Request for Application 30-2020-052-DHB BH I/DD Tailored Plan Section VII. RFA Attachments

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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. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	• N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for overseeing assigned care managers. For Medicaid and State-funded Services, these individuals are responsible for reviewing all Care Plans (Medicaid only) and ISPs for quality control and providing guidance to care managers on how to address members' complex health and social needs. For Medicaid, these individuals are responsible for ensuring fidelity to the Tailored Care Management model. For State-funded Services, this position only services recipients with I/DD and TBI.	• Must reside in North Carolina • If serving members with BH conditions, must: o Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT) or licensure as a Registered Nurse (RN) o Have three (3) years of experience providing care management, case management, or care coordination to the population being served • If serving members or recipients with an I/DD or TBI, must have one (1) of the following: o A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area or licensure as an RN; 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 field related to health, psychology, sociology, social work, nursing, or another relevant

Section VII. 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**
		human services area or licensure as an RN; and three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.
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 reside in North Carolina • Must be a Master's-level fully LCSW, fully LCMHC, fully LPA, or fully LMFT • 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	For Medicaid, these individuals shall be responsible for providing integrated whole-person care management under	• Must reside in North Carolina • Must hold a Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant

Section VII. 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**
State-funded Services	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.	human services area or licensure as an RN. • If serving members with BH needs, must have two (2) years of experience working directly with individuals with BH conditions. • If serving members or recipients with an I/DD or TBI, must have two (2) years of experience working directly with individuals with I/DD or TBI • If serving members with LTSS needs, the care manager, must have the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. 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, as described above
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).	• Must reside in North Carolina
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	• Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs • Must meet the care manager supervisor qualifications described above and outlined in *Section V.B.3.ii.(xiv)(c)Care Manager Qualifications.*

Section VII. 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**
	to receive in-reach and transition services.	
7. Full-Time Transition Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for: • individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting.	• Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs 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 individuals with I/DD or TBI; or • Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI.
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 reside in North Carolina • Must have NC Certified Peer Support Specialist Program Certification

Section VII. 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**
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 reside in North Carolina • 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.
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.*	Diversion Specialists: • Must reside in North Carolina; and, • Must 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 • Must have relevant and direct experience providing diversion services under TCLI.
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 reside in North Carolina • 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 reside in North Carolina • Must hold: o a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or o 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	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must reside in North Carolina • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN

Section VII. 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**
	Section V.C.3.e.iv for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. Coordinating and/or performing discharge planning functions for BH I/DD Tailored Plan members and state-funded recipients who are not receiving transition functions and activities described in *Section V.B.3.viii.(iv)* and *Section V.C.3.e.iv* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as the BH I/DD Tailored Plan liaison to ADATCs in the BH I/DD Tailored Plan's region.	plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: • Must reside in North Carolina • Must hold: o a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or o a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or o hold 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 reside in North Carolina • Fully dedicated to North Carolina DHHS programs

Section VII. 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**
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 reside in North Carolina • Fully dedicated to North Carolina DHHS programs
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.	• 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 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.	• 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 reside in North Carolina
19. Provider Relations and Service Line Staff for North Carolina Medicaid	These individuals coordinate communications between the BH I/DD Tailored Plan and providers.	• Must reside in North Carolina

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
Managed Care Program and State-funded Services		
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 reside in North Carolina
21. Provider Complaint, Grievance, and Appeal Coordinator for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs
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 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
24. Full-Time I/DD and TBI Utilization Management Staff for the North Carolina Medicaid Managed Care	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must be a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR § 483.430 (a) and N.C.G.S. § 122C-3

Section VII. 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		
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 reside in North Carolina
27. Liaison to DHB and the DMH/DD/SAS for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with DHB and DMH/DD/SAS	• Must reside in North Carolina
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 reside in North Carolina
29. Special Investigations Unit (SIU) Lead for the North Carolina Medicaid Managed	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate	• Fully dedicated to North Carolina DHHS programs • Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, or pre-

Section VII. 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**
Care Program and State-funded Services	with the Department and OCPI, as well as ensure timely resolution of investigation.	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, or pre-law, 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 reside in North Carolina
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 reside in North Carolina • Minimum of seven (7) years of management experience, preferably in human services

Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies

The *Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies* below documents the list of Clinical Coverage Policies the Department maintains currently for its NC Medicaid Direct program for Medicaid and NC Health Choice-covered 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.

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies

SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy	YES	YES
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Health Choice State Plan, Section 6.2.14 NC Clinical Coverage Policy 15	YES	YES
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy IL-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)	YES	YES

[1] 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. Medicaid and NC Health Choice clinical coverage policies are available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

[2] The Department reserves the right to update the clinical coverage policies for covered benefits.

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	**KEY REFERENCES[1,2]**	**COVERED BY**	
		MEDICAID	**NC HEALTH CHOICE**
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	YES	YES
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes	YES	YES
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	YES	YES
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	YES	YES
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	**KEY REFERENCES[1,2]**	**COVERED BY**	
		MEDICAID	**NC HEALTH CHOICE**
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 Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments 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	YES	YES
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	YES	YES
Durable medical equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Health Choice State Plan Section 6.2.12, 6.2.13 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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*	YES	NO
Family planning services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Health Choice State Plan Section 6.2.9 NC Clinical Coverage Policy 1E-7, Family Planning Services	YES	YES
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 Health Choice State Plan Section 6.2.5	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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	YES	NO
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	YES	YES
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	YES	YES
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	**KEY REFERENCES[1,2]**	**COVERED BY**	
		MEDICAID	**NC HEALTH CHOICE**
	NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 3A		
Home infusion therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy	YES	YES
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 Health Choice State Plan Section 6.2.14 NC Clinical Coverage Policy 3D, Hospice Services	YES	YES
ICF-IID services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities	YES	NO
Innovations waiver services	8P: North Carolina Innovations	YES (Innovations waiver enrollees only)	NO
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	North Carolina Medicaid State Plan, Att. 3.1-E NC Health Choice State Plan, Section 6.2.1 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 Health Choice State Plan Section 6.2.10 NC Clinical Coverage Policy 8B, Inpatient BH Services	YES	YES
Inpatient and Outpatient BH services (Covered by both Medicaid and NCHC)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Diagnostic Assessment	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	Intensive-In-Home Services Multisystemic Therapy Child and Adolescent Day Treatment Partial Hospitalization Substance Abuse Intensive Outpatient Program Outpatient Opioid Treatment Programs 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) 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 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		

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	NC Clinical Coverage Policy 8G – Peer Supports NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH)		
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Health Choice State Plan, Section 6.2.8 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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
		COVERED BY	
SERVICE	KEY REFERENCES[1,2]	MEDICAID	NC HEALTH CHOICE
	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	YES	NO
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 NC Medicaid Managed Care NEMT Policy Guidance	YES	NO
Nursing facility services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities		
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home	YES	NO
Occupational therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15 NC Health Choice State Plan Sections 6.2.14, 6.2.24 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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	YES	YES
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services	YES	YES
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 NC Health Choice State Plan Section 6.2.12 G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21	YES	YES
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	YES	NO
Outpatient and residential BH services (only covered By Medicaid)	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:	YES	NO

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	• Psychosocial Rehabilitation • Professional Treatment Services in a Facility Based Crisis System • Substance Abuse Comprehensive Outpatient Treatment Program • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Community Residential Treatment • Ambulatory Detoxification Services • Non-Hospital Medical Detoxification Services • Medically Supervised or Alcohol or Drug Abuse Treatment Center (ADATC) Detoxification • Community Support Team		
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 NC Health Choice State Plan, Section 6.2.2	YES	YES
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)	YES	NO

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the-Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older	YES	YES
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, Pages7c, 7c.15 NC Health Choice State Plan Sections 6.2.14, 6.2.22 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)	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
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 Health Choice State Plan, Section 6.2.3 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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation		

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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		

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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	YES	YES
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 Health Choice State Plan, Sections 6.2.6, 6.2.7 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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	**KEY REFERENCES[1,2]**	**COVERED BY**	
		MEDICAID	**NC HEALTH CHOICE**
	NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters *Section V.B.2.iii. Pharmacy Benefits* of the Contract		
Private duty nursing services (PDN)	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age	YES	NO
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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	YES	YES
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 Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services	YES	YES
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Health Choice State Plan Section 6.2.5 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	YES	NO
Speech, hearing and language disorder services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16 NC Health Choice State Plan Sections 6.2.14, 6.2.22 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)	YES	YES
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	**KEY REFERENCES[1,2]**	**COVERED BY**	
		MEDICAID	**NC HEALTH CHOICE**
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	YES	NO
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	YES	YES

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	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		

Section VII. Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies			
SERVICE	KEY REFERENCES[1,2]	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants		
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device	YES	YES
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	YES	YES

Attachment C. Approved Behavioral Health In Lieu of Services for Medicaid

The *Section VII. Attachment C. Table 1: Department-Approved Behavioral Health In Lieu of Services* for Medicaid below is a list of all BH In Lieu of Services (ILOS) that have been approved by the Department as described in *Section V.B.2. Benefits*. Offerors must submit the standardized ILOS Service Request Form to the Department for approval if they wish to offer any of these ILOS. Per this Contract, Offeror may use the BH ILOS services or settings that are a medically appropriate, cost-effective alternative to a State Plan covered service.

Section VII. Attachment C. Table 1: Department-Approved Behavioral Health In Lieu of Services for Medicaid
• Behavioral Health Urgent Care • Institution for Mental Disease for acute psychiatric care • Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI) • Rapid Care Services • Family Centered Treatment • Long Term Community Support

Attachment D. Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of BH I/DD Tailored Plan services beginning on July 1, 2022. The Department may make adjustments after Contract Award but in no event will a Key Milestone or Deliverable be due earlier than provided for below.

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
1.	Contract Award	The date the Department will award the Managed Care Contract for BH I/DD Tailored Plans	6/11/2021
2.	Commencement of BH I/DD Tailored Plan Implementation Planning	The date the BH I/DD Tailored Plan Implementation Team must be ready to commence Implementation Planning activities	6/11/2021
3.	Draft Implementation Plan	The date the BH I/DD Tailored Plan's Implementation Plan Draft must be submitted to the Department	Contract Award + fourteen (14) days
4.	Identification of additional resources for Implementation Team	The date the BH I/DD Tailored Plan must identify any additional resources needed to support the implementation activities	Contract Award + twenty (20) days
5.	Submission of BH I/DD Tailored Plan Operating Plan	The date the BH I/DD Tailored Plan's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
6.	Submission of key technology deliverables	The date the BH I/DD Tailored Plan submits to the Department: • Security Compliance Plan • Encounter and Claims Implementation Approach • System Interface Design	Contract Award + thirty (30) days
7.	Submission of Business Continuity Plan	The date the BH I/DD Tailored Plan's Business Continuity Plan must be submitted to the Department	Contract Award + thirty (30) days
8.	Submission of key Medicaid and State-funded provider materials	The date the BH I/DD Tailored Plan submits to the Department: • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual	Contract Award + thirty (30) days

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
9.	Submission of member and recipient education efforts	The date the BH I/DD Tailored Plan submits its planned member and recipient education efforts to the Department	Contract Award + sixty (60) days
10.	Acquisition of service line phone numbers	The date the BH I/DD Tailored Plan must have its service line phone number acquired and operationalized	Contract Award + sixty (60) days
11.	Submission of Tobacco Cessation Plan	The date the BH I/DD Tailored Plan must submit a Tobacco Cessation Plan to the Department	Contract Award + ninety (90) days
12.	Submission of Fraud Prevention Plan	The date the BH I/DD Tailored Plan must submit a Fraud Prevention Plan to the Department for review and approval	Contract Award + ninety (90) days
13.	Establishment of BH I/DD Tailored Plan Office and Call Center(s) in NC	The date the BH I/DD Tailored Plan must begin implementing call center(s) and staff in North Carolina	Contract Award + ninety (90) days
14.	Submission of Locum Tenens Policy	The date the BH I/DD Tailored Plan submits to the Department the Locum Tenens Policy	Contract Award + ninety (90) days
15.	Tribal Engagement Strategy (as applicable)	The date the BH I/DD Tailored Plan's Tribal Engagement Strategy Medicaid must be submitted to the Department for review	Contract Award + ninety (90) days
16.	Pharmacy Provider Network Audit Program	The date the BH I/DD Tailored Plan's Pharmacy Provider Network Audit Program Medicaid must be submitted to the Department	Contract Award + ninety (90) days
17.	Mail Order Program Policy	The date the BH I/DD Tailored Plan's Mail Order Program Policy Medicaid, including a sample of all member mail order-related correspondence, must be submitted to the Department	Contract Award + ninety (90) days
18.	Good Faith Provider Contracting Policy	The date the BH I/DD Tailored Plan shall develop and submit Good Faith Provider Contracting Policy that includes a description of how the BH I/DD Tailored Plan will conclude that a "good faith" contracting effort has been made and/or refused and the Objective	Contract Award + ninety (90) days

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	Key Milestone	Description	Tentative Date
		Quality Standards used in contracting decisions	
19.	Submission of Third Party Liability Policy	The date the BH I/DD Tailored Plan submits to the Department the Third Party Liability Policy	Contract Award + ninety (90) days
20.	Whistleblower Policy	The date the BH I/DD Tailored Plan shall develop and submit a Whistleblower Policy related to whistleblower protections	Contract Award + ninety (90) days
21.	Submission of key member and recipient materials	The date the BH I/DD Tailored Plan submits to the Department: • Member Enrollment and Disenrollment Policy • Member ID Card • Member Welcome Packet • Recipient Welcome Packet • Member and Recipient Mailing Policy • Member and Recipient Rights and Responsibilities Policy	Contract Award + ninety (90) days
22.	Opioid Misuse Prevention and Treatment Program Policy	The date the BH I/DD Tailored Plan shall develop and submit an Opioid Misuse Prevention Program Policy for Medicaid	Contract Award + ninety (90) days
23.	Submission of Training Program	The date the BH I/DD Tailored Plan's training and evaluation program must be submitted to the Department	Contract Award + ninety (90) days
24.	Submission of Transition of Care Policy	The date the BH I/DD Tailored Plan shall submit the Medicaid Transition of Care Policy to the Department for review and approval	Contract Award + ninety (90) days
25.	Provider Grievances and Appeals Policies	The date the BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policies for both Medicaid and State-funded services	Contract Award + one hundred twenty (120) days
26.	State-funded Recipient Eligibility Policy	The date the BH I/DD Tailored Plan must submit the recipient eligibility policy to the Department for review and approval	Contract Award + one hundred fifty (150) days

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
27.	Submission of key clinical and care management materials	The date the BH I/DD Tailored Plan submits to the Department • Medicaid and State-funded Care Management Policies • Medicaid and State-funded UM Program Policies • Medicaid EPSDT Policy • Medicaid NEMT Policy • System of Care Policy • In-Reach and Transition Policy	Contract Award + one hundred fifty (150) days
28.	Submission of Local Community Collaboratives Strategy	The date the BH I/DD Tailored Plan must submit the Local Community Collaboratives Strategy to the Department for review and approval	Contract Award + one hundred fifty (150) days
29.	Submission of VBP Assessment and VBP Strategy for Medicaid	The date the BH I/DD Tailored Plan's first retrospective VBP Assessment and prospective VBP Strategy must be submitted to the Department	Contract Award + six (6) months
30.	Draft BH I/DD Tailored Plan marketing materials	The date the BH I/DD Tailored Plan's marketing materials must be submitted to the Department	Sixty (60) days before Commencement of BH I/DD Tailored Plan Marketing Activities
31.	Contracting with AMH+ and CMAs for Tailored Care Management	The date the contracts must be finalized with certified AMH+ practices and CMAs for Tailored Care Management	Ninety (90) days before BH I/DD Tailored Plan launch
32.	Contracting with PCPs	The date the contracts must be finalized with providers to allow for PCP assignment	Ninety (90) days before BH I/DD Tailored Plan launch
33.	PCP Auto Assignment	The date that PCP auto assignment must be completed for members enrolling in BH I/DD Tailored Plans at launch	Sixty (60) days before BH I/DD Tailored Plan launch
34.	Commencement of Marketing Activities	The date the BH I/DD Tailored Plan is allowed to begin marketing activities	Sixty (60) days before BH I/DD Tailored Plan launch

Section VII. Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	**Key Milestone**	**Description**	**Tentative Date**
35.	Tailored Care Management Member Enrollment Packets	The date BH I/DD Tailored Plans will send members their Tailored Care Management enrollment packet, with information on their care management assignment, options for changing their assignment, and a Tailored Care Management opt-out form	Thirty (30) days before BH I/DD Tailored Plan launch
36.	BH I/DD Tailored Plan Launch	The date the BH I/DD Tailored Plan must begin delivering health care services to members and recipients	July 1, 2022
37.	Funding of Risk Reserves	The BH I/DD Tailored Plan must meet the capital requirements as outlined in *Section V.B.7.iii.(vii) Financial Viability* and *Section V.C.7.i. Financial Viability*	July 1, 2022

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 within thirty (30) days of Contract Award. The BH I/DD Tailored Plan will also be required to report the Innovations and TBI waiver measures listed *in Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measurers* and *Section VII. 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.

Section VII. Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	NA	Child and Adolescent Well-Care Visit	NCQA	Annually Calendar Year	June 1
2.	NA	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	CMS	Annually Calendar Year	June 1
3.	0038	Childhood Immunization Status (Combo 10)	NCQA	Annually Calendar Year	June 1
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA	Annually Calendar Year	June 1
5.	9999	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	NCQA	Annually Calendar Year	June 1
6.	1407	Immunizations for Adolescents	NCQA	Annually Calendar Year	June 1
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Annually Calendar Year	June 1
8.	NA	Well-Child Visits in the First 30 Months of Life	NCQA	Annually Calendar Year	June 1

Section VII. Attachment E.1. Table 2: Survey Measures and General Measures: Adult					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	0105	Antidepressant Medication Management	NCQA	Annually Calendar Year	June 1
2.	0032	Cervical Cancer Screening	NCQA	Annually Calendar Year	June 1
3.	0033	Chlamydia Screening in Women	NCQA	Annually Calendar Year	June 1
4.	0059	HbA1c Poor Control (>9.0%)[1]	NCQA	Annually Calendar Year	June 1
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA	Annually Calendar Year	June 1
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC	Annually Calendar Year	June 1
7.	0018	Controlling High Blood Pressure	NCQA	Annually Calendar Year	June 1
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	Annually Calendar Year	June 1
9.	0039	Flu Vaccinations for Adults	NCQA	Annually Calendar Year	June 1
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA	Annually Calendar Year	June 1
11.	0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	Annually Calendar Year	June 1
12.	1768	Plan All Cause Readmissions	NCQA	Annually Calendar Year	June 1
13.	0418/ 0418e	Screening for Depression and Follow-up Plan[2]	NCQA	Annually Calendar Year	June 1

[1]Pending additional information regarding the collection of clinical data

[2] Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in patients where it’s not appropriate

Section VII. Attachment E.1. Table 2: Survey Measures and General Measures: Adult					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
14.	2940	Use of Opioids at High Dosage in-Persons Without Cancer	PQA	Annually Calendar Year	June 1
15.	2950	Use of Opioids from Multiple Providers in-Persons Without Cancer	PQA	Annually Calendar Year	June 1

Section VII. Attachment E.1. Table 3: Survey Measures and General Measures: Maternal					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	NA	Percentage of Low Birthweight Births (Live Births Weighing Less than 2,500 Grams)	NC DHHS	Annually Calendar Year	June 1
2.	1517	Prenatal and Postpartum Care	NCQA	Annually Calendar Year	June 1

Section VII. Attachment E.1. Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction					
Ref #	**NQF #**	**Measure Name**	**Steward**	**Frequency**	**Submission**
1.	0006	CAHPS Survey	AHRQ	Annually Calendar Year	June 1

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
14.	Percentage of beneficiaries reporting that their ISP has the services that they need	NC DHHS	Annually Fiscal Year	November 1

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
15.	Proportion of ISPs 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 11
16.	Proportion of ISPs in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of individuals whose annual ISP was revised or updated	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
18.	Proportion of individuals for whom an annual ISP took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
19.	Number and percentage of waiver participants whose ISPs were revised, as applicable, by the Care Coordinator to address their changing needs	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 3 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP.	NC DHHS	Quarterly 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
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within 45 days of ISP approval.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
22.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly 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
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly 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.	Percentage of Innovations waiver 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.	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries	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

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, 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
30.	Percentage of BH I/DD TP Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Number and percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly 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.	Percentage of level 2 and 3 incidents reported within required 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

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
34.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly 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.	Percentage of restrictive interventions (both restraint and seclusion) resulting 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 proportion of claims paid by the BH I/DD TP for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
38.	The consistency of NC Innovations capitated rates (The proportion of the BH I/DD TP Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM)	NC DHHS	Annually Fiscal Year	November 1
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly 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

Section VII. Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
40.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly 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
41.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly 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
42.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly 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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
3.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
5.	Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
6.	Proportion of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
7.	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of Individual Support Plans that address identified health and safety risk factors	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
17.	Proportion of new waiver beneficiaries receiving services according to their ISP within 45 days of ISP approval	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	NC DHHS	Quarterly 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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly 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
23.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation 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
24.	Number and Percentage of deaths where required BH I/DD TP 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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
25.	Percentage of medication errors resulting 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
26.	Percentage 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
27.	Percentage of level 2 and 3 incidents reported within required time frames	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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
28.	Percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required.	NC DHHS	Quarterly 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.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation 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
30.	Percentage of restrictive interventions resulting 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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	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
32.	Percent of restrictive interventions used by a trained staff member.	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.	Percent of restrictive interventions that are documented according to state policy.	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

Section VII. Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Submission**
34.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	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
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 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.	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

2. BH I/DD Tailored Plan Quality Metrics for State-funded Services

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be released no later than six (6) months prior to BH I/DD Tailored Plan launch. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance measures.

Measures that the BH I/DD Tailored Plan will be expected to calculate and report with associated liquidated damages are indicated with an asterisk (*). The full list of performance measures, service level agreements and associated liquidated damages are listed in *Section VII. Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*.

Section VII. Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
1.	Initiation of Services	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
2.	Engagement in Services	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
3.	Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
4.	State Hospital Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
5.	ADATC Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
6.	Community MH Inpatient Readmissions within thirty (30) Days	NC DHHS	Quarterly	a. February 15

Section VII. Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	**Measure**	**Steward**	**Measurement Period**	**Report Due**
			a. July – September b. October – December c. January – March d. April - June	b. May 15 c. August 15 d. November 15
7.	Community SUD Inpatient Readmission within thirty (30) Days	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
8.	TCLI Population Employment	NC DHHS	July - June	June 1
9.	**Housing Retention: Maintains at Least Same Level of Individuals in Supportive Housing as Targeted Under TCLI***	NC DHHS	Quarterly a. July – September b. October – December c. January – March d. April - June	a. February 15 b. May 15 c. August 15 d. November 15
10.	**Housing Retention: No Fewer than 90% of People In Supportive Housing Slots Remain in Supportive Housing***	NC DHHS	Quarterly a. September + 12-month lookback b. December + 12-month lookback c. March + 12-month lookback d. June + 12-month lookback	a. November 15 b. February 15 c. May 15 d. August 15

Attachment F. BH I/DD Tailored Plan Network Adequacy Standards

1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid

At a minimum, Offeror's Medicaid network shall consist of hospitals, physicians, advanced practice nurses, SUD and mental health treatment providers, I/DD and TBI providers, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section V.B.4.i. Provider Network.*

For the purposes of this attachment and the BH I/DD Tailored Plan Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties which will be covered by the applicable BH I/DD Tailored Plan." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

More background information is available at: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf. The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all members have timely access to all covered health care services, Offeror shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Certain service types not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include: hospitals, pharmacies, occupational, physical, or speech therapists, pulmonology specialty, 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. Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid* and *Section VII. Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid.*

Section VII. 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	≥ 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

Section VII. Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
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[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
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient BH Services	• ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members • *Research-based BH treatment for Autism Spectrum Disorder (ASD)*: Not subject to standard	• ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members • *Research-based BH 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 Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members	• *Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2 providers of each service within 45 minutes or

[1] Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Child and Adolescent Day Treatment Services:* Not subject to standard	45 miles of residence for at least 95% of members • *Child and Adolescent Day Treatment Services:* Not subject to standard
9	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: o 2+ facilities within each BH I/DD Tailored Plan Region, OR o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* ≥ 1 provider within each BH I/DD Tailored Plan Region • *Non-Hospital Medical Detoxification:* ≥ 2 provider within each BH I/DD Tailored Plan Region • *Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:* ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
10	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12	Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
13	All State Plan LTSS (except nursing facilities)*	≥ 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, • *Substance Abuse Medically Monitored Residential Treatment:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region *(refer to 10A NCAC 27G.3400)* • *Substance Abuse Non-Medical Community Residential Treatment*:	

Section VII. Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		o *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) o *Adolescent:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region o *Women & Children:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region • *Substance Abuse Halfway House*: o *Adult:* Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[2] o *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • *Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:* Not subject to standard	
16	1915(c) HCBS Waiver Services: NC Innovations	• *Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:* ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification*: Not subject to standard	
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• *Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:* ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports:* ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification*: N/A	

[2] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. 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) • Office-based opioid treatment (OBOT) • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (BH I/DD)	• Psychosocial rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory detoxification • Non-hospital medical detoxification (adult) • Ambulatory withdrawal management with extended on-site monitoring • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)
4.	Inpatient BH Services	*Inpatient Hospital – Adult* • Acute care hospitals with adult inpatient psychiatric beds • Other hospitals with adult inpatient psychiatric beds • Acute care hospitals with adult inpatient substance use beds • Other hospitals with adult inpatient substance use beds *Inpatient Hospital – Adolescent / Children* • Acute care hospitals with adolescent inpatient psychiatric beds • Other hospitals with adolescent inpatient psychiatric beds • Acute care hospitals with adolescent inpatient substance use beds • Other hospitals with adolescent inpatient substance use beds • Acute care hospitals with child inpatient psychiatric beds • Other hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	• Partial hospitalization (adults and children)

Section VII. Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
6.	Residential Treatment Services	• Residential treatment facility services • Substance abuse non-medical community residential treatment • Substance abuse medically monitored residential treatment • Psychiatric residential treatment facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities ICF-IID:
7.	Community/Mobile Services	• Assertive community treatment • Community support team • Intensive in-home services • Multi-systemic therapy services • Peer supports • Diagnostic assessment
8.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications
9.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy

Section VII. Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
		• Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Vehicle Modifications

Offeror 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. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) calendar days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) calendar days for member less than six (6) months of age Within thirty (30) calendar days for members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours

Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) calendar days
Prenatal Care			
5	Initial Appointment – 1st or 2nd Trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within fourteen (14) calendar days
5a	Initial Appointment – high risk pregnancy or 3rd Trimester		Within five (5) calendar days
Specialty Care			
6	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
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. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within two (2) hours

Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
11	Emergency Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
12	Emergency Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
14	Urgent Care Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
15	Urgent Care Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and*	Within twenty-four (24) hours

Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
		Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients	
16	Routine Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within fourteen (14) calendar days
17	Routine Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice 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. Attachment F.1. Table 1: BH I/DD Tailored Plan Time or Distance Standards for Medicaid* and *Section VII. Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid* as found in this attachment:

Section VII. 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

Section VII. Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	**Service Type**
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[3]
21.	Radiology
22.	Rheumatology
23.	Urology

[3] Not subject to separate adult and pediatric provider standards.

2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services

At a minimum, Offeror's State-funded Services network shall consist of mental health, SUD, I/DD and TBI providers and Three-Way Contract inpatient care providers, and all other provider types necessary to support capacity to make all services sufficiently available as described in *Section V.C.4.a. Provider Network.*

For the purposes of this attachment and the BH I/DD Tailored Plan Network Adequacy Standards, "urban" is defined as non-rural counties, or counties with average population densities of two hundred fifty (250) or more people per square mile. This definition includes twenty (20) counties that are categorized by the North Carolina Rural Economic Development Center as "regional cities or suburban counties" or "urban counties which will be covered by the applicable BH I/DD Tailored Plan." "Rural" is defined as a county with average population density of less than two hundred fifty (250) people per square mile.

More background information is available at: http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf. The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all members have timely access to all covered health care services, Offeror 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. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice 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. 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. Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients[1] *Assertive Engagement:* To be determined	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients *Assertive Engagement:* To be determined
2	Location-Based Services^	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive*	• *Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive*

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

<table>
<tr><th colspan="4">Section VII. Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards</th></tr>
<tr><th>Reference Number</th><th>Service Type</th><th>Urban Standard</th><th>Rural Standard</th></tr>
<tr><td></td><td></td><td>Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients
• Child and Adolescent Day Treatment Services: Not subject to standard</td><td>Outpatient Program, Outpatient Opioid Treatment (OTP): ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients
• Child and Adolescent Day Treatment Services: Not subject to standard</td></tr>
<tr><td>3</td><td>Crisis Services^</td><td colspan="2">• Facility based crisis for adults: The greater of:
o 2+ facilities within each BH I/DD Tailored Plan Region, OR
o 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available).
• Non-Hospital Medical Detoxification: ≥ 2 provider within each BH I/DD Tailored Plan Region
• Ambulatory Detoxification and BH Urgent Care: ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region</td></tr>
<tr><td>4</td><td>Inpatient BH Services</td><td colspan="2">≥ 1 provider within each BH I/DD Tailored Plan Region</td></tr>
<tr><td>6</td><td>Community/Mobile Services^</td><td colspan="2">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.</td></tr>
<tr><td>7</td><td>Residential Treatment Services</td><td colspan="2">• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region
• Substance Abuse Halfway House:
o Adult: Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[2]
o Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)</td></tr>
</table>

[2] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
		• *Substance Abuse Medically Monitored Community Residential Treatment*: Access to ≥1 licensed provider • *Substance Abuse Non-Medical Community Residential Treatment*: o *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department) o *Adolescent:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region o *Women & Children:* Contract with all designated CASPs within the BH I/DD Tailored Plan's Region • *Substance Use Residential Supports & Mental Health Recovery Residential Services:* To be determined	
8	Employment and Housing Services	• *Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use):* 100% of eligible recipients must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. • *Individual Placement and Support-Supported Employment (Adult MH):* 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *Meaningful day and prevocational services:* 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • *Clinically Managed Population-specific High Intensity Residential Programs*: To be determined • *TBI long-term residential rehabilitation services*: Not subject to standard	
9	Case Management	• *Case Management (Adult BH, Child/HFW):* 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. Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards and Section VII. Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards.*

Section VII. 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	SUD
1	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y
		Assertive Engagement		Y		Y
2	Location-Based Services^	Psychosocial Rehabilitation		Y		
		Substance Abuse Comprehensive Outpatient				Y
		Substance Abuse Intensive Outpatient Program				Y
		Outpatient Opioid Therapy				Y
3	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y
		Mobile Crisis	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y
		Ambulatory Detoxification				Y
		BH Urgent Care	Y	Y	Y	Y
4	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y
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 Supports				Y
		Mental Health Recovery and Residential Services		Y		
7	Community/Mobile Services^	Assertive Community Treatment		Y		
		Community Support Team		Y		Y
		Peer Supports		Y		Y
		Transition Management Service		Y		
8	Employment and Housing Services	Meaningful day and prevocational services	Y			
		Residential Services	Y	Y		

Section VII. 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**	**SUD**
		Respite Services	Y		Y	
		Individual Placement and Supports (IPS)-Supported Employment	Y	Y		Y
		TBI Long-term Residential Rehabilitation Services	Y			
		Clinically Managed Population-specific High Intensity Residential Programs	Y			
9	Case Management	Case Management		Y	Y[3]	Y

Offeror 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. 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. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice 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. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health*	Emergency Services available immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

[3] The Department intends to offer slots for high fidelity wraparound services for children and adolescents.

Section VII. Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
		Choice Members and State-funded Recipients	
3	Emergency Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice 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. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice 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.Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours
6	Urgent Care Services for SUDs	Refer to *Section VII.Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within twenty-four (24) hours

Section VII. Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
7	Routine Services for Mental Health	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within fourteen (14) calendar days
8	Routine Services for SUDs	Refer to *Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients*	Within forty-eight (48) hours

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.
   c. Contract Term: The contract term shall not exceed the term of the BH I/DD Tailored Plan Contract with the State.
   d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination.
   e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
      i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
         1. Transition of administrative duties and records; and
         2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
   f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation requirements as outlined in the BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.

ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:

1. During the provider credentialing transition period, no less frequently than every five (5) years.
2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.

g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan and 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 to receive the service; and

ii. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.

i. Provider Accessibility: The contract must address provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:

i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;

ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and

iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the provider.

j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the BH I/DD Tailored Plan, before rendering health care services.

k. Medical Records: The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:

i. Maintain confidentiality of member medical records and personal information and other health records as required by law;

ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and

iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made

available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Member Appeals and Grievances: The contract must address the provider's obligation to cooperate with the member in regard to member appeals and grievance procedures.

m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.

n. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.

o. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the BH I/DD Tailored Plan's web-based billing process.

p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
   i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
   ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
   iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.

q. Utilization Management (UM): The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.

s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.

t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.B.4.v. Provider Grievances and Appeals.*

u. Assignment: Provisions on assignment of the contract must include that:
   i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
   ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.

w. Interpreting and Translation Services: The contract must have provisions that indicate:

   i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.

   ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

   iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

x. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.

y. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.

z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

aa. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.

bb. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:

   i. G. S. 58-3-200(c).

   ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).

   iii. G.S. 58-50-270(1), (2), and (3a).

   iv. G.S. 58-50-275 (a) and (b).

   v. G.S. 58-50-280 (a) through (d).

   vi. G.S. 58-50-285 (a) and (b).

   vii. G.S. 58-51-37 (d) and (e).

cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.

dd. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in *Section V.B.4.iv. Provider Payments* of the BH I/DD Tailored Plan Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the BH I/DD Tailored Plan shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Section VII. 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.

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

a. Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members

b. Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members

c. Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members

d. Section VII. Attachment M.6. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members

3. All contracts between BH I/DD Tailored Plan and providers that are created or amended, must include the following provisions verbatim, except BH I/DD Tailored Plan may insert appropriate term(s), including pronouns, to refer to the BH I/DD Tailored Plan, the provider, the BH I/DD Tailored Plan/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:

a. Compliance with state and federal laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

b. Hold Member Harmless

The [Provider] agrees to hold the member harmless for charges for any covered service. The [Provider] agrees not to bill a member for medically necessary services covered by the Company so long as the member is eligible for coverage.

c. Liability

The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

d. Non-discrimination

Equitable Treatment of Members

The [Provider] agrees to render Provider Services to members with the same degree of care and skills as customarily provided to the [Provider's] patients who are not members, according to generally accepted standards of medical practice. The [Provider] and [Company] agree that members and non-members should be treated equitably. The [Provider] agrees not to discriminate against members on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.

e. Department authority related to the Medicaid program

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

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.

The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC Department of Health and Human Services.

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. Provider ownership disclosure

The [Provider] agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs.

The [Provider] agrees to notify, in writing, the [Company] and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

h. G.S. 58-3-225, Prompt claim payments under health benefit plans.

Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, BH I/DD Tailored Plan shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the [Provider's] failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i. For Medical claims (including BH):
   1. The [Company] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the provider whether the claim is clean or pend the claim and request from the provider all additional information needed to process the claim.
   2. The [Company] shall pay or deny a clean medical claim at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
   3. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

ii. For Pharmacy Claims:
   1. The [Company] shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.

2. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.

iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [Company] shall deny the claim per § 58-3-225 (d).

1. The [Company] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

iv. If the [Company] fails to pay a clean claim in full pursuant to this provision, the [Company] shall pay the [Provider] interest and liquidated damages. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

v. Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] liquidated damages equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

vi. The [Company] shall pay the interest and liquidated damages from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to requests the interest or the liquidated damages.

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.

c. Contract Term: The contract term shall not exceed the term of the BH I/DD Tailored Plan Contract with the Department.

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 BH I/DD Tailored Plan’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 to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.

   i. 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 to receive the service.

h. 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.

i. 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.

j. 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.

k. 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.

l. 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.

m. 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.

n. 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.

o. 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.

p. 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.

q. Quality Management: The contract must address the provider’s participation in the compliance process and the Network Continuous Quality Improvement process.

r. 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.

s. 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.*

t. 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.

u. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.

v. 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.

w. 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.

x. 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).

y. 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.

z. 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.

2. **All contracts between BH I/DD Tailored Plan and providers that are created or amended, must include the following provisions verbatim, except BH I/DD Tailored Plan may insert appropriate term(s), including pronouns, to refer to the BH I/DD Tailored Plan, the provider, the BH I/DD Tailored Plan/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:**

   a. Compliance with state laws

      The [Provider] understands and agrees that it is subject to all state laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's State-funded Services contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state funds. The [Provider] understands and agrees that any violation by a provider of a state law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under Federal or state law.

   b. Hold Recipient Harmless

      The [Provider] agrees to hold the recipient harmless for charges for any covered service. The [Provider] agrees not to bill a recipient for medically necessary services covered by the Company so long as the recipient is eligible for coverage.

   c. Liability

      The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

   d. Non-discrimination: Equitable Treatment of Recipients:

      The [Provider] agrees to render Provider Services to recipients of State-funded Services with the same degree of care and skills as customarily provided to the [Provider's] patients who are not recipients, according to generally accepted standards of medical practice. The [Provider] and [Company] agree that recipients and non-recipients should be treated equitably. The [Provider] agrees not to discriminate against recipients on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.

   e. Access to provider records

      The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

      i. NC DHHS, its State-funded Services personnel, or its designee;
      ii. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
      iii. The North Carolina Office of State Auditor, or its designee;

iv. A state law enforcement agency; and

v. Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.

f. The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the NC DHHS.

g. Provider ownership disclosure

The [Provider] agrees to notify, in writing, the [Company] and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction.

Attachment H. Addendum for Indian Health Care Providers

The BH I/DD Tailored Plan shall use the following addendum, without change, with all provider contracts with Indian Health Care Providers (IHCPs).

1. **Purpose of Addendum; Supersession.**
   The purpose of this BH I/DD Tailored Plan Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between ____(herein "BH I/DD Tailored Plan") and ____(herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the BH I/DD Tailored Plan's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions. [1]

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

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

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

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

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

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

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

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

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

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

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[1] Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

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

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

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

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

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

- ☐ IHS.
- ☐ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.
- ☐ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 450 et seq.
- ☐ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
- ☐ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost Sharing Exemption for Indians; No Reduction in Payments.

The BH I/DD Tailored Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. Member Option to Select the IHCP as Primary Health Care IHCP.

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

6. Agreement to Pay IHCP.

The BH I/DD Tailored Plan shall pay the IHCP for covered Medicaid Managed Care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

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

8. **Applicability of Federal Laws not Generally Applicable to other Providers.**
   Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving BH I/DD Tailored Plan members. Applicable provisions may include, but are not limited to, those laws cited within this Addendum.

9. **Non-Taxable Entity.**
   To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a BH I/DD Tailored Plan to collect or remit any federal, state, or local tax.

10. **Insurance and Indemnification.**
    a. Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.
    b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the BH I/DD Tailored Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.
    c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the BH I/DD Tailored Plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the BH I/DD Tailored Plan network provider agreement

or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC §§ 1621t and 1647a, the BH I/DD Tailored Plan shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the BH I/DD Tailored Plan shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

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

13. Governing Law.

The BH I/DD Tailored Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the BH I/DD Tailored Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

To the extent the BH I/DD Tailored Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

15. Claims Format.

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

16. Payment of Claims.

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

17. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the BH I/DD Tailored Plan as to its hours and days of service. At the request of the BH I/DD Tailored Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the BH I/DD Tailored Plan.

19. **Sovereign Immunity.**
    Nothing in the BH I/DD Tailored Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. **Endorsement.**
    IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the BH I/DD Tailored Plan.

APPROVALS

For the BH I/DD Tailored Plan:

*Date:*_________________________________

*Signature:*______________________________

For the IHCP:

Date: ____________________________________

*Signature:*_________________________________

<u>Applicable Federal Laws Referenced in Section 8 of this Addendum</u>

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

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

(c) An urban Indian organization that is an IHCP:
   (1) IHCIA, 25 U.S.C. § 1601 et seq.
   (2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
   (3) HIPAA, 45 C.F.R. Parts 160 and 164.

Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers

The following are the reasons for which the BH I/DD Tailored Plan must allow a provider to appeal an adverse decision made by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall provide an appeals process to providers in accordance with *Section V.B.4.v. Provider Grievances and Appeals for Medicaid and Section V.C.4.e. Provider Grievances and Appeals for State-funded Services.*

Section VII. Attachment I.1. Table 1: Provider Appeals for Medicaid, NC Health Choice Providers, and State-funded Services Providers	
Reference Number	**Appeal Criteria**
For Network Providers	
1	A network provider has the right to appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a network provider for the following reasons: a) Program Integrity related findings or activities; b) Finding of fraud, waste, or abuse by the BH I/DD Tailored Plan; c) Finding of or recovery of an overpayment by the BH I/DD Tailored Plan; d) Withhold or suspension of a payment related to fraud, waste, or abuse concerns; e) Termination of, or determination not to renew, an existing contract for LHD care/case management services; f) Determination to de-certify an AMH+ or CMA (applicable to Medicaid providers only); and g) Violation of terms between the BH I/DD Tailored Plan and provider.
For Out-of-Network Providers	
2	An out-of-network provider may appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to an out-of-network provider for the following reasons: a) An out-of-network payment arrangement; b) Finding of waste or abuse by the BH I/DD Tailored Plan; and c) Finding of or recovery of an overpayment by the BH I/DD Tailored Plan.

Attachment J. Reporting Requirements

The following tables detail the reports that the BH I/DD Tailored Plan must submit to the Department. The Department will provide additional details on report format, fields and frequency after Contract Award. 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 *Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services* and *Attachment J. Table 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 *Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *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 *Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services*. The Department will provide additional details and on report format, fields and frequency after Contract Award.

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

Section VII. 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 and Management		
1. BH I/DD Tailored Plan 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

Section VII. 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. BH I/DD Tailored Plan Delegation Report	Report for each core Medicaid operations entity and SFS, including evidence of the BH I/DD Tailored Plan's oversight activities and describing entity performance including key operating priorities, key metrics, corrective actions taken, and 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. Planned Marketing Procedures, Activities, and Methods Report	Annual report of planned marketing activities including number/types of events, locations, description of materials distributed, and number of members or recipients reached.	Annually
4. Member and Recipient Appeals and Grievances Report	Monthly 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.	Monthly
5. Monthly TCLI and CHCN Report	Monthly report containing the names and member Medicaid ID numbers of the Transitions to Community Living Initiative and Children with Complex Needs in the BH I/DD Tailored Plan's Region.	Monthly
C. Care Management		
1. System of Care Report	Quarterly report of System of Care activities, including, but not limited to, coordination of care across child public service systems, Community Collaboratives, care planning, and implementation of evidence-based practices in communities.	Quarterly
D. Community Inclusion		
1. Daily Reporting on Community Living 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 individuals with Serious Mental Illness (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

Section VII. 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. Daily Reporting on Rental Subsidies	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
E. Providers		
1. Network Access Plan	At least annual plan demonstrating that the BH I/DD Tailored Plan has the capacity to serve the expected enrollment on a regional basis.	Annually
2. Network Adequacy Exceptions Report	Quarterly report of active granted network adequacy exceptions, including date of approval, description of how members' and recipients' needs are being met, the BH I/DD Tailored Plan work to alleviate the inadequacy, and the specific network adequacy to which the exception applies.	Quarterly
3. Network Adequacy Exceptions Narrative Report	Narrative quarterly report of active granted network adequacy exceptions, including date of approval, description of how members' and recipients' needs are being met, the PHPs work to alleviate the inadequacy, and the specific network adequacy to which the exception applies. Submit with Network Adequacy Exceptions Report	Quarterly
4. Network Activity Report	Quarterly report with various data relating to network access including accounting for new and terminated providers, patient access under transitions of care, PCP selection/assignment, and provider outreach efforts during the reporting period.	Quarterly
5. 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
6. Provider Contracting Determinations and Activities Narrative Report	Quarterly and ad hoc narrative report providing the turn-around-time and statistics for key provider contracting and service functions, including issuance to the provider of a Quality Determinations, provider welcome packets, and other quality determination activities made by the during the reporting period, including break down of data by provider type and by specified turn-around time periods. Submit with Provider Contracting Determinations and Activities Narrative Report.	Quarterly & Ad hoc
7. Ad-Hoc Network Adequacy Report	Ad hoc report of network adequacy results which measures accessibility data to demonstrate the distance from the members' or recipients' residences that a member or recipient must travel to reach contracted providers for each of the applicable provider types for adult and pediatric/child populations separately (as applicable).	Ad hoc
8. Network Adequacy Annual	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where members or recipients live.	Annually

Section VII. 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**
Submission Report		
9. 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
10. 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
11. 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
12. Litigated Provider Appeals Report	Monthly report on litigated provider of appeals, including number/type of appeal and appeal outcomes.	Monthly
13. Provider Quality Assurance Report	Quarterly report of survey results which measures providers' 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
14. BH I/DD Tailored Plan Affiliation Report	Ad hoc report that contains all doctors, health professionals, and facilities paid by a BH I/DD Tailored Plan to provide service to plan members or recipients. The results from the reports from each BH I/DD Tailored Plan will consolidated and shared broadly with provider community so they can validate that their data and contracting details are correct, at the individual practitioner level.	Ad Hoc
F. Quality and Value		
1. QAPI Report	Quarterly QAPI update on activities outlined in the QAPI.	Quarterly
2. PIP Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
3. Interim Quality Measures Report	Monthly BH I/DD Tailored Plan interim performance on quality measures.	Monthly
4. Experience of Care and Health Outcomes Survey – Enrollee Data	PIHP submits data on recipients or recipients in the BH I/DD Tailored Plan's Catchment Area to the EQRO. The EQRO uses this data to complete the annual survey.	Annually

Section VII. 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**
G. 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
H. 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
I. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the BH I/DD Tailored Plan, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members and Recipients	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. Other Member & Recipient Complaints Report	Monthly report detailing a cumulative listing of member and recipient 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
6. Overpayment Recoveries	Annual report of overpayment recoveries.	Annually
7. Program Integrity Termination Report	Monthly report on staff terminations related to suspected and confirmed fraud.	Monthly
8. Compliance Plan	Written policies, procedures and standards of conduct as required.	Annually

Section VII. 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**
9. Litigation Reports	Copies of all court decisions involving NC State-funded Services and BH I/DD Tailored Plan and recipient providers.	Monthly
10. 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

Section VII. 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	Quarterly report containing demographic information on network providers. *Note: Ad-hoc upon request.*	Quarterly
B. Quality and Value		
1. Quality Measures Extract	Annual extract providing quality calculated measure percentages, and numerators/denominators sets, quarterly interim calculated measures on select measures.	Annually

Section VII. 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. Quarterly Member Incentive Programs Report	Quarterly report of member outreach, utilization, and metrics for all Member Incentive Programs.	Quarterly
2. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
3. BH I/DD Tailored Plan Enrollment Summary Report	Monthly summary report highlighting key member 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
4. Change in Member	Weekly report used to notify NC Medicaid of changes in member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly

Section VII. 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**
Circumstances Report		
5. 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
6. 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 90 days.	Ad hoc
7. Innovations 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
B. Benefits		
1. Institution for Mental Disease (IMD) Report	Weekly summary of members who are receiving acute psychiatric care or SUD services in an IMD, including name, Medicaid ID number, DOB, eligibility category, SUD diagnosis, provider name, provider NPI, facility admission date, facility discharge date, revenue or procedure code, and billed and paid units.	Weekly
2. Medical Prior Authorization Report	Monthly report that lists each prior approval requests by individual member, service type, determination date, and approval status.	Monthly
3. Pharmacy Benefit Determination/Prior Authorization Report	Monthly that lists prior approval requests by individual member, service type, determination date, and approval status.	Monthly
4. Antipsychotic Safety Monitoring Report for Members to Age 17	Monthly report describing safety monitoring activities related to psychotropic drug use in members to age seventeen 17.	Monthly
5. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
6. ProDUR Alert Report Aggregate	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
7. Top GCNs and GC3s	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly

Section VII. 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**
8. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
9. Pharmacy Financial Arrangements Attestation	Annual pharmacy financial arrangements attestation.	Annually
10. EPSDT Reports	Quarterly report listing volume of approvals and denials, types of services required, and total paid claims.	Quarterly
11. 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
12. Quarterly Prevention and Population Health Report	Quarterly report of all members outreached, utilization and key program metrics.	Quarterly
13. Annual Prevention and Population Health Report	Annual report of all members outreached, utilization and key program metrics.	Annually
14. Quarterly Tobacco Cessation Program Report	Quarterly report of tobacco cessation program utilization and outcomes.	Quarterly
15. Annual Tobacco Cessation Program Report	Annual report of tobacco cessation program utilization and outcomes.	Annually
16. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
17. Annual Opioid Misuse and Prevention Program Report	Annual report on utilization and outcomes of the Opioid Misuse Prevention Program.	Annually
18. Healthy Opportunities Pilot Program Report	*Applicable to BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Program Regions only:* Report on Pilot program implementation metrics, including but not limited to: Pilot program enrollment, Pilot service utilization, Pilot program expenditures, Pilot-participating member health outcomes, Pilot-participating member cost and utilization metrics, and expenditures on and utilization of services and other resources managed by the BH I/DD Tailored Plan, to demonstrate compliance with the applicable guidance.	*To be defined by Department in further guidance*

Section VII. 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**
	Further guidance on Pilot-related reporting frequency, format and content will be provided by the Department prior to service launch.	
19. Psychotropic Medications for Youth Report	Monthly report to identify trends/usage of psychotropic medications in children 17 years of age and younger.	Monthly
20. Crossover-Related NEMT Appointments Scheduled	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
21. Crossover-Related Status Reports on Transitions of Care	Weekly reporting identifying and reconciling data for members who are transitioning to the BH I/DD Tailored Plan during the Crossover time period.	Weekly
22. Ongoing Status Reports on Transitions of Care	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
23. Quarterly Admission & Readmission Report	Quarterly summary report of admission and readmission.	Quarterly
24. Annual Admission & Readmission Report	Annual summary report of admission and readmission.	Annually
C. Care Management		
1. CMARC and CMHRP Corrective Action Plan Report	Quarterly Care Management for At-Risk Children & Care Management (CMARC) for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.	Quarterly
2. Quarterly CMARC Performance Report	Quarterly performance report for CMARC.	Quarterly
3. Annual CMARC Performance Report	Annual performance report for CMARC.	Annually
4. Quarterly Care Management for High-Risk Pregnancy (CMHRP)	Quarterly performance report for CMHRP.	Quarterly

Section VII. 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**
Performance Report		
5. Annual CMHRP Performance Report	Annual performance report for CMHRP.	Annually
6. 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
7. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
8. Tailored Care Management Assignment and Engagement Report	Monthly report of: • Number of members assigned to and actively engaged in care management at each AMH+ practice, CMA, and the BH I/DD Tailored Plan by acuity tier and disability group (SMI/SED, SUD, I/DD, TBI) • Number and type of care management contacts and core Health Home services provided per month for each Member	Monthly
9. AMH Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.	Monthly
10. AMH Contracting Report	Monthly report of AMH medical home payments.	Monthly
11. Tailored Care Management Payment Report	Monthly report of Tailored Care Management payments to AMH+ practices and CMAs.	Monthly
12. Quarterly AMH+/CMA Quality Measures Report	Quarterly AMH+/CMA performance on quality measures.	Quarterly
13. Annual AMH+/CMA Quality Measures Report	Annual AMH+/CMA performance on quality measures.	Annually
14. ABD Screening for Care Management Report	Monthly report monitoring expedited screening protocols for all newly enrolled ABD members not already receiving LTSS services	Monthly

Section VII. 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**
15. LTSS Service Disposition Report	Monthly report tracking identified service-specific enrollment, eligibility and utilization trends of members enrolled in an identified service. This report will be used to compare LTSS beneficiaries serviced under managed care with those NC Medicaid Direct beneficiaries receiving comparable services.	Monthly
16. 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
17. LTSS Care Planning Trends Report	Quarterly report on identifying care planning trends for members with LTSS needs (employment, caregiver support needs, etc.).	Quarterly
18. LTSS Care Management Intervention Report	Quarterly report tracking specific care management interventions utilized by LTSS members, BH I/DD Tailored Plan observations of challenges experienced, and BH I/DD Tailored Plan identified opportunities or trends	Quarterly
19. LTSS/ Children's Developmental Services Agencies (CDSA) Coordination Report	Quarterly report on CDSA Enrollment and Disenrollment tracking.	Quarterly
20. Care Management Comprehensive Assessment and Care Plan and Individual Supports Plan (ISP) Tracking Report	Quarterly report listing the timing of completion by disability group (SMI/SED, SUD, I/DD, TBI) of: • Care Management Comprehensive Assessments, including completion of standardized Healthy Opportunities questions required by the Department, and • Care Plans/ISPs.	Quarterly
21. Ongoing Transitions of Care Status Report	Weekly report providing the status of BH I/DD Tailored Plan's ongoing transitions of care (TOC) activities aligned with TOC responsibilities specified in the RFA and the Department's Transitions of Care policy.	Weekly
22. High Needs Member Follow-up at Crossover Report	Weekly report providing status updates on engagement activities and service disposition of High Need members (e.g., those in crisis, those who are hospitalized, and those using a high volume of services).	Weekly
23. Acuity Tier Report	Monthly report (trended) providing number of members assigned to each acuity tier.	Monthly
24. Provider-based Care Management Report	Quarterly report on percentage of members actively engaged in Tailored Care Management that are receiving care management through a Provider-based Care Management approach (i.e., care management through an AMH+ or CMA).	Quarterly

Section VII. 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**
25. Tailored Care Management Ineligibility Report	Quarterly report listing members ineligible for Tailored Care Management (members obtaining Assertive Community Treatment (ACT), members residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), members participating in Care Management for At-Risk Children, and members receiving High-Fidelity Wraparound.)	Quarterly
26. Care Manager Training Report	Annual attestation that care managers have received required training and refreshers.	Annually
27. Care Manager Staffing Report	Quarterly report that describes the BH I/DD Tailored Plan's efforts to build its care management workforce, including but not limited to • Number of care managers employed by the BH I/DD Tailored Plan, each AMH+ CMA, and contracted CINs or Other Partners. • Number of supervising care managers employed by the BH I/DD Tailored Plan, each AMH+, CMA, and contracted CINs or Other Partners.	Quarterly
28. High-Fidelity Wraparound Report	Quarterly report demonstrating • Fidelity to the High-Fidelity Wraparound model using the WFI-EZ • Members' length of stay in High-Fidelity Wraparound • Use of crisis services, including length of service • Residential placements (after initial return home, number of additional placements during High-Fidelity Wraparound, and length of stay in placements during High-Fidelity Wraparound) • Number of informal supports at the end of High-Fidelity Wraparound • Increase in self-efficacy and skills using the Transition Asset Tool	Quarterly
29. AMH+/CMA/CIN or Other Partner Oversight Report	Monthly report providing • Roster of contracted AMH+ practices and CMAs and their contracted CIN or Other Partners • AMH+ practices and CMAs recertified by the BH I/DD Tailored Plan • AMH+ practices and CMAs determined to be out of compliance with Tailored Care Management requirements • AMH+ practices and CMAs that have remediated identified issues and determined to be back in compliance	Monthly
30. Innovations Waiver Tailored Care Management Report	Quarterly report providing the number of members enrolled in the Innovations Waiver actively engaged in Tailored Care Management and the number engaged in Provider-based Care Management approaches (i.e., care management through an AMH+ or CMA)	Quarterly

Section VII. 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**
31. Monthly report of members receiving transitional care management, including the outcomes of the transition at 3 month, 6 month, 9 month, and 12 month increments	Monthly report of members receiving transitional care management, including the outcomes of the transition at 3 month, 6 month, 9 month, and 12 month of a member's receipt of such service	Monthly
D. In-Reach and Transitions		
1. MFP Applicant Status Report	A report of Money Follows the Person applicants waiting to transition from an institutional setting	Monthly
2. MFP Participant Status Report	A report of Money Follows the Person participants who are in the 365-day follow-along period post-transition from an institutional setting	Monthly
3. Rate of Institutionalization	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 overall, by diagnosis (e.g., I/DD, TBI, 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
4. In-Reach Activity Report	Number and percentage of members eligible for in-reach activities who are engaged for in-reach activities; number and percentage of members who began transition planning following in-reach. To be reported overall, by diagnosis (e.g., I/DD, TBI, 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
5. Diversion Activity Report	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 overall, by diagnosis (e.g., I/DD, TBI, SMI, SED).	Quarterly
6. Transition Activity Report for Members age 18 and above	Number and percentage of Members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting where member was discharged (e.g., ICF-IID, State Developmental Center, state psychiatric hospital, ACH).	Quarterly

Section VII. 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**
7. Transition Activity for PRTF Residents, Members Under Age 18 in a State Psychiatric Facility, and Members Receiving Residential Treatment Levels II/Program Type, III, and IV	• Average length of stay; • Total number of members in a PRTF, members under age 18 in a state psychiatric facility, and members receiving Residential Treatment Levels II/Program Type, III, and IV; and • Percentage of members under age 18 in a PRTF, Residential Treatment Levels II/Program Type, III, and IV, or state psychiatric facility.	Quarterly
E. Providers		
1. Essential Provider Alternate Arrangements Report	Quarterly report of active approved essential provider alternate arrangements, including information relating to the essential provider covered by the alternate arrangement, date of approval, description of how members needs are being met, and the BH I/DD Tailored Plan work to alleviate the inadequacy.	Quarterly
2. Essential Provider Alternate Arrangements Narrative Report	Quarterly narrative report accompanying Essential Provider Alternate Arrangements Report.	Quarterly
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. Provider Preventable Conditions Log	Quarterly report of Provider Preventable Conditions.	Quarterly
6. Rate Ceiling Necessity Report	Report to identify provider types for which the BH I/DD Tailored Plan recommends an establishment of a rate ceiling, to include information supporting the recommendation.	Ad hoc

Section VII. 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**
7. FQHC/RHC Summary Remittance Advice Report	Quarterly report to support additional directed payments to certain providers including FQHC/RHCs. BH I/DD Tailored Plans will leverage template to enable Wrap Payments for FQHCs and RHCs. Report includes a payment summary section and a detailed section, broken out by month, that shows Encounter, MID, Patient ID, Last Name, MEG, Procedure Code, Modifier, DOS, Amount Paid, and Payment Date. Different payments are broken out by service category. Report is broken out by each applicable NPI for FQHCs. Report excludes denied claims and Medicare Primary Claims, including Medicare Part C (Medicare Advantage).	Quarterly
8. Local Health Department Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: local health departments. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each Local Health Department the amounts in accordance with the invoice summary.	Quarterly
9. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: public ambulance providers. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each Public Ambulance Provider the amounts in accordance with the invoice summary.	Quarterly
10. 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
11. Summary UNC_ECU Physician Claims Report	Quarterly report. BH I/DD Tailored Plans will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
12. 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

Section VII. 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**
F. Quality and Value		
1. VBP Assessment	A report listing the VBP contracts and payments made under VBP arrangements during the relevant reporting period.	Annually
2. VBP Strategy Report	Numerical tables quantifying the BH/IDD Tailored Plan's projected VBP contracts in the coming year, and the amount of payments the BH I/DD Tailored Plan anticipates will fall under these contracts.	Annually
3. VBP Strategy Narrative Report	Annual narrative report accompanying VBP Strategy Report.	Annually
4. Quality Measures Report	Annual BH I/DD Tailored Plan performance on quality measures.	Annually
5. Interim Quality Measures Report	Monthly BH I/DD Tailored Plan interim performance on quality measures.	Monthly
6. Experience of Care and Health Outcomes Survey – Enrollee Data	BH I/DD Tailored Plan submits data on members in the BH I/DD Tailored Plan's Catchment Area to the EQRO. The EQRO uses this data to complete the annual survey.	Annually
7. Physician Incentive Arrangements	Report of physician incentive plans operated under 42 CFR § 422.208.	Annually
G. Stakeholder Engagement		
1. Tribal Engagement Report (as indicated)	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
H. Compliance		
1. Dual-Eligibility Report	Monthly report of members whose claims should have been presented to Medicare before submission to the BH I/DD Tailored Plan.	Monthly
2. Pharmacy Fraud, Waste, and Abuse: Prescribers, Pharmacies, Members	Quarterly summary of potential and actual pharmacy fraud, waste and abuse by provider/member, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. NCID Holders/FAMS users	Report listing all of the current NCID holders/FAMS-users in their BH I/DD Tailored Plan.	Monthly
4. Critical Incident Reports	Report of incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance abuse services.	Ad hoc

Section VII. 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**
I. Financial Requirements		
1. Monthly Financial Schedule	Monthly financial report providing the Department with details on BH I/DD Tailored Plan financial operations and performance for the applicable reporting period. Report will include, but not be limited to, balance sheet, income statement, and expenditure summaries by service and expenditure type, medical loss ratio (MLR) statistics and claim lag. Elements of the report will be used to compare financials to encounter submissions to identify discrepancies.	Monthly
2. Quarterly Financial Schedule	Quarterly financial report providing the Department with details on BH I/DD Tailored Plan financial operations and performance for the applicable reporting period. Report will include, but not be limited to, utilization statistics, payments made under alternative payment models, recoupments, and timely provider payment statistics and other items.	Quarterly
3. Final Year End Financial Schedule	Annual culminative report providing the Department with details on BH I/DD Tailored Plan financial operations and performance for the applicable reporting period. Report will include, but not be limited to, utilization statistics, payments made under alternative payment models, recoupments, and timely provider payment statistics and other items.	Annually
4. Monthly Claim Lag Report	As required to include the historical claims liability information as outlined that are associated with the specific claim type for which the lag report is being completed.	Monthly
5. Evaluation of the Cost Effectiveness of the Alternate (In-Lieu) Service	Annual report providing an evaluation on the cost effectiveness of in-lieu of services.	Annually
6. Audited Financial Statements	Annual submission of the audited financial statements. 42 C.F.R. § 438.3(m).	Annually
7. Cost Allocation Plan	Annual submission of the cost allocation plan.	Annually
8. Annual BH I/DD Tailored Plan Medical Loss Ratio (MLR) Report	Annual Medical Loss Ratio report providing information on the components of the CMS-defined MLR and the Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. § 438.8(k)(1)(i) - (xiii).	Annually
9. NAIC Filings	Regulatory filings will be provided upon request by the Department.	Ad hoc
10. Claim payment summary by category of	This report will include claims payment history by category of service for certain providers (NPI) as requested by the Department.	Annually

Section VII. 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**
service and provider (NPI)		
11. Total Cost of Care (TCOC) and Cost Growth Report	As required in Section 5.(6)a. of Session Law 2015-245, annual report to monitor cost growth. Report will also provide a summary of cost drivers and steps the BH I/DD Tailored Plan is taking to address the cost drivers and mitigate future cost growth.	Annually
12. Pharmacy Saving Report	As required in Section 5.(6)b. of Session Law 2015-245, as amending by 2016-121, ad hoc report to support Department monitoring of net pharmacy savings.	Ad hoc

Section VII. 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. BH I/DD Tailored Plan 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, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Weekly
2. Clearinghouse Daily Uploads Extract: MEM012	Daily extract of each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan to a member or recipient and each grievance received by BH I/DD Tailored Plan from members or recipients.	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. Care Management Interaction Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
3. Medical Prior Authorization Extract	Monthly extract providing information on medical prior approval requests by individual member, service type, determination date, and approval status.	Monthly
4. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly

Section VII. 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. NMC VAH Alert	Alert of member's admission to Neuro-Medical Center (NMC) or Veterans' Home (VAH) reflects the member's admission to a state-operated neuro-medical center or into DMVA-operated veterans' home.	Ad hoc
2. Nursing Facility Admission Anticipated Disenrollment Alert	Nursing Facility Admission Anticipated Disenrollment Alert reflects the BH I/DD Tailored Plan's determination that a member's projected length of stay in the nursing facility will result in the member's disenrollment from the BH I/DD Tailored Plan.	Ad hoc

Section VII. Attachment. J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Eligibility		
1. Medicaid Applications Report	Quarterly report of Medicaid applications completed by individuals seeking State-funded Services.	Quarterly
2. Income Profile Report	Quarterly report of individuals accessing State-funded Services by income band, as defined by the State (e.g., 0 – 50%, 50 – 100% of FPL, etc.).	Quarterly
B. Care Management and Prevention		
1. Care Management Comprehensive Assessment Tracking	Quarterly report tracking completion of Care Management Comprehensive Assessments.	Quarterly
2. Individual Supports Plan (ISP) Tracking	Quarterly report tracking completion of ISPs by disability group.	Quarterly
3. Care Management Contact Report	Monthly report tracking the number of care management contacts by location (e.g., face-to-face in-person, two-way, real-time interactive audio and video or telephonic)	Monthly
4. Care Manager Staffing Reporting	Annual report providing the number of BH I/DD Tailored Plan-employed care managers	Annually
5. Transitional Care Management Report	Monthly report of recipients receiving transitional care management, including the settings involved in the transition.	Monthly
6. Traumatic Brain Injury (TBI) Report	Annual and quarterly report on administration of State-funded TBI programming expenditures and associated services.	Annually
7. TBI Screening	Quarterly report on call center screenings that identify recipients	Quarterly

Section VII. Attachment. J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
Report	with potential TBI and their access to mental health, SUD, I/DD, or other services.	
8. Children with Complex Needs Data and Reports	Quarterly report on children with complex needs, including Medicaid-eligible children between the ages of 5 and up to, but under, the age of 21 with a developmental disability (including I/DD and/or Autism Spectrum Disorder), and a mental health disorder, who are "at-risk" of not being able to enter or remain in a community setting.	Quarterly
9. 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
10. 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
11. Recipient I/DD Needs Assessment Profile Report	Ongoing report of BH I/DD Tailored Plan provider's recipient I/DD needs assessment using the North Carolina Support Needs Assessment Profile (NC-SNAP), or a different assessment determined by the State.	Ongoing
12. I/DD Surveys	Annual or semi-annual reporting of information on recipient with I/DDs including information on I/DD service utilization, expenditures, and recipient characteristics using survey tools as determined by the Department (including, but not limited to, the National Core Indicators Survey, Residential Information Systems Project Survey, ICI Day and Employment Survey, and the State of the State on Developmental Disabilities Survey).	Annually
C. Quality and Value		
1. Consumer Perception of Care Report	Annual report of consumer perception of care and quality improvement information through the Consumer Perception of Care Survey Tool.	Annually
D. Financial Requirements		
1. BH I/DD Tailored Plan State-funded Claims Report	Report of claims records of State-funded Services through NCTracks, in accordance with timeliness standards described within *Section V.C.6. Claims Management*. Claims should cover all services that cannot be credited to any fee for service or Medicaid account (i.e., "shadow claims").	Ongoing
2. Information on Appropriate Use of Block Grant and State-Funds	Annual report on use of block grant and state-funds, including single stream and non-unit cost reimbursement (UCR) expenses, invoices, and other financial information. The Department may request additional submissions of information pertaining to use of these funds on an ad hoc basis.	Annually
3. Block Grant Report	Monthly report submitted to the State's Consumer Data Warehouse (CDW) on demographics, outcomes measures, and other record types not available through claims (e.g., recipient living situation, consumer surveys, services and utilization,	Monthly

Section VII. Attachment. J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	readmissions, social connectedness, and employment), as determined by the Department.	
4. 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-annually
5. BH I/DD Tailored Plan State-funded Services Financial Reports	Financial reports of all BH I/DD Tailored Plan financial indicators for the applicable reporting period, with Title XIX Medicaid expenditures accounted for and tracked separately from services provided using non-Medicaid funding, as described within *Section V.C.7. Financial Requirements* Monthly report will include, but not be limited to, detailed accounts of assets and liabilities, fund balances, revenues, expenses, profitability, and risk reserves. Annual audited financial reports will include, but not be limited to, the same criteria as monthly reports and be prepared by an independent Certified Public Accountant (CPA).	Monthly and Annual
6. BH I/DD Tailored Plan State-funded Services Annual Budget	Annual budget, as presented to the Governing Board of BH I/DD Tailored Plan, in sufficient detail to identify revenues by funding source, as described within *Section V.C.7. Financial Requirements*.	Annual

Attachment K. Risk Level Matrix for Medicaid and State-funded Services

The BH I/DD Tailored Plan agrees and acknowledges that the Risk Level Matrix is intended to be an illustrative, non-exhaustive list of the types of acts, failures to act, behaviors, and/or practices that may be assigned to a specific level by the Department upon consideration of some or all of the factors described in the Contract.

If the BH I/DD Tailored Plan is found to be noncompliant with the terms, conditions, or requirements of the Contract or of any other violation by the Department, the BH I/DD Tailored Plan agrees and acknowledges that the Risk Level Matrix, as provided in the Contract, is for demonstrative purposes only, and the Department retains the sole discretion to assign an appropriate level to each type of noncompliance or violation by the BH I/DD Tailored Plan based on the nature of the noncompliance or violation as described in the Contract.

The BH I/DD Tailored Plan further agrees and acknowledges that the content included in the examples of noncompliant behavior and/or practices in the Risk Level Matrix are not the full scope of violations subject to a Risk Level assignment by the Department and that if a specific example of noncompliant behavior or practice identified in the Matrix occurs, the Department is not obligated to assign the noncompliant behavior or practice in accordance with the level provided in this Matrix.

Section VII. Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of Medicaid Managed Care	Failure to substantially provide medically necessary covered services Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract Imposing on members premiums or cost sharing that are in excess of that permitted by the Department Failure to substantially meet minimum care management and care coordination requirements Failure to substantially meet minimum Transition of Care Policy requirements Failure to substantially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception) Denying coverage for out-of-network care when no reasonable access to an in-network provider is available Continuing failure to resolve member and provider appeals and grievances within specified timeframes

Section VII. Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to maintain BH I/DD Tailored Plan license in good standing with DOI Failure to timely submit accurate and/or complete encounter data in the required file format Misrepresenting or falsifying information that it furnishes to CMS or to the Department Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation Failure to substantially comply with the claims processing requirements and standards Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) Failure to substantially comply with the Preferred Drug List requirements Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation One or more Level 2 violations within a contract year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize member(s) health, safety, and welfare or access to care	Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract Failure to comply with established rate floors and fee schedules as required under the Contract Failure to make additional directed payments to certain providers as required under the Contract Failure to make provider contracting decisions within required timeframes EQRO or other program audit reports with substantial findings Failure to comply with member services requirements (including hours of operation, call center, and online portal) Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the

Section VII. Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	**Examples of Noncompliant Behavior and/or Practices**
	security of such information and/or failure to timely report violations in the access, use, and disclosure of PHI Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation Two or more Level 3 violations within a contract year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program	Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) Failure to notify the Department and members of terminated network providers within required timeframes Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) Using unapproved member notices, educational materials, and handbooks and marketing materials Engaging in prohibited marketing activities and practices Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation Three or more Level 4 violations within a contract year
LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation of the managed care program	Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports) Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation Failure to comply with time frames for distributing (or providing access to) Member Handbooks, identification cards, provider

Section VII. Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	**Examples of Noncompliant Behavior and/or Practices**
	directories, and educational materials to members (or potential members) Failure to meet minimum requirements requiring coordination and cooperation with external entities EQRO or other program audit reports with non-substantial findings Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements) Failure to timely furnish a policy, handbook, directory, or manual upon request by a member or potential member as required under the Contract

Section VII. Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	**Examples of Noncompliant Behavior and/or Practices**
LEVEL 1 Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of recipient(s); reduces recipients' access to care; and/or the integrity of State-funded Services	Failure to substantially provide medically necessary covered services Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract Failure to substantially meet minimum case management and care coordination requirements Failure to substantially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception) Continuing failure to resolve recipient complaints and appeals and provider appeals and grievances within specified timeframes Failure to maintain BH I/DD Tailored Plan license in good standing with DOI

Section VII. Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to timely submit accurate and/or complete encounter data in the required file format Misrepresenting or falsifying information that it furnishes to the Department Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation Failure to substantially comply with the claims processing requirements and standards Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation One or more Level 2 violations within a contract year
LEVEL 2 Action(s) or inaction(s) that jeopardize the integrity of State-funded Services, but does not necessarily jeopardize recipient(s) health, safety, and welfare or access to care	Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract Failure to make quality determinations for provider contracting within required timeframes EQRO or other program audit reports with substantial findings Failure to comply with recipient services requirements (including hours of operation, call center, and online portal) Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the security of such information and/or failure to timely report violations in the access, use, and disclosure of PHI Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation Two or more Level 3 violations within a contract year
LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of State-funded Services	Failure to submit to the Department within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring Departmental review and/or approval

Section VII. Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to comply with provider relations requirements (including hours of operation, call center, and online portal) Failure to notify the Department and recipients of terminated network providers within required timeframes Failure to respond to or complete a request made by the Department (or other agencies with oversight responsibilities) within the specified timeframe and in the manner and format requested Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines) Using unapproved recipient notices, educational materials, and handbooks and marketing materials Engaging in prohibited marketing activities and practices Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation Three or more Level 4 violations within a contract year
LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation State-funded Services	Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports) Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation Failure to comply with time frames for distributing (or providing access to) Recipient Handbooks, provider directories, and educational materials to recipients (or potential recipients) Failure to meet minimum requirements requiring coordination and cooperation with external entities EQRO or other program audit reports with non-substantial findings Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements)

Section VII. Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	**Examples of Noncompliant Behavior and/or Practices**
	Failure to timely furnish a policy, handbook, directory, or manual upon request by a recipient or potential recipient as required under the Contract

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

1. Appeal: A review by the Plan of an adverse benefit determination.
2. Co-Payment: Also known as a "Copay" is a fixed amount paid by the Member for certain covered health care services. The copay amount may vary by service or provider. Example: A member cost of $1.00 for a generic prescription.
3. Durable Medical Equipment (DME): Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is appropriate for home use and is not useful to a person without illness or injury. For devices classified as DME after January 1, 2012, has an expected life of three (3) years.
4. Emergency Medical Condition: A medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.
5. Emergency Medical Transportation: Medically necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.
6. Emergency Room Care: Care given for a medical emergency, in a part of the hospital where emergency diagnosis and treatment of illness or injury is provided, when it is believed that one's health is in danger and every second counts.
7. Emergency Services: Inpatient and outpatient services by a qualified provider needed to evaluate or stabilize an emergency medical condition.
8. Excluded Services: Services that are not covered by the PHP.
9. Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes the Member's right to dispute an extension of time proposed by the PHP to make an authorization decision.
10. Habilitation Services and Devices: Health care services that help a Member keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings.
11. Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.
12. Home Health Care: Certain medically necessary services provided to Members in any setting in which normal life activities take place other than a hospital, nursing facility, or intermediate care facility. Services include skilled nursing, physical therapy, speech-language pathology, and occupational therapy, home health aide services, and medical supplies.

13. Hospice Services: Special services for patients and their families during the final stages of illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.
14. Hospitalization: Care in a hospital that requires admission as an inpatient for a duration lasting more than twenty-four (24) hours. An overnight stay for observation could be outpatient care.
15. Hospital Outpatient Care: Care for a Member in a hospital, or distinct part of a hospital, for professional services of a duration less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.
16. Medically Necessary: Those covered services that are within generally accepted standards of medical care in the community and not experimental.
17. Network: A group of doctors, hospitals, pharmacies, and other health care experts contracted by the PHP to provide health care services.
18. Non-participating provider: Non-Par or non-participating providers are physicians or other health care providers that have not entered into an agreement with the PHP and are not part of the Network, unlike participating providers. They may also be called out-of-network providers.
19. Participating Provider: Par or participating providers are physicians or other health care providers that have an agreement with the PHP and are part of its Network. These agreements outline the terms and conditions of participation for both the payer and the provider.
20. Physician Services: Health care services a licensed medical physician, or physician extender such as a nurse practitioner or physician assistant, provides, orders, or coordinates.
21. Plan (or Health Plan): The company providing you with health insurance.
22. Preauthorization: The approval needed from your plan before you can get certain health care services or medicines.
23. Premium: The amount paid for health insurance monthly. In addition to a premium, other costs for health care, including a deductible, copayments, and coinsurance may also be required.
24. Prescription Drug Coverage: Refers to how the PHP helps pay for its Members' prescription drugs and medications.
25. Prescription Drugs: Also known as prescription medication or prescription medicine, is a pharmaceutical drug that legally requires a medical prescription to be dispensed.
26. Primary Care Physician: A licensed medical doctor (MD) or doctor of osteopathy (DO) that provides and coordinates patient needs and initiates and monitors referrals for specialized services when required. See Primary Care Provider.
27. Primary Care Provider (PCP): The participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Member to provide and coordinate the Member's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.
28. Provider: A health care professional or a facility that delivers health care services, like a doctor, hospital, or pharmacy.

29. Rehabilitation Services and Devices: Health care services and equipment that help keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to sickness, injury, or disablement. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient or outpatient settings.
30. Skilled Nursing Care: Care that requires the skill of a licensed nurse.
31. Specialist: A provider that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
32. Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get Urgent Care in a walk-in clinic for a non-life-threatening injury (like the flu or sprained ankle).

Attachment M. POLICIES

1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy

a. Background

i. The Department will ensure that Medicaid[1] and NC Health Choice beneficiaries, their families and caregivers are supported in the transition to Medicaid Managed Care and BH I/DD Tailored Plans throughout the enrollment process, including enrolling in a BH I/DD Tailored Plan and selecting a PCP. The Department will ensure beneficiaries and their families experience a smooth transition from NC Medicaid Direct and LME/MCOs or Standard Plans to BH I/DD Tailored Plans and have the tools and resources to access care throughout BH I/DD Tailored Plan implementation.

b. Scope

i. The North Carolina BH I/DD Tailored Plan and Medicaid Managed Care Enrollment Policy outlines the expectations of the Department, the Enrollment Broker, and the BH I/DD Tailored Plan in the enrollment of beneficiaries into BH I/DD Tailored Plans. The intent of this Policy is not to replace any existing enrollment processes related to NC Medicaid Direct.

c. Identification of Beneficiaries Eligible for a BH I/DD Tailored Plan

i. In accordance with Section 4.(5). of Session Law 2015-245, as amended,[2] the Department will conduct regular data reviews to identify beneficiaries who meet one or more of the following criteria for enrollment in a BH I/DD Tailored Plan:

1. Beneficiaries being served by the Innovations waiver;[3]
2. Beneficiaries being served by the TBI waiver;[4]
3. Beneficiaries being served by Transitions to Community Living Initiative (TCLI);
4. Beneficiaries on the waiting list for the Innovations waiver;
5. Beneficiaries on the waiting list for the TBI waiver;
6. Beneficiaries who have used a Medicaid service that will only be available through a BH I/DD Tailored Plan as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
7. Beneficiaries who have used a BH, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
8. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina;
9. Beneficiaries who have a qualifying I/DD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations;*

[1] "Medicaid" includes both Medicaid and NC Health Choice programs within this Policy unless noted otherwise.
[2] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.
[3] All Medicaid beneficiaries who are enrolled in the Innovations waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.
[4] All Medicaid beneficiaries who are enrolled in the TBI waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.

10. Beneficiaries who have a qualifying mental health diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;[5,6]
11. Beneficiaries who have a qualifying SUD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;[7]
12. Beneficiaries who have had two (2) or more psychiatric hospitalizations or readmissions within eighteen (18) months;
13. Beneficiaries who have had an admission to a State psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode(s) in a State-owned facility;
14. Beneficiaries who have had two (2) or more visits to the emergency department for a psychiatric problem within eighteen (18) months; and
15. Beneficiaries who have had two (2) or more episodes using BH crisis services within eighteen (18) months.

ii. The Department will employ the processes described below to identify existing Medicaid and NC Health Choice beneficiaries as eligible for a BH I/DD Tailored Plan.

1. In the period prior to Standard Plan launch:

   a. The Department will conduct data reviews to identify beneficiaries meeting BH I/DD Tailored Plan data-based eligibility criteria using dates of service to be determined by the Department.
   b. Beneficiaries identified by the Department as meeting the BH I/DD Tailored Plan eligibility criteria based on available data or through the request to enroll in a BH I/DD Tailored Plan process will remain in their delivery system at Standard Plan launch.

2. In the period between Standard Plan and BH I/DD Tailored Plan launch:

   a. The Department will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet BH I/DD Tailored Plan data-based eligibility criteria.
   b. The Department will send beneficiaries identified as BH I/DD Tailored Plan eligible a notice informing them of their BH I/DD Tailored Plan eligibility and auto-enroll them in NC Medicaid Direct/the LME/MCO in their Region.
   c. Beneficiaries who are not identified and auto-enrolled through the Department's data review will have the option to request to enroll in NC Medicaid Direct/LME/MCO by submitting a request for to the Department for review.

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[5] The list of Medicaid-covered enhanced BH services can be found in NC Medicaid and Health Choice Clinical Coverage Policy 8-A.

[6] Beneficiaries who meet the following criteria for SMI or SED are determined BH I/DD Tailored Plan eligible: (1) beneficiaries under 18 years of age with a claim or encounter with a date of service since the lookback period that includes a schizophrenia or schizoaffective disorder, regardless of service utilization; (2) beneficiaries with a claim/encounter demonstrating use of electroconvulsive therapy since January 1, 2018, regardless of diagnosis; and (3) beneficiaries who have used clozapine or long acting injectable anti-psychotics since January 1, 2018, regardless of diagnosis.

[7] The list of Medicaid-covered enhanced BH services can be found in NC Medicaid and Health Choice Clinical Coverage Policy 8-A.

d. Prior to BH I/DD Tailored Plan launch, the Department will reassess BH I/DD Tailored Plan eligibility for beneficiaries who were previously identified as meeting the BH I/DD Tailored Plan eligibility criteria who receive Medicaid services through NC Medicaid Direct/LME/MCOs based on a more recent lookback period.

    i. Beneficiaries who no longer meet the BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in Standard Plans at BH I/DD Tailored Plan launch unless they are excluded from Standard Plan enrollment, in which case, they will be auto-enrolled in NC Medicaid Direct.
    ii. The Department will send beneficiaries who continue to meet the BH I/DD Tailored Plan eligibility criteria based on data reviews or the request to enroll in a BH I/DD Tailored Plan process at the point of the reassessment a notice indicating that they will be enrolled in a BH I/DD Tailored Plan and can elect to enroll in a Standard Plan at any point during the coverage year unless they are excluded from Standard Plans, in which case they can enroll in NC Medicaid Direct at any point during the coverage year.

        1. The Department will transmit BH I/DD Tailored Plan assignment to the BH I/DD Tailored Plan through an 834 eligibility file.
        2. If a beneficiary selects a Standard Plan prior to the scheduled transition date to BH I/DD Tailored Plans, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit Standard Plan selection to the Standard Plan through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary chooses to enroll in a Standard Plan, the beneficiary will not have access to services only covered by BH I/DD Tailored Plans (unless the beneficiary is under age 21 and the service is covered through EPSDT).
        3. If the beneficiary is excluded from Standard Plan enrollment and elects to enroll in NC Medicaid Direct prior to the scheduled transition to BH I/DD Tailored Plans, the Enrollment Broker will transmit the NC Medicaid Direct selection to the Department through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary who is excluded from Standard Plan enrollment chooses to enroll in NC Medicaid, the beneficiary will not have access to non-State Plan services only covered by BH I/DD Tailored Plans (e.g., waiver services, in lieu of services, and value-added services).

e. For a beneficiary who is eligible for a BH I/DD Tailored Plan and is either auto-assigned to a BH I/DD Tailored Plan or selects a Standard Plan, coverage by the BH I/DD Tailored Plan or Standard Plan begins on the first day of BH I/DD Tailored Plan launch.

3. Period after BH I/DD Tailored Plan implementation (ongoing enrollment)

    a. Standard Plan members

i. The Department will regularly review encounter, claims and other relevant and available data to identify Standard Plan members who newly meet BH I/DD Tailored Plan data-based eligibility criteria.
ii. The Department will send a notice to Standard Plan members identified as eligible for a BH I/DD Tailored Plan.
iii. Beneficiaries enrolled in a Standard Plan who are identified by the Department's data review as meeting BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in a BH I/DD Tailored Plan the first of the month following identification, unless the member calls prior to the end of the month to request to continue enrollment in the Standard Plan. Beneficiaries who are auto-enrolled in the BH I/DD Tailored Plan will have the option to re-enroll in a Standard Plan.
iv. Beneficiaries who are not identified through the Department's data review will have the option to request a review for BH I/DD Tailored Plan enrollment as described below. In cases where the Department approves a beneficiary's request, the beneficiary will be enrolled in a BH I/DD Tailored Plan on the first day of the following month.

b. If a Medicaid applicant is determined eligible for Medicaid, Medicaid Managed Care mandatory and BH I/DD Tailored Plan eligible based upon available data or an approved request for BH I/DD Tailored Plan enrollment, the Department will auto-assign the applicant to the regional BH I/DD Tailored Plan through an 834 eligibility file.

i. Coverage by the BH I/DD Tailored Plan begins on the first day of the month in which Medicaid eligibility is determined. The Department is considering seeking legislative change to make BH I/DD Tailored Plan coverage effective prior to the date of the Medicaid eligibility determination. New Medicaid beneficiaries will have an opportunity to select a Standard Plan at any point during the coverage year unless the beneficiary is excluded from Standard Plan enrollment. If the beneficiary is excluded from Standard Plan enrollment, the beneficiary can elect to enroll in NC Medicaid Direct at any point during the coverage year.

d. Request for Enrollment in a BH I/DD Tailored Plan

i. The Department will allow a beneficiary who is enrolled in a Standard Plan, the Statewide Specialized Foster Care Plan, or NC Medicaid Direct (and not part of an excluded group) to request to enroll in a BH I/DD Tailored Plan if the beneficiary is not otherwise identified through available data.

ii. The Enrollment Broker will provide information to beneficiaries via phone, chat, website, and mail on how to request to enroll in a BH I/DD Tailored Plan.

iii. Beneficiaries may request to enroll in a BH I/DD Tailored Plan using one of the following forms:

1. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form
2. Request to Enroll in a BH I/DD Tailored Plan: Provider Form

iv. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form

1. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form, the beneficiary (or guardian/legally responsible person) submits a form that indicates

whether the beneficiary meets at least one of the eligibility criteria for a BH I/DD Tailored Plan as outlined in Section 4.(5) of Session Law 2015-245, as amended.[8]

2. The beneficiary's care manager may assist the beneficiary to complete the form. If the care manager assists the beneficiary to complete the form, the care manager must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
3. The beneficiary must provide either documentation of their needs or contact information for their provider with permission for the Department to contact the provider.
4. The beneficiary (or authorized representative[9]) must sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.

v. Request to Enroll in a BH I/DD Tailored Plan: Provider Form

1. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, the beneficiary (or guardian/legally responsible person) may work with their provider to complete a form indicating the reason(s) the beneficiary is believed to be eligible for the BH I/DD Tailored Plan.
2. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
3. The beneficiary (or authorized representative) must also sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.
4. The beneficiary or authorized representative or provider transmits the completed form.
5. The Enrollment Broker will transmit the request to the Department for review within twenty-four (24) hours of receipt.
6. The Department will review the form and determine whether the beneficiary is eligible for a BH I/DD Tailored Plan according to the following timeframes:
    a. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form will be reviewed in eight (8) Calendar Days
    b. Request to Enroll in a BH I/DD Tailored Plan: Provider Form will be reviewed in five (5) Calendar Days
7. The Department will transmit the beneficiary's transfer to a BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the transfer, unless there is a service need as outlined in the next section.

vi. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Only Available in the BH I/DD Tailored Plans

1. Beneficiaries enrolled in Standard Plans who have a need for a service only available in BH I/DD Tailored Plans (i.e., a service-related request) will be able to transfer to a BH I/DD Tailored Plan through the following process.
    a. The provider must submit the service authorization request and the Request to Enroll in a BH I/DD Tailored Plan: Provider Form to the Department on behalf of the Standard Plan member.
    b. The Standard Plan member or legal guardian must sign the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, which acknowledges the request and that approval will lead to immediate disenrollment from Standard Plan and enrollment in a BH I/DD Tailored Plan.

[8] Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.
[9] Authorized representative refers to the beneficiary's legal guardian.

c. The Department will review and enroll the Standard Plan member in a BH I/DD Tailored Plan effective within one (1) business day retroactive to the date of the request.[10]

e. Beneficiaries Part of Excluded or Delayed groups who Become Eligible for Limited Medicaid Managed Care on the Basis of BH I/DD Tailored Plan Eligibility, as Described in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans*

i. The Department believes that certain members of groups that are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The Department is exploring a legislative change to allow certain groups of beneficiaries that are otherwise excluded or delayed from Medicaid Managed Care to become eligible for a limited set of benefits from Medicaid Managed Care on the basis of BH I/DD Tailored Plan eligibility.

ii. Pending legislative change, beneficiaries who are enrolled in both full Medicare and Medicaid and are determined to be BH I/DD Tailored Plan eligible will be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for coverage of BH, I/DD, and TBI benefits (limited Medicaid Managed Care).

iii. The Department is also considering a similar approach for beneficiaries who are medically needy, participate in the NC HIPP program, or served through CAP/C or CAP/DA and determined to be BH I/DD Tailored Plan eligible to be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI benefits (limited Medicaid Managed Care).

iv. The Department will transmit the auto-assignment to the assigned BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the date the beneficiary is determined to meet BH I/DD Tailored Plan eligibility. Because the beneficiary is otherwise excluded or delayed from Medicaid Managed Care, the beneficiary will not be permitted to choose a Standard Plan during the coverage year; however, the beneficiary will have the option to move back to NC Medicaid Direct.

f. Ongoing Review of Enrollment in a Behavioral Health I/DD Tailored Plan

i. On an ongoing basis, the Department will review the service utilization of BH I/DD Tailored Plan members as well as Standard Plan members who had been flagged in the past as BH I/DD Tailored Plan eligible but chose to enroll in a Standard Plan, to determine whether they should continue to be enrolled, or eligible to enroll, in BH I/DD Tailored Plans.

1. Behavioral Health I/DD Tailored Plan-eligible individuals, whether they are enrolled in a Standard Plan or BH I/DD Tailored Plan, will continue to be eligible for a BH I/DD Tailored Plan if they either have a qualifying I/DD diagnosis, have TBI needs as described in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans* or have used a Medicaid or State-funded BH service other than outpatient therapy and medication management in the past twenty-four (24) months prior to their annual redetermination date.
2. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan at renewal and noticed as part of the annual redetermination notice. Beneficiaries who do not meet one of the criteria above and are excluded from Standard Plan enrollment will be enrolled in NC Medicaid Direct.

[10] For Standard Plan Members transferring to the Behavioral Health I/DD Tailored Plan in order to obtain a service only available through the Behavioral Health I/DD Tailored Plan, the timeline for processing the service authorization period—both for standard and expedited requests—will begin when the Department receives the request to transfer to a Behavioral Health I/DD Tailored Plan.

g. Medicaid Eligibility Redeterminations

i. At a member's annual Medicaid renewal, if a member is redetermined eligible for Medicaid, continues to be eligible for a BH I/DD Tailored Plan, and has not elected to enroll in a Standard Plan, the Department will auto-assign the member into the same BH I/DD Tailored Plan from the prior eligibility year, provided that the member's Medicaid county of eligibility remains in the same BH I/DD Tailored Plan Region.

    1. If the member's eligibility has moved to a county that is part of a different BH I/DD Tailored Plan Region, the Department will auto-assign the member into the BH I/DD Tailored Plan in the member's new county of eligibility.
    2. The member will continue to have the opportunity to elect to enroll in a Standard Plan at any point during the coverage year. Members who are excluded from Standard Plan enrollment have the opportunity to elect to enroll in NC Medicaid Direct at any point during the coverage year.

ii. The member may select a Standard Plan at his or her Medicaid redetermination if he or she is not excluded from Standard Plans. If the member selects a Standard Plan, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit the Standard Plan selection to the Standard Plan through an 834 eligibility file. Coverage of the member by the Standard Plan will begin on the first day of the next month in which the member selected the Standard Plan. Members who are excluded from Standard Plan enrollment may elect to enroll in NC Medicaid Direct at their Medicaid redetermination.

iii. If a member is determined based on data reviews to no longer be eligible for BH I/DD Tailored Plan but still eligible for Medicaid and the member believes that they are still eligible, the member will have the opportunity to submit a Request to Enroll in a BH I/DD Tailored Plan.

iv. If a member is determined to no longer be eligible for Medicaid, the member will be notified and disenrolled from the BH I/DD Tailored Plan by the Department.

h. Special Enrollment Cases

i. Exempt populations

    1. Exempt populations as defined in *Section V.B.1.i.(iii)(a)* that are BH I/DD Tailored Plan eligible will be able to enroll in BH I/DD Tailored Plans.
    2. The Enrollment Broker will provide choice counseling to exempt populations and support BH I/DD Tailored Plan, Standard Plan, NC Medicaid Direct, EBCI Tribal Option (as applicable), and PCP selection throughout the beneficiary's eligibility year.
    3. If a beneficiary in an exempt population selects a BH I/DD Tailored Plan, the Enrollment Broker will transmit the BH I/DD Tailored Plan selection to the Department. The Department will transmit BH I/DD Tailored Plan selection to the BH I/DD Tailored Plan through an 834 eligibility file.
    4. If a beneficiary in an exempt population elects to move from a BH I/DD Tailored Plan to a Standard Plan or other delivery system (such as NC Medicaid Direct or EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan or delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan or delivery system.[11]

[11] There may be instances (e.g., an urgent medical need), as determined by the Department and based on the beneficiary's needs, in which enrollment in the new PHP or the new delivery system may become effective sooner, including mid-month.

5. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system at redetermination and at any point during the year,

ii. Deemed newborns

1. The Department shall release forthcoming guidance on its policy regarding whether deemed newborns will be enrolled in their mothers' BH I/DD Tailored Plan.

i. Disenrollment from BH I/DD Tailored Plans and Medicaid Managed Care

i. Member disenrollment from the BH I/DD Tailored Plan may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from a BH I/DD Tailored Plan to a Standard Plan.

ii. Member requested disenrollment

1. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the BH I/DD Tailored Plan to the Enrollment Broker by phone, mail, in-person, or electronically.
2. A member who is not excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if applicable) any time during the coverage year.[12]
3. A member who is excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to NC Medicaid Direct any time during the coverage year.
4. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
5. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
6. The Enrollment Broker will process disenrollment requests in accordance with the following:
    a. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
    b. The Enrollment Broker will notify the Department of its decision by the next business day following receipt of the request.
7. Notice of disenrollment determination
    a. The Department will notify the member or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
    b. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.[13]
8. Expedited review of member initiated requests for disenrollment
    a. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need.

[12] Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan.
[13] 42 C.F.R. § 438.56(e).

For purposes of this subsection, an urgent medical need means continued enrollment in the BH I/DD Tailored Plan could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

b. The Enrollment Broker will process requests for expedited review in accordance with the following:

   i. The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
   ii. The Department will evaluate and decide whether to approve or deny the request.

c. The Department will notify the member, or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.

iii. Disenrollment required by the Department

1. The Department may disenroll a member from Medicaid Managed Care for any of the following reasons:

   a. Loss of eligibility

      i. If the Department determines that a member is no longer eligible for Medicaid, the member will be notified by the Department and the member will be disenrolled from the BH I/DD Tailored Plan. The disenrollment effective date will be the last date of the member's Medicaid eligibility.
      ii. If a member is disenrolled from a BH I/DD Tailored Plan solely because the member loses his or her eligibility for Medicaid for a period of two (2) months or less, the member will automatically be reenrolled in the BH I/DD Tailored Plan upon reenrollment in Medicaid.[14]

   b. Change in Medicaid eligibility category

      i. If the Department determines that a member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.i.(iii)(*c) the member will be notified by the Department and the Department will disenroll the member from the BH I/DD Tailored Plan. The disenrollment effective date will be the date when the member's change in eligibility category was effective.

   c. Nursing facility long-term stays

      i. A member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from the BH I/DD Tailored Plan on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[15]
      ii. The BH I/DD Tailored Plan shall utilize the Department-developed standardized process for monitoring length of stay for members in

[14] 42 C.F.R. § 438.56(g).
[15] Session Law 2015-245, as amended by Session Law 2018-49.

nursing facilities to ensure members receive appropriate levels of care and to report to the Department members who need to be disenrolled due to stays that exceed ninety (90) calendar days.

iii. To monitor and report a member's length of stay in a nursing facility the BH I/DD Tailored Plan must use the following process:

1. Within thirty (30) days of admission to a nursing facility, the BH I/DD Tailored Plan will assess a member's health care needs and estimate the potential length of stay. If the member requires a stay for longer than ninety (90) calendar days, the BH I/DD Tailored Plan must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.
2. The BH I/DD Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.
3. The Department will send the BH I/DD Tailored Plan and the member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the member's disenrollment from the BH I/DD Tailored Plan.
4. The BH I/DD Tailored Plan must notify the Department with an attestation of any member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.
5. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.

2. Neuro-Medical Centers and Veterans Homes

a. A beneficiary, otherwise eligible for enrollment in the BH I/DD Tailored Plan, residing in a state-owned Neuro-Medical Center[16] or a DMVA-operated Veterans Home[17] when the Department implements the BH I/DD Tailored Plan is excluded and will receive care in these facilities through NC Medicaid Direct.
b. A member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of BH I/DD Tailored Plans will be disenrolled from the BH I/DD Tailored Plan by the Department.

i. The Neuro-Medical Center or Veterans Home will submit the member's information, including date of admission, to the Department within fourteen (14) calendar days of admission.
ii. The Department will notify the member and the BH I/DD Tailored Plan of the disenrollment and the disenrollment effective date.
iii. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.

[16] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities
[17] North Carolina Department of Health and Human Services, Facilities, https://www.ncdhhs.gov/divisions/dsohf/facilities

iv. In accordance with 42 C.F.R. § 438.56(f), members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department.

j. BH I/DD Tailored Plan and Managed Care Enrollment Policy Changes

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes.

2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members

a. Background

i. The Advanced Medical Home (AMH) program refers to an initiative under which a Standard Plan or BH I/DD Tailored Plan must pay Medical Home Fees to all participating primary care practices that act as PCPs. In the context of BH I/DD Tailored Plans, only AMH practices certified as AMH+ practices will play the lead role in providing Tailored Care Management. However, BH I/DD Tailored Plans must include the standard terms and conditions below in contracts with all practices participating in the AMH program and must pay Medical Home Fees as set out in *Section V.B.4.iv.(xvii) Payments of Medical Home Fees to Advanced Medical Homes*

ii. An AMH "practice" will be defined by an NPI and service location.

b. Standard Terms and Conditions for BH I/DD Tailored Plan Contracts with All Advanced Medical Home Providers

i. Accept members and be listed as a PCP in the BH I/DD Tailored Plan's member-facing materials for the purpose of providing care to members and managing their healthcare needs.

ii. Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.

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

iv. Provide direct patient care a minimum of thirty (30) office hours per week.

v. Provide preventive services, in accordance with Section VII. Attachment M.2. Table 1: Required Preventive Services.

vi. Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan's medical record documentation guidelines.

vii. Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.

viii. Transfer the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.

ix. Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan's network adequacy standards.

x. Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.

xi. Review and use member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level UM and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.

xii. Review and use the monthly enrollment report provided by the BH I/DD Tailored Plan for the purpose of participating in BH I/DD Tailored Plan or practice-based population health or care management activities.

Section VII. Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus, Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenza Type B Vaccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Section VII. Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

3. AMH+ Practice and CMA Certification Policy

a. Background

i. 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.

1. 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.
2. 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, NC Health Choice, 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.

ii. Beginning at BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan will assume responsibility for certifying provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs. The BH I/DD Tailored Plan must assess providers applying to become an AMH+ practice or CMA against the criteria in this policy. The Department will release additional guidance prior to BH I/DD Tailored Plan launch to describe the parameters for certification by BH I/DD Tailored Plans.

b. Eligibility

i. To become certified as an AMH+ practice or CMA, an organization must meet the requirements for an AMH+ practice or CMA, given at *Section V.B.3.ii.(ii)Delivery of Tailored Care Management*

c. Organizational Standing and Experience Criteria

i. 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.

ii. 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):

   1. Mental health and SUD

      a. Adult
      b. Child/adolescent

   2. I/DD (not enrolled in the Innovations Waiver)
   3. TBI (not enrolled in the TBI Waiver)
   4. Innovations Waiver
   5. TBI Waiver
   6. Co-occurring I/DD and behavioral health

      a. Adult
      b. Child/adolescent

iii. 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.

iv. 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.

v. The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.

vi. 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.

vii. The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.

viii. 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.

   1. Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

d. Staffing Criteria

i. 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.*

ii. 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.

   1. 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.

2. 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.

iii. 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.

1. 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 or NC Health Choice and/or has supported similar efforts in other states.
2. 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.
3. AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section V.B.3.ii.(xiv)(b)*.

e. Population Health and HIT Criteria

i. The AMH+ or CMA must have implemented an EHR that is in use by the AMH+ practice or CMA's providers to record, store, and transmit their assigned members' clinical information, including medication adherence.

ii. The AMH+ or CMA must use a single care management data system, whether or not integrated within the same system as the EHR, which allows care managers to perform the following care management functions, at minimum:

1. Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
2. Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
3. Electronically document and store the Care Plan or ISP;
4. Incorporate claims and encounter data;
5. Provide role-based access to each member of the multidisciplinary care team;
6. Electronically and securely transmit (at minimum) the Care Management Comprehensive Assessment, Care Plan or ISP and reports/summaries of care to each member of the multidisciplinary care team;
7. Track care management encounters electronically, including date and time of each encounter, personnel involved and whether the encounter was in-person or telephonic
8. Track referrals; and
9. Allow care managers to:
    a. Identify risk factors for individual members
    b. Develop actionable Care Plans and ISPs

c. Monitor and quickly respond to changes in a member's health status
d. Track a member's referrals and provide alerts where care gaps occur
e. Monitor a member's medication adherence
f. Transmit and share reports and summary of care records with care team members
g. Support data analytics and performance and send quality measures (where applicable).

iii. 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:

1. 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;
2. 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
3. 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.

iv. 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*

v. 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*

vi. 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.

vii. 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.

viii. 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.

ix. Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled beneficiaries and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

f. Quality Measurement Criteria

i. 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.

ii. 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.

iii. AMH+ practices and CMAs may need to perform tasks including:

1. Abstracting data from patient charts;
2. Performing quality assurance to validate the accuracy of data in patient charts that is used for quality measurement purposes;
3. Using additional codes to fully document patient status and needs in order to improve the accuracy of quality measurement; and
4. 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.

iv. As covered in *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification,* BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

g. Other Tailored Care Management Criteria

i. 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.

ii. AMH+ practices and CMAs must meet the same contact requirements as the BH I/DD Tailored Plan*. See Section V.B.3.ii.(x) Ongoing Care Management*

iii. 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*

iv. 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*

v. 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.

1. 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*

vi. 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*

vii. 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*

viii. 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*.

ix. 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.*

4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members

a. Background

i. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing healthcare costs among participating providers.

b. Scope

i. The scope of this Policy covers the requirements that must be in agreements between the BH I/DD Tailored Plan and providers who offer prenatal, perinatal and postpartum services and thus are part of the Pregnancy Management Program outlined below and in *Section V.B.3.v.(iii) Pregnancy Management Program.*

c. Pregnancy Management Program Requirements

i. The BH I/DD Tailored Plan shall incorporate the following requirements for providers of the Pregnancy Management Program into their contracts with all providers of prenatal, perinatal and postpartum care:

1. Complete the standardized risk-screening tool at each initial visit.
2. Allow the BH I/DD Tailored Plan or the BH I/DD Tailored Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators.
3. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
4. Commit to decreasing the cesarean section rate among nulliparous women.
5. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation.
6. Complete a high-risk screening on each pregnant BH I/DD Tailored Plan member in the program and integrate the plan of care with Tailored Care Management and/or Care Management for High-Risk Pregnancy.
7. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate (Note: The Department will set the rate annually, which will be at or below twenty (20) percent).
8. Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.

ii. Require that BH I/DD Tailored Plan network providers send, within one (1) Business Day of the provider completing the screening, all screening information and applicable medical record information for members in care management for high-risk pregnancies to the applicable BH I/DD Tailored Plans, AMH+ practices or CMAs (as applicable), and the LHDs that are contracted for the provision of providing care management services for high-risk pregnancy.

5. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members

a. Background

i. "Care Management for High-Risk Pregnancy" refers to care management services provided to a subset of high-risk pregnant women by Local Health Departments (LHDs). Refer to the Contract for additional detail regarding Care Management for High-Risk Pregnancy in *Section V.B.3.v.(ii) Local Health Departments*.

ii. For Contract Year 1, LHDs shall have "right of first refusal" as contracted providers of Care Management for High-Risk Pregnant Women. Women participating in Care Management for High-Risk Pregnant Women with an LHD are also eligible for Tailored Care Management (i.e., a second care manager) to address other needs that are not included in the LHD model.

iii. After Contract Year 1, Care Management for High-Risk Pregnancy shall be fully subsumed into the Tailored Care Management model.

b. Scope

i. The scope of this Policy covers the agreement between the BH I/DD Tailored Plan and LHD providers offering Care Management for High-Risk Pregnancy, as outlined below and in the Contract.

c. General Contracting Requirement

i. LHD shall accept referrals from the BH I/DD Tailored Plan for Care Management for High-Risk Pregnancy services.

d. Care Management for High-Risk Pregnancy: Outreach

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

ii. LHD shall contact patients identified as having a priority risk factor through claims data (emergency department utilization, antepartum hospitalization, utilization of Labor and Delivery triage unit) for referral to prenatal care and to engage in care management.

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

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

ii. LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcomes.

iii. LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs) and patient self-referral and provide appropriate assessment and follow-up to those patients based on the level of need.

iv. LHD shall review available BH I/DD Tailored Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

v. LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

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

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

ii. LHD shall utilize assessment findings, including those conducted by the BH I/DD Tailored Plan, to determine level of need for care management support.

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

iv. LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and continually update that documentation as new information is obtained.

v. LHD shall assign case status based on level of patient need.

g. Care Management for High-Risk Pregnancy: Interventions

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

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

iii. LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.

iv. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.

v. LHD shall refer the identified population to childbirth education, oral health, BH or other needed services included in the member's BH I/DD Tailored Plan Network.

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

h. Care Management for High-Risk Pregnancy: Integration with the BH I/DD Tailored Plan and Health Care Providers

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

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

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

iv. LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.

v. LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.

vi. LHD shall ensure understanding of the BH I/DD Tailored Plan's prior authorization processes relevant to referrals.

i. Care Management for High-Risk Pregnancy: Collaboration with BH I/DD Tailored Plan

i. LHD shall work with the BH I/DD Tailored Plan to ensure program goals are met.

ii. LHD shall review and monitor BH I/DD Tailored Plan reports created for the Pregnancy Management Program and Care Management for High-Risk Pregnancy services to identify individuals at greatest risk.

iii. LHD shall communicate with the BH I/DD Tailored Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

iv. LHD shall participate in pregnancy care management and other relevant meetings hosted by the BH I/DD Tailored Plan.

j. Care Management for High-Risk Pregnancy: Training

i. LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by the BH I/DD Tailored Plan and/or the Department, including webinars, new hire orientation or other programmatic training.

ii. LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by the BH I/DD Tailored Plan and/or the Department.

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

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

k. Care Management for High-Risk Pregnancy: Staffing

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

1. Registered nurses
2. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.
3. Care managers for High-Risk Pregnancy hired prior to September 1, 2011, without a Bachelor's or Master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

ii. LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.

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

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

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

vi. LHD shall ensure that pregnancy care managers demonstrate:

1. Proficiency with the technologies required to perform care management functions
2. Motivational interviewing skills and knowledge of adult teaching and learning principles
3. Ability to effectively communicate with families and providers
4. Critical thinking skills, clinical judgment and problem-solving abilities

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

1. Provision of program updates to care managers
2. Daily availability for case consultation and caseload oversight
3. Regular meetings with direct service care management staff
4. Utilization of reports to actively assess individual care manager performance
5. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual

viii. LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following BH I/DD Tailored Plan/Department guidance about communication with the BH I/DD Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

1. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.

6. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members

a. Background

i. Care Management for At-Risk Children are care management services provided by LHDs to a subset of the Medicaid population ages zero (0) to five (5) identified as being "high risk."

ii. For Contract Year 1, LHDs shall have the right of first refusal to conduct Care Management for At-Risk Children for BH I/DD Tailored Plan-eligible children ages zero (0) to five (5) who are already enrolled in Care Management for At-Risk Children at the time of BH I/DD Tailored Plan launch. Children enrolled in Care Management for At-Risk Children will not be eligible for Tailored Care Management while enrolled in Care Management for At-Risk Children because the two programs provide duplicative services.

iii. After the launch of BH I/DD Tailored Plans, children covered by BH I/DD Tailored Plans who would otherwise have become eligible for Care Management for At-Risk Children will be enrolled into Tailored Care Management and not into Care Management for At-Risk Children.

iv. After Contract Year 1, Care Management for At-Risk Children shall be fully subsumed into the Tailored Care Management model.

b. Scope

i. The scope of this Policy covers the required terms that must be included in agreements between the BH I/DD Tailored Plan and LHD providers offering Care Management for At-Risk Children outlined below and in the Contract.

c. Care Management for At-Risk Children: General Requirements

i. LHD shall collaborate with out-of-county organizations providing Tailored Care Management—AMH+ practices, CMAs, and BH I/DD Tailored Plans—to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county.

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

iii. LHD shall utilize NCCARE360 to identify and connect members with additional community resources.

d. Care Management for At-Risk Children: Family Engagement

a. LHD shall involve families (or a legal guardian, when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care.
b. LHD shall foster self-management skill building when working with families of children.
c. LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

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

i. LHD shall review and monitor BH I/DD Tailored Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to ensure the child is appropriately linked to preventive and primary care services and to identify individuals at risk.

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

f. Care Management for At-Risk Children: Plan of Care

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

ii. LHD shall ensure children/families are well linked to the child's PCP.

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

iv. LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the child and use any locally developed resource list (including NCCARE360) to ensure families are well linked to resources to meet the identified need.

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

g. Care Management for At-Risk Children: Integration with BH I/DD Tailored Plans and Health Providers

i. LHD shall collaborate with the member's PCP to facilitate implementation of patient-centered plans and goals targeted to meet individual children's needs.

ii. LHD shall ensure that changes in the care management level of care or in the need for patient support and follow-up and other relevant updates (especially during periods of transition) are communicated to the PCP and to the BH I/DD Tailored Plan.

iii. LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.

iv. LHD shall ensure understanding of BH I/DD Tailored Plans' prior authorization processes relevant to referrals.

h. Care Management for At-Risk Children: Service Provision

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

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

i. Care Management for At-Risk Children: Training

i. LHD shall participate in Department or BH I/DD Tailored Plan-sponsored webinars, trainings and continuing education opportunities as provided.

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

j. Care Management for At-Risk Children: Staffing

i. LHD shall hire care managers who meet Care Management for At-Risk Children care coordination competencies and have at least one of the following qualifications:

1. Registered nurses

2. Social workers with a Bachelor's degree in social work (BSW, BA in SW, or BS in SW) or Master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education-accredited social work degree program.

    a. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as social workers under the Office of State Personnel guidelines.

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

iii. LHD shall ensure that Care Management for At-Risk Children care managers demonstrate:

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

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

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

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

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

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

ix. LHD shall ensure that community health workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children care manager.

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

1. Provision of program updates to care managers
2. Daily availability for case consultation and caseload oversight
3. Regular meetings with direct service care management staff
4. Utilization of monthly and on-demand reports to actively assess individual care manager performance

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

7. Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers

a. Background

This Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, 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 using the Department's applicable Objective Quality Standards. For network providers of Medicaid BH, I/DD, and TBI services, the BH I/DD Tailored Plan has the authority to maintain a closed network for these services as set forth in Section 4.(10)(a)(1)(IV) of Session Law 2018-48. The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the BH I/DD Tailored Plan in selection and retention of network providers for Medicaid BH, I/DD, and TBI services.

b. Scope

This Policy applies to the BH I/DD Tailored Plan and covers credentialing and re-credentialing policies for both individual and organizational providers. The Policy shall apply to all types of providers, including but not limited to acute, primary, BH, SUD, and LTSS [42 C.F.R. § 438.214(b)(1)].

c. Policy Statement

The BH I/DD Tailored Plan shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of their medical service providers. Each BH I/DD Tailored Plan must ensure that the responsibility for recommendations regarding objective quality determinations (i.e., network contracting decisions) will rest with a Provider Network Participation Committee.

d. Centralized Provider Enrollment and Credentialing

i. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:

1. 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 or Health Choice programs (or both) or as a State-funded Services provider.
    a. The information shall be collected, verified, and maintained as the Department's Objective Quality Standards required to participate as a Medicaid Enrolled provider or State-funded Services Enrolled provider.
    b. 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.
2. 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).
3. 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.

4. 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.
   a. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the NC Medicaid Direct program or provide State-funded services.
5. Providers will be reverified and recredentialed every three (3) years, except as otherwise specifically permitted by the Department in the Contract.
6. A BH I/DD Tailored Plan shall use its Provider Credentialing and Re-credentialing Policy to decide whether to contract with a Medicaid- or State-funded Services Enrolled provider in accordance with the standards contained in this Policy.

e. Provider Credentialing and Re-credentialing Policy

i. The BH I/DD Tailored Plan shall develop and implement, as part of its Credentialing and Re-credentialing Policy, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:

1. Meet the requirements specified in 42 C.F.R. § 438.214;
2. Meet the requirements specified in this Contract;
3. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, mental health, substance use disorders, and long-term services and supports providers;
4. 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.
5. Establish a documented process for making network contracting decisions using the Department's Objective Quality Standards for participation as a Medicaid Enrolled provider or State-funded Services provider;
6. 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).
7. 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.
8. 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;
9. 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
10. 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.
11. Identify standards and establish a documented process for making network contracting decisions on State-funded Services providers.

12. Describe the information that providers will be requested to submit as part of the contracting process.
13. 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).
14. 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.
    a. BH I/DD Tailored Plan shall make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the credentialing information provided by the Department.
15. BH I/DD Tailored Plan shall re-credential providers as follows:
    a. During the Provider Credentialing Transition Period, no less frequently than every three (3) years.
    b. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
16. Include all previous versions, be published on the BH I/DD Tailored Plan's website and include the Policy effective dates.

ii. BH I/DD Tailored Plan shall follow this Policy and its Provider Credentialing and Re-credentialing 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.

iii. BH I/DD Tailored Plan shall have discretion to make network contracting decisions consistent with the Policy and the BH I/DD Tailored Plan's Provider Credentialing and Re-credentialing Policy.

iv. BH I/DD Tailored Plan shall publish its approved Provider Credentialing and Re-credentialing Policy, including all previous versions, on the BH I/DD Tailored Plan's website and include the effective date of each policy.

8. Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members

1. Identification of inherited metabolic disorders caused by a defect in the enzymes or their co-factors that metabolize protein, carbohydrate or fat are included in the Newborn Metabolic Screening Program. Inborn errors of metabolism (IEM) generally refer to gene mutations or gene deletions that alter metabolism in the body. While rare, IEM disorder may manifest at any stage of life from infancy to adulthood. Early identification of IEM correlates with significant reduction in morbidity, mortality, and associated disabilities of those affected. Once identified treatment of an IEM is referred to a specialized treatment facility. Treatment is based on symptomatic therapy which may include the following strategies; substrate restriction, stimulation or stabilization of residual enzyme activity; replacement of deficient products; removal of toxic metabolites or blocking their production; and enzyme replacement therapy. Avoidance of catabolism is essential at all treatment stages.
2. Nutrition therapy is integral to the treatment of IEM. Nutrition therapy is used to both correct the metabolic imbalance and ensure adequate energy, protein, and nutrients for normal growth and development among affected individuals. The metabolic team at the specialized treatment facility caring for affected individual will prescribe a dietary regimen often requiring the use of specialized formulas. Continual monitoring of nutrient intake, laboratory values, and the individual's growth are needed for evaluation of the adequacy of the prescribed diet.
3. IEM disorders are complex and affect neurological, physical, and nutritional status. The dietary regimen is crucial to the health and survival of an affected individual. Ineffective management of the disease state may result in toxicity to certain organs, brain damage, developmental impairment and central, peripheral nervous system disorders as well as death. Most of the dietary regimens for IEM require the use of special formula. It is recommended that BH I/DD Tailored Plan cover the full cost of therapeutic diets prescribed by the metabolic team. Monitoring of the compliance of the restricted diet and follow up on the growth and development status of all individuals with IEM should be part of the individualized Care Plan.
4. Once a client is established with a specialized treatment facility a nutrition Care Plan is developed and products prescribed. The current system of product coverage is four pronged:
    a. Clients with health insurance coverage fill their prescription through pharmacies or Durable Medical Equipment (DME) Centers. Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) are required.
    b. Clients with Medicaid or Health Choice coverage are served by Innovation Health Center (IHC). Certificate of Medical Necessity/Prior Approval Form (triplicate NC Medicaid form), Prescription and Oral Nutrition Product Request Form (NC Medicaid form) as well as completed IHC Metabolic Order Form are sent by the specialized treatment facility to IHC for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. Medicaid is billed for the cost of the product.
    c. Clients participating in WIC are served through the Nutrition Services Branch (NSB). Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering. Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. WIC funds are used to pay the metabolic product invoices.
    d. Clients with no other means of access to prescribed metabolic formulas (as determined by the specialized treatment center) are served through a State program. Prescriptions and completed NSB Metabolic Order Forms are sent by the specialized treatment facility to NSB for ordering.

Orders are shipped from the manufacturer to the main office of the local WIC agency for pick-up by the client/family. State funds are used to pay the metabolic product invoices.

5. The BH I/DD Tailored Plan will need to establish working relationships with each product provision entity or other entity to provide coverage of the prescribed metabolic formulas.

DHHS/DPH/Nutrition Services Branch Contacts		
Contact Name	Title	Contact Email Address
Grisel Rivera	Nutrition Program Supervisor	Grisel.rivera@dhhs.nc.gov
Mary Anne Burghardt	State Director, Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	maryanne.burghardt@dhhs.nc.gov

Innovation Health Contact		
Contact Name	Title	Contact Email Address
Cindy Edwards	Finance and Operations Manager	cedwards@innovationhealthcenter.org

Specialty Treatment Center Contacts		
Facility	Contact Name	Contact Email Address
UNC Hospitals	Emily Ramsey, MPH, RD, CSP, LD	Emily.Ramsey@unchealth.unc.edu
UNC Hospitals	Christi Hall, MS, RD	Christine.Hall@unchealth.unc.edu
Duke University Medical Center	Surekha Pendyal, MSc, Med, RD	surekha.pendyal@dm.duke.edu
Atrium Health – Levine Children's Specialty Center	Sara Erickson	Sara.Erickson@carolinashealthcare.org

6. Members with IEM will require tracking while enrolled with a BH I/DD Tailored Plan. If a member with IEM does not appear on a BH I/DD Tailored Plan monthly enrollment roster, the BH I/DD Tailored Plan must follow up with the Department, to confirm disenrollment, and specialized treatment facility to assure that the member has ongoing coverage with another provider. The IEM client requires life-long intervention and treatment and must have the added safety net of the prior BH I/DD Tailored Plan confirming coverage after leaving their plan.

9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients

a. Background

The BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients provides the BH I/DD Tailored Plans with a detailed description of the Department's classifications of required BH services for the purpose of appointment wait time standards and routine, urgent and emergent care.

b. Behavioral Health Services Definitions

i. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.

ii. Adult Facility-Based Crisis Services: a state-funded crisis service for the purpose of network adequacy standards.

iii. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.

iv. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.

v. Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of network adequacy standards.

vi. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

vii. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.

viii. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

ix. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

x. Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xi. Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xii. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xiii. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xiv. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xv. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.

xvi. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xvii. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

xviii. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.

xix. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.

xx. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxi. Urgent Care for Mental Health:

1. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
2. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.

xxii. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.

xxiii. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

xxiv. Urgent care for SUD:

1. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
2. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.

xxv. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD

according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

xxvi. Specialized Services: as partial hospitalization for children and adults for the purposes of the network adequacy standards.

10. Non-Emergency Medical Transportation (NEMT) Policy

I. INTRODUCTION

Non-Emergency Medical Transportation (NEMT) is a critical service benefit to ensure that Medicaid members have access and availability to Medicaid covered services, including services carved out of Medicaid Managed Care as well as Value-Added and In Lieu of Services, to obtain medically necessary health care. Medicaid Managed Care Health plans shall provide:

1. NEMT services to ensure that eligible and enrolled Members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid and NC Health Choice enrolled providers.
2. NEMT services in an amount, duration and scope no less than the amount, duration and scope for the same services furnished to members under the Medicaid Direct (formally known as Medicaid Fee-For-Service) program.
3. Scheduling, payment and expense reimbursement for Non-Emergency Medical Transportation (NEMT) services.
4. NEMT services for all eligible and enrolled health plan Members:
    a. When the Member lacks both means and mode to arrange for their transportation.
    b. When the Member has access to a suitable mode of transportation, but lacks the means to use it, the health plan must assist with the means through gas vouchers, mileage reimbursement, etc.
    c. Travel related expenses including food, parking fees/tolls, transportation vouchers (i.e., taxis, ride sharing services, public transit), and mileage.
    d. The obligation for the health plan to provide transportation is not without qualifications and prior authorization.

II. HEALTH PLAN CRITERIA FOR PROVISION OF NEMT SERVICES

A. The Health Plan shall develop, submit and maintain an NEMT Policy

The health plan is required to submit for approval their NEMT Policy to NC Medicaid (the State) ninety (90) days after Contract Award, thirty days (30) after any NEMT contract amendment and annually thereafter.

1. The Policy shall include, at a minimum, the following:
    a. Transportation options available to Members;
    b. Methods and process by which to request transportation;
    c. Driver and vehicle requirements;
    d. Process for transportation assessment;
    e. Member rights and responsibilities; and
    f. Hours of operation

2. The Policy shall adhere to the following:
    a. Transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than one (1) hour before the appointment; nor must wait more than one (1) hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;
    b. Members cannot be required to make transportation requests in person;

c. Urgent transportation services are exempt from any advance notice requirement;
d. The Department's requirements for written materials; and
e. All other requirements as indicated in this policy as well as Contract #30-190029-DHB Prepaid Health Plan Services.

B. The Health Plan only pays for transportation:

1. By the least expensive mode available and appropriate for the enrolled/eligible Medicaid member,
2. To a Medicaid covered service provided by a North Carolina Medicaid enrolled provider. Generally, this will be the nearest appropriate medical provider and can include a bordering state.

NEMT services must include transportation to and from Medicaid covered services under NC Medicaid Managed Care and Managed Care carved out services (e.g., Dental).

NEMT Services can include transportation to and from Value-Added and In Lieu of Services.

C. Individuals/Members Not Eligible to Receive NEMT Services from the Health Plan include:

1. NC Medicaid Direct beneficiaries
2. North Carolina Health Choice (NCHC) members – NEMT is not a covered service for NCHC members unless offered by the health plan as a Value-Added Service
3. Members in a Nursing home -The facility is responsible for providing transportation to their patients
4. Members transferring between facilities and/or hospitals

D. Hours of Operation

1. The health plan shall provide transportation after normal business hours when the medical service required by the member is available only during those hours.
2. The health plan shall have a phone system with an answering machine or other message recording device for taking transportation requests or cancellations 24 hours per day. The messages shall be retrieved during normal business hours. The instructions to clients on the answering machine or other recording device shall advise callers to dial 911 if they are having an emergency.

E. Designated Staffing

The health plan must have designated staffing that have responsibility for:

1. Facilitating Members transition of care related to transportation services.
2. Informing Members of the availability of Medicaid NEMT services (as
defined in section II.B.2 or section IV in this policy guidance);
3. Informing Members that there is no cost to the Member;
4. Informing Members of who may accompany a Member without cost;
5. How to request, modify, reschedule, or cancel a transportation trip request (including any advance notification requirements);

6. Expected Member conduct and procedures for no-show;
7. Receiving “problem” calls from Members; and,
8. Completing necessary Transportation documentation, equivalent forms or system interfaces that capture all required data fields to track each trip and/or reimbursement request - from intake through disposition.

F. NEMT Mode of Transportation Services Shall Include:

1. NEMT transportation providers including public transportation, taxis, van, wheel-chair vans, mini-bus, mountain area transports or other transportation systems and non-emergency ambulance transportation.
2. Other transportation services including volunteers, family members and friends as well as non-emergency air travel.

G. Compliance with Transportation Policy (self-auditing)

Providing Medicaid transportation services to members who need those services and the proper utilization of NEMT services by members are important goals of Medicaid transportation policy. In order to attain these goals, the health plan is required to perform a self-audit of NEMT services.

1. The health plan must randomly sample 2% of the trips, or 200 trips whichever is less per calendar quarter.
2. Trips documented for self-auditing must capture all the data fields included in section VI.B. Utilization Documentation.
3. All modes of transportation must be included in the sample.
4. The health plan should maintain a control file with findings of the quarterly review and documentation of action taken.

The established self-audit process shall be outlined in the health plan's NEMT Policy and submitted to the Department for approval. The health plan’s self-audit quarterly results shall be submitted to the Department annually for review.

H. Reporting Fraud, Waste and Abuse

Ensure all Members receiving transportation services have been made aware of how to report suspected fraud, waste, and abuse (see Member Handbook). For additional requirements see policy guidance section X. Reporting Fraud, Waste and Abuse.

I. NEMT Provider Network Participation Requirements and Adequacy

1. NEMT Provider Networks and Adequacy

   The health plan is required to develop a network of NEMT providers to fulfill the requirements as outlined in this policy and in Contract #30-190029-DHB Prepaid Health Plan Services. This includes ensuring that its NEMT provider network can:

   a. Transport a Member on time for their appointment, but no sooner that one (1) hour before their appointment; nor have to wait more than one (1) hour after the conclusion of the treatment; nor be pick up prior to the completion of treatment.

b. Accommodate timely, urgent transportation services (e.g., trips to pharmacy and other ancillary service providers such as labs or radiology) without any advance notice requirement.
c. Transport a member in the mode most appropriate to meet the member's needs and circumstances.
d. Assure transportation is provided to members in a timely and cost-effective manner.

To ensure the NEMT provider network and adequacy requirements are met, PRV027-J: NEMT Provider Contracting Report will be added to Attachment J of Contract #30-190029-DHB Prepaid Health Plan Services and will be required to be submitted to the State on a quarterly basis through the formal PCDU process with the same time-line as the PRV004-J: Network Data Details Extract until such time until Medicaid Managed Care launches. Following launch, DHB Health Plan Administration will determine new/or additional report requirements.

2. Development of a comprehensive NEMT provider network is necessary to:
   a. Ensure that members have timely access and availability to obtain medically necessary routine and urgent medical care;
   b. Through NEMT provider network contracting, support and promote the coordination of public and private/independent transportation services across geographies, jurisdictions, and program areas for the development of a seamless transportation network;
   c. Support the provision of dependable transportation options to Medicaid members;
   d. Demonstrate that the health plan has the capacity to transport on a non-emergent basis the expected enrollment statewide and/or in its region.

   If administration of the health plans NEMT network is contracted out, the subcontractor is required to carry out all the responsibilities placed upon the health plan by the NEMT Managed Care Policy Guidance as well as contractual requirements.

   Summarily, development and maintenance of a robust NEMT provider network that maintains strong provider and community participation and demonstrates an understanding of the transportation needs of the North Carolina Medicaid Managed Care population to ensure access and availability to high quality care and services to all members is essential.

3. NEMT Network Participation
   Notwithstanding any other provisions in the Contract #30-190029-DHB Prepaid Health Plan Services related to provider network participation (e.g., contracting requirements, standard terms and conditions, any willing provider, good faith contracting and negotiation, etc.), health plans and/or their subcontracted transportation brokers shall not:
   a. Include exclusivity or non-compete provisions in their contracts with transportation providers,
   b. Require a transportation provider to participate in the governance of a Provider Led Entity (PLE) or,

c. Otherwise prohibit provider from providing services for or contracting with any other health plan.

4. Provider Credentialing and Enrollment Process
The health plan shall ensure that its NEMT providers as well as its subcontracted transportation broker, if applicable, must enroll as a Medicaid provider by completing a Provider Enrollment application online at www.nctracks.nc.gov. Providers of NEMT services may be from within the state of North Carolina and/or the approved bordering state areas as referenced in section IV.F. Health plan transportation brokers can be within the state of North Carolina or Out-of-State.
   a. Affordable Care Act fee and a North Carolina application fee are required.
   b. NEMT providers should be enrolled with the following taxonomy codes:
      i. NEMT Transportation Brokers should enroll through NCTracks using Taxonomy Code 347E00000X.
      ii. All other NEMT Transportation providers should enroll through NCTracks using one of the following taxonomy codes:

NEMT TAXONOMY CODES		
Taxonomy Code	**Description**	**Washington Publishing Company Definition**
343900000X	Transportation Services /Non-Emergency Medical Transport (Van)	A land vehicle with a capacity to meet special high, clearance, access, and seating, for the conveyance of persons in non-emergency situations. The vehicle may or may not be required to meet local county or state regulations.
344600000X	Transportation Services /Taxi	The land commercial vehicle used for transporting of persons in non-emergency situations. The vehicle meets local, county, or state regulations set forth by the jurisdiction where it is located.
347B00000X	Transportation Services /Bus	A public or private organization or business licensed to provide bus services
347C00000X	Transportation Services /Private Vehicle (Gas Reimbursement)	An individual paid to provide non-emergency transportation using their privately owned/leased vehicle.
347D00000X	Transportation Services /Train	An organization or business licensed to provide passenger train service, including light rail, subway, and traditional services.

iii. For health plans that are providing ALS and BLS services, the transportation providers should enroll through NCTracks using one of the following taxonomy codes:

ALS/BLS TRANSPORTATION TAXONOMY CODES		
Taxonomy Code	**Description**	**Washington Publishing Company Definition**
341600000X	Transportation Services Ambulance	An emergency vehicle used for transporting patients to a health care facility after injury or illness. Types of ambulances used in the United States include ground (surface) ambulance, rotor-wing (helicopter), and fixed-wing aircraft (airplane)
3416A0800X	Emergency Air Ambulance	Definition to come...
3416L0300X	Land Ambulance Transport	Definition to come...
3416S0300X	Transportation Services Ambulance	Definition to come...
343800000X	Transportation Services /Secured Medical Transport (Van)	A public or privately-owned transportation service with vehicles, specially equipped to provide enhanced safety, security and passenger restraint, and staffed by one or more individuals trained to work with patients in crisis situations resulting from mental or emotional illness and/or substance abuse.

c. NEMT providers can enroll with a National Provider Identifier (NPI) or enroll as Atypical providers. Obtaining an NPI is not required.

d. Online training is required.

   i. For training, please refer your contracted providers to the NCTracks website www.nctracks.nc.gov or their call center, 1-800-688-6696.

e. No certification, accreditation or license is required.

f. On-Site Visit is required

   i. All accepted provider types that provide NEMT services (see above NEMT taxonomy codes) will receive a State compliance monitoring visit.

      1. Providers are screened based on the categorical risk level of the taxonomy code selected. For NEMT services, this include moderate to high risk.
      2. Compliant and approved NEMT providers will be displayed on the daily Provider Directory file.

III. MEMBER RIGHTS AND RESPONSIBILITIES

The local agency/DSS must give or mail the DMA-5046, The Medicaid Transportation Assistance – Notice of Rights/Responsibilities, to the beneficiary/member at each Medicaid application and recertification. This includes all types of eligibility except Medicare Qualified Beneficiaries (MQB), NC Health Choice, and those beneficiaries who reside in long term care facilities.

If the health plan offers NEMT as a Value-Added Service for NC Health Choice members, the health plan must develop and provide these members their rights and responsibilities upon initial trip request and annually thereafter.

A. Rights of the Member

1. To be informed of the availability of Medicaid transportation.

2. To have the transportation policy explained including how to request a trip or cancel a trip, limitations on transportation, personal conduct and no-shows.

3. To be transported to medical appointments if unable to arrange or pay for transportation:
   a. By means appropriate to circumstances
   b. To arrive at medical provider in time for their scheduled appointment

4. To request a hearing if the request for transportation assistance is denied

B. Responsibilities of the Member

1. To use those transportation resources which are available and appropriate to their needs in the most efficient and effective manner.

2. To utilize transportation services, such as gas vouchers, appropriately.

3. To travel to the requested location and receive a Medicaid covered service.

4. To make timely requests for transportation assistance.

5. To be ready and at the designated place for transportation pick-up or cancel the transportation request timely.

6. To follow the instructions of the driver.

7. To respect and not violate the rights of other passengers and the driver, such as not creating a disturbance or engaging in threatening language or behavior.

IV. DESCRIPTION OF MEDICAID MANAGED CARE NEMT COVERED SERVICE

A. NEMT Covered Service

Non-Emergent transportation to Medicaid services, including carved out services, and value-added and in lieu of services, is required to assure access to medical care and treatment provided by a qualified Medicaid provider (enrolled in NC Medicaid and NC Health Choice).

Key NEMT services are listed in Contract #30-190029-DHB Prepaid Health Plan Services and include:

1. 42 C.F.R. §431.53

2. 42 C.F.R. §440.170
3. North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att.3.1-A, Page 18
4. NC Medicaid Managed Care Policy Guidance - NEMT

B. NEMT Transportation to NC Enrolled Provider

The health plan must provide NEMT services to a Medicaid covered service provided by a North Carolina Medicaid enrolled provider. Generally, this will be the nearest appropriate medical provider and can include a bordering state.

C. NEMT for Transition of Care Services

For newly enrolled Members transitioning to a health plan from Medicaid Direct or another health plan, the health plan is required to follow the Department's Transition of Care Policy. Health plans must ensure that transportation services are coordinated and that prescheduled transportation appointments are successfully managed with minimal disruption to the Members established provider relationships and care treatment plans. Health plans are required to have NEMT and Transition of Care Policies that addresses how coordination of transportation will be managed.

D. NEMT Value-Added Services

Health plans may choose to add NEMT services for NC Health Choice Members, who are currently ineligible for the service, under Medicaid Managed Care benefit plan that are delivered at the health plan's discretion and are not included in the capitation rate calculations. These services need to be formally submitted to the Department for approval as a Value-Added Service. NEMT Value-Added Services are designed to improve quality and health outcomes and/or reduce costs by reducing the need for more expensive care.

E. Non-Emergency Ambulance Transportation (NEAT)

Please refer to current NC Medicaid Ambulance Services Clinical Coverage Policy No: 15 for additional benefit coverage information for NEAT.

F. Transportation Providers and Border/Out-of-State Trips

The health plan can contract with in-state and border (i.e., providers that reside within forty (40) miles of the NC state line) network providers for NEMT Services.

Appropriate NEMT services must accommodate medically necessary trips to and from boarding and out-of-state network medical providers. Refer to Section VII. for advance notice for out-of-state and bordering state trip requests. For a list of NC border zip codes: https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information/zip-codes.html.

V. ASSESSMENT AND PRIOR AUTHORIZATION FOR TRANSPORTATION SERVICES

For the purpose of NEMT, the assessment process is defined as review of the member's most current circumstances to determine the means and mode of NEMT services appropriate to fit the needs of the member.

A. Assessment Purpose

When a request for transportation is made, an assessment of the request must be completed. The purpose of the assessment is to:

1. Determine the Member's eligibility for transportation services,
2. Determine any special needs requirements,
3. Determine mode of transportation, and
4. Assess other sources that may be available to the Member

B. Assessment Process

1. An assessment must be completed in its entirety:
   a. At the initial request for transportation assistance
   b. At least once a year after initial request
   c. When there is a change in situation which may impact the need for transportation assistance
   d. To coincide with each Medicaid recertification, if the Member is still in need of services
2. The assessment process should assess the amount, duration, and scope that the member has previously had or to establish current need for transportation services. Considerations should be given to the following areas listed below:
   a. Assess how medical transportation has previously been provided and why it is not available now.
      i. Does the enrolled/eligible Member have access to a vehicle that can be used to get to and from medical appointments?
      ii. Ask the enrolled/eligible Member and/or authorized representative if she/he has a working vehicle.
      iii. Ask the enrolled/eligible Member and/or parent, guardian, legally authorized representative, advocate if he/she has friends, relatives or neighbors who would be willing to transport him/her to medical appointments.
   b. Ask the enrolled/eligible Member and/or parent, guardian, legally authorized representative, advocate how he/she has been getting to medically necessary appointments.
      i. Drives self
      ii. Friend/relative/neighbor provides transportation
      iii. Takes a bus
      iv. Takes a cab
      v. Other. Document who (e.g. organization name, DSS Agency, non-profit)
   c. Ask if there is a reason the Member can no longer use the source, he/she had been using for transportation to get to medical appointments.
      i. If the Member has access to a vehicle, find out why that vehicle cannot currently be used to transport him to medical appointments. If Member states that he cannot afford to pay for gas, explain that gas reimbursement is available.
      ii. If the Member states that he cannot afford to pay (for gas, bus fare, car repairs, insurance, vehicle registration, cab fare, etc.) accept their statement.

d. If it is determined that the Member can provide their own transportation, the request should be denied.

C. Assessment by Other Entities

The health plan may subcontract with other entities to have transportation assessments completed. However, before they begin the process, the health plan is responsible for assuring that:

1. The subcontractor follows the defined assessment process, outlined in this policy guidance; and
2. Documentation of the NEMT assessment, service determinations (any increase or decrease in amount, duration, scope or frequency), prior authorization decisions, copies of notices, approval, and denials are reviewed and audited by the health plan and comply with guidelines.

D. Special Member Considerations for NEMT Services

1. Ask the Member about special needs or impediments to using certain forms of transportation. Does the Member use/require?
   a. An attendant (required for children under age 18 unless they are emancipated), who may or may not be a parent. Other members may need an attendant due to special medical, physical or mental impediments;
   b. Mobility Device – ask what type of mobility device is used (wheelchair, scooter, etc.);
   c. Cane/crutches/walker;
   d. Portable oxygen tank;
   e. Service animal, or
   f. Have a condition, such as blindness, deafness or disorientation which can impact transportation options;
2. Ask the Member if he/she has other special needs.
   a. Member is a minor child that needs to be accompanied by an adult
   b. Accompanying translator
   c. Other member considerations
3. If any criteria in V.D.1 or V.D.2 are met the special needs indicator on the encounters information should be yes (Y).

E. Prior Authorization Process

For transportation services for which the health plan requires prior authorization, meaning a medical necessity review, the health plan must follow the prior authorization standards outlined in Contract #30-190029-DHB Prepaid Health Plan Services. The health plan may subcontract with other entities to have transportation prior authorization completed. However, before they begin the process, the health plan is responsible for assuring that:

1. The subcontractor follows the defined prior authorization process, outlined in Contract #30-190029-DHB Prepaid Health Plan Services; and
2. Documentation of the prior authorization decisions, copies of notices, authorizations, approval, and denials are received by the health plan and comply with guidelines.

F. Documenting NEMT Trip Requests

All NEMT requests and prior authorizations should be documented appropriately.

All trip requests and the prior authorization outcomes must be logged, including approval date or denial date, reason for denial, and, when applicable, the date the Notice of Adverse Benefit Determination (NABD) was sent to the member.

If the NEMT prior authorization request is approved, the member must be notified of the means and mode granted.

If the NEMT prior authorization request is denied, the member must be notified via a Notice of Adverse Benefit Determination (NABD) which indicates why the request was denied and the process for the member to appeal the determination.

VI. SCHEDULING NON-EMERGENCY MEDICAL TRANSPORTATION

A. Transportation Requests

1. Health plans shall not require members to make transportation requests more than two (2) business days in advance.

2. The member should be able to contact the Member Services Department or transportation coordinator at health plan to request assistance for all medical service trips during their health plan enrollment period. The request may include multiple trips (reference VI.C. Types of Approvals).

3. All requests for medical transportation by Medicaid members must be documented and treated as trip requests even if it appears obvious that the individual will not be entitled to NEMT for the trip requested.

4. Health plans shall ensure that an attendant (e.g., parent, guardian, neighbor, friend, other relative) is present with:
   a. Members under the age of eighteen (18), unless emancipated, at no additional cost to the member or attendant. The attendant may or may not be the parent.
   b. Members with special medical, physical or mental impediments, at no additional cost to the Member or attendant. The attendant may or may not be the parent.

B. Utilization Documentation

Utilization Documentation should be captured via BCM011-J: Non-Emergency Medical Transportation (NEMT) Report. The health plan/and or the subcontractor should capture the following for each scheduled trip at a minimum, including no-shows:

1. Date of request,
2. Date of trip,
3. Medicaid Identification Number of the individual obtaining a Medicaid covered service (do not provide the MID of anyone traveling with this individual)

4. NEMT Source Type (Member, Provider, Case Manager, Other)

5. Destination (name of medical provider/business and address)
6. Whether the trip is approved and, if not, the date notice was sent
7. Date denial notice sent (if applicable)
8. Mode of transport
9. Number of additional riders
10. No-shows (member was a no-show, provider was a no-show,)
11. Special needs and considerations
12. Trip Location (must identify out-of-state or bordering state trips)
13. Appeal Date of each NEMT member appeal
14. Appeal Decision of each NEMT member appeal
15. Appeal Decision Date of each NEMT member appeal

The health plan and/or subcontractor should maintain the following transportation utilization information for each Member's trip request:

1. Prior Authorization Documentation (e.g. date or date span, method and mode)
2. NEMT Utilization Documentation (Section VI.B)
3. Documentations of Approval and Denial notices
4. Dates or documentation of no-show and conduct policy was reviewed with the member
5. Rights and Responsibilities notification for members who are NC Health choice and receiving NEMT as a Value-Added Service.

C. Types of Approvals

The health plan must provide NEMT services and may approve transportation in one of the following manners based on the member's situation and needs:

1. Individual Medical Trips
    a. Approve trips to medical services as needed for members that meet requirements for transportation assistance.
    b. To avoid providing services to ineligible members, Medicaid eligibility must be verified for each month in which NEMT is requested before approving a transportation request.

2. Series of Appointments

    Transportation can be approved for a series of appointments with a medical provider if the provider is Medicaid enrolled and the service(s) is covered. The transportation coordinator must verify the series of appointments with the provider.
    a. The member must contact the transportation coordinator to request assistance for all medical visits during the designated period.
    b. The transportation coordinator must verify Medicaid eligibility prior to scheduling each trip in the series of appointments, as well as document that the trip is for a Medicaid enrolled provider/Medicaid covered service.
    c. Example: Ms. Sky Blue states that she must visit her heart specialist every two months for a checkup and blood work. Approve bi-monthly visits to this provider for the length of her Medicaid certification period.
    Eligibility for each month must be verified prior to scheduling each trip.

        If Ms. Blue has other transportation needs, she must contact the transportation coordinator and request assistance for those trips separately.

D. Notification Requirements for Trip Requests and Prior Authorization

Members shall have access to a formal appeals and grievance process regarding all NEMT determinations. The member has the right to request an appeal if they disagree with a decision made on their NEMT trip request (including trip requests that require prior authorization). Written notification must be sent to Members when a trip request requiring prior authorization is approved and for all trip denials (including changes in the amount, duration, frequency and scope of the request). The health plan must include and maintain this information in their utilization documentation as specified in the policy guidance.

1. Approvals

   The member must receive written notification of approval when prior authorization was required to approve the trip or series of trips. The member may be notified verbally of trip approvals when NEMT requests are initiated by phone if known at the time of the call.

2. Denials

   The health plan must follow the formal appeals process for all NEMT trip request denials (including trip requests that require prior authorization) and ensure the following:

   a. An NABD, documenting the reasons for the decision, is sent for each request that is denied (including changes in the amount, duration, frequency and scope of the request). If a series of appointments are requested, only one NABD is needed to deny one, all, or any of the trips included in the request.
   b. If multiple members in a household are denied NEMT services, that all members receive a separate NABD.
   c. Copies of the NABD notices are retained in the utilization documentation transportation file.
   d. That trip requests are not denied when the member fails to comply with the advance notice policy, if services are provided on a different date or a gas voucher is issued.
   e. That trip requests are not denied due to the health plan's lack of resources. The health plan must develop an adequate network to meet the needs of the members (reference section II.I).

3. Reporting

   The health plans must comply with the Member Appeals and Grievance reporting requirements outlined in their contracts with the Department.

VII. ADVANCE NOTICE, NO-SHOW AND CONDUCT POLICIES

A. Advance Notice Policy

1. The health plan cannot require the member to make transportation requests in person.

2. While members should be encouraged to make transportation requests as far in advance as possible, they cannot be required to make such requests more than three business days before their scheduled medical appointment and five days for trips at a greater distance.

3. Urgent transportation services are exempt from any advance notice requirement. The health plan must make an attempt to satisfy any urgent request for transportation.

   Example: the doctor refers the member for a test that must be completed same day or within days.

4. The member must be informed in writing of the advance notice policy (i.e., Member Handbook).

B. No-Show Policy

A No-Show is when a member does not go to the medical appointment. This includes Members issued gas vouchers and mileage reimbursement. The purpose of a no-show policy is to establish consistent rules and procedures to follow when a member misses a scheduled trip without good cause.

1. The health plan can develop their own no-show policy so long as it is no less restrictive than the no-show policy outlined in MA-3550/2910. The health plan is required to explain their no-show policy and provide a written copy of it to the member.

2. For reference, the MA-3550/2910 No-Show Policy is below:
   a. The member must be ready and at the designated place for pick up at the time required by the transportation vendor.
   b. The member must complete their trip and show evidence in order to be issued a gas voucher for mileage.
   c. The member must call the number provided for trip requests to cancel scheduled transportation at least 24 hours in advance. Cancellations made less than 24 hours in advance may count as one “no-show,” unless there was good cause for the cancellation.
   d. A first missed trip without good cause will result in counseling by phone, (by letter if the member cannot be reached by phone) that further missed trips may result in a suspension of transportation services for a period of thirty days. Document the phone conversation in the member’s NEMT utilization documentation.
   e. A second missed trip within three months of the first missed trip will result in a telephone call (or letter if the member cannot be reached by phone) warning that the next missed trip will result in a suspension of transportation services for a period of thirty days. Document the phone conversation or file the letter in the Member’s NEMT utilization documentation.
   f. A third missed trip within three months of the first missed trip will result in a 30-day suspension of the member’s transportation services. The member should be notified of their transportation suspension through the formal appeals and grievance process (NABD) informing the member of their transportation impact, the suspension dates, and their previous no-show information.
   g. Continue to follow the no-show policy above after the suspension has ended.

Example: Raven Nevermore is a no show for scheduled NEMT appointments on March 16, April 22 and May 2. After counseling and warnings have occurred, Raven is suspended from transportation assistance for May 16 through June 14. Raven requests transportation services for an appointment on June 18. Raven is a no-show for this trip as well. Raven can be suspended for another 30 days because she has missed three appointments in a three-month span.

3. Good Cause

   Good cause consists of illness of the member or illness/death of the member's spouse, child or parent.

4. Exception to suspension for critical needs members.

   Critical needs members, such as those receiving dialysis or chemotherapy, cannot be denied transportation to critical services, no matter how many transportation appointments they miss. However, these individuals can be suspended from receiving NEMT to their non-critical appointments.

C. Conduct Policy

1. The health plan can develop their own conduct policy so long as it is no less restrictive than the conduct policy outlined in MA-3550/2910. The health plan is required to explain their conduct policy and provide a written copy of it to the member.

2. For reference, the MA-3550/2910 Conduct Policy is below:
   a. Any conduct which jeopardizes the safety of other passengers and/or the driver will result in suspension of transportation services by the health plan for 30 days.
   b. Public transit systems and other NEMT providers shall have conduct policies. NEMT riders are subject to the conduct policies of the transportation providers. Violation of such conduct policies may result in suspension of transportation services in accordance with the vendor's policy. A vendor's suspension from their services may exceed 30 days.
   c. Any Member who has been suspended from transportation services due to violation of the conduct policy shall be provided a gas voucher or mileage reimbursement in advance, if unable to pay, for trips to Medicaid covered services as long as he remains otherwise eligible for transportation assistance.
   d. Any member who has a time limited suspension from transportation services due to violation of the conduct policy should receive an NABD with the reason and timespan of their transportation service suspension.

IX. NEMT ENCOUNTERS

All NEMT trip requests are to be submitted through the EPS process. Please reference the Encounter Data Submission Guide and the EPS 837-P Companion Guide for more detailed information regarding NEMT Encounters. In summary, NEMT encounters should capture each leg of the trip request as a separate encounter that includes the following information:

1. **Billing Provider**: NEMT Broker or subcontractor

2. **Rendering Provider**: NEMT provider who provided the service
   a. For claims related to mileage reimbursement, meals, lodging, and commercial air, submit the same rendering provider as the billing provider.
   b. Meals, Lodging, and Commercial Air: Submit [Name] and [NPI/Atypical]

i. Name: meal, lodging, or Commercial Air
ii. NPI/Atypical: Billing Provider

c. Mileage reimbursement: Submit [Name] and [NPI/Atypical]
    i. Name: Name of the member or volunteer that will receive the reimbursement
    ii. NPI/Atypical: Billing Provider

3. **Trip Number:** 9 characters long (must add leading zeros) and must be unique for each encounter.

4. **Special Needs Indicator**: Determined during the initial assessment and NEMT prior authorization process.

5. **Type of Attendant**: Medical Professional, Non-Medical Professional or Parent, No Attendant. Reference IX.F for more information regarding attendant information

6. **Number of Individuals Accompanying the Member**: This will be the number of individuals who are accompanying the member on the trip excluding the attendant.

7. **Member Picked Up Indicator:** This will help determine no-shows for members and providers.

8. **Date the Trip was Requested**: Must be in the yyyymmdd format and on or before the date of the trip.

9. **Transportation HCPCS:** Reference section IX.C for the list of approved transportation procedure codes.

10. **Unit Measurement Code:**
    a. MJ: Transportation waiting time in ½ hour increments for minutes for procedure code T2007
    b. UN: Unites for all other procedure codes

11. **Actual Miles of the Trip:** The actual miles of the trip associated to the transportation mileage procedure codes or the number of minutes spent waiting for the member.

12. **Place of Service:**
    a. 99 for taxi, bus, mini-bus, van, car
    b. 41 for ambulance – land
    c. 42 for ambulance

13. **Trip Type:** This will distinguish different legs of the trip
    a. **Initial**: First leg of the trip
    b. **Return**: Last leg of the trip
    c. **Transfer**: All the legs in-between the initial and return trip to be marked with the corresponding trip leg number

14. **Trip Leg:** The number (1-9) of the trip leg in order to sequence the legs of the trip. A trip leg is defined as an instance of pickup/origination and drop off/destination

of the Member for their requested trip.

15. **Transportation Type**: Reference II.F for the different types of NEMT transportation types and below is the code and description allocated for NEMT encounters.

Code	Description
PT	Public Transportation
WV	Wheelchair Van
MV	Multi-person Van
TX	Taxi
AM	Ambulance
VN	Van
MB	Mini-Bus
MT	Mountain Area Transports
PV	Private/Personal Vehicle
OT	Other

16. **Appointment Time**: The appointment time should be either the time of the appointment specified by the member or the time the member specified to arrive for their appointment. If the member is being taken to an appointment, the appointment time should be supplied in military time format. If the member is being taken somewhere but there is no appointment time, the time should be entered as 0000.

17. **Scheduled Pickup Time:** The time the member has indicated that they should be picked up, this should be in military time format.

18. **Pickup Location:** Allowed pickup locations are indicated below.

Code	Description
AD	Adult Day Care
AL	Intensive Assisted Living
CL	Clinic
DI	Dialysis
DN	Dental
DO	Doctor’s Office
DR	Drug Rehabilitation
DS	Day Support

HM	Home
HO	Hospital
LX	Lab and X-Ray
MH	Mental Health
NH	Nursing Home
OS	Out of State Transportation
PR	Physical Rehabilitation
PT	Psych Transport
PV	Patient Visitation
RC	Respite Care
RE	Residence
RX	Pharmacy
SC	School
SE	Supported Employment
SG	Surgical Center
SP	Specialist
UN	Unknown
OT	Other

Use the out-of-state transportation code (Code OS) when the pickup or drop-off state is outside the State of North Carolina.

19. **Arrival Time:** The time the driver arrives at the pickup (origin) location

20. **Departure Time:** The time the driver leaves the pick-up (origin) location

21. **Drop-off Location:** See valid values from section VIII.r Pickup Locations

22. **Drop-off Time**: The time the driver arrives at the drop-off (destination) location

23. **Pick Up Location:** Pick-up Address, including street, city, state, and zip code.

24. **Drop Off Location:** Drop-off Address, including street, city, state, and zip code.

A. NEMT Encounters Special Considerations

1. Cancelled trips should be reported as denied trips through the encounters process.

2. Duplicate encounters will be validated against same claim number, or the same

billing and rendering provider, member, date of service, procedure codes/modifier, and trip leg.

3. An ICD-10-CM diagnosis code is required on all NEMT encounters. Diagnosis code Z76.89 is recommended.

Note: transportation benefits that are defined as value-added services should be reported using the submission rules for value-added services encounters and not under NEMT.

Please reference the EPS Business Rules Spreadsheet for the list of NEMT encounters business rules and the Encounter Data Submission Guide and the EPS 837-P Companion Guide for additional clarification on NEMT encounter file layout.

X. COMPLIANCE AND RISK MANAGEMENT

The health plan is responsible to ensure that their contracted NEMT participating providers are in compliance with all the risk management procedures outlined below. **These requirements do not apply to Members and financially responsible persons who seek reimbursement for mileage.**

A. Safety and Risk Management Monitoring

From a risk and compliance monitoring perspective, the health plan and/or designated entity shall:

1. Ensure contracts with NEMT providers include all provisions specified in this policy.

2. Ensure all appropriate contract NEMT providers are enrolled with the State Medicaid program.

3. Ensure contracts include a certification and/or assurance of compliance with contractual safety and risk obligations.

4. Conduct an annual review of contractors to ensure all contract requirements are met.

5. Ensure contracted NEMT Providers maintain a file for their staff, approved volunteers, and member relatives and friends who are reimbursed directly for NEMT services.
    a. The health plan is required to review these files to assure that all information is current within timeframes specified in the health plan's fraud, waste, and abuse monitoring plan.

6. Ensure all contracted NEMT providers maintain the following for their staff and approved volunteers:
    a. Driver's License;
    b. Current vehicle registration/inspection;
    c. Current driving record;
    d. Liability insurance;
    e. An agreement stating that the staff/agency volunteers will report all changes

7. Ensure that member relatives and friends providing NEMT services via reimbursement possess the following:
   a. Driver's License;
   b. Current vehicle registration/inspection;
   c. Liability insurance;
   d. An agreement stating that the staff/volunteers/ member relatives and friends will report all changes;

   These files are required to be reviewed at time of initial Member request for a relative/friend to provide transportation when Member changes the relative/friend providing transport and annually thereafter to assure that all information is current.

8. Ensure liability Insurance is met for the following:
   Sufficient insurance coverage is necessary to adequately protect the contracted NEMT provider and the members transported. A guide for minimum coverage shall be the amount required for common carrier passenger vehicles by the North Carolina Utilities Commission (see http://www.ncuc.net/ncrules/chapter02.pdf, Rule 02-36).
   a. Commercial Vehicles
      i. The health plan should require contracted transportation providers to carry liability at the minimum statutory requirements.
      ii. When commercial vehicles (16 passengers or more) are used to provide member transportation services, the health plan should obtain a copy of the private contractor's Certificate of Insurance documenting that the health plan transportation coordinator or designee is an "additional insured." The party identified as an "additional insured" will be notified 30 days in advance of a contractor dropping any coverage.
   b. "For Hire" Vehicles
      i. "For Hire" passenger vehicles are defined as vehicles used for compensation to transport the general public as well as human service members and are, therefore, subject to the regulations of the N.C. Public Utilities Commission. Taxi cabs and public transportation systems do not fall into this category.
      ii. Transportation providers licensed as "For Hire" public conveyance operators must meet statutory requirements for their classification and operator responsibilities. Currently, $1.5 million liability insurance coverage is required on vehicles with a seating capacity of 15 passengers or less, including the driver, and $5 million coverage for vehicles designed to transport more than 15 passengers, including the driver.
   c. Taxi Cabs
      Liability insurance requirements are set by local ordinances and can vary widely from county to county. Any taxi service used for NEMT must carry at least the minimum liability insurance coverage for their vehicle's classification for their local ordinance (for minimum liability requirements for passenger vehicles, see https://www.ncdot.gov/dmv/title-registration/insurance-requirements/Pages/default.aspx).

9. Ensure the validity of licensed operators
   a. The health plan and/or designated entity is required to attest that contracted NEMT providers are meeting all contractual requirements by periodically reviewing driver licenses and verifying all drivers are at least 18 years of age and properly licensed to operate a vehicle and driving records are reviewed

every 12 months. If the review is performed by a designated entity, the designated entity is required to periodically (at the discretion of the health plan) provide to the health plan a sample of their reviews.

b. The health plan is required to ensure that all drivers are at least 18 years of age and properly licensed to operate the specific vehicle used to transport Members. This also applies to family members, friends, etc., reimbursed to transport the Member, but not to Members and financially responsible persons.

10. Ensure that vehicle state inspections are valid
The health plan and/or designated entity is required to ensure that all vehicles used to transport members have valid State registration and State inspection. This also applies to family members, friends, etc., reimbursed by the agency to transport the Member, but not to Member and financially responsible persons.

11. Alcohol and Drug Testing
The health plan and/or designated entity shall ensure both private and public contract transportation providers to participate in a random alcohol and drug testing program which meets the requirements of the Federal Transit Authority (FTA) (see https://www.transit.dot.gov/drug-alcohol-program). The providers shall be contractually obligated to pay for the alcohol and drug testing program.

12. Background Checks
The health plan and/or designated entity shall ensure a criminal background check is performed on all employed or agency volunteer drivers through the North Carolina Law Enforcement Division or, if not a resident of North Carolina for at least 5 consecutive years, the National Crime Information Center (NCIC) prior to employment or volunteer enlistment and every three years thereafter. Conviction, guilty plea or plea of no contest to any of the following is grounds for disqualification from employment/volunteer service if committed within the 10-year period preceding the date of the background check.
    a. Murder
    b. Rape or aggravated sexual abuse,
    c. Kidnapping or hostage taking,
    d. Assault inflicting serious bodily injury,
    e. A federal crime of terrorism,
    f. Unlawful possession, use, sale, distribution, or manufacture of an explosive device,
    g. Unlawful possession, use, sale, distribution, or manufacture of a weapon,
    h. Elder abuse/exploitation,
    i. Child abuse/neglect,
    j. Illegal sale or possession of a Schedule I or II controlled substance,
    k. Conspiracy to commit any of the above.

13. Driving Record
    a. The health plan and/or designated entity is required to ensure the NEMT providers have a driver screening policy for employees, and volunteers who transport members.
    b. The driving records of all drivers shall be reviewed every 12 months.

c. Drivers must have no more than two chargeable accidents or moving violations in the past three years and must not have a driver's license suspension or revocation within the past five years.

d. Applicants for driver positions shall be required to submit a copy of their driving record for the last three years prior to the date of application.

e. Driving records may be obtained from the Department of Motor Vehicles (DMV). Accept the DMV information provided by the applicant unless questionable.

f. The driver screening policy does not apply to members, financially responsible persons, or family and friends of the member.

B. Provider Transportation Contract

A written contract, signed by the vendor, must be obtained by the health plan or its transportation broker when purchasing private transportation. The document must authorize services and include the following contract requirements:

1. A guarantee the contractor will meet all safety and liability requirements for its vehicles and employees as specified above;

2. An obligation to maintain records documenting compliance with all vehicle and employee requirements as specified above;

3. An obligation that no more than one quarter of one percent of all trips be missed by the vendor (vendor no-show) during the contract year;

4. An obligation to meet on-time performance standards such that no more than five percent (5%) of trips should be late for Member drop off to their appointment per month (past the member's appointment time);

5. An obligation to report any changes such as insurance provider, business ownership, provider enrollment status;

6. An obligation to allow monitoring of records to ensure all contract requirements are met;

7. An obligation to report all no-shows daily and cancellations monthly;

8. If the health plan agrees to pay for no-shows or driver wait time, an obligation that all charges for no-shows or driver wait time are separately invoiced from Medicaid transportation reimbursable costs;

9. An obligation to record all member complaints which deal with matters in the vendor's control, including the date that the complaint was made, the nature of the complaint and what steps were taken to resolve the complaint.

   Example 1: A Member complains about the speed of the vehicle in which he was transported. This complaint must be logged.

   ***Example 2**: A Member complains that the driver was late. This complaint must be logged.*

Example 3*: A Member complains that one of the other passengers was talking on a cell phone for the entire trip. There is no need to log this complaint.*

10. An obligation to have written policies and procedures regarding how drivers handle and report incidents, including client emergencies, vehicle breakdowns, accidents and other service delays;

11. An obligation to use the provided transportation billing codes on invoices to the health plan for reimbursements or filing claims.

12. An obligation to meet all Provider Enrollment requirements.

C. Direct Services to Members by Contract Transportation Providers

1. Contract transportation providers include public transportation, taxis, vans, and non-medically necessary ambulance transportation.

2. Billing Codes
For non-emergency transportation costs, use the following billing codes for encounter data reporting:

HCPCS	HCPCS Code Description
A0021	Ambulance service, outside state per mile (Medicaid only)
A0080	Non-emergency transportation, per mile – vehicle provided by volunteer (individual or organization) with no vested interest
A0090	Non-emergency transportation, per mile – vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation, taxi
A0110	Non-emergency transportation and bus, intra or interstate carrier
A0120	Non-emergency transportation; mini-bus, mountain area transports or other transportation systems
A0130	Non-emergency transportation: wheel-chair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or interstate
A0160	Non-emergency transportation: per mile – case worker or social worker
A0170	Transportation ancillary – parking fees, tolls, other
A0180	Non-emergency transportation – ancillary – lodging - recipient
A0190	Non-emergency transportation – ancillary – meals- recipient
A0200	Non-emergency transportation – ancillary – lodging- escort
A0210	Non-emergency transportation – ancillary – meals - escort

A0380	BLS mileage (per mile)
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies, defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0390	ALS mileage (per mile)
A0392	ALS specialized service disposable supplies, defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulance)
A0394	ALS specialized service disposable supplies – IV drug therapy
A0396	ALS specialized service disposable supplies – esophageal intubation
A0398	ALS routine disposable supplies
A0420	Ambulance waiting time (ALS or BLS) one half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra Ambulance Attendant, ground (ALS or BLS) or air (fixed or rotary winged); requires medical review
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic intercept (PI) rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers
A0433	Advanced life support, level 2 (ALS 2)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0999	Unlisted ambulance service
S0215	Non-emergency transportation; 2, per mile
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)

S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
S9975	Transplant related lodging, meals and transportation, per diem
S9976	Lodging, per diem, not otherwise classified
S9977	Meals, per diem, not otherwise specified
S9992	Transportation costs to and from trial location and local transportation costs (e.g., fares for taxicab or bus) for clinical trial participant and one caregiver/companion
T2001	Non-emergency transportation; patient attendant/escort
T2002	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass
T2005	Non-emergency transportation; stretcher van
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments
T2049	Non-emergency transportation; stretcher van, 2; per mile

D. Other Transportation Services Provided by the Health Plan

1. Volunteers using their own vehicles,

2. Direct payments such as gas vouchers and mileage reimbursement to members, family members and friends (see E., Gas Vouchers and Reimbursement below for more information on gas vouchers and mileage reimbursement),

3. Attendant expenses,

4. Travel-Related expenses (see below for more information on travel-related expenses), and

5. Ancillary Costs and Attendant Pay

6. Non-Emergency Air Travel

E. Gas Vouchers and Mileage Reimbursement

1. Gas vouchers are issued to eligible Members who can use their own car or a friend/relative's car for transportation to a Medicaid covered service.

2. Gas vouchers can be redeemed at local gas stations and may not exceed the current IRS rate or half the IRS rate unless the gas provider requires a minimum rate.

3. Mileage reimbursement may not exceed the current IRS rate or half the IRS rate.

4. Both mileage reimbursement and gas vouchers must be provided in an amount sufficient to cover the cost of gas.

5. Because Members are unlikely to have fuel efficient vehicles, the amount of fuel required to complete the trip must be calculated using a conservative miles-per-gallon figure.

6. Mileage reimbursement issued should be the exact amount and not rounded to the nearest dollar.

F. Attendants

1. All attendants, including family members, are entitled to reimbursement of expenses incurred during transportation at the least expensive rate that is appropriate to the member's circumstances, including reimbursement for return trips with or without the member;
   a. *Attendants, other than family members, may charge for their time.*
   b. *Non-medical professionals*

      The health plan, at its discretion, may use the state or, if greater, the county per diem, but must not exceed the state minimum hourly wage (Minimum Wage in N.C.). The attendant may also be the driver if it's the least expensive means;
   c. *Medical professionals serving as attendants*

      If the medical professional administers medical services during the trip, he can bill Medicaid for that service. Do not pay the attendant when he can bill Medicaid directly.
   d. *If the medical professional does not perform a medical service during the trip, maximum reimbursement for the attendant cannot exceed the hourly minimum wage.*

2. Vendor delivery charges for prescriptions as long as it meets least expensive criteria;

3. Reimbursement for travel for parents/guardians to care for, or be taught how to care for, an in-patient child (necessity verified through NEMT prior authorization);

4. If both parents are accompanying the child, reimbursement for the other parent must be necessity verified.

G. Travel-Related Expenses

1. Reimbursement for travel related expenses may not exceed the state mileage sustenance and lodging reimbursement rates. The rates can be found in section 5.1, travel policies for State Employees, of the budget manual: https://www.osbm.nc.gov/library/budget-manuals. Additionally, please stay

current with budget memos.

2. The health plan has the option of providing money for travel related expenses to the member in advance or after the trip is completed.

3. If the worker feels that verification of the appointment is necessary, he should request the appointment card or contact the provider.

4. Breakfast
   Under State policy, reimbursement for breakfast may be claimed if the member must leave before 6:00 a.m.

5. Lunch
   Reimbursement for lunch is only allowable on overnight stays. If a day trip will last from morning through afternoon the health plan should counsel the member to make arrangements for lunch. At the health plan's discretion, lunch may be provided for the member and attendant.

6. Dinner
   Reimbursement for dinner is allowable if the member does not return until after 8:00 p.m.

7. Parking Fees, Tolls
   Reimbursement for parking fees and tolls is allowable if reimbursement is based only on mileage. If transportation is reimbursed on a per-trip basis, parking fees and tolls are already included in the payment for the trip.

8. Overnight lodging
   a. When the medical service is available only in another county, city, or state, medical condition, travel time and distance may warrant staying overnight.
   b. Allowable expenses include overnight lodging and meals for eligible members while in transit to and from the medical resource.
   c. Lodging and transportation to and from the lodging must be determined to be less expensive than daily travel from home (unless deemed medically necessary).
   d. Overnight lodging, not to exceed the state rate or, at the health plan's discretion, the county reimbursement rate if higher, can be reimbursed. If the county per diem is higher than the state per diem, the health plan may choose but is not required to use the higher reimbursement rate.

H. Non-Reimbursable costs

1. Expenses of an attendant to sit and wait following member admission to a medical facility.

2. Transportation provided when free or lower cost suitable transportation was available.

3. Purchase price of a vehicle for transportation. The purchase of a vehicle may be recovered over the life of the vehicle through trip reimbursement.

4. Trip costs higher than appropriate when less expensive means of transportation is available.

5. Routine transportation to school on a school day even though health services may be provided in the school during normal school hours.

6. Travel to visit a hospitalized patient (except to provide or learn to provide care for an in-patient child).

7. Empty miles.
   a. Miles to or from a transportation vendor's office/home/garage to or from the Medicaid member's residence are not compensated by Medicaid.
   b. Medicaid only pays from point of Member pickup to the point of drop off.
   c. The cost of empty miles should be factored in the total cost in setting mileage rates.
   d. Exceptions for Empty Miles
      i. For Public Transportation systems, a "share ride" system can be implemented to ensure a cost-effective utilization of public transportation systems.
      ii. Share rides refers to a cost based on the total vehicle's miles divided by the total # of passengers instead of a cost based on the point of pick-up and drop-off of each passenger.

8. Ambulance transportation of a deceased person.

9. Transportation costs incurred by a vendor not contracted with the health plan

10. Trips when the Member is not seen by the provider due to the fault of the Member (e.g. member did not bring proper documentation, x-rays, etc.)

11. No-Shows (refer to section VII. Advance, No-Show, and Conduct Policies)

XI. REPORTING FRAUD, WASTE AND ABUSE

The Office of Compliance and Program Integrity mission is to protect the resources of the Division of Health Benefits by reducing or eliminating fraud, waste, and abuse (FWA) of providers and members in the NC Medicaid Program. The health plan's NEMT Policy is required to include information on the following:

A. Definition of Fraud, Waste and Abuse

1. **FRAUD**: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefits to himself or some other person.

2. **WASTE**: Costs that could have been avoided without a negative impact on quality.

3. **ABUSE:** Occurs when provider practices are inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health.

B. Procedures

1. Any matters involving potential or suspected Medicaid fraud, waste, and abuse shall be investigated by the health plan's Special Investigations Unit.
2. As required by contract, the health plan shall refer credible allegations of fraud, waste and abuse to the Department. The health plan staff shall work collaboratively to ensure that all fraud, waste and abuse referrals get routed to the appropriate contacts.
3. The health plan shall ensure all its Members have been made aware of how to report suspected fraud, waste, or abuse.
4. Individuals may remain anonymous; however, sometimes to conduct an effective investigation, staff may need to contact individuals. Individual name will not be shared with anyone investigated. In rare cases involving legal proceedings, an individual name may need to be revealed.

C. Examples of Medicaid Member fraud, waste and abuse:

1. A Member does not report all income when applying for Medicaid
2. A Member does not report other insurance when applying for Medicaid
3. A non-Member uses a Member's card with or without the Member's knowledge

D. Examples of Medicaid Provider fraud, waste and abuse:

1. A provider's credentials are not accurate
2. A provider bills for services that were not rendered
3. A provider performs and bills for services not medically necessary

E. Fraud, Waste and Abuse Reporting

Report complaints by accessing one of the following methods:

1. State Medicaid Fraud, Waste and Program Abuse Tip-Line Phone: (919) 814-0181;
2. Health Plan Fraud, Waste and Program Abuse Tip-Line Phone
3. Health Plan Online Confidential Complaint Form
4. State Online Confidential Complaint Form: https://medicaid.ncdhhs.gov/reportfraud

XII. DEFINITIONS

A. Attendant – A person whose presence is needed to assist the member during transport.

B. Certification Period – The period of time for which assistance is requested and in which all eligibility factors except need and reserve (when applicable) must be met. Generally, certification periods last 6 or 12 months.

C. Family Members & Friends – Family members other than spouses and parents of minor children, as well as other non-related individuals, who comprise a Medicaid Member's potential support for transportation needs.

D. **Gas Voucher –** A voucher that is issued to the Member or other drivers with which he/she may purchase gasoline at a contracted station.

E. **In Lieu of Services (ILOS)** – Services or settings that are not covered under the North Carolina Medicaid State Plan but are a medically appropriate, cost-effective alternative to a State Plan covered service.

F. **Least Expensive Means –** Most cost-effective mode of transportation.

G. **Local Agency-**County Department of Social Services

H. **Mileage Reimbursement –** Reimbursement to a Medicaid Member and/or other driver based on a specific rate per mile driven to allow a Medicaid Member to receive covered services.

I. **Mountain Area Transport –** Allows for alternate transportation sources due to mountainous regions including buses and vans.

J. **Mobility Device –** Wheelchair, scooter or other device used to aid personal mobility.

K. **NCTracks-** Medicaid Management Information System (MMIS). North Carolina's Medicaid billing system

L. **Non-Emergency Medical Transportation (NEMT) –** Transportation to and from medical services on a non-emergent basis. Emergency transportation needs are provided by emergency service vehicles and are billed directly to Medicaid by the provider. NEMT needs for Medicaid Members are addressed by the health plan's Member Services Department and/or transportation coordinator when requested.

M. **NEMT Provider No-Show:** any instance where the transportation provider does not arrive for pick-up of member to scheduled trip.

N. **Prior Authorization-**An approval process for Members to be determined eligible on a trip by trip basis to receive NEMT services.

O. **Plan of Care (POC) –** A document which summarizes the CAP evaluation and assessment information into a statement of how the member's needs are to be met; outlines goals and objectives; and indicates the specific services needed, both formal and informal.

P. **Provider –** An individual or entity that provides a medical service, such as a doctor, hospital, pharmacy or transportation.

Q. **Provider Enrollment-**The application process to become a NC Medicaid provider for the purpose of rendering services.

R. **Public Transportation –** or public transit is shared transportation available for use by the general public. Public transportation includes buses, trolleys, trains, and ferries, share taxi in areas of low-demand, and paratransit for people who need a door-to-door service.

S. **Series of Appointments –** A group of transportation dates for medical services with the same medical provider which are requested and approved at the same time, rather than as they occur.

T. **Suitable Transportation –** The mode of transportation that is appropriate to the Medicaid Member's medical and other identified needs.

U. **Transportation Coordinator** – The person designated by the health plan to

coordinate Medicaid transportation trips. This person may be employed by the health plan or by a transportation broker under contract with the health plan to arranged transportation.

V. **Transportation Providers** consist of businesses with which the health plan contracts to provide Non-Emergency Medical Transportation. Providers may be public, such as local transit systems, or private, such as private van services. They are also referred to as providers.

W. **Trip –** A NEMT “trip” consists of the length between one pick-up and drop-off. For example, picking up a Member at his home and driving him to a doctor’s office is one trip. If the same Member is picked-up at the doctor’s office and driven back to his home that is a second trip. If before being driven home, the same member is driven to a drug store that would constitute a third trip.

X. **Urgent Transportation Need–** A need for transportation to a medical service which does not warrant ambulance transport but cannot be postponed to another time. Examples include acute illnesses, trip modification/transfer request, and non-emergent injuries, as well as necessary medical care that cannot be rescheduled to another time.

Y. **Value-Added Services** – Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the health plan’s discretion and are not included in capitation rate calculations. Value added services are designed to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.

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 NC DHHS as part of the NC DHHS centralized credentialing process. The information about tribal providers will be shared with BH I/DD Tailored Plans through DHB's existing process

2) Scope

This Policy applies to 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:

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 fee for service.

b) Payment

i) Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the OMB rate, for 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 BH I/DD Tailored Plan shall continue to follow those arrangements.

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 up to four (4) AIR 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 or pharmacy depending on the nature of the member's schedule.

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) 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*

(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 Medicaid Fee-for-Service 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.

v) BH I/DD Tailored Plan shall comply with BH I/DD Tailored Plan Contract Section V.F.1., *Engagement with Federally Recognized Tribes* 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.

c) Prompt Pay

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

(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 at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

(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 claim.

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

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

(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).

(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 and penalties if applicable).

(3) Pursuant to N.C. Gen. Stat. § 58-3-225(f), the BH I/DD Tailored Plan may require that claims be submitted within one hundred eighty (180) calendar days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) calendar days after the date of the Member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by the BH I/DD Tailored Plan and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

(4) Interest and Penalties

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

(b) In addition to the interest on late payments required by this Section, the BH I/DD Tailored Plan shall pay the provider a penalty equal to one percent (1%) of the claim for each calendar day following the date that the claim should have been paid as specified in the Contract.

(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 BH I/DD Tailored Plan Contract Section V.H.1.d., 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.

Attachment N. Addendum for Division of State Operated Healthcare Facilities

1. Background

The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.[1] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The BH I/DD Tailored Plan shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

2. Scope

The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, grievances and appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the BH I/DD Tailored Plan and DSOHF facilities.

3. Admissions.

When admitting a member or recipient to a DSOHF facility, the BH I/DD Tailored Plan must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:

a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):

i. The BH I/DD Tailored Plan or BH I/DD Tailored Plan designated community provider (e.g., BH community provider or hospital/emergency department) shall complete and submit a Regional Referral Form available on the Department's website[2] or initiate referral via the North Carolina BH Crisis Referral System ("BH-CRSys") as defined in *Section III.A. Definitions* to the DSOHF facility.

ii. The BH I/DD Tailored Plan must review the admission based on review of the information provided in the Regional Referral Form or BH-CRSYs.

iii. In cases where the member or recipient presents directly to a psychiatric hospital or ADATC for admission, the BH I/DD Tailored Plan shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.

iv. The BH I/DD Tailored Plan shall ensure that a BH I/DD Tailored Plan-employed utilization management staff member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;

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[1] DSOHF also serves individuals with neuro-medical needs in specialized treatment centers that are carved out of Medicaid Managed Care and therefore not included in the BH I/DD Tailored Plan contract.

[2] The Regional Referral Form for Admission to a State Psychiatric Hospital or ADATC is available at https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf.
https://files.nc.gov/ncdhhs/documents/files/Regional%20Referral%20Form%20-%20Admissions.pdf.

v. For members or recipients subject to involuntary commitment proceedings, the BH I/DD Tailored Plan must provide information or a representative who can assist the district court in determining if the member requires continued services. If the BH I/DD Tailored Plan elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the BH I/DD Tailored Plan.

vi. Prior to referral or authorization of any member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the BH I/DD Tailored Plan must verify that the referral is in accordance with the requirements of N.C.G.S. 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a State psychiatric hospital.

vii. For members who have multiple disorders and medical fragility or have multiple disorders and deafness, the BH I/DD Tailored Plan shall be designated by the Department to determine whether members have a high level of disability that alternative care is inappropriate, consistent with N.C.G.S. 122C-261(e)(4).

viii. In determining whether members are eligible for referral and/or authorization for admission to a State psychiatric hospital, the BH I/DD Tailored Plan must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.

b. State Developmental Centers:

i. The BH I/DD Tailored Plan must exhaust all options for community care and supports before it refers a member or recipient to a State Developmental Center.

ii. When a BH I/DD Tailored Plan refers a member or recipient to a State Developmental Center, the BH I/DD Tailored Plan must submit an application packet, inclusive of a letter of endorsement, to the State Developmental Center Admission/Discharge Coordinator;

iii. The BH I/DD Tailored Plan must comply with the DSOHF admission criteria and protocols; and

iv. The BH I/DD Tailored Plan must ensure timely execution of the Memorandum of Agreement (MOA)[3] with the member's or recipient's guardian regarding the member's discharge plan.

4. Authorization

The BH I/DD Tailored Plan must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid and State-funded clinical coverage policies as detailed in *Section V.B.2.i.(v) Utilization Management* and *Section V.C.2.a.vii. Utilization Management*, respectively, as well as the specific requirements listed below.

a. General Requirements for State Psychiatric Hospitals and ADATCs:

i. Emergency Services:

A. The BH I/DD Tailored Plan must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.

B. The BH I/DD Tailored Plan cannot refuse to cover emergency services based upon the DSOHF facility failing to notify the member's or recipient's PCP or BH I/DD Tailored Plan of the individual's screening and treatment following presentation for emergency services.

[3] The MOA is a formal agreement made between the State Developmental Center, legally responsible person/guardian, and the BH I/DD Tailored Plan identifying the responsibilities of all parties in supporting the individual to return to their home or community setting within the identified length of admission as specified in the MOA.

C. For members or recipients who present directly to the psychiatric hospital or ADATC as an emergency commitment or as a self-referral, the DSOHF facility shall submit a completed Electronic Authorization Request (EAR) to the BH I/DD Tailored Plan the next business day following an admission to request admission authorization.

D. Upon receipt of the EAR, the BH I/DD Tailored Plan must authorize and cover ongoing emergency medical services in accordance with applicable clinical coverage policies and consistent with the prudent layperson standard, as defined in EMTALA (Section 1867(a) of the Social Security Act).

ii. Inpatient Services:

A. The BH I/DD Tailored Plan must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services, provided that the deadline may be extended for one additional business day if: (i) the individual or DSOHF facility requests the extension; and (ii) the BH I/DD Tailored Plan justifies to the DSOHF facility a need for additional information and how the extension is in the member's or recipient's interest.

B. The BH I/DD Tailored Plan must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.

C. Following initial admission authorization, the BH I/DD Tailored Plan must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.

D. To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the BH I/DD Tailored Plan prior to the expiration of the prior authorization no later than the last covered day of the existing authorization, or the previous business day if the last covered day occurs on a weekend or holiday.

E. The BH I/DD Tailored Plan must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.

b. Requirements for Assessment and Stabilization

i. The BH I/DD Tailored Plan shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of members or recipients who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

ii. The BH I/DD Tailored Plan must identify an appropriate discharge plan for all such members or recipients beginning at admission.

c. Requirements for State Developmental Centers:

i. Initial authorization:

A. Prior to admission to a State Developmental Center, the BH I/DD Tailored Plan shall complete the ICF-IID level of care determination form (Level of Care Form) including obtaining the physician signature and send a copy to the facility's reimbursement office to complete the authorization to bill Medicaid.

B. If authorization is not received from the BH I/DD Tailored Plan by the time of admission to a State Developmental Center, the BH I/DD Tailored Plan shall promptly provide retrospective authorization after:

- The State Developmental Center sends the EAR to the BH I/DD Tailored Plan; and

- The State Developmental Center receives the Level of Care Form from the BH I/DD Tailored Plan, completes it and submits it to the BH I/DD Tailored Plan

ii. Re-authorization:

A. To reauthorize services in a State Developmental Center, the facility must send a completed Level of Care Form, Person Centered Plan (PCP) if it has been updated since the previous authorization, and psychological evaluation to the BH I/DD Tailored Plan prior to the expiration of the initial authorization.

B. Upon receipt of the required documentation, the BH I/DD Tailored Plan must approve or deny the request in accordance with the standard timeframes for service authorization requests. Authorization shall be for at least 180 days from the date of the physician signature on the Level of Care Form.

iii. Facility-based respite services for members enrolled in the Innovations waiver:

A. The BH I/DD Tailored Plan shall issue prior authorization for Respite Facility Based services provided at a State Developmental Center prior to a member's admission.

5. Member and Recipient Grievances

a. The DSOHF facility and the Department will manage and resolve all member or recipient clinical concerns, or grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with grievance procedures established by the Department.

b. The BH I/DD Tailored Plan must agree that DSOHF facilities shall refer any unresolved patient grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the BH I/DD Tailored Plan Hotline number for reporting any grievances.)

6. Event Reporting and Abuse/Neglect/Exploitation.

a. The BH I/DD Tailored Plan must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to members or recipients receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.

b. The BH I/DD Tailored Plan must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.

c. The DSOHF facility will cooperate with the BH I/DD Tailored Plan's written request for information regarding any individual safety events/allegations involving members or recipients to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the BH I/DD Tailored Plan with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the BH I/DD Tailored Plan's request.

d. The BH I/DD Tailored Plan shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The BH I/DD Tailored Plan shall provide the DSOHF a written summary of its finding within thirty (30) days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

Attachment O. Business Continuity Management Plan

The Offeror may use the Business Continuity Management Program Sample Template.

Doc. Version No.	
Date Prepared	
Prepared By	
Division Director Signature	
Date Approved	

INTRODUCTION

(Who is this document for?) *This document is intended for use by management, the business owner, technical experts, and business continuity staff who interact with this system. It provides a strategy for business recovery and work around procedures should the system and its infrastructure fail. Possible events taken into account in developing this plan are disasters, both natural and man-made, up to and including complete destruction of the facility.*

PLAN OBJECTIVES

This business recovery plan:

- Captures the essential aspects of the business process supported by the system.
- Documents a way to continue business should the system fail.
- Documents the business recovery procedures for return to operational status.
- Documents a way to convert back to business as usual after the system is available.

SYSTEM OVERVIEW

How does this application/system operate and what does it do?

COMMUNICATION PLAN

Notification

When the application is unavailable, who is notified and how?

ROLES, RESPONSIBILITIES AND AUTHORITY

List areas of support and roles of each.

Example:

Application Support:

An Application analyst is responsible for the following:

Hardware Support

A MaPS Systems Engineer is responsible for the following:

Database Support

A DBA is responsible for the following:

Business Recovery Services Vendor for Distributed Platforms:

- Describe services of business recovery vendor, if applicable.

Cross References

PLAN INITIATION

Criteria for Restoration of the Business Process due to a Business Disruption

The business recovery procedures described in this contingency plan will be invoked when one or more of the following takes place:

1.

2.

BUSINESS RECOVERY PROCEDURES

Section I: Application Support

Staffing

(The staff that need to be involved in the recovery process.)

Equipment and Components

(The equipment and components should be listed in their entirety including quantities and attributes. This is all of the hardware that the business unit must supply. This includes all necessary equipment particular to this application.)

Procedures

(Include plans for acquiring, replacing, and alternate siting of any equipment needed.)

Software and Data Backup Procedures

(This is all of the software that the business unit must supply and how it is backed up.)

Software and Data Recovery Procedures

(How the software in the above procedure is restored.)

Succession Plan

Application Support Order of Succession:

Name	Title	Area Code and Phone Number

Vendor List

Suppliers:

Vendor	Product/Service/Commodities	Area Code and Phone Number

Section II: Hardware Support

Staffing

(The staff that needs to be involved in the recovery process.)

Equipment Types

(Equipment and type)

Client Equipment:

Document any specialty equipment for the client, if any. Consider if workstation equipment requirements should be listed here or are included in a different section of the Business Continuity Plan.

Application Equipment

Document, if any.

Equipment Recovery Procedures

How is equipment recovered?

Software and Data Backup Procedures

The following steps will be taken to begin the business backup process:

Document procedures.

Software and Data Recovery Procedures

The following steps will be taken to begin the business recovery process:

Document procedures.

Succession Plan

Hardware Support Order of Succession:

Name	Title	Area Code and Phone Number

Vendor List

Hardware Services Suppliers:

Vendor	Product/Service/Commodities	Area Code and Phone Number

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Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

Table 1: Liquidated Damages for Medicaid Compliance Issues

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$5,000 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.*	$10,000 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.*	$1,000 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*.	$2,500 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 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 $50,000 per occurrence
Members		
6.	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*	$5,000 per occurrence
7.	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.*	$500 per occurrence per member
8.	Failure to comply with timeframes for providing member Welcome Packets, handbooks, identification cards, and provider directories as described in *Section V.B.1.iii. Member Engagement.*	$250 per occurrence per member

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
9.	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 $50,000 per occurrence
10.	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.*	$500 per occurrence
11.	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.	$5,000 per occurrence
12.	Failure to provide continuation or restoration of services where member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.1.vi. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department. AND $500 per calendar day for each day the BH I/DD Tailored Plan fails to provide continuation or restoration as required by the Department.
13.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.1.vi. Member Grievances and Appeals.*	$1,000 for each mediation or hearing that the BH I/DD Tailored Plan fails to attend as required
14.	Failure to comply with Transition of Care requirements as specified *Section V.B.1.ii. Transition of Care.*	$100 per calendar day, per member AND The value of the services the BH I/DD Tailored Plan failed to cover during the applicable transition of care period, as determined by the Department.
Benefits		
15.	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.	$5,000 per occurrence per member

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
16.	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.*	$5,000 per standard authorization request $7,500 per expedited authorization request
17.	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.*	$1,000 per occurrence
18.	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.*	$2,500 per occurrence
19.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.B.2.iii. Pharmacy Benefits.*	$2,500 per calendar day per occurrence
20.	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.*	$500 per occurrence per member
21.	Failure to comply with driver requirements as defined in the Department's NEMT Policy.	$1,500 per occurrence per driver
22.	Failure to comply with the assessment and scheduling requirements as defined in the Department's NEMT Policy.	$250 per occurrence per member
23.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	$1,500 per calendar day per vehicle
Care Management		
24.	Failure to timely develop and furnish to the Department its Care Management Policy as required by *Section V.B.3.ii. Tailored Care Management*	$250 per calendar day
25.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in the *Section V.B.3.ii. Tailored Care Management* (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	$500 per deficient/missing care management comprehensive assessment or plan
26.	Failure to adhere to the quarterly minimum contact requirements for a member's acuity tier as described in *Section V.B.3.ii.(x) Ongoing Care Management.*	$250 per contact not provided per member, i.e., failure to have two of the required contacts for a member would result in a $500 payment.

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
27.	Failure to comply with minimum Transitional Care Management requirements as described in *Section V.B.3.ii. Tailored Care Management.*	$250 per occurrence per member
28.	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.*	$500 per calendar day
29.	Failure to meet annual requirements established by the Department for the percentage of members actively engaged in Tailored Care Management who are obtaining Provider-based Care Management as set forth in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*. (liquidated damage to begin in second contract year)	Up to $100,000 per percentage below the requirement each calendar year
30.	Failure to comply with federal conflict-free case management requirements for members enrolled in the Innovations or TBI waiver	$500 per occurrence per member
31.	Failure to timely notify the Department of a notice of underperformance sent to an LHD or the termination of a contract with an LHD.	$500 per calendar day
32.	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.*	$2,000 per occurrence
33.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the BH I/DD Tailored Plan in at least 98% of Pilot service authorizations, as required in *Section V.B.3.x. Healthy Opportunities*.	$100 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

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
34.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to use BH I/DD Tailored Plan capitation to cover member's benefits prior to use of Healthy Opportunities Pilot program funds or as otherwise required in *Section V.B.3.x. Healthy Opportunities*.	$250 per occurrence AND Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service in each identified instance
Providers		
35.	Failure to update online and printed provider directory with accurate provider information as required by *Section V.B.4.ii. Provider Network Management.*	$1,000 per confirmed incident
36.	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.*	$100 per calendar day per member for failure to timely notify the affected member or Department
37.	Failure to follow the process and Objective Quality Standards established by the BH I/DD Tailored Plan's Credentialing and Re-Credentialing Policy as required by *Section V.B.4.ii.(viii) Credentialing and Re-Credentialing Process*.	$2,000 per occurrence per provider
38.	Failure to complete a decision to contract with a provider within forty-five (45) calendar days of receipt of complete Medicaid Enrolled Provider data from the Department of the Department's vendor by the Provider Network Participation Committee.	$50 per calendar day per provider
39.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.B.4.i. Provider Network*	$5,000 per calendar day
40.	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).	$2,500 per month for failure to meet any of the listed standards, either individually or in combination
41.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications	$250 per calendar day

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
42.	Failure to maintain accurate provider directory information as required by *Section V.B.4.ii. Provider Network Management*	$100 per confirmed incident
Quality and Value		
43.	Failure to submit quality measures including audited HEDIS and CAHPS results within the timeframes specified in *Section V.B.5.a. Quality Management and Quality Improvement.*	$5,000 per calendar day
44.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$1,000 per calendar day
45.	Failure to timely submit QAPI to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$1,000 per calendar day
46.	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.*	$100,000 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.*
Claims and Encounter Management		
47.	Failure to timely submit monthly encounter data set certification.	$1,000 per calendar day
Financial Requirements		
48.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Attachment J. Reporting Requirements.*	$2,000 per calendar day
49.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VII. Attachment J. Reporting Requirements.*	$1,000 per calendar day
50.	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 Attachment .J. Reporting Requirements.*	$2,000 per calendar day

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
51.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$1,000 per calendar day
Compliance		
52.	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.*	$5,000 per calendar day that the Department determines the BH I/DD Tailored Plan is not in compliance
53.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.K.1. Compliance Program* and *Section VII. Attachment J. Reporting Requirements.*	$1,000 per calendar day
54.	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. Attachment J. Reporting Requirements.*	$250 per calendar day
55.	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.	$2,500 per incident for failure to fully cooperate during an investigation
56.	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.	$250 per calendar day
57.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Attachment J. Reporting Requirements.*	$2,000 per calendar day
Technical Specifications		
58.	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.	$500 per member per occurrence

Section VII. Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
59.	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.	$500 per occurrence
60.	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.	$500 per member per occurrence, not to exceed $10,000,000
Directives and Deliverables		
61.	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.	$500 per calendar day
62.	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.	$1,000 per occurrence per committee
63.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$500 per calendar day the unapproved agreement or materials are in use
64.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g. prevention and population health management programs, drug utilization review program).	$ 20,000 per occurrence per plan or program
65.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	$500 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

Table 2: Liquidated Damages for State-Funded Services Compliance Issues

Section VII. Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
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*..	$5,000 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*.	$500 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 Interest*.	$1,250 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 $25,000 per occurrence
Providers		
5.	Failure to update online and printed provider directory as required by *Section V.C.4.b. Provider Network Management.*	$500 per confirmed incident
6.	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
7.	Failure to follow the Quality Determination process established by the BH I/DD Tailored Plan's Credentialing and Re-Credentialing Policy.	$1,000 per occurrence per provider
8.	Failure to complete a provider Quality Determination within forty-five (45) calendar days of receipt of all verified information by the Provider Network Participation Committee.	$25 per calendar day per provider
9.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.C.4.a. Provider Network*	$1,000 per calendar day

Section VII. Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
10.	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).	$1,250 per month for failure to meet any of the listed standards, either individually or in combination
11.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	$125 per calendar day
12.	Failure to maintain accurate provider directory information as required by *Section V.C.4.b. Provider Network Management.*	$50 per confirmed incident
Claims Management		
13.	Failure to timely submit monthly claims data set certification.	$500 per calendar day
Financial Requirements		
14.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Attachment J. Reporting Requirements.*	$1,000 per calendar day
15.	Failure to timely and accurately submit monthly financial reports in accordance with *Section VII. Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$500 per calendar day
Compliance		
16.	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
17.	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
18.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Attachment J. Reporting Requirements*.	$1,000 per calendar day

Section VII. Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
Technical Specifications		
19.	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 recipient per occurrence
20.	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.	$250 per recipient per occurrence
21.	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.	$250 per recipient per occurrence, not to exceed $5,000,000
Directives and Deliverables		
22.	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 that the Department determines the BH I/DD Tailored Plan is not in compliance
23.	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
24.	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
25.	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).	$10,000 per occurrence per plan or program
26.	Failure to provide a timely and acceptable corrective action plan 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 corrective action

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

Section VII. Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
2.	Call Response Time/Call Answer Timeliness – Member and Recipient Service Line	The BH I/DD Tailored Plan shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds 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 wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	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
5.	Call Response Time/Call Answer Timeliness - Behavioral Health Crisis Line	At least ninety-eight percent (98%) of calls shall be answered by a live voice within thirty (30) seconds.	The number of incoming calls answered by a live voice within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$15,000 per month

Section VII. Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
6.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
7.	Call Response Time/Call Answer Timeliness – Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds 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 wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	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

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

Section VII. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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	$1,000 per twenty-four (24) hour period
Member Grievances and Appeals					
2.	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	$10,000 per month
3.	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	$10,000 per month
4.	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	$5,000 per month

Section VII. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
Pharmacy Benefits					
5.	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 and NC Health Choice PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid and NC Health Choice PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid and NC Health Choice PDL.	Quarterly	$100,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater
Care Management					
6.	Contracting with AMH+ and CMAs	The BH I/DD Tailored Plan shall contract with 100 percent (100%) of the certified AMH+ practices and CMAs located in its Region, except for the exceptions cited in the contract (*Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*).	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the BH I/DD Tailored Plan divided by the total number of certified AMH+ practices and CMAs.	Monthly	$50,000 per month
In-Reach and Diversion					
7.	Number of Individuals Transitioned Into Supportive Housing	100% of the annual targets	This measures that all of the BH I/DD Tailored Plan's annual allotted TCLI housing slots are utilized by individuals eligible to transition to supportive housing.	Annual	$50,000 per year
Service Lines					
8.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line.	Monthly	$10,000 per month

Section VII. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
9.	Call Wait/Hold Times - Nurse Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month
10.	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 divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
11.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
12.	Call Wait/Hold Times - Pharmacy Line	The wait/hold time for callers to receive a live voice response shall be no longer than three (3) minutes for ninety-five percent (95%) of all incoming calls.	The time after the initial answer to an incoming call (including by an automatic voice response system) and a response by a live operator to a caller's inquiry during open hours of operation.	Monthly	$10,000 per month

Section VII. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
13.	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 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
Encounters					
14.	Encounter Data Timeliness/ Completeness – Medical	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of medical encounters within thirty (30) calendar days after adjudication whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	$50 per claim per calendar day
15.	Encounter Data Timeliness/ Completeness – Pharmacy	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of pharmacy encounters within seven (7) calendar days after adjudication 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.	Weekly	$100 per claim per calendar day
16.	Encounter Data Accuracy – Medical	The BH I/DD Tailored Plan shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims.	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	$25,000 per month

Section VII. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
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.	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	$50,000 per week
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 medical claims amounts reported on financial reports.	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	$10,000 per month
19.	Encounter Data Reconciliation —Pharmacy	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid pharmacy claims amounts reported on financial reports.	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	$10,000 per month
Website Functionality					
20.	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
21.	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. Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
22.	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
Access to Primary / Preventive Care for Individuals Under the NC Innovations Waiver					
23.	Access to Primary/ Preventive Care for Individuals under NC Innovations waiver	90%	The percentage of Medicaid enrollees continuously enrolled for the 12-month contract period under the 1915(c) NC Innovations waiver (ages 3 and older) who received at least one service under the NC Innovations waiver during the measurement period who also received a primary care or preventative health service. For persons ages three (3) to six (6) and ages twenty (20) and older, the person received a primary care or preventative health service during the measurement period. For persons ages seven (7) to nineteen (19), the person received a primary care or preventative health service during the previous two measurement periods.	Annually	$100,000 per year

Table 5: Metrics, SLAs and Liquidated Damages for State-Funded Services

Section VII. Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility Based Crisis Services for Mental Health Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	$50,000 per quarter
2.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for Substance Use Disorder Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	$50,000 per quarter
3.	BH I/DD Tailored Plan Maintains at Least Same Level of Individuals in Supportive Housing as targeted under TCLI.	Maintain 100% of TCLI annual target in supportive housing during the year.	The percentage of the annual allotted housing targets for whom eligible individuals have transition to supportive housing.	Annually	$25,000 or per year

Section VII. Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	BH I/DD Tailored Plan Has No Fewer than 90% of People In Supportive Housing Slots Remain in Supportive Housing	90% of individuals in Supportive Housing remain in supportive housing.	The percentage of individuals in supportive housing will remain in supportive housing.	Quarterly as a rolling 12-month lookback	$6,250 per quarter