submit to the Department at the time of requesting approval to offer a new or change an existing ILOS:

i. The BH I/DD Tailored Plan's parity-compliant recommendation for whether the new or changed ILOS shall be offered under a closed or open Network; and

ii. Rationale to support the BH I/DD Tailored Plan's parity-compliant recommendation where the BH I/DD Tailored Plan seeks approval to offer the ILOS under a Closed Network.

iii. The Department shall include as part of the BH I/DD Tailored Plan's ILOS approval notification the Department's determination on whether the approved ILOS shall be offered via a closed or open Network.

(e) Notwithstanding *Section V.B.4.ii.(i)(c)* or any other provision in this Contract, nothing shall preclude the BH I/DD Tailored Plan from taking adverse action, including, but not limited to, termination of a Provider's contract or ability to deliver services under a Provider's contract with the BH I/DD Tailored Plan in accordance with the BH I/DD Tailored Plan's contract with a Provider.

(f) The BH I/DD Tailored Plan shall have a provider monitoring program to ensure Providers are meeting Member needs and program requirements.

hhh. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (f) Tobacco-free Policy, (1)*** **is revised and restated in its entirety as follows:**

(1) Starting January 1, 2027, the BH I/DD Tailored Plan shall contract with Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy shall include a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to Members they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

iii. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (f) Tobacco-free Policy, (2)*** **is revised and restated in its entirety as follows:**

(2) Starting January 1, 2027, the following partial tobacco-free policy shall be required in Intermediate Care Facilities for Individuals with Intellectual Disabilities and adult I/DD residential services subject to the Home and Community Based Final Rule and in Adult Care Homes (ACH), family care homes, residential hospices, Skilled Nursing Facilities (SNFs), long term nursing facilities:

i. Use of tobacco products is prohibited indoors when the building or home in which the provider operates is under the provider's control as owner or lessee.

ii. Outdoor areas of the property under the provider's control as owner or lessee shall:

a) Ensure access to common outdoor space(s) free from exposure to tobacco use; and

b) Prohibit staff/employees from using tobacco products anywhere on the property.

c) Providers subject to the above-referenced partial tobacco-free policy requirement retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.

jjj. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (f) Tobacco-free Policy, (3) Provider Monitoring, i.*** **is revised and restated in its entirety as follows:**

i. Starting January 1, 2027, the BH I/DD Tailored Plan shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The BH I/DD Tailored Plan shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The BH I/DD Tailored Plan shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

kkk. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (v) Critical Incident Reporting*** **is revised and restated in its entirety as follows:**

(v) Critical Incident Reporting

(a) The BH I/DD Tailored Plan shall develop and submit to the Department a written policy or process for timely identification, response, reporting, and follow-up to Member incidents and for reviewing, investigating, and analyzing trends in critical incidents and deaths as defined in 10A NCAC 27G .0602. The policy or process shall be submitted by the BH I/DD Tailored Plan to the Department by September 1, 2025, and annually by June 30th of each calendar year

thereafter. The policy or process shall include preventative action efforts to minimize the occurrence of Member critical incidents and/or death.

(b) The BH I/DD Tailored Plan shall require Category A and B providers, as those terms are defined in 10A NCAC 27G .0602(8), to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602(4) and (5), in the NC Incident Response Improvement System.

(c) The BH I/DD Tailored Plan shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and 10A NCAC 27G .0605 to ensure the health and safety of the BH I/DD Tailored Plan's Members.

(d) BH I/DD Tailored Plan shall report on a quarterly cadence aggregate information on critical incidents and deaths in accordance with Department procedures as defined in 10A NCAC 27G.0609 to the BH I/DD Tailored Plan Board, the Human Rights committee and the CFAC quarterly.

(e) The BH I/DD Tailored Plan shall ensure that Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) ~~to~~ include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Fifth Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*. If a Provider is not complying with applicable critical incident and death reporting obligations, or the BH I/DD Tailored Plan identifies trends in incident reporting, the BH I/DD Tailored Plan shall utilize remedial measures permitted under the BH I/DD Tailored Plan's contract with the Provider, including but not limited to provider monitoring and corrective actions, to minimize occurrence of preventable incidents and to ensure health and safety of Members receiving services.

(f) Reserved.

(g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for Members obtaining services in DSOHF facilities as detailed in *Section VII. Second Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities*.

III. *Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (h) Provider Directory, (6)* is revised and restated in its entirety as follows:

(6) The Member facing Provider directory must comply with 42 C.F.R. § 438.10(h)(1). and shall include the following information, at a minimum:

i. Provider name;
ii. Provider demographics (first, middle, and last name, gender);
iii. Provider DBA Name;
iv. Reserved;
v. Provider type (PCP, etc.);
vi. Reserved;
vii. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
viii. Street address(as) of service location(s);
ix. County(ies) of service location(s);
x. Telephone number(s) at each location;
xi. After hours telephone number(s) at each location;
xii. Provider specialty by location;
xiii. Whether provider is accepting new beneficiaries;
xiv. Whether provider serves Medicaid beneficiaries;
xv. Whether BH provider is serving children and adolescents;

xvi. Provider's cultural and linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
xvii. Whether provider has completed Cultural and Linguistic Competency training,
xviii. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
xix. A telephone number at the BH I/DD Tailored Plan where a member can call to confirm the information in the directory;
xx. Essential provider indicator;
xxi. Whether the Provider offers telehealth services; and
xxii. Website URL as applicable.

mmm. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xvi) Payments to Certified Advance Medical Home Plus (AMH+) Practices and Care management agencies (CMAs) for Tailored Care Management, (a)-(b)*** **is revised and restated in its entirety as follows:**

(a) For Tailored Care Management, the BH I/DD Tailored Plan shall pay AMH+ practices and CMAs:
  (1) A monthly Tailored Care Management payment as defined in *Section III.D.34.d.* of this Contract to the Tailored Care Management entity for each assigned Member to whom the Tailored Care Management entity delivered at least one Tailored Care Management contact as defined in *Section V.B.3.ii(x)(I)* of this Contract during the month. For Medicaid Members, the Tailored Care Management payment shall be a fixed rate prescribed by the Department. This Tailored Care Management payment shall not be placed at risk. 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 to the Member.
  (2) Performance incentive payment, if earned by the AMH+ practice or CMA. The performance incentive payment shall be based on the AMH+ practice or CMA meeting one or more of the TCM measure set metrics included in the Department's Technical Specifications Manual. The BH I/DD Tailored Plan shall have the discretion to decide which TCM measure set metrics must be met, the applicability of this provision to number or percentage of AMHs+/CMAs, and the frequency of payment and reporting for any performance incentive payments issued.
  (3) Prior to the release of the TCM measure set 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+ practices 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 the AMH+ and CMA TCM measure set, the BH I/DD Tailored Plan shall follow the guidance as described in the TCM Provider Manual for a performance incentives program.
(b) Contacts delivered by the assigned care manager or care manager extender shall 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 as a qualifying contact and be eligible for payment.

nnn. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xix) Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services), (d), (1)-(2)*** **is revised and restated in its entirety as follows:**

(1) Physical health and pharmacy services when the BH I/DD Tailored Plan has not made a "good faith" effort as defined in the BH I/DD Tailored Plan's Good Faith Provider Contracting Policy; and
(2) BH, I/DD, and TBI services when the BH I/DD Tailored Plan has not made a "good faith" effort to contract with the provider in accordance with the BH I/DD Tailored Plan's Good Faith Provider

Contracting Policy or the BH I/DD Tailored Plan has exercised its authority to maintain a closed network for services as set forth in NCGS § 108D-23.

ooo. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xxxiii) Electronic Visit Verification System (EVV), (b)*** **is revised and restated in its entirety as follows:**

(b) This reimbursement rate increase applies to the following services:
(1) TBI Personal Care;
(2) Reserved;
(3) TBI In-home Intensive;
(4) TBI Community Living and Support Group (In - Home Services Only);
(5) TBI Community Living and Supports Individual (In - Home Services Only);
(6) TBI Community Living – Periodic (In-Home Services Only);
(7) Innovations Community Living & Supports;
(8) Innovations Supported Living Periodic;
(9) Innovations – Community Living and Supports Individual (In-Home Services Only);
(10) Reserved;
(11) Reserved;
(12) Reserved;
(13) 1915(i) Services - Individual and Transitional Support;
(14) 1915(i) Services - Community Living and Supports;
(15) 1915(i) Services - Community Living and Supports- Group;
(16) State Plan PCS - Any Member under 21 years of age regardless of setting, In-home care agencies serving a Member 21 years of age or older;
(17) Home Health - Physical Therapy;
(18) Home Health - Physical Therapy evaluation;
(19) Home Health - Occupational Therapy;
(20) Home Health - Occupational Therapy evaluation;
(21) Home Health - Speech-language Pathology services;
(22) Home Health - Speech-language Pathology services evaluation;
(23) Home Health - Skilled nursing: Initial assessment/re-assessment (Initial assessment of a new patient or sixty (60) Calendar Day re-assessment);
(24) Home Health - Skilled nursing: Treatment, teaching/training, observation/evaluation;
(25) Home Health - Skilled nursing: venipuncture;
(26) Home Health - Skilled nursing: Pre-filling insulin syringes/Medi-Planners; and
(27) Home Health - Home Health Aide.

ppp. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xlv) Payments to Innovation Waiver Vendors, (a)*** **is revised and restated as follows with no revisions to subsections (1)-(6):**

(a) Consistent with clinical coverage policy 8P, BH I/DD Tailored Plans shall make direct payments to a vendor for the following Innovations Waiver services after UM approval of the service is received regardless of whether the Member receives TCM from the Plan, AMH+, CMA: Assistive Technology Equipment and Supplies;

qqq. ***Section V. B. Medicaid, 5. Quality and Value, i. Care Management and Quality Improvement, (xiii) Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330), (e)*** **is revised and restated in its entirety as follows:**

(e) The BH I/DD Tailored Plan shall conduct at least one (1) non-clinical performance improvement project on an annual basis that is related the Department's Quality Strategy.

(1) No less than thirty (30) Calendar Days before amending a non-clinical performance measure, the Department shall propose a non-clinical measure and provide the BH I/DD Tailored Plan no less than thirty (30) Calendar Days to submit feedback on the measure proposed.

rrr. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards, (a)*** **is revised and restated in its entirety as follows:**

(a) The BH I/DD Tailored Plan shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when Department decisions warrant reprocessing (i.e., Member retrospective eligibility determinations or plan enrollment changes). The BH I/DD Tailored Plan, and any Subcontractors who process claims on behalf of the BH I/DD Tailored Plan, shall have the capability to accept and process claims through an industry-standard Health care Clearinghouse in standard HIPAA transaction formats (ASC X12, 837P and 837I).

sss. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards, (d), (2)*** **is revised and restated in its entirety as follows:**

(2) The BH I/DD Tailored Plan shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate member enrollment or program changes. The BH I/DD Tailored Plan, and any Subcontractors who process claims on behalf of the BH I/DD Tailored Plan, shall implement Health Care Clearinghouse integration.

ttt. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (a), (1) Medical Claims, ii.*** **is revised and restated in its entirety as follows:**

ii. The BH I/DD Tailored Plan shall pay or deny a medical Clean Claim within thirty (30) Calendar Days of receipt of the Clean Claim.

uuu. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (vi) System Standards*** **is revised to add the following:**

(d) The solution for electronic claim submission shall, at a minimum, allow providers to submit claim transactions electronically through an industry standard Health care Clearinghouse, in standard HIPAA transaction formats (ASC X12, 837P and 837I). The BH I/DD Tailored Plan and Subcontractor(s) that process claims on behalf of the BH I/DD Tailored Plan, shall implement, if not already implemented, the capability to accept and process claims through an industry-standard Health care Clearinghouse in standard HIPAA transaction formats (ASC X12, 837P and 837I) by no later than October 1, 2025.

vvv. ***Section V. B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Standards and Frequency, (a), (1) Timeliness, i.*** **is revised and restated in its entirety as follows:**

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 payments, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.

www. ***Section V. B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Standards and Frequency, (a), (1) Timeliness, iii. a)*** **is revised and restated in its entirety as follows:**

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. This includes encounter data for monthly medical home payments and value-based payments to Providers. A complete list of value-based payment types can be referenced in the *Encounter Data Submission Guide*.

xxx. ***Section V. B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Standards and Frequency, (a), (2) Accuracy, i. a)*** **is revised and restated in its entirety as follows:**

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. This includes encounter data for monthly medical home payments and value-based payments to providers. A complete list of value-based payment types can be referenced in the *Encounter Data Submission Guide*.

yyy. ***Section V. B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Standards and Frequency, (a)*** **is revised to add the following:**

(4) Historical Value-based Payment Encounters

i. The BH I/DD Tailored Plan shall submit no later than one hundred eighty (180) Calendar Days from the availability of additional value-based payment (VBP) encounter types within the EPS, all encounters for those VBP payment types made prior to the implementation of the new VBP encounter type. A complete list of value-based payment types can be referenced in the *Encounter Data Submission Guide*.

zzz. ***Section V. B. Medicaid, 8. Technical Specifications, i. Data Exchange Model, (i)*** **is revised and restated in its entirety as follows:**

(i) The following table provides a point in time, high-level view of the primary data exchanges associated with the BH I/DD Tailored Plan, the Department, AMH+s/CMAs, and Department Vendors. As the program evolves and technical designs are finalized the data exchanges depicted below will change. The BH I/DD Tailored Plan will be responsible for implementing the data exchanges as defined by the Department.

aaaa. ***Section V. B. Medicaid, 8. Technical Specifications, vii. BH I/DD Tailored Plan Data Management and Health Information Systems, (i)*** **is revised to add the following:**

(g) The BH I/DD Tailored Plan shall utilize the 834 file, NC Tracks, HIE, and the BH I/DD Tailored Plan's Network data to maintain Member contact information provided to AMH+ practices and CMAs in accordance with *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification* of this Contract.

bbbb. ***Section V. C. State-funded Services, 1. Recipients, b. Recipient Engagement, viii. Written and Verbal Recipient Materials, a), 4, i.*** **is revised and restated as follows:**

i. Taglines are required on materials that are critical for potential recipients and recipients to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, recipient handbooks, appeal and grievance notices, and denial and termination notices. For all materials requiring a

tagline, the BH I/DD Tailored Plan shall use the Department-developed Auxiliary Aids and Interpreter Services Tagline Template.

cccc. *Section V. C. State-funded Services, 2. Services, a. State-funded BH, I/DD, and TBI Services, ii.* is revised and restated as follows:

ii. The BH I/DD Tailored Plan shall provide all State-funded BH, I/DD and TBI services, and employee-related positions, listed in this Contract subject to available resources.

dddd. *Section V. C. State-funded Services, 3. Care Management and Prevention* is revised to add the following:

i. Justice Involved Programs
  i. Department of Adult Corrections (DAC) Priority Re-entry
    a) To support individuals with SMI the BH I/DD Tailored Plans shall support the DAC Priority Re-entry program. The BH I/DD Tailored Plan shall employ care coordinators and peer support specialists to be responsible for the care coordination of the individuals on the High Priority Re-entry List provided monthly by the DAC. The BH I/DD Tailored Plan shall link individuals on the High Priority Re-entry List to community behavioral providers, physical health providers, and other prison transition supports.
    b) BH I/DD Tailored Plan shall assign at least three full-time equivalent care coordinators to provide DAC Priority Re-entry program services to individuals identified on the High Priority Re-entry List.
    c) BH I/DD Tailored Plan shall assign at least two full-time equivalent peer support specialists to provide DAC Priority Re-entry program services to individuals identified on the High Priority Re-entry List. Peer support specialists shall be certified and have at least one (1) year of experience, preferably with lived experience with justice involvement.
    d) The BH I/DD Tailored Plan shall report DAC Priority Re-Entry Outcomes, as described in *Section VII. Fourth Revised and Restated Attachment J. Reporting Requirements*.
  ii. Juvenile Justice Behavioral Health (JJBH)
    a) The BH I/DD Tailored Plan shall support and fund JJBH local teams to enable justice involved youth and their families access to treatment and natural and community supports to address their behavioral health needs and prevent further involvement in the justice system.
    b) The BH I/DD Tailored Plan shall assign JJBH Liaisons to coordinate JJBH team services for youth at risk of or with juvenile justice involvement. JJBH teams should be structured as follows:
      1. BH I/DD Tailored Plan - JJBH Liaisons;
      2. Local juvenile justice leadership/staff (e.g., chief court judge/court counselors, court liaisons, etc.);
      3. DSS representatives;
      4. Treatment and service providers (including nonprofits);
      5. School behavioral health support staff (e.g., social workers, clinicians, behavior support staff, etc.),
      6. Representation of youth voice;
      7. Representation of family voice (e.g., Family Partners); and
      8. Community programs/partners.
    c) The BH I/DD Tailored Plan shall submit to the Department a JJBH equitable funding plan by September 1, 2025 or no later than sixty (60) Calendar Days after the Department issues the BH I/DD Tailored Plan allocation letter, describing how the BH I/DD Tailored Plan will use funding to improve access to JJBH services in all counties within their catchment area and address JJBH service access for specific populations/subpopulations (i.e., historically

marginalized groups). The BH I/DD Tailored Plan JJBH equitable funding plan will be subject to Department review and approval.

iii. Treatment Accountability for Safer Communities (TASC)

a) Recipients may be served by TASC providers to maintain compliance with probationary or other judicial orders. The BH I/DD Tailored Plans shall coordinate with TASC providers to facilitate connecting State-funded Service Recipients to State-funded services.

b) The BH I/DD Tailored Plans shall participate in quarterly performance monitoring meetings with TASC Directors and the Department.

eeee. ***Section V. C. State-funded Services, 4. Providers, b. Provider Network Management, iii. Provider Contracting, v) DSOHF Facilities, 1., ii.*** **is revised in its entirety as follows:**

ii. Reserved;

ffff. ***Section V. C. State-funded Services, 4. Providers, b. Provider Network Management, iv. Critical Incident Reporting, g)*** **is revised in its entirety as follows:**

g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for Members and Recipients obtaining services in a DSOHF facilities as detailed in *Section VII. Attachment N. Addendum for Division of State Operated Health Care Facilities.*

gggg. ***Section V. C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, xi. Performance Improvement Projects (PIPs), e)*** **is revised in its entirety as follows:**

e) Reserved.

III. <u>Modifications to Section VII. Attachments</u>

Specific Attachments are modified as stated herein.

a. ***Section VII. Fourth Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*** **is revised and restated in its entirety as** ***Section VII. Fifth Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*** **and attached to this Amendment.**

b. ***Section VII. Third Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies*** **and attached to this Amendment.**

c. ***Section VII. Third Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics*** **is revised and restated in its entirety as** ***Section VII. Fourth*** **Revised and Restated** ***Attachment E*****. BH I/DD Tailored Plan Quality Metrics and attached to this Amendment.**

d. ***Section VII. Third Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards*** **and attached to this Amendment.**

e. ***Section VII. Fourth 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. Fifth Revised***

and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts **and attached to this Amendment.**

f. ***Section VII. Third Revised and Restated Attachment J. Reporting Requirements*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment J. Reporting Requirements*** **and attached to this Amendment.**

g. ***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*** **is revised and restated in its entirety as** ***Section VII. Third 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.**

h. ***Section VII. Second Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy*** **and attached to this Amendment.**

i. ***Section VII. Third Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers*** **and attached to this Amendment.**

j. ***Section VII. Second Revised and Restated Attachment M. 11. Tribal Payment Policy*** **is revised and restated in its entirety as** ***Section VII. Third M. 11. Tribal Payment Policy*** **and attached to this Amendment.**

k. ***Section VII. Second/Third Revised and Restated Attachment M. 13. Approved <TP NAME> In Lieu of Services*** **is revised and restated in its entirety as** ***Section VII. Third/Fourth Revised and Restated Attachment M. 13. Approved <TP NAME> In Lieu of Services.***

l. ***Section VII. Third Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages*** **and attached to this Amendment.**

IV. Effective Date

This Amendment is effective July 1, 2025, unless otherwise explicitly stated herein, upon the later of the execution dates by the Parties, subject to approval by CMS.

V. Other Requirements

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

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

Department of Health and Human Services, Division of Health Benefits

_____ Date: _____
Jay Ludlam, Deputy Secretary
NC Medicaid

BH I/DD Tailored Plan Name

_____ Date: _____
BH I/DD Tailored Plan Authorized Signature

Fifth 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. Fifth 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 Individual Support Plans 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: o 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 o A master's degree in a human service field

Section VII. Fifth 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, but not the required

Section VII. Fifth 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**
		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: o Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. o 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.

Section VII. Fifth 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**
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 at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
7. Reserved.		
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. • 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.

Section VII. Fifth 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**
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.
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.
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 Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; **or** ○ 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	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

Section VII. Fifth 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**
	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.	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 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.

Section VII. Fifth 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**
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 Managed Care Program and State-funded Services	These individuals coordinate communication with members and recipients.	• Must meet North Carolina Residency requirements.
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	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must meet North Carolina Residency requirements.

Section VII. Fifth 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**
Program and State-funded Services		
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.
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.

Section VII. Fifth 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**
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.
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

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		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.
34. Housing Development Coordinator	The Housing Development Coordinator's job responsibilities shall include but not be limited to the following: 1. Map existing permanent supportive housing (PSH), PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process. Utilize the map and other information sources to develop plans to target new stock development or access to untapped existing stock within the BH I/DD Tailored Plan Region. 2. Engage public housing authorities (PHAs), Continuums of Care (COCs), and Balance of State (BoS) with the BH I/DD Tailored Plan, NCHFA, grant, and other housing resources to develop housing stock and access throughout the BH I/DD Tailored Plan Region. 3. Develop regional housing databases for the BH I/DD Tailored Plan's Region connecting public stock with private housing options for TCL staff. 4. Utilize public notices of newly initiated housing developments, assertively engage private developers linking them with BH I/DD Tailored Plan, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and rehabilitation in exchange for access agreements for individuals with disabilities. 5. Technically assist existing TCL staff and TCL provider engagement with their improved access of computerized housing availability systems, giving priority to, and more effectively offering and getting access for, TCL individuals to Targeted Key Housing. 6. Specify the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams. 7. Ad hoc participation in Local Barriers Committee to address housing barriers and participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations. 8. In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and	• Must hold a Bachelor's degree with at least two (2) years of experience working with individuals and the housing systems serving people with SMI/SPMI obtaining and maintaining PSH. This position shall apply these skills to the development of permanent supportive housing within the BH I/DD Tailored Plan Region aligned with TCL.

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices. In collaboration with DAAS, improve timely communication between DHHS Regional Housing Coordinators, landlords and TCL service providers. 9. Work within the BH I/DD Tailored Plan and with external housing providers to develop Enhanced Bridge Housing, TCL priority to BH I/DD Tailored Plan or Public Housing Authority-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches.	
35. TCL Quality Assurance (QA) Specialist	This position manages TCL Quality Assurance Performance Improvement (QAPI) activities. The TCL Quality Assurance Specialist job responsibilities shall include but not limited to the following: 1. Serve as the organization's TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives. 2. Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of life survey administration, and Root Cause Analyses (RCAs). 3. Develop and implement procedures including member outcomes monitoring to ensure the quality of mental health and employment services and that the frequency and intensity of services are sufficient to help individuals achieve increased independence and community integration, housing stability, and reduced institutional contacts and incidents of harm. Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits. 4. Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues. 5. Provide support for Local Barriers Committee to identify, aggregate, and report barriers to member community integration and transitions to and maintenance of supportive community housing. 6. Develop and strengthen processes as needed to ensure compliance with and timeliness of required provider reporting, member assessments and surveys, and other data submissions, including incidents of harm reporting via the DHHS IRIS system or its replacement, service outcomes assessments via NC-TOPPS, TCL Quality of Life surveys, and other required data submissions and reporting tools Provide support as needed for TCL team members to develop and implement data	• Must hold a Bachelor's degree with a least two (2) years of experience in QA, preferably in a behavioral or medical managed care environment.

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	collection tools and procedures to ensure all program requirements are met; to support tracking, monitoring, and reporting; and to evaluate and ensure the quality of TCL services and functions.	
36. TCL Data Analyst	This position provides data support for TCL Quality Assurance Performance Improvement (QAPI) activities and required reporting and manages and carries out procedures to ensure TCL data accuracy. The TCL Data Analyst's responsibilities shall include but are not limited to the following: 1. Serve as the organization's TCL data quality point of contact for DHHS;. 2. Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; 3. Regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVe, internal client data management systems, NCTracks extracts provided by the Department); 4. Identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy; 5. Collect and aggregate data for required TCL reporting; 6. Conduct ongoing monitoring to ensure timely Quality of Life survey administration; and 7. Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and evaluation of the effectiveness of QAPI activities and initiatives.	• Must hold a Bachelor's degree with a least two (2) years of experience in data management and analysis, preferably in a behavioral or medical managed care environment.
37. Supported Employment Specialist	This individual's job responsibilities shall include but not be limited to the following: 1. As the BH I/DD Tailored Plan's point of contact, engage in statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE; 2. Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE;	• Must hold a Bachelor's degree and have at least two (2) years of experience working with adults with SMI/SPMI. Preference for experience obtaining competitive employment for adults with SMI/SPMI (preferably utilizing Individual Placement and Supports

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	3. Provide direct technical assistance to sustain existing IPS providers by working within the BH I/DD Tailored Plan to implement a stable NC CORE payment model standardized by the Department; 4. Review all provider's current IPS Fidelity Reviews, technically assist with recommended improvements, develop plans of correction for long-standing provider fidelity issues, and when required by reviewers assist during IPS Fidelity Reviews; 5. Facilitate, technically support, record provider feedback, and invite trainers to in-network IPS Collaboratives that include ACT Employment Specialists, and Peer-run Entities involved in IPS support; 6. Ensure and improve providers' NC CORE linkage to Vocational Rehabilitation (VR) offices throughout the BH I/DD Tailored Plan's Region, attend key statewide VR meetings, invite VR offices into IPS collaboratives, and assertively engage VR regional leadership to problem-solve and improve NC CORE service to TCL members; 7. Facilitate the expansion of benefits counseling within network providers, improve VR benefits counseling linkage, and when possible, improve relationships with Social Security Administration offices and IPS providers. Furthermore, serve as the point of contact with the Department for meetings involving the statewide benefits counseling electronic system; 8. Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional BH I/DD Tailored Plan departments; 9. Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve; 10. Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships; and 11. As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models.	(IPS), Vocational Rehabilitation, or other research-based employment model).
38. Outreach Diversion Specialist	North Carolina Certified Peer Support Specialist with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships. This position applies these skills to Transitions to Community Living for individuals being	• Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS)

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP). The Outreach Diversion Specialist's job responsibilities shall include but not be limited to the following: • Educating the member (and their family, as appropriate) on the choice to the remain in the community); • Providing referrals and linkages to available individualized community-based supports and services; • Developing a Community Integration Plan for those who choose to remain in the community; and • Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps taken to address concerns and objections to the admission.	
39. BH I/DD Tailored Plan Transition Coordinator	This individual shall be solely responsible for performing the following tasks for TCL members, which cannot be delegated to the Tailored Care Manager: (a) Convene a transition team; (b) Schedule and convene transition planning / personal care plan meetings; (c) Facilitate discussion of a crisis plan, disaster plan, and emergency plan; (d) Ensure housing and financial support needs of the TCL member are addressed; (e) Ensure health and safety monitoring needs of the TCL member are addressed; and (f) Plan for and facilitate check-ins between the final transition planning meeting and move-in of the TCL member at the community-based supportive housing.	• 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 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

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		individuals with I/DD; 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. • Must meet North Carolina Residency requirements.
40. Housing Supervisor	Role involves but is not limited to the following: • Creating, editing, and implementing existing or new housing policy; • Integrating the housing team into the Plan's TCL efforts and process to develop, fund, and maintain access to supportive housing for TCL members; and • Closely work with the TCL quality assurance staff to provide data reported internally and externally on the Plan's catchment-wide housing strategy, development, access, TCL member tenure, and other housing related issues.	Five or more years of full time experience working in the field of developing, managing, and/or coordinating access to affordable housing, including without limitation: (1) professional experience in successfully operating a Housing First Model as it applies to people with disabilities transitioning into their chosen community; (2) at least one year as a lead or supervisor of employees in an affordable housing program. *Any existing staff employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a housing supervisor position shall be grandfathered and shall not be required to meet the qualifications set forth above.
41. TCL Program Manager	Role involves but is not limited to the following: • Facilitate cross-functional teams that create and implement recovery oriented, person-centered care plans; • Create and implement Housing First, Employment First, Integrated Care, Recovery-Oriented Care, and Social Drivers of Health policies and procedures;	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	• Cross-functionally integrate TCL transition efforts across all BH I/DD Tailored Plan departments, and supervise the elevation of transition barriers to the Plan's Local Barriers Committee; and • Closely work with the TCL quality assurance staff to provide TCL data reported internally and externally.	disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management *Any existing staff currently employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above
42. Barriers and Training Coordinator	Role involves but is not limited to the following: • Coordinate and help ensure staff completion of all trainings required by the Department pursuant to the Contract for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members; • Develop, coordinate and help ensure staff completion of any additional TCL in-person and virtual trainings which may be required or requested by the Department for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members or the PIHP's TCL efforts; • Coordinate and facilitate BH I/DD Tailored Plan / PIHP's monthly Local Barriers Committee meetings, and track and facilitate any potential barrier issues and questions to be addressed by the BH I/DD Tailored Plan / PIHP and its Local Barriers Committee; • Develop the agenda for Local Barriers Committee meetings, and be responsible for maintaining and forwarding to the Department the minutes of each Local Barriers Committee meeting and the Local Barriers Committee tracker within 14 calendar days after each meeting; • Work collaboratively with Local Barriers Committee members, BH I/DD Tailored Plan / PIHP staff, and network providers to help ensure timely identification and reporting of local barriers; exploration of potential resolutions and mitigation steps for local barriers; and identification of potential barrier patterns,	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management *Any existing staff currently employed by the BH I/DD

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	root causes, and any quality improvements needed to mitigate risk and help improve TCL outcomes; • Ensure the Department is notified of any urgent barriers and work collaboratively with the Department to address all unresolved local barriers; • Participate in ad hoc barriers intervention meetings scheduled by the Department; and • Facilitate the identification and tracking of barriers leading to housing separations for TCL members and where applicable, participate in the BH I/TT Tailored Plan / PIHP's root cause analysis process for deaths or level 3 incidents involving TCL members.	Tailored Plan prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above
43. Department of Adult Corrections (DAC) Priority Re-Entry Care Coordinator	• This individual is responsible for the care coordination for Recipients on the High Priority Re-entry list.	• Qualified Professional with at least one year experience with the forensic population. • Must meet North Carolina Residency requirements
44. Department of Adult Corrections (DAC) Priority Re-Entry Peer Support Specialist	• This individual is responsible for collaborating with BH I/DD Tailored Plan staff and physical and behavioral health providers to identify complex care needs and clinical service linkage needs. • Facilitate and accompany Member/Recipient on visits to health services, wraparound services (e.g., housing, transportation, employment, food assistance), and probation/parole. • Educate Member/Recipient about services covered under the North Carolina State Plan for Medical Assistance, Medicaid 1915(b)(c) waiver, or the State-funded Service array.	• Peer certified with at least one year forensic experience or lived experience with justice involvement. • Must meet North Carolina Residency requirements
45. Juvenile Justice Behavioral Health (JJBH) Liaison	• This individual is responsible for serving as the care coordinator for justice involved youth and families as well as coordinating with JJBH partnerships. • Work with JJBH local teams to develop processes and an annual Plan of Work that will address needs, challenges and goals. Consult with Department Juvenile Justice • Lead and external technical assistance support as needed. • Establish partnerships and build relationships with DJJ staff, court officials, local treatment providers, community organizations, juvenile detention centers, etc. to enhance youth access to and utilization of behavioral health services. • Work with internal and external stakeholders to ensure JJBH domains and System of Care are integrated into all JJBH processes. • Host/facilitate regular JJBH local team meetings. • Meet regularly with Department Juvenile Justice Lead. Prepare updates on local team status.	• Bachelor's degree required; master's degree preferred. • Minimum of 5 years of experience working with youth with juvenile justice involvement, mental health, substance use, and/or intellectual/develop mental disability population. • Must have working knowledge of the juvenile justice system and System of Care

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Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
	• Monitor local team and juvenile detention center funding allocation and utilization.	• Must meet North Carolina Residency requirements
46. Treatment Accountability for Safer Communities (TASC) Manager	• This individual is responsible for overseeing TASC contracts to monitor performance of the programs and coordinate with TASC Directors and Department leads.	• Qualified Professional with experience with the forensic population. • Must meet North Carolina Residency requirements

Fourth Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies

Fourth 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.

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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 1L-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

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SERVICE	**KEY REFERENCES**
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

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SERVICE	**KEY REFERENCES**
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

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SERVICE	**KEY REFERENCES**
	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 Facility Based Crisis System 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-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-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 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) [£] NC Clinical Coverage Policy 8D-6: Medically Monitored Intensive Inpatient Services [£] 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

[£] Clinical coverage policy is being promulgated with effective date July 1, 2024.
[£] Clinical coverage policy is being promulgated with effective date July 1, 2024.

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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) NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-9: Opioid Treatment Program (OTP) NC Clinical Coverage Policy 8A-12: Substance Abuse Intensive Outpatient Program (SAIOP) NC Clinical Coverage Policy 8A-13: Substance Use Comprehensive Outpatient Treatment Program (SACOT)
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

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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, 13e 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) in In-Home Settings NC Clinical Coverage Policy 3L-1, State Plan Personal Care Services (PCS) in Congregate Settings
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

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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, 13e ID775 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.l, 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

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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, 13e NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	42 C.F.R. § 410.78 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

Section VII. Fourth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	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
1915(i) Option Services	NC Clinical Coverage Policy 8H-1: Supported Employment for IDD and TBI NC Clinical Coverage Policy 8H-2: Individual Placement and Support (IPS) NC Clinical Coverage Policy 8H-3: Individual and Transitional Support (ITS) NC Clinical Coverage Policy 8H-4: Respite NC Clinical Coverage Policy 8H-5: Community Living and Supports (CLS) NC Clinical Coverage Policy 8H-6: Community Transition

Fourth 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 *Section VII. Fourth 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. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measurers* and *Section VII. Fourth 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. Fourth 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. Fourth Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric			
Ref #	**CBE #**	**Measure Name**	**Steward**
This entire table is reserved.			

Section VII. Fourth and Restated Attachment E.1. Table 2: Survey Measures and General Measures			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0105	Antidepressant Medication Management (AMM)	NCQA
2.	0032	Cervical Cancer Screening (CCS/CCS-E)	NCQA
3.	0033	Chlamydia Screening in Women (CHL)	NCQA
4.	0059/ 0575	Glycemic Status Assessment for Patients with Diabetes (GSD) Ù	NCQA

^ The Department requires both administrative and hybrid reporting for this measure.

Section VII. Fourth and Restated Attachment E.1. Table 2: Survey Measures and General Measures			
Ref #	**NQF #**	**Measure Name**	**Steward**
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)[Ù]	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
9.	Reserved.		
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	Screening for Depression and Follow-Up Plan (CDF)	CMS
14.	Reserved		
15.	Reserved		
16.	NA	Rate of Screening for Health-Related Resource Needs (HRRN)*	NC DHHS
17.	NA	Total Cost of Care (TCOC)	Health Partners
18.	NA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
19.	1800	Asthma Medication Ratio (AMR)	NCQA
20.	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA
21.	0034	Colorectal Cancer Screening (COL-E)	NCQA
22.	Reserved.		
23.	1516	Child and Adolescent Well-Care Visits (WCV)	NCQA
24.	0038	Childhood Immunization Status (Combination 10) (CIS/CIS-E)	NCQA
25.	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA
26.	1407	Immunizations for Adolescents (Combination 2) (IMA/IMA-E)	NCQA
27.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA
28.	1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
29.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
30.	NA	Low Birth Weight*[64]	NC DHHS

Section VII. Fourth and Restated Attachment E.1. Table 2: Survey Measures and General Measures			
Ref #	**NQF #**	**Measure Name**	**Steward**
31.	NA 1517	Prenatal and Postpartum Care (PPC)66	NCQA
32.	NA	Rate of Screening for Pregnancy Risk*Ù^	NC DHHS
33.	3620	Adult Immunization Status (AIS-E)	NCQA
34.	NA	Antibiotic Utilization for Respiratory Conditions (AXR)	NCQA
35.	2372	Breast Cancer Screening (BCS-E)	NCQA
36.	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA

Section VII. Fourth Revised and Restated Attachment E.1. Table 3: Survey Measures and General Measures: Maternal					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
This entire table is reserved.					

Section VII. Fourth 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. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number and percent of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1

^^ The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

Section VII. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
3.	Per Waiver Performance measure number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services. Numerator: Number of new C waiver participants who received an initial LOC evaluation.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Number and percent of annual Level of Care evaluations for Innovations Waiver enrollees which were appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
5.	Number and percent of New Level of Care evaluations appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
6.	Reserved.			
7.	Number and percent of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to BH I/DD Tailored Plan monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Number and percent 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.	Number and percent of 1915 (c) waiver providers with a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Number and percent of monitored non-licensed and non-certified providers, who have been found to be out of compliance and have plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Number and percent of monitored non-licensed and non-certified providers that are compliant with Innovations Waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Number and percent of monitored provider agencies wherein all staff completed all mandated training for 1915 (c) Waiver.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			

Section VII. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
14.	Number and percent of beneficiaries reporting that their Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Number and percent of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
16.	Number and percent of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
17.	Number and percent of individuals whose annual Individual Support Plan was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November ~~1~~1
18.	Number and percent of Innovations Waiver beneficiaries for whom an annual Individual Support Plan took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November ~~1~~1
19.	Number and percent of Innovations waiver participants whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Reserved.			
21.	Number and percent of new 1915(c) waiver beneficiaries receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Number and percent of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Number and percent of Innovations waiver beneficiaries reporting their Tailored Care Manager helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Number and percent of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
25.	Number and percent of deaths where required BH I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November
26.	Number and percent of actions taken to protect the beneficiary from additional harm, where indicated as a percent of all actions where protective actions were indicated.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
27.	Number and percent of beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
28.	Number and percent of Innovations waiver beneficiaries not requiring medical treatment or hospitalization due to medication errors.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
29.	Number and percent of incidents that were not critical involving Innovations Waiver enrollees referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Annually Fiscal Year	 November 1
30.	Reserved.			
31.	Number and percent of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Annually Fiscal Year	 November 1

Section VII. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
32.	Number and percent of level 2 or 3 incidents where BH I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
33.	Number and Percent of level 2 and 3 incidents reported within required state policy timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
34.	Reserved.			
35.	Number and Percent of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
36.	Number and Percent of restrictive interventions (both restraint and seclusion) that did not result in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	 a. February 1 b. May 1 c. August 1 d. November 1
37.	The number and percent of claims that are coded and paid in accordance with the reimbursement methodology specified in the approved waiver for services rendered.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
38.	Reserved.			
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			

Section VII. Fourth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
43.	Number and percent of Innovations Waiver enrollees who are receiving services as specified in the Individual Support Plan.	NCDHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
44.	Number and percent of Innovations Waiver Members ages 21 and older who had a primary care or preventative care visit during the Innovations Waiver year.	NCDHHS	Annually Fiscal Year	November 1
45.	Number and percent of Innovations Waiver Members under the age of 21 who had a primary care or preventative care visit during the Innovations waiver year.	NC DHHS	Annually Fiscal Year	November 1
46.	Number and percent of Innovations waiver applicants for whom a Level of Care evaluation is completed at the time services previously identified as being needed at a future time become necessary.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
47.	Number and percent of capitation payments to the BH I/DD Tailored Plans that are made in accordance with the CMS approved actuarially sound rate methodology.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
48.	Number and percent of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
1.	Number and percent of new TBI Waiver enrollees who have a Level of Care 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 1
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 1
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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 1
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 1
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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 1
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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 1
17.	Proportion of new waiver beneficiaries receiving services according to their Individual Support Plan within 45 days of Individual Support Plan 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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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. Fourth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of 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
4.	Reserved.			
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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
18.	Reserved.			
19.	Percentage of beneficiaries reporting that their Care Plan/ISP Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
20.	Reserved.			

Section VII. Fourth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
21.	Proportion of Care Plans/ISPs Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
22.	Reserved.			
23.	Reserved.			
24.	Reserved.			
25.	Reserved.			
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP Individual Support Plan within 45 days of ISP Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
27.	Reserved.			
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.	Reserved.			
31.	Reserved.			
32.	Reserved.			
33.	Reserved.			
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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.	Reserved.			
38.	Reserved.			
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
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

Section VII. Fourth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
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
46.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services who are age twenty (20) or 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. 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. Third Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*.

Section VII. Fourth 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**	**Measure**
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

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. Fourth 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

Section VII. Fourth Attachment E.2. Table 4: BH I/DD Tailored Plan Combined Quality Metrics for Medicaid and State-funded Services				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Department Provided**
1.	Ready for Discharge: Number of Members and Recipients who are clinically stabilized and no longer need the level of care provided by the State Psychiatric Hospital.	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month
2.	Children in PRTFs: Number of Members and Recipients eighteen years of age or younger in PRTF, including admissions (in state, out of state within 40 miles, out of state & DSS involved/not DSS involved) and re-admissions.	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month
3.	Members and Recipients on the Innovations Waiver waitlist who are receiving any Medicaid or State-funded BH I/DD Tailored Plan service	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month

Fourth 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, the BH I/DD Tailored Plan'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.

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 conducted at least annually. Certain service types are 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. Fourth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid and Section VII. Fourth Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid.

Section VII. Fourth 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 Behavioral Health service within 30 minutes or 30 miles of residence for at least 95% of Members • *Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard	≥ 2 Providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of Members • *Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8.	Location-Based Services	• P*sychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program Services:* ≥ 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	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program Services:* ≥ 2 Providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members. • *Child and Adolescent Day Treatment Services:* Not subject to standard

[1] Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.
[2] Measured for members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Fourth 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**
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 Providers within each BH I/DD Tailored Plan Region • *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), Mobile Crisis Management:* ≥ 2 Providers of each crisis service within each BH I/DD Tailored Plan Region	
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 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 ninety (90) Calendar Days after licensure requirements are established ○ *Adolescent: Contract with all designated CASPs statewide* ○ *Women & Children:* Contract with all designated CASPs statewide	

Section VII. Fourth 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**

		• *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.5600)
		• *Psychiatric Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard
		• *Medically monitored intensive inpatient services (once policy is added)*	

16.	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, 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 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.	

[3] BH I/DD Tailored Plans must also ensure that gender non-conforming Members have access to *Clinically Managed Low-Intensity Residential Treatment Services*.

Section VII. Fourth 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**
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.	

Section VII. Fourth 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 • 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 • Opioid Treatment Program Service (adult) • Child and Adolescent Day Treatment Services
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 Withdrawal services (social setting detoxification)* • *Medically Monitored Withdrawal Management services (Non-hospital medical detoxification)* (adult) • Mobile Crisis Management
4.	Inpatient BH Services	• Inpatient Hospital – Adult • Acute care hospitals with adult inpatient psychiatric beds • Medically Managed Intensive Inpatient Withdrawal Management (Acute care hospitals with adult inpatient substance use beds) • Medically Managed Intensive Inpatient services (Acute care hospitals with adult inpatient substance use beds) Inpatient Hospital – Adolescent/Children

Section VII. Fourth 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**
		• 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 • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): • Psychiatric Residential Treatment Facilities (PRTFs) • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)
7.	Community/Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports Services • 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

Section VII. Fourth 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**
		• 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 • 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)

BH I/DD Tailored Plan 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. Fourth 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 Members less than six (6) months of age Within thirty (30) Calendar Days for members six (6) months of 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}

Section VII. Fourth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
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
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.

Section VII. Fourth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
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 for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
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. Fourth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time or Distance Standards for Medicaid* and *Section VII. Fourth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid* as found in this attachment.

Section VII. Fourth 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
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, the BH I/DD Tailored Plan'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.

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 Plan~~s~~ 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. Fourth 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. Fourth 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. Fourth 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 Behavioral Health service within 30 minutes or 30 miles of residence for at least 95% of recipients[4] *Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard	≥ 2 providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of recipients Research-*Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
2.	Location-Based Services^	*Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Opioid Treatment Program Services*: ≥ 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, Opioid Treatment Program Services*: ≥ 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: ○ 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 for the most recent year available).	

[4] The Department defines recipients for the purposes of network adequacy as those who received State-funded Services in the previous year.

Section VII. Fourth 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**
		• *Ambulatory Withdrawal Management without Extended Onsite Monitoring Services:* ≥ 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^	Assertive Community Treatment, Community Support Team, Peer Supports (Individual & Group), Transition Management Service, Intensive In-home, BH Comprehensive Case Management, Multi-Systemic Therapy: 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.	
		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*:
		  ○ *Adult:* Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[6]
		• *Substance Abuse Medically Monitored Community Residential Treatment*: Access to ≥1 licensed provider
		• *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 ninety (90) Calendar Days after licensure requirements are established)
		• *Substance Use Residential Supports & Mental Health Recovery Residential Services:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region
		• Clinically managed high-intensity residential services, Clinically managed high-intensity residential services – Pregnant & Parenting, Clinically managed medium-intensity residential services – Adolescents: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (once policy is added)
		• *Medically monitored intensive inpatient services (once policy is added)*	

8.	Employment and Housing Services	• *Residential Supports, Supported Living Periodic, Respite:* 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 & Adult SUD):* 100% of eligible individuals must have a choice of two (2) provider	

[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. Fourth 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**
		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. • *Day Supports. Community Living Support, Supported Employment, Adult Day Vocational Programs (ADVP):* 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	

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. Fourth Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards and Section VII. Fourth Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standard.*

Section VII. Fourth 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
		Opioid Treatment Program Service				Y	
		Medically monitored intensive inpatient services				Y	
3.	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Medically Monitored Inpatient Withdrawal Management Services				Y	
		Ambulatory Withdrawal				Y	

Section VII. Fourth 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**
		Management without Extended Onsite Monitoring Services					
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	
		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 high intensity residential services – Pregnant & Parenting				Y	
		Clinically managed medium-intensity residential services - Adolescents					Y
		Clinically Managed High-intensity Residential Services –				Y	
		Medically monitored intensive inpatient services				Y	
7.	Community/ Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	

Section VII. Fourth 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**
		Transition Management Service		Y			
		Reserved.					
		Intensive In-home			Y		Y
		BH Comprehensive Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y
8.	Employment and Housing Services	Day Supports Group	Y				
		Community Living & Support	Y				
		Reserved.					
		Supported Employment	Y				
		Residential Supports	Y				
		Respite Services	Y		Y		
		Individual Placement and Supports (IPS)-Supported Employment		Y		Y	
		Reserved.					
		Clinically Managed Population-specific High Intensity Residential Programs				Y	
		Supported Living Periodic	Y				
		Adult Day Vocational Programs (ADVP)	Y				
		I/DD & TBI Care Management (TP Provided Only)	Y				

BH I/DD Tailored Plan 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. Fourth 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.
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

Fifth 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 for Medicaid

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. The contract may include a no-cause termination clause.
    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 Department 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 a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy 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 organization. The BH I/DD Tailored Plan shall include in Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. If a Provider is not complying with applicable critical incident and/or death reporting requirements or the BH I/DD Tailored Plan identifies trends in incident reporting, the BH I/DD Tailored Plan shall utilize remedial measures available under the contract with the Provider, including but not limited to provider monitoring and corrective actions, to remedy the noncompliance and minimize occurrence of preventable incidents.

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.

hh. Miscellaneous Provisions - The contract shall include provisions which address the following:

i. If the BH I/DD Tailored Plan determines that services, supplies, or other items are covered and Medically Necessary, the BH I/DD Tailored Plan shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the insured or the Provider of the service, supply, or other item.

ii. When the BH I/DD Tailored Plan offers to contract with a Provider, the BH I/DD Tailored Plan shall make available its schedule of fees, if any associated with the top 30 services or procedures most commonly billed by the class of Provider, with the exception of Value-Based Fees, which would not be included until Contract Year 2.

iii. Notice contact provisions - The contract shall address the following:

a. All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

b. Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five (5) Business Days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic

medium for a communication other than an amendment if agreed to by the insurer and the provider.

iv. Contract Amendments - The contract shall address the following:
   a. BH I/DD Tailored Plan shall send any proposed contract amendment to the notice contact of a health care provider. The proposed amendment shall be dated, labeled "Amendment," signed by the BH I/DD Tailored Plan, and include an effective date for the proposed amendment.
   b. A health care provider receiving a proposed amendment shall be given at least sixty (60) Calendar Days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within sixty (60) Calendar Days.
   c. If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the BH I/DD Tailored Plan shall be entitled to terminate the contract upon sixty (60) Calendar Days written notice to the health care provider.
   d. A health care provider and the BH I/DD Tailored Plan may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.

v. Policies and Procedures: The contract shall address the following:
   a. BH I/DD Tailored Plan's policies and procedures applicable to contracted health care providers shall be incorporated into the BH I/DD Tailored Plan's Provider Manual or posted to the BH I/DD Tailored Plan's website.
   b. The policies and procedures of the BH I/DD Tailored Plan shall not conflict with or override any term of a contract, including contract fee schedules.

vi. Provider Manual: The BH I/DD Tailored Plan shall include Department-developed standard terms and conditions included in the Tailored Care Management (TCM) Provider Manual Addendum: Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs in its contracts with Designated Pilot Care Management Entities.

2. Additional contract requirements are identified in the following Attachments:

a. AMH Provider Manual
b. *Section VII. Third 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. First Revised and Restated Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid Member*s

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 [BH I/DD Tailored Plan's] contract with NC DHHS could result in

liability for money damages, including 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 [BH I/DD Tailored Plan] 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 [BH I/DD Tailored Plan's], 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 [BH I/DD Tailored Plan] or any judgment rendered against the [BH I/DD Tailored Plan].

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 [BH I/DD Tailored Plan] 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 BH I/DD Tailored Plan and/or 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 [BH I/DD Tailored Plan] for processing and payments within three-hundred-sixty-five (365) Calendar Days from the date of covered service and, in the case of health care provider facility claims, within three-hundred-sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. When a Member is retroactively enrolled, [the BH I/DD Tailored Plan] shall not limit the time in which claims may be submitted by the [Provider] to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims. However, the [Provider's] failure to submit a claim within this timeframe 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 behavioral health):
        1. The [BH I/DD Tailored Plan] 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. The [BH I/DD Tailored Plan] shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The [BH I/DD Tailored Plan] shall implement the capability for EDI 277 and electronic method (portal or email) no later than BH I/DD Tailored Plan Launch if approved by the Department. If an extension is needed, the [BH I/DD Tailored Plan] may submit a request to the Department's Contract Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.
        2. The [BH I/DD Tailored Plan] shall pay or deny a clean medical claim within thirty (30) Calendar Days of receipt of the clean claim.
        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 [BH I/DD Tailored Plan] 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 [BH I/DD Tailored Plan] shall deny the claim per § 58-3-225 (d).

iv. The [BH I/DD Tailored Plan] 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 [BH I/DD Tailored Plan] fails to pay a clean claim in full pursuant to this provision, the [BH I/DD Tailored Plan] shall pay the [Provider] interest. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen (18) percent beginning on the first day following the date that the claim should have been paid or was underpaid.

vi. . The BH I/DD Tailored Plan shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. 58-3-225(k).

vii. The [BH I/DD Tailored Plan] shall pay the interest from subsections (v) and (vi) as provided in that subsection and shall not require the [Provider] to requests the interest or the liquidated damages.

viii. For purposes of claims payment, the [BH I/DD Tailored Plan] shall be deemed to have paid the claim as of the Date of Payment, and the [BH I/DD Tailored Plan] shall be deemed to have denied the claim as of the date the remittance advice is sent to the [Provider]. The [BH I/DD Tailored Plan] defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the [Provider] or the date a paper check is mailed to the [Provider.

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. Providers who may Elect to Implement a Tobacco-Free Policy
   Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings, or manufacturing sites that employ adults who receive group day services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy
2. Reserved.
3. Providers subject to Partial Tobacco-Free Policy
   Starting January 1, 2027, 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:
   [Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:
   (1) *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the Provider's control as owner or lessee.*
   (2) *For Outdoor areas of the property under, [PROVIDER's] control as owner or lessee shall:*
      i. Ensure access to common outdoor space(s) free from exposure to tobacco use; and
      ii. Prohibit staff/employees from using tobacco products anywhere on property.

4. Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.
5. Providers subject to Full Tobacco-Free Policy
   Starting January 1, 2027, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.
   [Provi*der] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on [Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.*

j. Contracts between the BH I/DD Tailored Plan and Providers must include the following definitions:
   1. "Amendment" – Any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order or by the BH I/DD Tailored Plan Contract is not an amendment.
   2. Contract" – A written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.
   3. "Health care provider" – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

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. The BH I/DD Tailored Plan shall include in Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. If a Provider is not complying with applicable critical incident and/or death reporting requirements or the BH I/DD Tailored Plan identifies trends in incident reporting, the BH I/DD Tailored Plan shall utilize remedial measures available under the contract with the Provider, including but not limited to provider monitoring and corrective actions, to remedy the noncompliance and to minimize occurrence of preventable incidents.

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.

ee. Facility Based Crisis (FBC) Providers: For all contracts with a facility-based crisis or Behavioral Health Urgent Care (BHUC) Provider, the contract must include provisions requiring the provider to:

i. Enroll and participate in the Department's bed registry system.

ii. Participate in local Crisis Community Collaboratives to facilitate crisis service access, coordinate with local stakeholders to develop regional community crisis plans, and address local crisis service barriers.

iii. Educate the community and other local providers about their crisis services.

iv. Accept individuals with mental health, substance use disorder, I/DD and or TBI, regardless of payor status or county of residence.

v. Submit information the BH I/DD Tailored Plan needs to complete the Crisis Facility Utilization Report and Crisis Service Funding Report as defined in Attachment J: Reporting Requirements.

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 BH I/DD Tailored Plan and/or 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.

Fourth 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 *Fourth Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State -funded Services* and *Fourth 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 *Fourth Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *Fourth Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *Fourth 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 *Fourth Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services*.

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

Section VII. Fourth 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. Reserved.		
6. Enrollment Summary Report	Monthly summary report highlighting key member and recipient enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid or NC Health Choice eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
7. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver slots and reserved capacity, and list of members on the Registry of Unmet Need (waiting list).	Monthly

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

Section VII. Fourth 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**
	Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
10. I/DD In Reach, Diversion, Transition Activity Report	This report is for IDD Members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
11. CIE Data Collection Tool	Report generated by completion of the CIE Data Collection Tool provided by the Department, regarding individuals receiving Adult Developmental Vocational Program (ADVP) services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment. This report includes without limitation and as applicable the following information regarding the individuals: involvement in post-secondary education, employment assessments, career planning, Supported Employment, Informed	Quarterly

Section VII. Fourth 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**
	Choice Decision Making, engagement in CIE, and the Member's hire date. For members engaged in CIE, the following data is also included: wages earned, and average hours worked per week.	
12. TBI Screening Report	Quarterly report on call center screenings that identify recipients with potential TBI and their access to mental health, SUD, I/DD, or other services.	Quarterly
13. Crisis Facility Utilization Report	Report of encounter and demographic information for individuals who are utilizing services at FBCs and BHUCs.	Monthly
14. Crisis Service Funding Report	Report on funding and expenditures for BHUC and FBC crisis services performed in a BH I/DD Tailored Plan catchment area.	Annually
C. Community Inclusion		
1. Daily Reporting on Community Integration Services and Supports	Daily report of information on community integration services (e.g., housing, in-reach and transition, diversion, Assertive Community Treatment (ACT), CST, supported employment, and other services) for members SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Transition to Community Living Database (TCLD), or other systems determined by the State.	Daily
2. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Daily reporting of rental subsidy information for, including but not limited to, individuals with SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVe) system.	Daily
3. IDD In Reach, Diversion, Transition Activity Report	This report is for I/DD members related to: <u>In Reach:</u> Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (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). <u>Diversion:</u> Number and percentage of members eligible for diversion activities who are engaged for diversion activities;	Quarterly

Section VII. Fourth 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**
	number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
D. Providers		
1. Reserved.		
2. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
3. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where members or recipients live.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually
5. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
6. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
7. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly until Tailored Plan launch;

Section VII. Fourth 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**
		Quarterly thereafter
8. Reserved.		
9. NEMT Provider Contracting Report	Non emergency provider contracting report at a detailed and summary level from the BH I/DD Tailored Plans.	First and Third Friday each month
E. Quality and Value		
1. Reserved.		
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
F. Stakeholder Engagement		
1. Local and County Outreach Report	Monthly report of county-based activities, issues and actions taken by BH I/DD Tailored Plan to collaborate with county organizations to address issues by county/Region.	Monthly
G. Program Administration		
1. Service Line Report**	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
2. Service Line Issue Summary Report**	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
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

Section VII. Fourth 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**
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by members and recipients, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries Report	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.	Quarterly

Section VII. Fourth 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. Fourth 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	Monthly

[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. Fourth 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**
	is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	
B. Benefits		
1. Institute of Mental Disease (IMD) Report	Bi-weekly summary of Members who are receiving acute care for SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis code and diagnosis name, Provider name, Provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Bi-Weekly
2. Pharmacy Benefit Determination / Prior Authorization Report	Monthly that lists prior approval requests by individual member, service type, determination date, and approval status.	Monthly
3. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
4. Top GCNs and GC3s Report	Quarterly summary report ranking top GSN and GC3 Medicaid claims.	Quarterly
5. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
6. Financial Arrangements with Drug Companies Report	Description of all financial terms and arrangements between the Tailored Plan and any pharmaceutical drug manufacturer or distributor.	Annually
7. EPSDT Reports	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.	Quarterly
8. Non-Emergency Medical 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.	[redacted]	
12. Reserved.		
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]

[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. Fourth 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**
14. Ongoing Transitions of Care Status Report	Monthly reporting identifying and reconciling data for members who are transitioning to and from the BH I/DD Tailored Plan on an ongoing basis.	Monthly
15. Reserved.		
16. Reserved.		
17. Innovations Waiver Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrated compliance with 1915(c) waiver assurances.	Quarterly
18. TBI Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
19. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(I) state plan performance measures.	Quarterly
20. 1915 Service Authorization Report	Authorized and billed 1915(i), 1915(c), 1915(b)(3) services for community living supports, community networking, supported employment, and supported living.	Quarterly
21. 1915(i) Transition Report	This report tracks the status of individuals transitioning to 1915(i) including assessment completion, assessment submission, and transition to 1915(i) services.	Monthly
22. EVV Key Metrics Report	Reporting of EVV program data/information	Monthly
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
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. Reserved.		
5. TCM Provider Contracting and Integration Report	Monthly TCM Provider contracting and integration status report.	Monthly
6. Nursing Facility Transitions Report	Quarterly report listing BH I/DD Tailored Plan members discharged from a nursing facility and to where they were discharged.	Quarterly
7. Reserved.		
8. Reserved.		

Section VII. Fourth 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**
9. Data Elements for Enhanced Validation (DEEV) Report	Monthly report. BH I/DD Tailored Plans will leverage the template to support post-production monitoring for Tailored Care Management (TCM).	Monthly
10. PCP Operational Monitoring Report	Monthly report of PCP assignment, changes, and panel limits.	Monthly
D. Reserved.		
1. Reserved	[redacted]	[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. Reserved.	[redacted]	
6. Reserved.		
7. Reserved.		
8. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
9. Reserved.	[redacted]	
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.	[redacted]	
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

Section VII. Fourth 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**
G. Stakeholder Engagement		
1. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
H. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others. Audited Financial Statements submitted as part of this reporting packet must comply with 42 CFR 438.3(m).	Monthly
2. Reserved.		
3. Reserved.		
4. Claims Monitoring Report	Monthly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	Monthly
5. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the BH I/DD Tailored Plan template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
6. Emergency Department Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the Emergency Department over thirty (30) consecutive hours, document escalation to appropriate parties including but not limited to BH I/DD Tailored Plan Clinical Director or designee.	Weekly
7. Service Associated Request Report	Tailored Plan decision regarding the service requested on the Request to Move: Provider Form.	Monthly
8. TPL Recovery Match Report	Report detailing those claims upon which the BH I/DD Tailored Plan has been unable to effectuate third party liability (TPL) recovery within one (1) year of the date of service.	Monthly

Section VII. Fourth 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**
9. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to BH I/DD Tailored Plan claim adjustment processing. The BH I/DD Tailored Plan must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc

Section VII. Fourth 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. Reserved.		

Section VII. Fourth 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. Fourth 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		
1. Reserved.		
B. Care Management and Prevention		
1. TBI Services Quarterly Expenditures Report*	Quarterly report on administration of State-funded TBI programming expenditures and associated services.	Quarterly
2. Reserved.		
3. Substance Abuse/Juvenile Justice Initiative Quarterly Report*	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
4. Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a Qualified Professional in Substance Abuse (QPSA).	Quarterly
5. TBI Annual Report	The annual report consists of a combination of both quantitative and qualitative information, which provides a more holistic understanding of service usage, trends and network adequacy for the TBI population within North Carolina's publicly funded service system.	Annually
6. Department of Adult Corrections (DAC) Priority Re-Entry Outcomes	BH I/DD Tailored Plan shall provide the Department with a report detailing DAC Priority Re-entry to include outcomes data for the DAC Priority Reentry individuals.	Monthly

Section VII. Fourth 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**
C. Quality and Value		
1. Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems 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.	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	Monthly

Section VII. Fourth 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**
	request additional submissions of information pertaining to use of these funds on an ad hoc basis.	
2. Reserved.		
3. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Narrative Compliance Report	Bi-annual narrative report on compliance with target and outcome prevention activities and measures for priority populations, as detailed in the SAPTBG.	Bi-Annual
4. Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR expenditures. This report will contain a certification portion attesting that all information included is accurate.	Monthly

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

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Section VII. Fourth 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, or at the discretion of the BH I/DD Tailored Plan
3. Healthy Opportunities Pilot Service Delivery Invoice Monitoring Report	Monthly report of BH I/DD Tailored Plan Pilot service delivery spending.	Monthly
4. Healthy Opportunities Pilot Administrative Payment Report	Quarterly report of BH I/DD Tailored Plan Pilot administrative fund spending.	Quarterly
5. Reserved.		
6. Reserved.		

Section VII. Fourth Revised and Restated Attachment J. Table 8: TCL Reporting Requirements		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due last day of the month for the prior month, or the first Business Day following the last day of the month if the last day falls on a weekend or holiday.
2. TCL Annual Service Capacity Report	Capacity analysis for ACT, CST, TMS, Crisis Services and IPS. Includes identification of barriers and projects/steps implemented to remove barriers	Annually Fiscal Year 2025
3. TCL Housing Performance Plan Measures Reporting Template	Report tracking TCL Housing Performance Plan Measures. This report indicates measures for each PHIP per quarter based on their reported Tier 1, Tier 2 Expectations, results provided by the BH I/DD Tailored Plan and the Department's verified results.	Quarterly

Section VII. Fourth Revised and Restated Attachment J. Table 8: TCL Reporting Requirements		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
4. TCL IPS Population and Utilization Report	Report on IPS TCL population and utilization of the service, includes updates on IPS cohorts (as part of ACT and standalone IPS)	Quarterly
5. TCL IPS Strategic Plan Progress Report	Report on TCL Strategic Plan progress, includes data required as part of the Department approved IPS Strategic Plan (as part of ACT and standalone IPS)	Quarterly
6. TCL ACT and IPS Report	Monthly report to monitor the total number of individuals receiving ACT, In-reach, and transition supports; the number of individuals receiving IPS services, including those served by fidelity teams, and the total that are in the priority population; information on the individuals receiving fidelity IPS services, including In/At-Risk checklist and identification of new IPS or ACT teams	Monthly

Third Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy

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.

a. 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*

b. 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 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.

c. 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)*.

d. 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. The care management data system can be a care management software platform or an EHR with a care management module, 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.

e. 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.

f. 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 shall follow the same contact requirements. 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***.**

Fourth 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 all BH I/DD Tailored Plan services as set forth in N.C. Gen. Stat. § 108D-23. 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:

    i. 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.

b. 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.

c. 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.

d. 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).

e. 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.

f. 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.

g. The Department shall not mandate BH I/DD Tailored Plan Network Providers enrolled with NC Medicaid to provide State-funded services.

h. Providers will be reverified and recredentialed as permitted by the Department in the Contract.

i. A BH I/DD Tailored Plan shall use the BH I/DD Tailored Plan's Provider Manual 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.

j. 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 BH I/DD Tailored Plan's policies and procedures, at a minimum, must:

i. Meet the requirements specified in 42 C.F.R. § 438.214;

ii. Meet the requirements specified in this Contract;

iii. Follow the Department's Uniform Credentialing and Re-credentialing Policy and any applicable requirements from the Contract, and address acute, primary, mental health, substance use disorders, and long-term services and supports providers;

iv. 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.

v. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider or State-funded Services provider;

vi. 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).

vii. 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.

viii. 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 or NC Exclusions List;

ix. 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

x. 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.

xi. Identify standards and establish a documented process for making network contracting decisions on State-funded Services providers.

xii. Describe the information that providers will be requested to submit as part of the contracting process.

xiii. 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).

xiv. 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.

xv. 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:

1. 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.

2. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.

xvi. 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.

xvii. BH I/DD Tailored Plan shall have discretion to make network contracting decisions consistent with the Policy.

Third Revised and Restated Attachment M. 11. Tribal Payment Policy

1) Background

This Tribal Payment Policy outlines the expectations of the Department regarding payment for covered services to Indian Health Care Providers (IHCP) by a BH I/DD Tailored Plan.

Indian Health Care Provider (IHCP) refers to 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 defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by State recognized Tribes are not considered IHCPs.

In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a "Tribal Provider Attestation." This "Tribal Provider Attestation" letter from the EBCI Chief's office shall be submitted to the Department as part of the Department's centralized credentialing process. The information about Tribal providers will be shared with the BH I/DD Tailored Plan through the Department's existing process.

2) Scope

This Policy applies to the BH I/DD Tailored Plans and covers payment for covered services provided by IHCPs and other Tribal providers. This Policy shall apply to all IHCPs/Tribal providers regardless of the provider's contracting status.

3) Policy Statement

The BH I/DD Tailored Plan shall implement the Tribal Payment Policy described below by developing and maintaining a written Tribal Payment Policy related to all IHCPs/ Tribal providers regardless of the provider's contracting status consistent with the Department's Tribal Payment Policy:

a) Claim Submission

i) Cherokee Indian Hospital (CIHA) will bill for inpatient and outpatient services and will be paid for these services in accordance with current NC Medicaid requirements.

ii) Other Indian Health Service (IHS)/Tribal/Urban (I/T/U) providers/Tribal providers will submit claims utilizing formats currently utilized when billing NC Tracks in NC Medicaid Direct.

b) Payment

i) Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the Office of Management and Budget (OMB) rate, for applicate AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The BH I/DD Tailored Plan shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with the BH I/DD Tailored Plan shall continue to follow those arrangements. OMB Tribal rates for hospital inpatient and outpatient services are included and identified on the hospital fee schedule available on the Fee Schedule and Covered Codes Portal.

(1) If a Member seeks care at an Indian health provider out of state, the services to the Member should be reimbursed by the OMB rate if applicable.

ii) To promote same day access and reduce barriers or burdens to a member such as transportation or taking time off from work, providers receiving the AIR rate may receive encounters per day (single day of service) such as but not limited to follows:

(1) Medical

(2) Dental;

(3) Behavioral; and,

(4) One (1) other such as optical

(5) The BH I/DD Tailored Plan shall reimburse I/T/U pharmacies for pharmacy claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan (a maximum of two (2) pharmacy AIR per patient per day):

(a) High-cost drugs are excluded and are paid based on DHBs outpatient pharmacy 'lessor of logic'

(b) If more than two (2) drugs are filled, additional drugs beyond the two (2) will be paid at zero dollars ($0) and should be used by the Tailored Plan for medication reconciliation.

(c) The Pharmacy Point of Sale OMB encounter rate (ER) fee schedule is found on the Fee Schedule and Covered Codes Portal. The fee schedule name is Indian Tribal (I/T/U) Pharmacy fee schedule.

(d) There is no Tribal OMB rate for Ambulatory Surgical Center services; the BH I/DD Tailored Plan should follow the Ambulatory Surgical Center fee schedule on the Fee Schedule and Covered Codes Portal.

iii) Tribal entity claims will not add up to the AIR rate since the AIR rate is established for all federally recognized Tribes. NC Medicaid adopted the AIR (also known as the OMB rate) as the rate to be used for the reimbursement of services provided by CIHA.

iv) The BH I/DD Tailored Plan shall comply with *BH I/DD Tailored Plan Contract Section V.D.4.h., Indian Health Care Provider (IHCP) Payments* of this Contract.

(1) In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the BH I/DD Tailored Plan shall reimburse IHCPs as follows:

(a) Those that are not enrolled as an FQHC, regardless of whether they participate in the BH I/DD Tailored Plan's Network:

(i) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or

(ii) The NC Medicaid Direct rate for services that do not have an applicable encounter rate.

(b) Those that are enrolled as FQHCs, but do not participate in the BH I/DD Tailored Plan's Network, an amount equal to the amount the BH I/DD Tailored Plan would pay a Network FQHC that is not an IHCP.

(2) The BH I/DD Tailored Plan shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.

(3) The Indian Tribal (I/T/U) Home Health Fee schedule is posted on the Fee Schedule and Covered Codes Portal and specific to just the Tribe codes and rates.

(4) The Skilled Nursing Facility Fee schedule is posted on the Fee Schedule and Covered Codes Portal and specific to just the Tribe codes and rates.

v) The BH I/DD Tailored Plan shall comply with *Section V.F.1. Engagement with Federally Recognized Tribes* of this Contract with regard to providing and maintaining a point of contact for IHCP billing issues to the Department.

(1) The BH I/DD Tailored Plan shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract.

vi) Ambulatory Surgical:

(1) All procedures billed that fall under one thousand dollars ($1000) will be billed at the Outpatient OMB Rate.

(2) All procedures that are one thousand dollars ($1000) and above will be billed at the Medicaid Fee Schedule.

vii) All non-OMB rates for Tribal payment follows the regular Medicaid Direct methodology and fee schedules for the BH I/DD Tailored Plan, unless otherwise defined in the Tribal Payment Policy.

c) Prompt Pay

i) The BH I/DD Tailored Plan shall comply with *Section V.H.1.d. Prompt Payment Standards* of this Contract.

(1) The BH I/DD Tailored Plan shall promptly pay Clean Claims, regardless of provider contracting status. The BH I/DD Tailored Plan shall reimburse medical and pharmacy providers in a timely and accurate manner when a clean medical or pharmacy claim is received.

(a) Medical Claims

(i) The BH I/DD Tailored Plan 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 timely process the claim.

(ii) The BH I/DD Tailored Plan shall pay or deny a Clean Medical Claim within thirty (30) calendar days of receipt of the clean claim.

(iii) A Medical Pended Claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

(b) Pharmacy Claims

(i) The BH I/DD Tailored Plan shall within fourteen (14) calendar days of receiving a Pharmacy Claim pay or deny a Clean Pharmacy Claim or pend the claim and request from the provider all additional information needed to timely process the clean claim.

(ii) A Pharmacy Pended Claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.

(c) Reserved.

(d) If the requested additional information on a Medical or Pharmacy Pended Claim is not submitted within ninety (90) calendar days of the notice requesting the required additional information, the BH I/DD Tailored Plan may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).

(e) For purposes of claims payment, the BH I/DD Tailored Plan shall be deemed to have paid the claim as of the Date of Payment, and the BH I/DD Tailored Plan shall be deemed to have denied the claim as of the date the remittance advice is sent.

(2) The BH I/DD Tailored Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest if applicable).

(3) Claim Submission Timeframes:

Pursuant to N.C. Gen. Stat. § 58-3-225(f), 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 by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) 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 three hundred sixty-five (365) 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.

(a) 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 three hundred and sixty-five (365) Calendar Days from the date of enrollment.

(b) When a claim requires financial eligibility determination, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined.

(4) Interest and Penalties

(a) The BH I/DD Tailored Plan shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.

(b) Reserved.

(c) The BH I/DD Tailored Plan shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).

(5) The BH I/DD Tailored Plan shall maintain written or electronic records of its activities under this Section in accordance with N.C. Gen. Stat. § 58-3-225(i).

(6) For purposes of actions which must be taken by a BH I/DD Tailored Plan as found in *Section V.H.1.d.* of this Contract, Prompt Pay Standards, if the referenced calendar day falls on a weekend or a

holiday, the first business day following that day will be considered the date the required action must be taken.

d) Other Payment Sources

i) Due to the change in payer hierarchy, the BH I/DD Tailored Plan will allow for timely payment for Tribal providers without delaying payments due to coordination of benefits. Medicare and Medicaid are payers of first resort for Tribal members and providers. Tribal and IHS funds are payers of last resort.

ii) Tribal self-funded insurance is not a billable source for the Eastern Band of Cherokee Indians (EBCI), and therefore, BH I/DD Tailored Plan shall not attempt to coordinate benefits with that plan.

e) Sovereignty

i) No contractual relationship shall deny or alter tribal sovereignty.

Third/Fourth Revised and Restated 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. The BH I/DD Tailored Plan shall ensure that Members are provided the rights outlined in *Section V.B.2.i.(vii)* In Lieu of Services for all approved In Lieu of Services;
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:

Third Revised and Restated Attachment L. 7. Approved Alliance Health In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Child Assertive Community Treatment	Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.	Psychiatric Residential Treatment Facility (PRTF) Level III Group Home	Eligible population includes youth with a primary mental health diagnosis. High risk for out of home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment Symptoms at a severity level where PRTF or other intensive residential treatment The duration of service is up to twenty-eight (28) weeks maximum and provided per week.	H0040 U5 HA
Long Term Community Supports (LTCS)	Long Term Community Supports (LTCS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community.	Individuals with Intellectual Disabilities (ICF)	Eligible population includes individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. Medicaid eligible: Age 22 or older and meet ICF-IID eligibility criteria	T2016 U5 U1- Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5
In Home Therapy Services:	Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or	Intensive In-Home Services (IIHS)	Eligible population is for children and adolescents ages 3-20 years of age in need of individual and family therapy services, parenting, and coping skills practice in their environment, as well as some coordination of care due to complex psychosocial	H2022 HE U5 H2022 TS U5

	multisystem involvement.		situations and/or multisystem involvement. The duration of service is one (1) unit per week, with length of service one hundred eighty (180) days	
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions.	Residential Level II Family Type (TFC) Psychiatric Residential Treatment Facility (PRTF)	Eligible population involves a step down from a higher level of care, DSS involvement in the last year, Juvenile Justice involvement in the last 6 months, behavioral health Emergency Room visit and/or hospitalization in the last 6 months, multiple school suspensions within the past year, and crisis intervention in the last 6 months. FCT treats the youth and his/her family through individualized therapeutic interventions. Decrease in crisis episodes and inpatient stays. FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of readmission. The duration of service is six (6) months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4
Transitional Youth Services (TYS)	The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently.	Residential Level II Family Type (TFC) Level III Residential Facility Services	Eligible population is Members who are leaving the foster care or juvenile justice systems, or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. The duration of service is one unit for 9-12 months length of service.	H2022 U5

	The interventions focus on rehabilitating member strengths and skills as well as linking the member to available resources to assist him/her in relearning a sense of accountability for his/her own behavior.			
Behavioral Health Crisis Assessment and Intervention (BHCAI)	BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting. Members experiencing a behavioral health crisis meeting Emergent or Urgent Triage Standards. BHCAI-Per Event-Per Diem (2-23 hours). Rapid Response-Per Diem (14 days or less).	Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)	Eligible population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	T2016 U5 or T2016 U6
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders.	Emergency Depts Inpatient Psychiatric Hospitalization	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care DocuSign Envelope	Residential Level II Family Type (TFC) Residential Treatment Services Level II Group Home	Eligible population Children, youth, and young adults with Serious Emotional Disturbance (SED) that have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and	H0032 - U5

	ID: 1C2730A0-0635-487A-88F6-DC0BC6D74C71 #30-2022-007-DHB-1 Amendment 1 Page 141 of 148 to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW. The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.		parental mental health and substance use problems, Involved in (or history of) multiple child-serving. Systems (e.g., child welfare, juvenile justice). The duration of service is 9-12 months	
Short Term Residential Stabilization	Residential Supports provides individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Facility Based Crisis	Eligible population includes individuals in need of and receiving comprehensive and intensive habilitative supports– aggressive, consistent implementation of a program of specialized and generic	T2016 TF U5

	their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the person's life skills, provide the supervision needed, maximize their self-sufficiency, increase self-determination and ensure the person's opportunity to have full membership in his/her community. Residential Supports includes learning new skills, practice and/or improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source. Residential Supports are provided to individuals who live in a community residential setting that meets the home and community-based characteristics. Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and		habilitative training. Medicaid eligible Age 21 or older Meet ICF-IID eligibility criteria and/or the definition of developmental disability. The duration of service is 30 days for initial authorization and for concurrent is every 30 days. Services maximum is 180 days.	

	single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports.			
Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)	Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Psychiatric Residential Treatment Facility (PRTF)	Eligible population includes Individuals with Complex Needs are the ages of 5 and under 21, with a developmental and/or intellectual disability and a mental health disorder diagnosis who are Medicaid eligible and at risk of not being able to return to or maintain placement in a community with I/DD diagnosis and meet the ICF/IDD level of care consistent with the Innovations Wavier. The individual also has co-occurring MH diagnosis or significant behavioral challenges for which services and supports require significant experience and expertise in dual diagnosis.	H0018 HA

Third Revised and Restated Attachment L. 7. Approved Partners Health Management In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Long Term Community Supports (LTCS)	Long Term Community Supports (LTCS) consist of a broad range of residential and day services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community. LTCS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD). ICF-IID is an all-inclusive service that includes residential and also supports the members' meaningful day activities. Our LTCS service is broken down into 5 levels which delineate the services provided at each level. Each level of our LTCS service supports staffing to create a person-centered meaningful day for the member.	Individuals Community and Residential (ICF-IDD)	Eligible population includes Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; age 22 and over. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services.	T2016 U5 U1- Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5
Rapid Response	Rapid Response Homes are licensed therapeutic foster homes with a	Emergency Department-Family Based Crisis (ED/FBC)	Target population includes members aged 5-20 with Child MH/SU, including individuals	S9484 U5 (low) S9484 HK U5 (high)

	North Carolina Licensed Child Placing Agency or licensed alternative family living (AFL) homes that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect, provide short term treatment, and prevent or minimize the need for out-of-home placements.	Psychiatric Residential Treatment Facility (PRTF)	with MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their condition and presenting symptoms. Youth are presenting in crisis, however, do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed. Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and reevaluation/assessment and further development of the crisis plan as needed.	
In Home Therapy Services	In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents.	Intensive In-Home (IIHS)	Target population includes children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. Duration of Service is 1 unit a week, 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5

Behavioral Health Urgent Care (BHUC)	Behavioral Health Urgent Care (BHUC) A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral.	Emergency Department Visit Inpatient Psychiatric Hospital Admission	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co- occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. The duration of service is per 1 unit per event (2 hours per episode)	T2016 U5
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders	Inpatient Psychiatric Hospitalization	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160
Rapid Care Services Children and Adults with Mental Illness and/or Substance use disorders	Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the	Emergency Department Visit Inpatient Psychiatric Hospitalization	Emergency Department Visit Inpatient Psychiatric Hospitalization Target population includes members ages 3 and older and provides an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses. Rapid Care Services may be provided to members in crisis who need short-term intensive evaluation, which can include a multi-disciplinary team of individuals such as clinicians,	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High

	ongoing treatment needs of the member.		psychiatrists, nurses, and peer support specialists. The member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation AND the individual's medical needs are stable and appropriate for this level of care. Duration of Service 1 unit per day-Maximus length of service is 23 hours.	
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.	Intensive In-Home Residential Treatment Level III	Target population includes members ages 3-20 with mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is monthly maximum of 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4
Residential Services-Complex Need	Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring conditions and complex	Psychiatric Residential Treatment Facility (PRTF) Inpatient Psychiatric Hospitalization	Target population includes children and adults, ages 5 through 21 with either: Primary mental health (MH) diagnosis and I/DD diagnosis or borderline intellectual	H0018 HA

	presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.		functioning with traits that inhibit optimal functioning OR Primary I/DD diagnosis with co-occurring MH diagnosis.	
Individual Rehabilitation, Coordination, & Support Services	The purpose of this service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the individual's living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary's skills develop. Services are based on medical necessity, person-centered, shall be directly related to the beneficiary's diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the individual's Person-Centered Plan. This service was developed in response	Psychosocial Rehabilitation	Target population includes ages 18 and older for individual has receiving a comprehensive clinical assessment and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or Substance use disorder (SUD). Duration of service is 1-unit per week, 52 weeks.	H2017 U5

	to COVID-19 state of emergency and intended to be used only during a state of emergency, natural disaster, or situation where member is unable to attend PSR on site due to personal extenuating circumstances.			
High Fidelity Wraparound (HFW)	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, physical health, child welfare, juvenile/criminal justice, and education), experience serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in PRTFs or other institutional settings, and/or are aging out of Department of Social Services (DSS) care.	Psychiatric Residential Treatment Facility (PRTF) Residential Level III Placement	Target population includes Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability AND Based on the current comprehensive clinical assessment including the use of the CALOCUS or CANS, functional impairment is demonstrated to indicate this level of service. Duration of Service is 12-18 months	H0032 - U5
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-up to age 21with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live	Residential Level II Family Type (TFC) Intensive In-Home Services (IIHS)	Target population includes members ages 16-21 are eligible for this service when there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference manual), Must demonstrate a deficit in at least one independent living	H2022 U5

	independently. Transitional Youth Services staff assist and support the member in identifying goals and addressing barriers to independence. This process considers all systems affecting the member, including family, school/work, peers, individual needs, and the community. All services are delivered in the member's natural environment to increase the likelihood of sustaining the progress made during the intervention. The aim of the program is to give members the skills and resources to resolve and prevent future problems in areas like housing, employment, parenting, or involvement with the court or social services. The interventions focus on member strengths and skills, as well as linking the member to available resources. Transitional Youth Services' staff work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning the life skills needed to support themselves, and working or pursuing education. The assigned Transitional Youth Services Staff will work closely with the probation officer, courts, family, and any other involved formal and		skill or essential life component. Duration of service is 1-unit= 1 month or according to the Benefit Plan. 9 months-12 months	

	informal resources to ensure collaboration around the goals of services, interventions being provided, and discharge recommendations.			

Fourth Revised and Restated Attachment L. 7. Approved Trillium Health Resources In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Behavioral Health Crisis Assessment and Intervention (BH-CAI)	A designated service that is designed to provide triage, crisis risk assessment, evaluation, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital Emergency Department.	Emergency Departments	Target population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. (Per Event) 1-Per Person/This service is designed to be completed during regular and extended business hours of Tier III settings up of at least 12 hours; and up to 23 hours, 59 minutes in Tier IV settings.	T2016 U5 or T2016 U6
Family Centered Treatment (FCT)	Family Centered Treatment is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice. Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is intended to promote permanency goals. FCT treats the youth and his/her family through individualized	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)	Target Population include a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

	therapeutic interventions.			
Community Living Facilities and Support (CLFS)	Community Living Facilities and Supports (CLFS) consist of a broad range of services for adults with developmental disabilities who, through the Person Center Plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community. CLFS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities. CLFS for individuals with Intellectual disability is an alternative definition in lieu of ICF-IID under the Medicaid 1915 b benefit. This service enables Trillium to provide comprehensive and individualized active treatment services to adults to maintain and promote their functional status and independence. This is also an alternative to home and community-based services waivers for individuals that potentially meet the ICF/ID level of care.	Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)-Community & Institutional	Target Population includes for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. •Medicaid eligible •Meet NC GS 122c definition for Developmental Disability	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5

High Fidelity Wrap-around (HFW)	High Fidelity Wraparound (HFW) is an intensive, teambased, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. Typically, this would be for youth with primary mental health diagnosis with co-occurring substance use disorder or an individual with co-occurring intellectual or developmental disabilities in the mild-moderate range. High Fidelity Wraparound is also utilized in a pro-active manner to serve those high-risk youth that are involved with multiple agencies.	Level II Group Setting & Program Level II Family Setting & Program	Target Population includes children, youth, and young adults with Serious Emotional Disturbance (SED) and have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and/or substance use problems. Duration of service is 12 months:	H0032 - U5
Family Navigator	Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Targeted Population includes ages 3-64 for members diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of	T2041 U5

	experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience IDD or TBI. Family Navigator is a way of working with children, adolescents and/or adults with an IDD or TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. home, hospitals, jail, shelters, streets, etc.) using a variety of methods. It is designed as a short-term outreach and engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.		challenges navigation complex systems. Service is designed to meet the needs of the member. Maximum per month is 40 units (15 minutes) per month	
Acute and Subacute Services Provided in an Institute for	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined	Emergency Department Inpatient Stay	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality	0160

Mental Disease	in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD. Providers must follow the requirements for inpatient level of care outlined in the Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.		testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	

Third Revised and Restated Attachment L. 7. Approved Vaya Health In Lieu of Services				
Service Name	**Definition of ILOS**	**Covered Medicaid State plan service or setting for which each ILOS is a substitute**	**Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.**	**Specific coding for each ILOS to be used on claims and encounter data;**
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD.	Inpatient hospitalization Facility Based Crisis	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160
Outpatient Plus	Outpatient Plus ("OPT Plus") is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals of any	Intensive In-Home Community Support Team	Target Population includes member has a mental health or SUD diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material); Member does not have service restrictions due to their NC Medicaid program eligibility category that	H2021 U5

	age with complex clinical needs that basic outpatient therapy cannot adequately address.		would make them ineligible for this service. Duration of service is one unit equals one hour of service- 412 units with length of service 180 days.	
Critical Time Intervention Termination effective date: 03/31/2025	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition, CTI defines a critical transition as occurring within no more than 45 days from the start of service.	Community Support Assertive Community Treatment Team Emergency Department visits Inpatient Psychiatric Admission	Target Population includes individuals discharge from psychiatric inpatient settings, release from correctional settings, transition out of foster care settings into adult services, transition from homelessness in housing	H0032 U5 HK
Behavioral Health Crisis Risk Assessment and Intervention (BHCAI)	A designated service that is designed to provide triage, crisis risk assessment, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital emergency department (ED). Individuals receiving this service have primary behavioral health needs and an	Emergency Department Inpatient Hospital	Targeted Population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. Members experiencing a behavioral health crisis meeting emergent or urgent triage standards.	T2016 U5 or T2016 U6

	urgency determination of urgent or emergent. Individuals receiving this service will be evaluated, stabilized, and/or referred to the most appropriate level of care.		One unit per event-4-6 hours. One per crisis episode. If two visits occur within 30-90 days, the LME/MCO must be notified of the rapid recidivism.	
Family Centered Treatment	Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services. FCT is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare	Residential Level II Program Type Residential Level III (1-4 beds)	Target Population includes Children and adolescents (ages 3-21) who have an MH/SUD diagnosis (some with co-occurring IDD) and are at risk of out of home placement or have previously been unsuccessful in residential treatment, or currently in residential treatment where discharge has been delayed due to identified need for family systems treatment. Duration of service is 6-months:	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4

	departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.			
Residential Services – Complex Needs Termination effective 11/30/2025	This short-term residential treatment service focuses on members with primary diagnoses of intellectual/developmental disabilities (I/DD) with co-occurring mental health (MH) diagnoses or significant behavioral challenges. The members being served would benefit most from a multi-disciplinary approach with staff that are trained to treat I/DD, MH, and severe behaviors.	Psychiatric Residential Treatment Facility (PRTF) Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Target Population includes children and adults with dual diagnoses (I/DD and MH) who have high-level behavioral needs, have experienced multiple placements, and have difficulty functioning in community settings. This service is provided in a small group home or alternative family living setting with very structured supports. Families are actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential treatment settings, such as the member's own home or family home. Duration of service is billed one per day/180 units with length of service 6-months.	H0018 HA
Rapid Care Services	Rapid Care Services allow time for extended assessment, which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if	Emergency Department Inpatient Hospital	Targeted Population includes mental health and/or substance use disorder(s), the member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation. Duration of service is billed as one unit = one event per day and will utilize a two-tiered billing system	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High

	symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member. This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).		based on the amount of time spent at the site as outlined below. If a member receives less than 1.5 hours of intervention, the applicable outpatient, psychiatric, or other CPT codes would be utilized. This level of care is generally used for a duration of 23 hours or less, with optimal utilization between four to six hours per event. Rapid Care Services may be provided up to 23 hours per episode and will be performed in a facility that operates 24/7/365 days a year under psychiatric supervision. This facility must be able to accept individuals who are currently under involuntary petition for first evaluations.	
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in	Residential Level II	Target Population includes youth with a mental health or substance use disorder diagnosis, youth requires coordination between two or more service agencies, including medical or non-medical providers; and youth has current or past history within the last six months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior. Duration of service is 36-48 units per member/12 months; maximum of 18 months.	H0032U5

	a Psychiatric Residential Treatment Facility (PRTF) or other institutional settings, or are aging out of Department of Social Services (DSS) care.			
In-Home Therapy Services	In-Home Therapy Services (IHTS) consist of evidence-based therapy services and coordination of care interventions provided in the home for individuals with complex clinical needs that outpatient therapy alone cannot adequately address in a time-limited fashion.	Intensive In-Home	Target Population includes a mental health (MH) and/or substance use (SU) diagnosis, symptoms and behaviors at home, school, or in other community settings, due to the member's MH and/or SU disorder, are moderate to severe in nature and require intensive, coordinated clinical interventions; evidence of problems in at least two major life domains that are significantly affecting the member's behavioral health needs. Duration of service is one unit per week with a minimum of two hours combined therapy and coordination of care- 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5
Enhanced Crisis Response (ECR)	Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who	Emergency Department Inpatient Hospitalization	Target Population includes members ages 3-21 with mental health (MH) diagnoses, co-occurring MH and intellectual/ developmental disability (I/DD) diagnoses, and/or co-occurring MH and substance use disorder (SUD) diagnoses, OR potential diagnoses of the above based on current symptoms/behavioral health needs.	H2011 U5 U1 weekly unit

	provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible but no longer than two hours from receipt of the referral. For other referrals, response will be on the same day or by the end of the following day.		This service targets youth abandoned in the ED who are also at risk of intervention from DSS. The expected outcome is that the ECR provider quickly engages the guardian(s), creates a crisis plan, and links the member to services to support the guardian's ability to allow the youth to return home. The service also includes youth in DSS custody (in a DSS foster home or DSS shelter) who are at risk of presenting to the ED as a measure to assist with maintaining the youth in the community. Additionally, the intent of this service is to work with youth who remain inpatient due to difficulty with discharge planning. Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery.	
Long-Term Community Supports (LTCS)	Long-Term Community Supports (LTCS) is a community-based comprehensive service for adults (age 22 and older) with intellectual/	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	Target Population includes members 22 of age or older, meet ICF/IID level of care and/or the definition of developmental disability specified in NCGS § 122C-3(12a).	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 –

	developmental disabilities (I/DD) that provides individualized services and supports to a person who would otherwise be institutionalized in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).		Reside in an ICF/IID (when used for transition from an ICF/IID into a home or community-based setting) or is at risk of being placed in an ICF/IID, and be able to maintain health, safety, and well-being in the community with LTCS and other services and supports delivered in the home or community.	Level 2 T2016 U5 U3 – Level 3
Child- Focused Assertive Community Treatment	Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multidisciplinary approach to serve children in their residential setting. This includes homes, kinship placements, and Department of Social Services (DSS) foster homes, or the service may begin during transition from a therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). The team members providing the direct interventions to the child and family may vary based on the needs of the individual. The team will have daily meetings to prioritize activities,	Psychiatric Residential Treatment Facility (PRTF)	Target Population includes at risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment. Duration of service is 1-Unit per week-24 Units-6 months.	H0040 U5 HA

	share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within one to two hours.			
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses in reestablishing the knowledge and skills necessary to live independently.	Level II Family Type, Therapeutic Foster Care Residential Level II Program Type Residential Level III	Target Population includes members who are leaving the foster care or juvenile justice systems or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. Duration of service is billed one unit per month/The service is expected to achieve outcomes within six to 12 months (six-12 units of service). Additional units may be authorized in exceptional cases as medical necessity dictates. Transitional Youth Services Specialists work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning the life skills needed to support themselves, and working or pursuing education.	H2022 U5

Assertive Community Treatment Step Down (ACT SD) Termination effective date 12/31/2025	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT SD is a community based, person-centered and recovery focused service designed to assist the beneficiary in maintaining stable functioning and wellness while providing support for continued recovery.	Assertive Community Treatment (ACT)	Target Population includes beneficiaries with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six months	H0040 U5
First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) *New ILOS* Effective 07/01/2025	First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member's or beneficiary's first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-	Assertive Community Treatment (ACT)	Target Population includes members must have NC Medicaid or NC Health Choice based on residence in a county located within Vaya's region and be enrolled in Vaya's Behavioral Health and I/DD Tailored Plan or NC Medicaid Direct PIHP; The member must between the ages 15-30 years old, currently experiencing first-episode/onset of psychosis. Duration of Service is one event (or per diem) defined as a 15-minute, face-to-face contact, lasting a minimum of eight minutes.	H0040 HK U5

	ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration.			
Dual Diagnosis Capable (DDC) ACT *New ILOS* Effective 07/01/2025	Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD services with MH services. It helps people address both disorders at the same	SAIOP Facility-Based Crisis	Target Population include ages 18 and older with with a primary SUD diagnosis and a co-occurring MH diagnosis. A member who is appropriate for this service needs assertive engagement to develop treatment motivation. The member does not benefit from receiving services across multiple, disconnected providers, and may be at greater risk of hospitalization, relapse, and/or incarceration.	H0040 HH U5

	time—through the same service organization by the same team of treatment providers.			

Fourth 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. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
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 contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor 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
6.	Failure to open a Medicaid help center case or to confirm or request that DSS open a Rapid Response Team case as described in Sections *V.A.8.i.(i)* or *V.A.8.ii.(i)* of the Contract within one (1) Business Day of the BH I/DD Tailored Plan receiving a notification described in *Sections V.A.8.i.* or *V.A.8.ii.* of the Contract.	$500 per Member per Calendar Day
7.	Failure to develop a *Rapid Response Plan* and attach the Rapid Response Plan to the Member's Medicaid help center or Rapid Response Team case within seven (7) Business Days of the BH I/DD Tailored Plan receiving notification described in *Sections V.A.8.i.(i)* or *V.A.8.ii.(i)* of the Contract.	$500 per Member per Calendar Day
8.	Failure to update a Member's *Rapid Response Plan* and attach the updated *Rapid Response Plan* to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days from the last Rapid Response Plan update on a Member for whom the PIHP received notification described in *Sections V.A.8.i.* or *V.A.8.ii.* of	$500 per Member per Calendar Day

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	the Contract and who is staying in the Emergency Department, DSS Office, hotel, or similar placement while awaiting placement in a clinically appropriate setting for medically necessary services.	
	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.	Reserved.	[redacted]
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
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 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 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 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

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
		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
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.	Reserved.	[redacted]

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	D. Care Management	
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination 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 who has consented to receive Tailored Care Management as described in *Section V.B.3.ii. Tailored Care Management* (including a failure by the Member's assigned AMH+ practice or CMA to develop or complete the required assessment, Care Plan, or ISP).	$250 per deficient/missing care management comprehensive assessment or plan
3.	Reserved.	[redacted]
4.	Reserved.	
5.	Failure to notify the Department within 14 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
6.	Failure to meet annual requirements established by the Department for the percentage of Members who are assigned to a Provider-based Care Management as set forth in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*. (Effective July 1, 2024).	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 ninety-five percent (95%) 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	$125 per occurrence AND Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	funds or as otherwise required in *Section V.B.3.x. Healthy Opportunities*.	service in each identified instance
12.	Failure to timely document and honor a Member's request to opt out or opt back in to Tailored Care Management where the Member has submitted a Tailored Care Management Opt-out Form to the BH I/DD Tailored Plan as described in *Section V.B.3.ii.(iv)(b)(1)-(2) of the Contract.*	$500 per occurrence per Member
13.	Failure to timely process the Member's choice of Tailored Care Management as described in the Tailored Care Management Auto Assignment Requirements Document and *Section V.B.3.ii.(v)(i)* of the Contract.	$500 per occurrence per Member
14.	Failure to comply with minimum Transitional Care Management requirements for Members engaged in Tailored Care Management as described in *Section V.B.3.ii Tailored Care Management* of the Contract.	$125 per occurrence per Member
15.	Failure to comply with minimum care coordination requirements for Members with a Behavioral Health transitional care need as described in *Section V.B.3 Care Management* of the Contract.	$125 per occurrence per Member
	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.	
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.	
8.	Failure to remove Providers that are not actively enrolled in NC Medicaid from the BH I/DD Tailored Plan PHP Network File within one (1) Business Day as specified in *Section V.B.4. Provider Network Management.*	$50 per provider per Business Day.

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
9.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.D.K.5. Technical Specifications.*	$500 per occurrence
	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. Third 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. Third 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. Third Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day
4.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Third 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 Department determines BH I/DD Tailored Plan is not in compliance

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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. Third 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. Third 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 *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Third 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
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

Section VII. Fourth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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. 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 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. Fourth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2025)		
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

Section VII. Fourth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	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.	
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 PIHP Network Data File that meets the Department's specifications.	$125 per Calendar Day
7.	Reserved.	
	C. Claims Management	
1.	Reserved.	
	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
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

Section VII. Fourth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2025)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
3.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Third 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 Department determines 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
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

Table 3: Metrics, SLAs and Liquidated Damages for Unified Services

Section VII. Fourth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2025)					
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 by a live operator 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
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

Section VII. Fourth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 thirty (30) seconds.	The number of incoming calls answered by a live operator 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	$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 by a live operator 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
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
10.	Provider Welcome Packet Timeliness	The BH I/DD Tailored Plan shall meet or	The number of Provider Welcome Packet sent by the BH I/DD Tailored Plan within the	Quarterly	97.99% - 95%: $2,500 per quarter

Section VII. Fourth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in Section *V.B.4. iii Provider Relations and Engagement*.	required timeframe divided by the total number of new providers who have executed a contract with the BH I/DD Tailored Plan during the measurement period		94.99% - 80%: $3,750 per quarter 79.99% or less: $5,000 per quarter
11.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook *Applies if the BH I/DD Tailored Plan utilizes separate mailings to send components of the Welcome Packet*	The BH I/DD Tailored Plan shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification cards) mailed within the timeframes specified in *V.B.1.iii. Member Engagement.*	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the BH I/DD Tailored Plan within the required timeframe divided by the total number of new Members enrolled in the BH I/DD Tailored Plan during the measurement period.	Monthly	98.99% - 95%: $2,500 per month 94.99% - 80%: $3,750 per month 79.99% or less: $5,000 per month
12.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the BH I/DD Tailored Plan utilizes a single mailing to send all components of the*	The BH I/DD Tailored Plan shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the BH I/DD Tailored Plan within the required timeframe divided by the total number of new Members enrolled in the BH I/DD Tailored Plan during the measurement period.	Monthly	98.99% - 95%: $2,500 per month 94.99% - 80%: $3,750 per month 79.99% or less: $5,000 per month

Section VII. Fourth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	Welcome Packet (welcome letter, Member handbook, and identification card)	within the timeframes specified in *V.B.1.iii. Member Engagement*.			
13.	Non-Emergency Medical Transportation – Approved Trips	The BH I/DD Tailored Plan shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the BH I/DD Tailored Plan minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-T-TP operational report, divided by the total number of NEMT trips approved by the BH I/DD Tailored Plan. *NEMT trips for hospital discharges will not be included in determining compliance with this SLA.*	Monthly	99.25%-99.49% = $7,500 per month 99.01%-99.24% = $10,000 per month 99% or less = $12,500 per month

Table 4: Metrics, SLAs and Liquidated Damages for Medicaid Services

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
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	96.00% - 97.99% = $2,500 per month 95.99% or less = $5,000 per month
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	99.01% - 99.49% = $3,750 per month 99.00% or less = $5,000 per month

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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	96.00% - 97.99% = $1,750 per month 95.99% or less = $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	$50,000 per quarter
D. Care Management					
1.	Contracting with AMH+ and CMAs	The BH I/DD Tailored Plan shall contract with one hundred percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in *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 and willing AMH+ practices and CMAs.	Monthly	$25,000 per month
E. In-Reach and Diversion					
1.	Reserved.	[redacted]			

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 by a live operator within thirty (30) seconds of being queued to an agent and abandoned within thirty (30) seconds of being queued to an agent 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
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 by a live operator 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

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 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
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 by a live operator 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

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 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 by a live operator 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
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 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.				

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
14	Encounter Data Timeliness – Medical	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of medical encounters 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	$25 per encounter per Calendar Day
15	Encounter Data Timeliness – Pharmacy	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of pharmacy encounters 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

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
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

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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 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.	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
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

Section VII. Fourth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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
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 Innovations Waiver beneficiaries three (3) to six (6) years of age and twenty (20) years of age and older, the person received a primary care or preventative health service during the measurement period. For Innovations Waiver beneficiaries seven (7) to nineteen (19) years of age, the person received a primary care or preventative health service during the previous two measurement periods.	Annually	$50,000 per year

Section VII. Fourth Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services (Effective July 1, 2025)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Reserved.				
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 one to seven (1-7) Calendar 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 one to seven (1-7) Calendar Days after discharge.	Quarterly	$50,000 per quarter

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Section VII. Fourth 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.	Reserved.		
2.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.		$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 per HSO
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