

Amendment Number 1

Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

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

Background:

North Carolina will launch the NC Medicaid Managed Care Behavioral Health and Intellectual/Developmental Disability Tailored Plan December 1, 2022. This plan is an integrated health plan for individuals with significant behavioral health needs and intellectual/developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians.

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

The Parties agree as follows:

1. Request for Application #30-2020-052-DHB Behavioral Health and Intellectual/Developmental Disability Tailored Plan is revised and restated in its entirety and attached hereto.
2. Each Party is executing this Agreement at this time under the expressed commitment by each other to negotiate in good faith a formal amendment for execution prior to the Effective Date. The Parties envision that Amendment will align and perform a "true-up" of the requirements of this Medicaid Direct PIHP contract with the requirements of the pending or any other Tailored Plan Amendment. The Parties each further agree to negotiate in good faith to eliminate inconsistencies in, to minimize duplicative efforts and obligations between, and to reconcile these related contracts. Until execution of this proposed amendment, the Department agrees it will not hold PIHPs responsible for any readiness or other perceived issues that relate to such inconsistencies and needed amendment.

3. Effective Date: This Amendment is effective upon the later of the execution dates by the Parties, subject to approval by CMS.

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

Execution:

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

North Carolina Department of Health and Human Services

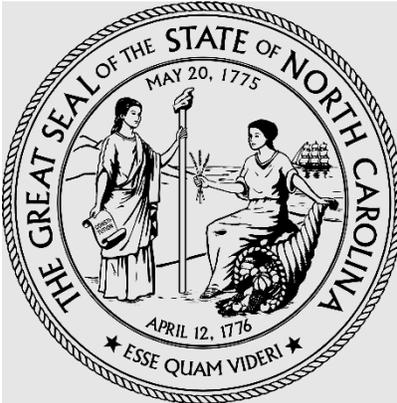
Dave Richard, Deputy Secretary

Date: _____

TP Name

TP Authorized Signature

Date: _____



STATE OF NORTH CAROLINA

Department of Health and Human Services

First Revised and Restated

Request for Applications #: 30-2020-052-DHB

BH I/DD Tailored Plan

Date of Issue:

November 13, 2020

Application Opening Date:

February 2, 2021

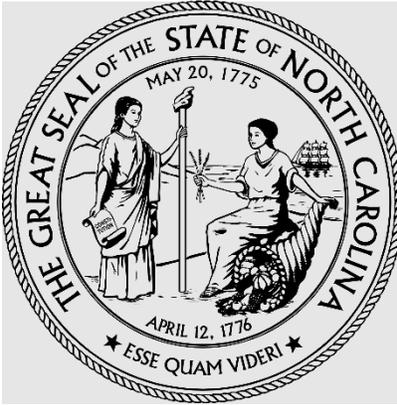
Direct all inquiries concerning this RFA to:

Kimberley Kilpatrick

Contract and Compliance Specialist

Email: Medicaid.Procurement@dhhs.nc.gov

Phone: 919-527-7015



STATE OF NORTH CAROLINA

First Revised and Restated Request for Application

30-2020-052-DHB

For internal State agency processing, please provide your company's Federal Employer Identification Number or alternate identification number (e.g. Social Security Number). Pursuant to North Carolina General Statute 132-1.10(b) this identification number shall not be released to the public. **This page will be removed and shredded, or otherwise kept confidential**, before the procurement file is made available for public inspection.

This page is to be filled out and returned with your Application.

ID Number:

Federal ID Number or Social Security Number

Applicant Name

STATE OF NORTH CAROLINA

Department of Health and Human Services

Refer ALL Inquiries regarding this RFA to:

Kimberley Kilpatrick
Contract and Compliance Specialist
Medicaid.Procurement@dhhs.nc.gov
919-527-7015

Request for Application # 30-2020-052-DHB

Issue Date: November 13, 2020

Applications will be publicly opened: February 2, 2021 at 4:00 p.m. ET

Contract Type: Open Market

Commodity Number:

Description: Tailored Plan

Using Agency: Department of Health and Human Services,
Division of Health Benefits

EXECUTION

In compliance with this Request for Application (RFA), and subject to all the conditions herein, the undersigned Applicant offers and agrees to furnish and deliver any or all items at the capitation rates and other payments established by the Department. By executing this application, the Applicant confirms it has read, understands, and will comply with all specifications and requirements in the RFA and any addendums in the event of contract award. By executing this application, the undersigned Applicant certifies that this application is submitted competitively and without collusion (N.C. Gen. Stat. § 143-54), that none of its officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934 (N.C. Gen. Stat. § 143-59.2), and that it is not an ineligible Contractor as set forth in N.C. Gen. Stat. § 143-59.1. False certification is a Class I felony. Furthermore, by executing this application, the undersigned certifies to the best of Applicant's knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal or State department or agency. As required by N.C. Gen. Stat. § 143-48.5, the undersigned Applicant certifies that it, and each of its subcontractors for any Contract awarded as a result of this RFA, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the Federal E-Verify system. N.C. Gen. Stat. § 133-32 and Executive Order 24 (2009) prohibit the offer to, or acceptance by, any State Employee associated with the preparing plans, specifications, estimates for public Contract; or awarding or administering public Contracts; or inspecting or supervising delivery of the public Contract of any gift from anyone with a Contract with the State, or from any person seeking to do business with the State. By executing this application, you attest, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

Failure to execute/sign application prior to submittal shall render application invalid and it WILL BE REJECTED. Late applications will not be accepted.

APPLICANT:		
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:
PRINCIPAL PLACE OF BUSINESS ADDRESS IF DIFFERENT FROM ABOVE		
PRINT NAME & TITLE OF PERSON SIGNING ON BEHALF OF APPLICANT:		FAX NUMBER:
APPLICANT'S AUTHORIZED SIGNATURE:	DATE:	EMAIL:

Application valid for at least **240** Calendar Days from date of application opening unless extended by the State in writing. After this time, any withdrawal of application shall be made in writing, effective upon receipt by the agency issuing this RFA.

ACCEPTANCE OF APPLICATION

If any or all parts of this application are accepted by the State of North Carolina, an authorized representative of the Department of Health and Human Services shall affix his/her signature hereto and this document and all provisions of this Request for Application along with the Applicant's application, and the written results of any negotiations shall then constitute the written agreement between the parties. A copy of this acceptance will be forwarded to the successful Applicant.

FOR STATE USE ONLY: Application accepted, and Contract awarded by:

(Signature, Name and Title of Authorized Representative of NC DHHS)

Date

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I. Introduction

A. Vision for North Carolina's Medicaid Managed Care Program

1. As directed by the North Carolina General Assembly (General Assembly), North Carolina is transitioning its Medicaid and NC Health Choice programs' care delivery system from a predominately Medicaid Fee for Service model to an integrated Medicaid Managed Care model. Through integrated Medicaid Managed Care—where one managed care plan provides physical health, behavioral health (BH), intellectual and developmental disability (I/DD), traumatic brain injury (TBI), long-term care, and pharmacy services—the North Carolina Department of Health and Human Services (hereinafter referred to as “the Department”) seeks to advance integrated and high-value care for Medicaid beneficiaries, improve population health, engage and support providers, and establish a sustainable program with more predictable costs.
2. The North Carolina Department of Health and Human Services' (the Department's) goal in transitioning to Medicaid Managed Care is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both medical and non-medical drivers of health.
3. The Department believes that Medicaid beneficiaries with high needs will benefit from specialized managed care plans. As directed by the General Assembly, the Department is creating four types of integrated Medicaid Managed Care plans to serve Medicaid and NC Health Choice beneficiaries:
 - a. **Standard Plans**, which will serve the majority of the Medicaid and NC Health Choice population and will launch on July 1, 2021;
 - b. **Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans**, which will serve populations with more severe BH conditions—including mental illness and severe substance use disorders—I/DD, and TBI, and are intended to go live on July 1, 2022; and
 - c. **Statewide Specialized Foster Care Plan**, which is intended to launch after BH I/DD Tailored Plans at a date to be confirmed by the Department.
 - d. **Eastern Band of Cherokee Indians (EBCI) Tribal Option**, which will serve federally recognized tribal members and other individuals eligible to receive Indian Health Services, and is intended to launch on July 1, 2021.
4. The Department recognizes Local Management Entity-Managed Care Organizations' (LME/MCO) expertise in serving populations with significant BH needs, I/DDs, and TBIs. As directed by the North Carolina General Assembly, through this Request for Applications (RFA), for the first BH I/DD Tailored Plan contract, only LME/MCOs are eligible to respond to the RFA to serve as BH I/DD Tailored Plans. BH I/DD Tailored Plans will support the goals of Medicaid Managed Care through:
 - a. Delivering **whole-person care** through the coordination of services addressing physical health, BH, I/DD, TBI, long-term services and supports (LTSS), pharmacy, and unmet health-related resource needs with the goal of improved health outcomes and more efficient and effective use of resources;

- b. Uniting communities, providers and health care systems to **address the full set of factors that impact health** while deploying cost-effective resources that are needs-based and outcomes driven;
 - c. Overseeing a transition to **provider-based care management** at the site of care, in the home or in the community to promote in-person interaction with members;
 - d. Improving the Medicaid Managed Care **member experience** with a simple, timely, and user-friendly eligibility and enrollment process focused on high-quality, Culturally and Linguistically Appropriate Services;
 - e. Maintaining broad **provider participation in NC Medicaid** by removing or mitigating provider administrative burden from the health delivery system; and
 - f. Supporting the Department’s overall vision of creating a **healthier North Carolina**.
5. The Department envisions that through Medicaid Managed Care and provision of State-funded Services BH I/DD Tailored Plans will address the **unique needs of Historically Marginalized Populations including people of color and others who have been marginalized** across Department service sectors. The Department recognizes to combat historical health inequities, a disproportionate share of resources need to be committed to disparate populations.

B. Background on North Carolina’s Medicaid Transformation

1. In September 2015, the General Assembly enacted North Carolina Session Law 2015-245¹ directing the transition of North Carolina’s Medicaid program from a predominantly Fee-for-Service model to an integrated Medicaid Managed Care model. North Carolina State law requires the Department, through the Division of Health Benefits (DHB), to implement a Medicaid Managed Care program.
2. As directed by the General Assembly, the Department is delegating direct management of services, and financial risk to new Medicaid Managed Care Plans, including Standard Plans, BH I/DD Tailored Plans, and a Statewide Specialized Foster Care Plan. Each of these plans will receive a monthly, actuarially sound, capitated payment and will contract with providers to deliver health services to their members. The Department is monitoring and overseeing the administrative, operational, clinical, and financial function of the Medicaid Managed Care Plans to ensure adherence to their contract and the Department’s expectations.
3. With the launch of Medicaid Managed Care on July 1, 2021, most North Carolina Medicaid and NC Health Choice populations will be mandatorily enrolled in Standard Plans.
4. Certain populations that may be better served outside of Medicaid Managed Care are not required to enroll. These populations may be “exempt” from Medicaid Managed Care in that the Beneficiary may choose to enroll in either NC Medicaid Direct—North Carolina’s Fee-for-Service Medicaid program—or Medicaid Managed Care, or “excluded” in that the beneficiaries are required to remain enrolled in NC

¹ Session Law 2015-245 has been amended by Session Law 2016-121; Section 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186; Section 11H.10.(c) of Session Law 2018-5; Sections 4-6 of Session Law 2018-49; Session Law 2018-48; Sections 12-13A of Session Law 2019-81; and Section 12.(b)-(c) of Session Law 2020-88. Pursuant to Section 14. of Session Law 2019-81, most of the provisions contained in Session 2015-245 and its subsequent amendments have been codified in Article 4 of Chapter 108D of the General Statutes.

Medicaid Direct and do not have the option to enroll in Medicaid Managed Care. These populations are described in detail in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans*.

5. In July 2022, the Department intends to launch BH I/DD Tailored Plans. Populations that will be eligible for BH I/DD Tailored Plans are established in N.C. Gen. Stat. § 108D-40(a)(12) and are described in more detail in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans*. As directed by law, the Department exempted populations that will be eligible for BH I/DD Tailored Plans from Medicaid Managed Care until such point that BH I/DD Tailored Plans are available, at which point, they will become eligible for BH I/DD Tailored Plans.
6. The Department consulted with the State's only federally recognized tribe, the EBCI, and jointly concluded that Tribal members and individuals eligible to receive Indian Health Services will benefit from having a Tribal-designed and operated managed care option and defaulting to the Tribal Option, with the choice to opt into NC Medicaid Direct, a Standard Plan, or BH I/DD Tailored Plan (if eligible). The Department and EBCI will continue to collaborate on the development and implementation of the EBCI Tribal Option. The Tribal Option will operate primarily in five western NC counties—Cherokee, Graham, Haywood, Jackson, and Swain—under which the EBCI has increasing responsibility for total cost of care over time. The Tribal Option will support the Tribe's sovereignty in managing the care needs of Indian enrollees and will consider and address the unique cultural, BH, I/DD, medical, long-term services and supports, and other health-related needs of the EBCI families. The Department intends to launch the EBCI Tribal Option in July 2021.

C. Specific Background Regarding BH I/DD Tailored Plans

1. In June 2018, the North Carolina General Assembly enacted North Carolina Session Law 2018-48, which amended Session Law 2015-245 to create BH I/DD Tailored Plans.²
2. BH I/DD Tailored Plans will be targeted toward Medicaid and NC Health Choice populations with more severe BH conditions—including mental illness and severe substance use disorders—I/DD, and TBI, as specified in N.C. Gen. Stat. § 108D-60.
3. The Department believes that certain groups of beneficiaries meeting one or more of the criteria in N.C. Gen. Stat. § 108D-40(a)(12), who are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The Department is exploring a change in state law to allow beneficiaries who are medically needy, participate in the NC HIPP program, or are enrolled in the CAP/C or CAP/DA waivers and meet one of the BH I/DD Tailored Plan eligibility criteria to enroll in a BH I/DD Tailored Plan for Medicaid-covered behavioral health, I/DD, and TBI services. They would receive all other Medicaid-covered services through NC Medicaid Direct.
4. BH I/DD Tailored Plans will be integrated Medicaid Managed Care plans and, as specified under N.C. Gen. Stat. § 108D-60, are required to cover the services specified in this RFA that address the spectrum of their members' needs, including those related to physical health, BH, I/DD, TBI, long-term services and supports, and pharmacy services.
5. BH I/DD Tailored Plans will administer two (2) of the State's Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waivers: the North Carolina Innovations waiver for individuals with

² Pursuant to Section 14. of Session Law 2019-81, these provisions have now been codified in Article 4 of Chapter 108D of the General Statutes.

I/DD and the TBI waiver for individuals with a TBI in limited geographies.³ The Innovations and TBI waivers provide a community-based alternative to institutional care for BH I/DD Tailored Plan members who meet medical necessity for an institutional level of care.

- a. BH I/DD Tailored Plans will administer the Innovations waiver and the TBI waiver (if applicable) in alignment with the following goals:
 - i. Valuing and supporting waiver beneficiaries to be fully functioning members of their community;
 - ii. Promoting promising practices that result in real life outcomes for beneficiaries; and
 - iii. Offering service options that will facilitate each beneficiary’s ability to live in the home of their choice, have employment or engage in a purposeful day of their choice and achieve their life goals.
 - b. BH I/DD Tailored Plans will be responsible for determining eligibility for the Innovations and TBI waivers and managing access to their Department-allocated waiver slots. BH I/DD Tailored Plans will administer Innovations waiver and TBI waiver services to eligible Innovations waiver and TBI waiver beneficiaries who are members of their BH I/DD Tailored Plan.
6. BH I/DD Tailored Plans will be responsible for managing the state’s non-Medicaid or State-funded mental health, developmental disabilities, substance use disorder, and TBI services, which are targeted to uninsured and underinsured North Carolinians.
- a. The Department has leveraged its deep experience administering State-funded Services in partnership with the LME/MCOs and the local counties to inform the overall design and structure of the BH I/DD Tailored Plans. After the transition to BH I/DD Tailored Plans, BH I/DD Tailored Plans in their role as area authorities as defined by N.C. Gen. Stat. § 122C-3(20c) will retain their central role in administering state-funded BH, I/DD, and TBI services, as directed by the Department, to address the needs of their communities.
 - b. With the transition to BH I/DD Tailored Plans, the Department seeks to emphasize the following priorities of the delivery of State-funded Services and aims to:
 - i. Promote consistency and equity in access to State-funded Services to those with the greatest needs;
 - ii. Focus the State-funded Services array on effective treatments that are based on best and/or promising practices consistent with Department priorities;
 - iii. Maximize the impact of limited funding; and
 - iv. Ensure the appropriate quality and oversight of State-funded Services.
 - c. State-funded Services are funded through a combination of state funding and federal Substance Abuse and Mental Health Services Administration (SAMHSA) block grants. The Department expects to disburse non-Medicaid funds to the BH I/DD Tailored Plans and require the BH I/DD Tailored Plans to use funds available to authorize and manage delivery of State-funded Services consistent with federal and state guidelines.

³ As of the release date of the RFA, the TBI Waiver is only available in Wake, Durham, Johnston and Cumberland counties.

7. The Department remains committed to preventing institutionalization and providing services and supports in the most therapeutically appropriate and integrated settings for all North Carolinians. Recognizing the accomplishments of the Transitions to Community Living Initiative (TCLI), the BH I/DD Tailored Plans will be responsible for expanding the principles of TCLI within funding allocations and as outlined in this contract through provisions addressing in-reach, transition and diversion, for members with SMI, serious emotional disturbance (SED), I/DD and TBI diagnoses, and recipients with SMI, who are in or at risk of entry to an institutional setting or an adult care home (ACH) as detailed in *Section V.B.3.xiii and Section V.C.3.d-e*.

The Department has begun the process of developing a new Olmstead Plan to advance innovation, coordination and whole-person, systemic change that accelerates community inclusion opportunities for individuals with SMI, SED, I/DD and TBI diagnoses. The BH I/DD Tailored Plans will be responsible for implementing relevant provisions of the Olmstead Plan when it is completed.

8. BH I/DD Tailored Plans shall strive for all mental health, SUD, I/DD, and TBI services and supports funded by Medicaid and State funds to be high quality and sufficient to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harm, and decrease the incidence of hospital contacts and institutionalization.
9. BH I/DD Tailored Plans will be responsible for providing access to the array and intensity of services and supports necessary to enable members or recipients with SMI, SED, I/DD, or TBI diagnoses who reside in or are at risk of entry into institutional settings and ACHs to successfully transition to and live in community-based settings.
10. BH I/DD Tailored Plans will engage with local stakeholders, including county agencies (e.g., local law enforcement, local school districts, magistrates), safety net hospitals, community providers, federal and state tribes, members and recipients, and families to understand the needs of the counties they serve and inform system planning for both Medicaid members and State-funded Services recipients. The Department recognizes that these close and collaborative relationships are critical to promoting and sustaining local and regional investments in the community behavioral health, I/DD, and TBI services.

D. Catchment Areas

Each BH I/DD Tailored Plan shall operate in its Catchment Area as defined in *Section VII. Attachment T: BH I/DD Tailored Plan Catchment Areas*.

II. General Procurement Information and Notice to Applicants

A. Important Notices

Applicants are Cautioned to Read Carefully

1. **Read, Review, and Comply:** It is the Applicant's responsibility to read and review this entire document, including all attachments, and comply with all instructions specified herein.
2. **Execution of Application:** Failure to sign the Execution Page in the indicated space or return all attachments, completed and signed where required, may render the application non-responsive and it may be rejected.
3. **Resulting Contract:** Under the State's procurement process, **any contract resulting from this RFA will consist of the RFA and the Applicant's Response**, along with any addenda to the RFA, written clarifications, best and final offers (BAFO), and negotiation documents. The Contractor will be obligated to perform services as proposed in its application, unless otherwise modified by clarification, BAFO, negotiation, or Contract Amendment, or superseded by a document with higher order of precedence. See *Section III.C.18. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE* for more information and the order of precedence of the contract documents and *Section II.C. Request for Application Functionality and Related Notices* for more information on the RFA, changes in specifications, and instructions regarding modifications to the terms and conditions.
4. **Potential Negotiations:** The Department reserves the right to enter into negotiations with any Applicant to establish a contract that is in the best interest of the Department or State. Such negotiations are at the Department's sole discretion and may result in modifications to the RFA, and/or the Applicant's application.
5. **Events and Deadlines:**
 - a. **Pre-application Conference** will be hosted by the Department on November 18, 2020. See *Section II.D.2. Pre-application Conference* for details and instructions.
 - b. **Questions** concerning this RFA must be submitted in writing by November 25, 2020. See *Section II.D.3. Questions Concerning this Request for Application* for details and instructions.
 - c. **Submission of Applications** will be accepted until February 2, 2021 at 2:00 p.m. ET. See *Section II.E. Submission of Applications* for details and instructions.
6. **Applicant Eligibility for BH I/DD Tailored Plan Applications:**

Only Local Management Entity/Managed Care Organizations (LME/MCOs), as that term is defined in N.C. Gen. Stat. § 122C-3(20c), holding a contract with the Department as of the date applications are due pursuant to this RFA are eligible to submit applications for BH I/DD Tailored Plan Contracts.

B. General Procurement Information & Instructions

1. **INFORMATION AND DESCRIPTIVE LITERATURE:** The Applicant shall furnish all information requested as part of this RFA. Each Applicant shall submit with their application detailed narratives, diagrams, exhibits, examples, sketches, descriptive literature, complete specifications, etc. to support the services and products offered.
2. **RECYCLING AND SOURCE REDUCTION:** It is the policy of the State to encourage and promote the purchase of products with recycled content to the extent economically practicable, and to purchase items which are reusable, refillable, repairable, more durable, and less toxic to the extent that the purchase or use is practicable and cost-effective. The State also encourages and promotes using minimal packaging and the use of recycled/recyclable products in the packaging of commodities

purchased. However, no sacrifice in quality of packaging will be acceptable. The Applicant remains responsible for providing packaging that will adequately protect the commodity and contain it for its intended use. Applicants are strongly urged to bring to the attention of purchasers those products or packaging they offer which have recycled content and that are recyclable.

3. *SUSTAINABILITY*: To support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort. Pursuant to Executive Order 156 (1999), it is desirable that all applications meet the following:
 - a. All copies of the application are printed double-sided;
 - b. All submittals and copies are printed on recycled paper with a minimum post-consumer content of thirty percent (30%);
 - c. Unless necessary, all applications and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable; and
 - d. Materials should be submitted in a format which allows for easy removal, filing and/or recycling of paper and binder materials. Use of oversized paper is strongly discouraged unless necessary for clarity or legibility.
4. *HISTORICALLY UNDERUTILIZED BUSINESSES*: Pursuant to N.C. Gen. Stat. § 143-48 and Executive Order 150 (1999), the Department invites and encourages participation in this procurement process by businesses owned by minorities, women, people with disabilities, business enterprises for people with disabilities, and nonprofit work centers for people who are blind and people with severe disabilities.
5. *MISCELLANEOUS*: Pronouns, whether masculine, feminine, or gender-non-specific, shall be read to be inclusive of all genders and shall be read to include the plural and vice versa.
6. *INFORMAL COMMENTS*: The Department shall not be bound by informal explanations, instructions or information given at any time by anyone on behalf of the Department prior to or during the competitive process or after award, including but not limited to policy papers, webinars, town hall meetings, question and answer documents or any other written or verbal statements whatsoever made outside this RFA and any formal Addenda issued. The Department is bound only by information provided in this RFA and in formal Addenda issued.
7. *COST FOR APPLICATION PREPARATION*: Any costs incurred by an Applicant in preparing or submitting applications are the Applicant's sole responsibility. The Department will not reimburse any Applicant for any costs incurred prior to award.
8. *APPLICANT'S REPRESENTATIVE*: Each Applicant shall submit with its application the name, title, email address, physical address, and telephone number of the person(s) with authority to bind the Applicant and answer questions or provide clarification concerning the firm's application. This information must be included in the Applicant's Application Response.
9. *INSPECTION AT APPLICANT'S SITE*: The Department reserves the right to inspect, at a reasonable time, the equipment/item, plant, or other facilities of a prospective Applicant prior to Contract Award, and during the Contract Term as necessary for the Department determination that such equipment/item, plant or other facilities conform with the specifications/requirements and are adequate and suitable for the proper and effective performance of the Contract.

C. RFA Functionality and Related Notices

1. RFA Functionality

- a. This RFA serves two functions:
 - i. Define the specifications of the services, which are sought by the Department to be provided by the BH I/DD Tailored Plans; and
 - ii. Provide the requirements and terms of any contract resulting from this procurement.
- b. All Terms and Conditions in this RFA shall be enforceable. The use of phrases such as “shall”, “will”, “must”, “required” and “requirements” are intended to create enforceable Contract conditions. In determining whether applications should be evaluated or rejected, the Department will take into consideration the degree to which the Applicant has proposed or failed to propose solutions that are responsive to the Department’s needs as describe in this RFA.

2. Notices Regarding RFA & Terms and Conditions

- a. It is the Applicant’s responsibility to read the instructions, terms and conditions, specifications, requirements, attachments and appendices, and any other components made a part of this RFA and comply with all instructions and directives. The Applicant is responsible for obtaining and complying with all Addenda and other changes that may be issued relating to this RFA.
- b. All questions and issues regarding any term, condition, instruction or other component within this RFA must be submitted in accordance with *Section II.D.3 Questions Concerning this Request for Application*. If the Department determines that any changes will be made as a result of the questions asked, then such decisions will be communicated in the form of an RFA Addendum posted on the State’s Interactive Purchasing System (IPS). The Department may also elect to leave open the possibility for later negotiation and amendment of specific provisions of the Contract that have been raised during the question and answer period. Other than through this process, and except as provided in *Section II.C.3. Proposed Modifications to Terms and Conditions*, the Department rejects and will not be required to evaluate or consider any additional or modified terms and conditions submitted with Applicant’s Application. This applies to any language appearing in or attached to the RFA document as part of the Applicant’s Response that purports to vary any terms and conditions, or Applicant’s instructions therein to render the application non-binding or subject to further negotiation.
- c. The Applicant’s Response to this RFA shall constitute a firm offer. **By execution and delivery of an application to this RFA, the Applicant agrees that any additional or modified terms and conditions, including Instructions to the Applicant, whether submitted purposely or inadvertently, or any purported condition to the application, shall have no force or effect, and will be disregarded. Noncompliance with, or any attempt to alter or delete, this paragraph shall constitute sufficient grounds to reject the Applicant’s application.**

3. Proposed Modifications to Terms and Conditions

- a. Applicants are urged and cautioned to inquire during the question period, in accordance with the instructions in this RFA, about whether specific language proposed as a modification is acceptable to or will be considered by the Department.
- b. Identification of objections or exceptions to the terms and conditions in the application itself shall not be allowed and shall be disregarded or the application rejected.
- c. If the Applicant wishes to suggest changes to any of the terms and conditions included in *Section III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections*, of this RFA, those *must be submitted in Section VIII.16. Request for Proposed Modifications to the Terms and Conditions*. The Department, in its sole discretion, may consider any proposed modifications identified by the Applicant. Where necessary, any modification(s) to the terms and conditions agreed upon by the Department may be incorporated as part of an

Addendum to the RFA, BAFO, negotiation document, Execution of Contract, or Contract Amendment after award. Other than through this process, the Department rejects and shall not be required to evaluate or consider any additional or modified terms, conditions, or instructions included in the Applicant's Response.

4. Changes in Requirements and Specifications

- a. The Applicant is cautioned that the requirements of this RFA can only be altered by written Addendum or other documents issued by the Department as described in this RFA, and that oral or emailed communications from whatever source(s) are of no effect.
- b. The Department reserves the right to modify any specification contained herein without modifying the timelines in this RFA. Any modification to specifications will be specified in an Addendum posted to IPS.

5. Rights Reserved

- a. The Applicant is made aware, pursuant to 01 NCAC 05B .0501, that in soliciting applications, any and all applications received may be rejected in whole or in part. Basis for rejection shall include, but not be limited to, the application being deemed unsatisfactory as to quantity, quality, delivery, price or service offered; the application not complying with conditions of the procurement document or with the intent of the proposed contract; lack of competitiveness by reason of collusion or otherwise or knowledge that reasonably available competition was not received; error(s) in specifications or indication that revision(s) would be to the State's advantage; cancellation of or changes in the intended project or other determination that the proposed requirement is no longer needed; limitation or lack of available funds; circumstances which prevent determination of the most advantageous application; any determination that rejection would be to the best interest of the Department or State.
- b. The Applicant is cautioned that this is a Request for Application, not a request to contract, and the Department reserves the unqualified right to reject all applications deemed failing to meet minimum qualifications, threshold criteria, not responsive, incomplete, or non-compliant with the requirements described herein; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina.
- c. The Department may also:
 - i. Modify provisions of this RFA in response to changes in law or as required by CMS;
 - ii. Waive any formality or informality;
 - iii. Waive a specification or requirement of the RFP if it is in the best interest of the Department or State;
 - iv. Waive any undesirable, inconsequential, or inconsistent provisions of this RFA;
 - v. Negotiate directly with one or more Applicants to achieve a contract that is in the best interest of the Department or State, if the responses to this solicitation demonstrate a lack of competition, or if applications are found non-responsive; and/or
 - vi. Cancel this RFA at any time. Notice of Cancellation will be posted on the IPS website.
- d. In the event that no Contract is awarded for a particular Region in response to this RFA, the Department reserves the right to award all or part of such Region at a later date to one or more qualified applicants or awardees.
- e. The Department reserves the right, including after Contract Award, to modify the list of counties for each BH I/DD Tailored Plan Region specified in *Section I. Table 1: List of Counties by BH I/DD Tailored Plan Region* and *Figure 1: Map of BH I/DD Tailored Plan Regions* to reflect any changes that occur pursuant to N.C. Gen. Stat. 122C-115, to ensure compliance with N.C. Gen. Stat. § 108D-

60(3), or when it is otherwise determined to be in the best interest of the Department or State to do so.

- f. In the event all responses are rejected, and the Department enters into negotiation, pursuant to 01 NCAC 05B .0503, the Department reserves the right to award a contract to the Applicant or Applicants, which, in its opinion, has (have) made the best response through the negotiation process.

D. Schedule and Important Events

- a. The Department will make every effort to adhere to the following schedule. The Department reserves the right to adjust the schedule and will post an Addendum on the IPS website for any schedule changes occurring prior to the opening of applications.

Section II. Table 1: RFA Schedule		
Activity	Responsible Party	Due Date
Issue Request for Application	Department	November 13, 2020
Preapplication Conference	Department	November 18, 2020, 9:00 a.m. – 12:00 noon ET
Deadline to Submit Written Questions	Applicant	November 25, 2020, 2:00 p.m. ET
Issue Addendum with Responses to Questions	Department	December 18, 2020
Deadline to Submit Applications	Applicant	February 2, 2021, 4:00 p.m. ET
Conduct Evaluation of Applications	Department	February 2, 2021 – July 25, 2021
Deadline to Submit Response to Supplemental Evaluation Questions for Empty Region(s)*	Applicant	TBD but Applicants will be notified at least two (2) weeks in advance of the due date
Contract Awards	Department	July 26, 2021

*If needed

2. Preapplication Conference

- a. The Department will hold a Preapplication Video Conference on November 18, 2020, 9:00 a.m. – 12:00 noon ET.
- b. The purpose of the conference is to allow the Department to review key priorities of Medicaid Managed Care and to provide Applicants with a clear understanding of the Scope of Services within this RFA.
- c. While Applicants may ask questions at the Preapplication Conference, the Department is not required to respond during the conference. The Department will respond to written questions from potential Applicants per the process described in this RFA.
- d. Applicants are not required to attend the Preapplication Conference in order to submit responses to this RFA.
- e. To ensure receipt of the video conference invite and instructions for participation, Applicants are required to pre-register for the conference by sending an email to Medicaid.Procurement@dhhs.nc.gov stating the name of the Applicant, the names and email addresses of Applicant representatives to attend, the current role of each representative, and requests for a sign language interpreter or other accommodations. Applicants must pre-register at this email address no later than 4:00 p.m. ET on November 17, 2020. There is no limit to the number of representatives Applicants may bring via a virtual conferencing platform.

- f. Audio and video recording will not be permitted. Statements and materials discussed at conference are informational only, are not binding upon the Department and do not replace reading, reviewing and complying with this RFA.

3. Questions Concerning this Request for Application

- a. Written questions concerning this RFA will be received until November 25, 2020, 2:00 p.m. ET.
- b. They must be sent via email to Medicaid.Procurement@dhhs.nc.gov. Insert “**Questions RFA #30-2020-052-DHB**” as the subject of the email. The questions should be submitted in the format below.

RFA Section	RFA Page Number	Question
<i>Example: V.A.1.a)</i>		

- c. The Department will prepare responses to all written questions submitted by the stated deadline and post an Addendum to IPS. The Applicant is cautioned that contacting anyone other than the Contract Specialist noted on the cover and Execution pages of this RFA may be grounds for rejection of said Applicant’s response.

4. Application Opening.

- a. The opening of applications will be conducted by the Department on **February 2, 2021, 4:00 p.m. ET**. Due to the COVID-19 pandemic the opening will be a virtual event conducted on Microsoft Teams.
- b. Applicants are not required to attend the Application Opening.
- c. To facilitate the virtual opening, any Applicant wishing to attend the Application Opening must pre-register by sending an email to Medicaid.Procurement@dhhs.nc.gov stating the name of the Applicant, the names and email addresses of Applicant representatives to attend, the current role of each representative, and any requests for a sign language interpreter or other accommodations. Applicants must pre-register at this email address no later than 12:00 PM ET on February 1, 2021.
- d. Audio and video recording will not be permitted. Statements and materials made at Application Opening are not binding upon the Department and do not replace compliance with this RFA.
- e. During the Application Opening, the Division will:
 - i. Request introductions and record the information for attendees and their represented entity;
 - ii. Open each application submission and record the applicant’s name, the number of boxes/ packets opened; and
 - iii. Announce the name of each Applicant.
- f. The Department will post a Tabulation on IPS following the Application Opening. The Tabulation will include the name of each Applicant for which an application was opened.

E. Submission of Applications

1. Consideration

- a. The Applicant must meet all the minimum qualifications of this RFA, as defined in *Section IV. Minimum Qualifications*, for its application to be evaluated.
- b. Applicant's application must clearly demonstrate compliance with all the requirements stated within this RFA. The Department reserves the right to reject applications deemed incomplete, non-responsive, or non-compliant with the RFA requirements; or when such rejection is deemed to be in the best interest of the Department or the State of North Carolina.
- c. The Applicant must demonstrate it will comply with the Scope of Services requirements within this RFA and provide a detailed description to demonstrate its ability to completely fulfill each requirement.

2. Responses to RFA Requirements and Scope of Services

- a. The Applicant must complete and return all documents and attachments as required in the RFA. Failure to complete and return all documents and attachments as indicated may result in disqualification.
- b. The application must clearly articulate and address all requirements of this RFA. The Applicant must provide a detailed narrative description with supporting information that may include diagrams, exhibits, examples, samples, sketches, descriptive literature, etc.
- c. For some requirements, the Applicant may need to provide an affirmative statement to the question or requirement by, at a minimum, inserting the word CONFIRM in its application.
- d. The Applicant must describe any limitations, qualifications or contingences impacting the ability to perform as required by the RFA.
- e. The Applicant must not include any assumptions in its application. The Applicant should seek clarity on any questions or concerns during the defined question period.
- f. The Applicant should exercise due diligence to ensure their response is consistent with the instructions, clearly written and addresses all requirements and questions of this RFA.

3. Required Application Documents

- a. To demonstrate the Applicant is qualified to meet the on-going demands of the Department and comply with federal and state requirements, as well as identify and include all the Contract documents in the application, the Applicant is required to return the following documents, completed and signed where indicated, and **in the order listed**, with their RFA response, the entirety of which shall be called the **Applicant's Response**.
 - i. RFA Cover Page with Title and RFA Number;
 - ii. **Completed** Applicant Name and Tax ID Number page;
 - iii. **Completed** and **signed** Execution Page;
 - iv. The entire body of this RFA, excluding attachments;
 - v. Each addendum released in conjunction with the RFA, including **signed** acknowledgement of receipt pages, as applicable;
 - vi. Section VII. Attachments A through P; and
 - vii. **Completed** *Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments*.
- b. The Applicant **should not** submit *Section IX. Medicaid Tailored Plan Draft Rate Book* with its response.
- c. **Except for Addenda issued in conjunction with this RFA, Applicants must request MS Word, Excel or fillable PDF versions of documents and attachments required to be completed and/or**

signed for Application submission from Medicaid.Procurement@dhhs.nc.gov. Applicants should obtain any addenda from the State's IPS website.

- d. The Applicant shall complete the *RFA #30-2020-052-DHB Applicant's Response Submission Checklist* as attached to Addendum #8. The Checklist identifies the materials to be submitted and notes items requiring completion and/or signature to assist Applicant in ensuring its response is complete and in the correct order. If there is any discrepancy between the Checklist and instructions regarding the completion of information or signatures in the RFA, the instruction shall prevail. Notwithstanding Section II.E.3.a. of the RFA regarding the order of required documents, Addendum #8 and the completed *Applicant's Response Submission Checklist* may be included at the front of the response prior to RFA Cover Page with Title and RFA Number and is not subject to the page numbering requirements.

4. Application Submission and Number of Copies

Sealed responses of the application, subject to the conditions made a part hereof and the receipt requirements described herein, must be received at the address indicated below.

The Department will issue an addendum at least two (2) weeks prior to the application due date with instructions for Applicants to make arrangements for hand delivery of applications by Applicant or Applicant's representative.

Section II. Table 2: Application Submission Address	
MAILING ADDRESS FOR DELIVERY OF APPLICATION VIA U.S. POSTAL SERVICE	OFFICE ADDRESS FOR DELIVERY BY ANY OTHER MEANS, SPECIAL DELIVERY, OVERNIGHT DELIVERY, OR BY ANY OTHER CARRIER
APPLICATION NUMBER: RFA #30-2020-052-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 1950 Mail Service Center Raleigh, NC 27699-1950	APPLICATION NUMBER: RFA #30-2020-052-DHB Attn: Kimberley Kilpatrick Department of Health and Human Services Division of Health Benefits 820 S. Boylan Ave. McBryde Building, Office 462 Raleigh, NC 27603

The Applicant **must** deliver the following simultaneously to the address identified above by the deadline to submit applications in *Section II. Table 1: RFA Schedule*:

- a. Hard Copies:
 - i. One (1) signed, original and two (2) copies of executed response of **Applicant's Response**; and
 - ii. Fifteen (15) copies of *Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments*.
- b. Soft Copies:
 - i. One (1) copy of the signed, original executed **Applicant's Response** submitted separately on a CD, DVD, or flash drive marked **RFA #30-2020-052-DHB**; and
 - ii. One (1) copy of the signed, original executed **Applicant's Response redacted** in accordance with Chapter 132 of the General Statutes, the Public Records Act, on a separate CD, DVD, or flash drive marked **RFA #30-2020-052-DHB**. For the purposes of this RFA, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Applicant and meets the definition of Confidential Information set forth in N.C. Gen. Stat. § 132-1.2. Any information removed by the Applicant should be

replaced with the word, “Redacted.” If the response does not contain Confidential Information, Applicant should submit a signed statement to that effect.

- c. Applicant or Applicant’s representative may hand deliver applications to 820 S. Boylan Ave, McBryde Building, Raleigh, NC 27603 as provided in this section.
- d. Due to the COVID-19 pandemic the Department will accept hand deliveries of applications by appointment only.
 - i. Appointments will be available during the following dates and times:

February 1, 2021	<ul style="list-style-type: none"> • 8:30 AM ET • 9:30 AM ET • 10:30 AM ET • 11:30 AM ET • 12:30 PM ET • 1:30 PM ET • 2:30 PM ET • 3:30 PM ET • 4:30 PM ET
February 2, 2021	<ul style="list-style-type: none"> • 8:30 AM ET • 9:30 AM ET • 10:30 AM ET • 11:30 AM ET • 12:30 PM ET • 1:30 PM ET

- ii. Appointments must be scheduled by emailing Medicaid.Procurement@dhhs.nc.gov. The email subject shall be “Schedule Delivery of RFA #30-2020-052-DHB Applications.” In the body of the email, indicate a first, second and third preference for the appointment date and time as well as any limitations the Applicant may have with scheduling delivery during these available times. The Department will make every effort to accommodate Applicant’s preference.
- iii. The Department will notify the Applicant of the date and time scheduled, and email an appointment invite with additional directions for locating the correct building entrance and contact information for the day of the delivery.
- iv. Due to the ongoing COVID-19 pandemic, the Applicant should limit the number of persons to only those necessary to support delivery of the applications. The Applicant will be required to adhere to COVID-19 safety protocols, including wearing a face covering, remaining six feet (6’) apart, limiting contact, and any others identified in the delivery appointment and directions email.
- e. If the Applicant is planning to deliver its response other than making an appointment for hand delivery (i.e., US postal service or commercial carrier), the Applicant *must notify the Department immediately* via email to Medicaid.Procurement@dhhs.nc.gov to confirm the process and address to use for such delivery.

Each document, or group of documents, specified in Section II.E.4.a should be provided as separate PDF files and named accordingly.

The electronic copies of the response must not be password protected.

IMPORTANT NOTE: It is the responsibility of the Applicant to have the above documents and electronic copies physically in the Office provided above by the specified time and date of opening, regardless of the method of delivery. This is an absolute requirement. The time of delivery will be marked on each application when received, and any application received after the submission deadline **will not be accepted or evaluated.**

All risk of late arrival due to unanticipated delay, whether delivered by hand, U.S. Postal Service, courier or other delivery service or method, is entirely on the Applicant. Note that the U.S. Postal Service generally does not deliver mail to the street address above, but to the State's Mail Service Center stated above. The Applicant is cautioned that applications sent via U.S. Mail, including Express Mail, may not be delivered by the Mail Service Center to the person named on Page 1 of this RFA by the Due Date and time to meet the application submission deadline. The Applicant is urged to take the possibility of delay into account when submitting an application.

5. Falsified Information

The Department may initiate proceedings to debar an Applicant from participation in the application process and from Contract Award as authorized by North Carolina law if it is determined that the Applicant has withheld relevant or provided false information.

F. Confidentiality and Prohibited Communications During Evaluation

1. As provided for in the North Carolina Administrative Code (NCAC), including but not limited to 01 NCAC 05B.0103, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation whether electronic, written or verbal, relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature. In accordance with these and other applicable rules and statutes, such materials shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by Chapter 132 of the General Statutes, **must be clearly marked as such with each page containing the trade secret or confidential information identified in boldface at the top and the bottom as "CONFIDENTIAL"** If only a portion of each page marked "CONFIDENTIAL" contains trade secret information, the trade secret information shall be designated with a contrasting color or by a box around such information. **In addition to marking confidential information as required by NCAC 05B.0103, confidential pages or portions of the response shall be reflected in the redacted copy submitted as instructed in Section II.E. Submission of Applications as applicable.** By submitting a redacted copy, the Applicant warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked **Confidential** and **Redacted** meet the requirements of G.S. § 132. The Applicant must identify the legal grounds for asserting that the information is confidential, including the citation to state law. **However, under no circumstances shall cost or price information be designated as confidential.**
2. Except as otherwise provided above, pursuant to N.C. Gen. Stat. § 132-1, et seq., information or documents provided to the Department in response to this RFA are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, N.C. Gen. Stat. § 132-1.2. Redacted copies provided by the Applicant to the Department may be released in response to public record requests without notification to the Applicant.

3. During the period spanning the issuance of the RFA and Contract Award, possession of applications, accompanying information, and subsequent negotiations are limited to personnel of the Department and any third parties involved in this procurement process.
4. Each Applicant submitting an application (including its representatives, Subcontractors and/or suppliers) is prohibited from having any communications with any person inside or outside the using agency, issuing agency, other government agency office, or body (including the purchaser named above, department secretary, agency head, members of the general assembly and/or governor's office), or private entity, if the communication refers to the content of Applicant's application or qualifications, the content of another Applicant's application, another Applicant's qualifications or ability to perform the Contract, and/or the transmittal of any other communication of information that could be reasonably considered to have the effect of directly or indirectly influencing the evaluation of application and/or the award of the Contract. An Applicant not in compliance with this provision shall be disqualified from Contract Award, unless it is determined in the Department's s discretion that the communication was harmless, that it was made without intent to influence and that the best interest of the Department would not be served by the disqualification. An Applicant's application may be disqualified if its Subcontractor and supplier engage in any of the foregoing communications during the time that the procurement is active (i.e., the issuance date of the procurement to the date of Contract Award). Only those discussions, communications or transmittals of information authorized or initiated by the issuing agency for this RFA or general inquiries directed to the purchaser regarding requirements of the RFA (prior to application submission) or the status of the Contract Award (after submission) are excepted from this provision.
5. The Department may serve as custodian of Applicant's confidential information and not as an arbiter of claims against Applicant's assertion of confidentiality. If an action is brought pursuant to N.C. Gen. Stat. § 132-9 to compel the Department to disclose information marked confidential, the Applicant agrees that it will intervene in the action through its counsel and participate in defending the Department, including any public official(s) or public employee(s). The Applicant agrees that it shall hold the Department, State of North Carolina, and any official(s) and individual(s) harmless from all damages, costs, and attorneys' fees awarded against the Department in the action. The Department agrees to promptly notify the Applicant in writing of any action seeking to compel the disclosure of Applicant's confidential information. The Department shall have the right, at its option and expense, to participate in the defense of the action through its counsel. The Department shall have no liability to Applicant with respect to the disclosure of Applicant's confidential information ordered by a court of competent authority pursuant to N.C. Gen. Stat. § 132-9 or other applicable law.

G. Evaluation and Contract Award

The Evaluation process will commence on the date and time responses are unsealed as defined in this RFA. The Department will evaluate each Applicant's Response in accordance with the method, process and criteria stated herein.

1. Evaluation Committee and Method

- a. An Evaluation Committee (Committee) will be established to review each Applicant's Response to the RFA and make award recommendations. The Department may designate other individuals or subject matter experts, including individuals from outside the Department, to assist in the evaluation process. The Department reserves the right to alter the composition of the Committee or designate other staff, individuals, or vendors from outside the Department to assist in the process.

- b. The Committee will review and evaluate all qualified responses submitted by the deadlines specified in this RFA. The Committee will be responsible for the entire evaluation process, including any clarifications, negotiations, or BAFOs.
- c. The Committee's evaluation determinations and recommendations will be by consensus.

2. Investigation and Inspection

- a. The Department may make such reasonable investigations or Readiness Reviews to determine the ability of the Applicant to perform the services, and the Applicant must furnish to the Department all such information and data within requested timeframes. The Department reserves the right to inspect Applicant's physical facilities, including any located outside of North Carolina prior to award and at any time during the Contract period to satisfy questions regarding the Applicant's capabilities. The Department further reserves the right to reject any application if the evidence submitted by, or investigations of, the Applicant fails to satisfy the Department that the Applicant is properly qualified to carry out the obligations of the Contract and to provide the required services. Department's investigation or inspection of Applicant's ability and physical facilities includes any entity or site used in the performance of any obligation under the Contract.
- b. The Department may request to review any policy, procedure, process, script, manual or other material used to fulfill a Scope of Services requirement and require changes as a condition of participation under the Contract.

3. Evaluation Process

The following descriptions are to provide general information about the Department's evaluation process. The Department reserves the right to modify the evaluation process, including the order or content of the following evaluation process components:

- a. The Committee will review each Applicant's Response to validate all required response documents are included and completed, and all instructions to Applicants have been followed. Failure to adhere to these requirements may render the Application incomplete and may be grounds for rejection during any part of the evaluation process.
- b. The Committee will determine if Minimum Qualifications are met as required in *Section IV. Minimum Qualifications*. If the Applicant does not provide the information required in *Section VIII. Second Revised and Restated Attachment Q.2. First Revised and Restated Minimum Qualifications Response*, or the Department determines that the Applicant does not meet the Minimum Qualifications, that Applicant's Response shall be excluded from further consideration and evaluation. Exclusion from further consideration may occur upon the Department's initial review or at any time during the evaluation process upon Department's determination that the Applicant fails to meet the Minimum Qualifications.
- c. The Committee will review and evaluate the Applicant's Response by identifying and describing strengths and weaknesses as well as any risks or issues, determining ratings relative to the evaluation criteria, and developing documentation, summaries or narratives of its determinations.
- d. The Committee will make an award recommendation. Upon approval of the recommendation by the Department, the Notice of Award will be issued with the Department executing a Contract with the successful Applicant(s).

4. Clarifications, Negotiations, and BAFOs

- a. The Department reserves the right to request Clarifications at any time from any Applicant, and such Clarifications will be submitted in writing to the Applicant to respond. However, the Department *is not required* to request Clarifications from any Applicant, and Applicants should exercise due diligence to ensure its Application is clear and addresses all the requirements and specifications of the RFA. Pursuant to 01 NCAC 05A .0112, Clarification means communications

between the State and an Applicant that may occur after receipt of Applicant's Response for the purpose of eliminating irregularities, informalities, or apparent clerical mistakes in an Application. A Clarification may also be used in order for the State to interpret an Application or Applications or to facilitate the State's evaluation of all Applications. A Clarification shall not be used to cure material deficiencies in an Application, alter the scope of an Application, or to negotiate. The Department may refuse to accept or consider, in whole or in part, the response to a Clarification provided by an Applicant.

- b. The Department reserves the right to enter into negotiations with any Applicant to establish a contract that is in the best interest of the Department or State. Such negotiations may result in modifications to the RFA and/or Applicant's Response.
- c. The Department may issue a BAFO request to any Applicant, requesting one or more Applicants change its (their) initial application(s).

5. In-Person or Oral Presentations

The Department reserves the right to request in-person or oral presentations from any Applicant as part the Committee's evaluation of Applications. In-person presentations shall be conducted in Raleigh, NC at a site chosen by the Department or may be held virtually by video conference. Oral presentations may be conducted by conference call. The presentations will address specific topics provided in advance to the Applicant. However, the Department *is not required* to request in-person or oral presentations from any or all Applicants and may limit any presentations only to those Applicants which are deemed competitive. Additional details regarding the scheduling of the in-person, oral or virtual presentations will be provided to selected Applicants by the Department upon determination that such presentation is needed. The Applicant is solely responsible for any costs associated with making in-person or oral presentations, including but not limited to travel and the preparation of additional materials.

6. Quality Review

The Department reserves the right to conduct a quality review of the RFA evaluation. Any changes to evaluation documentation, ratings, determinations or recommendations or other records of the Evaluation Committee as a result of the quality review will be made by consensus of the Committee.

7. Rescission

The Department may, at its discretion, allow an Applicant to rescind certain statements in the Applicant's Response, and such rescissions will be handled and documented as Clarifications. However, the Department *is not required* to allow statement rescissions from any Applicant.

8. Evaluation Criteria, Determination of Ratings and Award Recommendation

- a. The Department will evaluate the Applicant's Response for completeness and reasonableness and to determine if it complies with the instructions and minimum qualifications described in the RFA.
- b. Qualified applications will be evaluated, and award made based on considering the criteria specified below and a rating scale developed by the Department to result in an award(s) most advantageous to the Department and State. There is no guarantee of Contract Award regardless of the results of the evaluation.⁴

⁴ Refer to Section II. G. 10. Empty Region Scoring and Contract Award for scoring and Contract Award details in the event that an incumbent LME/MCO is not awarded a Contract.

- c. The evaluation criteria are listed in descending order of importance with no specific percentage or weight assigned as follows:

#	Criteria	Description
Threshold Criteria		
1	Integration	Ability to implement and sustain an integrated, well-coordinated system of care for members and recipients that addresses their physical and behavioral health and other health-related needs
2	Financial Management	Ability to develop systems and processes required to meet key financial management objectives
3	Care Management	Ability to provide comprehensive and provider-based care management
Other Criteria		
4	Providers	Ability to partner successfully with providers and maintain a sufficient network of accessible providers
5	Benefits & Services	Ability to deliver benefits and support members and recipients navigate transitions from institutional settings
6	Members & Recipients	Ability to support and engage members and recipients
7	Compliance	Ability to provide comprehensive oversight and program integrity
8	Quality & Population Health	Ability to develop a comprehensive quality improvement and value-based purchasing approach, improve population health, and address unmet health related resource needs
9	Administration & Management	Ability to implement and sustain organizational, operational, technical and administrative functions and capabilities
10	Use Cases	Ability to illustrate approach to caring for complex and vulnerable members and recipients
11	Qualifications & Experience	Ability to leverage prior experience to implement plan requirements
Empty Region Criteria (if needed)		
1	Financial Management	Ability to meet key financial management objectives and capital requirements in an expanded region.
2	Provider Network	Ability to partner successfully with providers to build and maintain a sufficient network of accessible providers that meets the needs of members in the empty region(s).
3	Stakeholder Engagement	Ability to manage community-based efforts focusing on health promotion, prevention, and collaboration and other community-based initiatives for the empty region(s).
4	Administration & Management	Ability to expand and sustain organizational, operational, technical and administrative functions and capabilities in the empty region(s).
5	Proximity to Empty Region	Whether the counties the Applicant serves as of the issue date of this RFA, or as modified pursuant to <i>Section II.C.5.e.</i> of this RFA, are contiguous to counties in the Empty region.

- d. Applications will be compared to the evaluation criteria. The Committee will identify and describe the strengths and weaknesses as well as risks and issues of the Application relative to the evaluation criteria and develop a narrative and summary of the results and its determinations, including a consensus rating of the Applicant’s Response for each evaluation criterion.
- e. The Committee will determine if the Applicant’s Response meets expectations and requirements for each criterion designated as “Threshold Criteria” in *Section II.G.8.c.* above. **An Applicant that does not meet expectations or requirements for any one of the three Threshold Criterion is not eligible for contract award**; however, Applicants meeting the Threshold Criteria are **not** guaranteed a Contract award.
- f. The Committee will determine if the Applicant’s Response meets expectations and requirements for each criterion designated as “Other Criteria” in *Section II.G.8.c.* above.
- g. An Applicant will be recommended for contract award if the Evaluation Committee determines, based on its review of the application and consensus ratings, that:
 - i. The application is responsive to the contract requirements; and,
 - ii. The Applicant will be able to perform the functions as required under the contract.

9. Contract Award

- a. Upon conducting a comprehensive, fair, and impartial evaluation of the applications received in response to this RFA, the Department will award five (5) to seven (7) regional contracts ensuring BH I/DD Tailored Plan coverage in all counties as a result of this RFA, pursuant to N.C. Gen. Stat. § 108D-60(3). Upon award, the Department will sign the “Acceptance of Application” found at the bottom of the Execution page or require the signing of an Execution of Contract, thus resulting in the formation of the Contract(s).
- b. All contracts are subject to CMS approval.
- c. Within two (2) State Business Days after notification of award, the Applicant must register in NC E-Procurement @ Your Service. See <http://vendor.ncgov.com>.

10. Empty Region Evaluation and Contract Award

- a. The Department will, at its discretion, award all or part of an Empty Region to one or more qualified Applicants, based on responses to Supplemental Evaluation Questions.⁵ Applicants must submit responses to the Supplemental Evaluation Questions in *Section VIII. Second Revised and Restated Attachment Q.17. Supplemental Evaluation Questions for Empty Region(s)* to be considered for the award of an Empty Region.
- b. Applicants not interested in being considered for the award of an Empty Region are not required to submit responses to the Supplemental Evaluation Questions. Declining to submit responses to the Supplemental Evaluation Questions will not affect consideration of the Applicant’s response for the Region in which it is operating as an LME/MCO at the time it submits its Application.
- c. The Department will notify eligible Applicants if there is an opportunity to submit responses to the Supplemental Evaluation Questions. Any Applicant that, at the time of the Applicant’s submission, is the LME/MCO serving the Region that becomes an Empty Region is not eligible for an award under this process.
- d. Minimum Qualifications for Award of an Empty Region: To be awarded a Contract for an Empty Region, the Applicant must, at a minimum:
 - i. Have been determined by the Department, based upon an evaluation of the Applicant’s Response, to meet the requirements necessary to secure a contract to become a BH/IDD Tailored Plan for the Region in which it operates as an LME/MCO at the time it submits its Application; and
 - ii. Respond to the Supplemental Evaluation Questions.

⁵ There will be only one (1) BH I/DD Tailored Plan operating in each county.

- e. Empty Region Evaluation and Award:
 - i. Responses to Supplemental Evaluation Questions will be evaluated using the same approach and process outlined above.
 - ii. The Committee will rank Applications for each Empty Region, taking into account the Committee's ratings and determinations with respect to all the evaluation criteria listed in *Section II.G.10.c*, including the Threshold Criteria and Other Criteria in addition to the Empty Region Criteria.
 - iii. The Committee will recommend Empty Region awards most advantageous to the Department or State, considering the ranking of Applicants who submitted responses to the Supplemental Evaluation Questions, the number of Empty Regions, the number of qualified Applicants, and the statutory requirement to award at least five (5) and no more than seven (7) BH I/DD Tailored Plan contracts.
 - iv. The Department reserves the right to divide an Empty Region and award the Empty Region to two (2) or more Applicants.

11. Protest Procedures:

- a. If an Applicant wishes to protest a Contract awarded as a result of this RFA, the Applicant shall submit a written request addressed to contact identified in *Section II.E.4. Application Submission and Number of Copies*. The protest request must include two (2) hardcopies and an electronic copy and be received in the proper office within thirty (30) Calendar Days from the Contract Award. Protest letters shall contain specific grounds and reasons for the protest, how the protesting party was harmed by the award made and any documentation providing support for the protesting party's claims. **Note:** Contract Award notices are sent only to the Applicant(s) awarded the Contract, and not to every person or firm responding to a solicitation. Application status and Award notices are posted at <https://www.ips.state.nc.us/ips/>. All protests will be handled following the process defined in the North Carolina Administrative Code, 01 NCAC 05B.1519, but will be administered by Department of Health and Humans Services personnel.
- b. If a protest is determined by the Department head to be valid, the following outcomes may occur:
 - i. Cancellation of the award, and the solicitation to contract is not reissued;
 - ii. Cancellation of the award, and the solicitation to contract is reissued;
 - iii. Cancellation of the award, and the contract is awarded to the next technically competent, qualified Applicant, as determined by the Department in its sole discretion, that agrees to honor its application.

III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections

A. Definitions

Unless otherwise specified herein, the following definitions apply to this Contract.

1. **1115 Demonstration Waiver:** As defined by Section 1115 of the Social Security Act, state demonstrations that give states additional flexibility to design and improve their programs by demonstrating and evaluating state-specific policy approaches to better serving Medicaid populations. Specifically, North Carolina's amended 1115 demonstration waiver application to the federal Centers for Medicare & Medicaid Services (CMS) focuses on the specific items of the Medicaid Managed Care transformation that require CMS waiver approval (waiver #11-W00313/4; <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>).
2. **Adult Care Home (ACH):** A licensed facility with seven (7) or more beds that provides residential care for aged or disabled persons whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.
3. **Advance Directive:** Has the same meaning as Advance Directive as defined in 42 C.F.R. § 489.100 and includes advance instructions for mental health treatment as defined in Part 2 of Article 3 of Chapter 122C of the General Statutes.
4. **Advanced Medical Home (AMH):** State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.
5. **Advanced Medical Home Plus (AMH+):** Primary care practices certified by the Department 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 and have certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch) as such.
6. **Adverse Benefit Determination:** Has the same meaning as Adverse Benefit Determination as defined in 42 C.F.R. § 438.400. Any decision to deny, reduce, suspend, or terminate waiver participation or requests for or placement on the Registry of Unmet Needs are considered Adverse Benefit Determinations consistent with the definition at 42 C.F.R. 438.400.
7. **Alcohol and Drug Abuse Treatment Center (ADATC):** State-operated treatment center that provides inpatient treatment, psychiatric stabilization and medical detoxification for adults with substance use and other co-occurring mental health diagnoses to prepare for ongoing community-based treatment and recovery.
8. **Allocation Letter:** Letter by which the Department disburses specific state or federal funds to the BH I/DD Tailored Plan and specifies the binding terms and conditions for using those funds.
9. **Alternative Services:** Services proposed by the BH I/DD Tailored Plan and approved by the Department to fill network adequacy and accessibility service needs that are met with the current state-funded service array.
10. **American Society of Addiction Medicine (ASAM) criteria:** Evidence-based guidelines for placement, continued stay, and transfer/discharge for the treatment of adolescents and adults with addiction and co-occurring conditions.

11. **Appeal:** Has the same meaning as Appeal as defined in 42 CFR 438.400(b).
12. **Applicant:** Supplier, bidder, proposer, firm, company, corporation, partnership, individual or other entity submitting an application in response to this RFA.
13. **Area Director:** The Area Director is the administrative head of the BH I/DD Tailored Plan. The Area Director is an employee of and serves at the pleasure of the entity's governing board and shall be appointed in accordance with N.C. Gen. Stat. § 122C-117(a)(7).
14. **Authorized Representative:** An individual, provider or organization designated by a Member , or authorized by law or court order, to act on their behalf in assisting with the individual's participation in the Medicaid Managed Care program. With written consent of the Member, or as otherwise legally authorized, an authorized representative may, for example, request an Appeal, file a Grievance, or request a State Fair Hearing on behalf of the Beneficiary with the exception that a Provider cannot request continuation of BH I/DD Tailored Plan benefits Authorized Representative may be used interchangeably with member wherever a member has a right under this Contract for purposes of exercising a right on behalf of that member. Sometimes referred to as Legally Responsible Person (LRP).
15. **Automated Call Distribution System (ACD):** An automated call center system that disperses incoming calls of all Members and potential Members to appropriate service line staff.
16. **Automated Voice Response System (AVRS):** An automated system that allows members to perform self-service activities and resolve simple inquiries without the need to interact with an agent. The AVRS interacts with the Member through voice prompts and recognition or numeric prompts.
17. **Behavioral Health (BH):** Mental health and substance use disorder.
18. **Behavioral Health Crisis Line:** A confidential, toll free service line available twenty-four (24) hours a day, seven (7) days a week, every day of the year to Members and Recipients which provides emergency referral with immediate access to trained, skilled, licensed BH professionals who provide assistance for any type of BH issue the Member may be experiencing, and offers assistance in linking Members and Recipients to supportive available community resources.
19. **Behavioral Health Crisis Referral System (BHCRS):** A secure web-based application that connects a statewide network of facilities that make referrals (Referring Facilities) with facilities that offer inpatient or facility-based treatment (Receiving Facilities) to assist facilities in timely and appropriate placement of individuals experiencing a BH crisis.
20. **Behavioral Health Intellectual/Developmental Disability Tailored Plan (BH I/DD Tailored Plan):** Has the same meaning as BH I/DD Tailored Plan as defined in N.C. Gen. Stat. § 108D-1(4).
21. **Beneficiary:** An individual who is enrolled in the North Carolina Medicaid or NC Health Choice programs but who may or may not be enrolled in the Medicaid Managed Care program.
22. **Beneficiary with Special Health Care Needs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals with: HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving Innovations or TBI waiver services.
23. **Business Associate Agreement (BAA):** Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the written agreement between a HIPAA-covered entity and HIPAA Business Associate, as defined in 45 C.F.R. 160.103.

24. **Business Day:** Business days are defined as traditional State workdays, Monday – Friday and includes traditional work hours 8:00 AM – 5:00 PM EST. North Carolina State holidays are excluded. A list of North Carolina State Holidays is located at the following link, accurate as of August 9, 2022: <https://oshr.nc.gov/state-employee-resources/benefits/leave/holidays>.
25. **Calendar Day:** Includes the time from midnight to midnight each day, and all days in a month, including weekends and holidays. Unless otherwise specified within the Contract, days are tracked as Calendar Days.
26. **Care Coordination:** The act of organizing patient care activities and sharing information among all the participants involved with a Member’s care to achieve safer and more effective care. Through organized care coordination, Members’ needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care addressing the member’s clinical needs and unmet health related resource needs.
27. **Care Management:** Team-based, person-centered approach to effectively managing patients’ medical, social, and behavioral conditions. Care Management shall include, at a minimum, the following:
 - a. High-risk care management (e.g., high utilizers / high-cost beneficiaries);
 - b. Care Needs Screening;
 - c. Identification of members in need of care management;
 - d. Development of Care Plans (across priority populations);
 - e. Development of comprehensive assessments (across priority populations);
 - f. Transitional Care Management: Management of member needs during transitions of care and care transitions (e.g. from hospital to home);
 - g. Care Management for special populations (including pregnant women and children at-risk of physical, development, or socio-emotional delay);
 - h. Chronic care management (e.g., management of multiple chronic conditions);
 - i. Coordination of services (e.g., appointment/wellness reminders and social services coordination/referrals);
 - j. Management of unmet health-related resource needs and high-risk social environments;
 - k. Management of high-cost procedures (e.g., transplant, specialty drugs);
 - l. Management of rare diseases (e.g., transplant, specialty drugs);
 - m. Management of medication-related clinical services which promote appropriate medication use and adherence, drug therapy monitoring for effectiveness, medication related adverse effects; and
 - n. Development and deployment of population health programs.
28. **Care Management Agency (CMA):** Provider organization with experience delivering BH, 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 to BH I/DD Tailored Plan members assigned to it, under the Tailored Care Management model as certified by the State (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan(s) (after launch).
29. **Care Management Comprehensive Assessment:** A person-centered assessment of a Member’s health care needs, functional needs, accessibility needs, strengths and supports, goals and other characteristics that will inform the Member’s ongoing Care Plan and treatment.
30. **Care Management for At-Risk Children:** Care management services provided to a subset of the Medicaid population ages 0-5 identified as being “high-risk.”

31. **Care Management for High Risk Pregnant Women:** Care management services provided to a subset of the Medicaid population who is pregnant and identified as “high-risk” by providers, local health departments (LHDs), social service agencies, Standard Plans, BH I/DD Tailored Plans, and/or PIHPs.
32. **Care Plan:** A written individualized person-centered plan of care for Members/Recipients with BH needs, that is developed using a collaborative approach led by the Member/Recipient or their guardian when appropriate, incorporates the results of the Care Management Comprehensive Assessment, and identifies the Member’s/Recipient’s desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the Member/Recipient to achieve those outcomes.
33. **Care Transitions:** The process of assisting a Member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions).
34. **Caregivers:** Family members, friends or neighbors who provide unpaid assistance to a person with a chronic illness or disabling condition.
35. **Catchment Area:** The group of counties for which a BH I/DD Tailored Plan arranges for services. Also referred to as Regions within this Contract.
36. **Child and Adolescent Needs and Strengths (CANS):** A multi-purpose tool developed for children and adolescent BH and developmental services to support decision making, including level of care and service planning; facilitate quality improvement initiatives; and allow for the monitoring of outcomes of services.
37. **Child/Adolescent Psychiatrist:** A physician who has completed an ACGME-accredited child/adolescent psychiatry fellowship and/or has board certified or has board-diplomat status as a child/adolescent psychiatrist.
38. **Children with Complex Needs:** Medicaid eligible children ages five (5) through twenty (20) with a developmental disability (including Intellectual Disability 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. The term “at risk” is defined for this purpose as acts or behaviors that present a substantial risk of harm to the child or to others.
39. **Child and Family Team:** Group consisting of a child/youth receiving services, parent/caregiver/guardian, and other community supports as determined by the child/youth and/or their parent/caregiver/guardian. The Child and Family Team is responsible for creating, implementing, and updating an individualized child and family plan on the child/youth’s needs. Child and Family team may include extended family members, community members, and individuals involved in the child/youth’s education, care, and support.
40. **Children with Medical Complexity (CMC):** Also known as “complex chronic” or “medically complex,” children who have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations, high health care need or utilization, and often the need for or use of medical technology.
41. **Choice Counseling:** Has the same meaning as Choice Counseling as defined in 42. C.F.R. § 438.2.
42. **Civil Monetary Penalty:** Financial penalties authorized or required to be imposed by States under federal requirements for certain conduct that is set forth in 42 C.F.R. § 438.700.
43. **Claim:** A request for payment by a healthcare Provider to an insurer for rendered services. Also refers to (1) a bill for services, (2) a line item of service, or (3) all services for one beneficiary within

a bill, as referenced at 42 CFR §447.45(b). Claims may be filed for professional, institutional, dental, and pharmacy transactions in conformance with existing laws (e.g., HIPAA) and using relevant industry standards (e.g., ASC X12N, NCPDP) and typically include information on the patient, Provider, diagnoses, procedures performed or services rendered, and related charges.

44. **Claim Adjudication:** The process of paying Claims submitted or denying them after comparing the claim data elements to the benefit or coverage requirements.
45. **Claim Adjudication Date:** The date the BH I/DD Tailored Plan or its Subcontractor processed a Claim for determination of payment, acceptance, denial, or rejection.
46. **Clean Claim:** A Claim submitted to a BH I/DD Tailored Plan by a Participating Provider which can be processed without obtaining additional information from the Participating Provider or their authorized representative in order to adjudicate the Claim. Pursuant to 42 CFR § 447.45(b), Clean Claim does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.
47. **Clinically Integrated Network (CIN) or Other Partner:** Entities with which Provider practices choose to partner to share responsibility for specific functions and capabilities required to operate as an AMH+ practice or CMA.
48. **Closed Loop Referral:** The capacity to know whether a Member accessed social services to which they were referred.
49. **Closed Network:** Has the same meaning as Closed Network defined in N.C. Gen. Stat. § 108D-1(6).
50. **Community Alternatives Program for Children (CAP/C):** A North Carolina Medicaid 1915(c) waiver program that provides home- and community-based services to medically fragile children who are at risk for institutionalization in a nursing home because of their medical needs (4141.R06.00; the approved waiver document is available at the following link, accurate as of August 9, 2022: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8233>).
51. **Community Alternatives Program for Disabled Adults (CAP/DA):** A North Carolina Medicaid 1915(c) waiver program that allows seniors and disabled adults ages eighteen (18) and older to receive support services in their own home, as an alternative to nursing home placement (#0132.R07.00; the approved waiver document is available at the following link, accurate as of August 9, 2022: <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8232>).
52. **Community Collaboratives:** Local and regional convenings of county agencies, community-based organizations, non-profits, Members, relatives/natural supports, and health care Providers, and peers, that meet regularly to identify and address community needs through coordinated efforts and system planning.
53. **Community Integration Plan (CIP):** A planning document completed as part of the diversion process that documents that community integration planning occurred and indicates which residential option and other services were chosen by the Member and/or their relatives or guardian.
54. **Community Mental Health Block Grant (CMHBG or MHBG):** The Substance Abuse and Mental Health Services Administration (SAMHSA) disburses these funds annually to North Carolina each year to support the state's efforts to provide comprehensive community mental health services, including prevention, early intervention, treatment and resiliency and/or recovery supports to children and youth at risk for or experiencing serious emotional disturbance (SED) and adults living with a serious mental illness (SMI).

55. **Compatible Medicaid NCCI Methodologies:** The six (6) NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology with medically unlikely edits for durable medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.
56. **Conflict of Interest:** Impermissible actual situations or circumstances through which the BH I/DD Tailored Plan, or entities or individuals closely affiliated with the BH I/DD Tailored Plan, will derive, or reasonably may be perceived as deriving, direct financial or other pecuniary benefit from its performance of this Contract other than through the compensation received according to the Contract for performance of the Contract, or that might impair, or reasonably be perceived as impairing, the BH I/DD Tailored Plan's ability to perform this Contract in the best interests of the State.
57. **Contract Award Date:** The date the Department signs the "Acceptance of Application" section of the Execution page and publishes the Notice of Award to the Interactive Purchasing System.
58. **Contract Effective Date:** This Contract is effective upon award.
59. **Contract Year:** The period where the BH I/DD Tailored Plan covers services under this Contract for Years 1 – 5 as indicated below:
- a. Contract Year 1: December 1, 2022 through June 30, 2023
 - b. Contract Year 2: July 1, 2023 through June 30, 2024
 - c. Contract Year 3: July 1, 2024 through June 30, 2025
 - d. Contract Year 4: July 1, 2025 through June 30, 2026
 - e. Contract Year 5: July 1, 2026 through December 1, 2026
60. **Contractor:** The Applicant awarded the Contract to perform the services and requirements defined therein. The Contractor is a BH I/DD Tailored Plan.
61. **Credentialing:** The approach to collecting and verifying Provider qualifications (e.g., the Provider's training and education, licensure, liability record); and determining, for Medicaid Managed Care and State-funded Services, whether to allow the Provider to be included in a BH I/DD Tailored Plan's network, subject to certain Department requirements.
62. **Crossover:** The timeframe immediately before and after implementation of BH I/DD Tailored Plans in the applicable Region. Crossover-related requirements and timeframes are activity-specific but are all designed to ensure continuity of care for the crossover population during this time of transition.
63. **Cross-over Population:** Refers to North Carolina Medicaid and NC Health Choice beneficiaries that are enrolled in the NC Medicaid Direct program and will transition to Medicaid Managed Care at a specific date determined by the Department.
64. **Cross Area Service Program (CASP):** DMH/DD/SAS designated specialty service program that is funded by the DMH/DD/SAS through federal and/or State funds to provide targeted services to an identified population segment (e.g. pregnant women, families, etc.). A CASP is designated by the DMH/DD/SAS as a result of a critical federal grant initiative or a priority state service initiative.

65. **Cultural and Linguistic Competency (or Culturally and Linguistically Competent):** The ability to understand, appreciate and interact effectively with people of different cultures and/or beliefs to ensure the needs of the individuals are met. The ability to interact effectively with people of different cultures helps to ensure the needs of all community members are addressed. It also refers to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession. Cultural and Linguistic Competency means to be respectful, responsive, and sensitive to the health beliefs, practices, cultural and linguistic needs of diverse populations and groups.
66. **Culturally and Linguistically Appropriate Services (CLAS):** Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.
67. **Date of Payment:** The point in time following the Claim Adjudication Date when reimbursement is generated for services, either initiated by date of Electronic Funds Transfer (EFT) or processes to generate a paper check.
68. **Date of Receipt:** Has the same meaning as Date of Receipt as defined in 42 C.F.R. § 447.45(d)(5).
69. **Denied Claim:** When a BH I/DD Tailored Plan or its Subcontractor refuses to reimburse a Participating Provider for all or a portion of the services submitted on the medical or pharmacy claim
70. **Diversion:** The process of identifying individuals living in the community who are at risk of requiring care in an institutional setting or an adult care home, and providing additional, more intensive supports and services to prevent further deterioration of their condition that could result in placement in an institutional setting or an adult care home.
71. **Dually-Eligible for Medicare and Medicaid:** Describes beneficiaries eligible for both Medicare and Medicaid.
72. **Duplicate Claim:** Any claim submitted by a Participating Provider for the same service provided to an individual on a specified date of service that was included in a previously submitted Claim.
73. **Durable Medical Equipment (DME):** Has the same meaning as Durable Medical Equipment as defined in 42 C.F.R. § 414.202.
74. **Eastern Band of Cherokee Indian (EBCI):** A federally recognized Indian Tribe located in southwestern North Carolina whose members are exempt from Medicaid Managed Care.
75. **Eastern Band of Cherokee Indian (EBCI) Tribal Option.** The tribal-designed and operated primary care case management entity option developed collaboratively by the Department and the EBCI. This includes the following counties: Cherokee, Graham, Haywood, Jackson and Swain Counties. Eligible Members in the following counties may opt in: Buncombe, Clay, Henderson, Macon, Madison, and Transylvania.
76. **Emergency Closure:** A closure of licensed residential care facilities that occurs without the Facility providing the required 30-day notice to residents and the state (or sixty (60) Calendar Days' notice as required for I/DD residential facilities pursuant to N.C.G.S. § 122C-63(b)) as described in posted lawful guidance.
77. **Emergency Medical Condition:** Has the same meaning as Emergency Medical Condition as defined in 42 C.F.R. § 438.114(a).
78. **Emergency Services:** Has the same meaning as Emergency Services as defined in 42 C.F.R. § 438.114(a).

79. **Empty Region:** Region served by an LME/MCO as of the issue date of this RFA for which that LME/MCO is not recommended to be awarded or awarded a BH I/DD Tailored Plan contract.
80. **Encounter:** A record of a rendered service provided by a healthcare provider irrespective of whether payment is required. Encounter data typically includes information otherwise present on a Claim.
81. **Enrollment:** The process through which a Beneficiary selects or is auto-enrolled to a Standard Plan, BH I/DD Tailored Plan, Medicaid Direct PIHP, Statewide Specialized Foster Care Plan and/or Tribal Option to receive North Carolina Medicaid or NC Health Choice benefits through the Medicaid Managed Care program.
82. **Enrollment Broker (EB):** Has the same meaning as Enrollment Broker as defined in 42 C.F.R. § 438.810(a).
83. **Essential Providers:** Federally qualified health centers, rural health centers, free clinics, local health departments, State Veteran’s Homes, and any other Providers as designated by the Department in accordance with N.C. Gen. Stat. § 108D-22(b).
84. **Excluded Person:** A person or corporate entity who appears on one or more of the Exclusion Lists.
85. **Exclusion List:** Lists the BH I/DD Tailored Plan must check to determine the exclusion status of all providers and ensure that the BH I/DD Tailored Plan does not pay federal funds to excluded persons or entities, including:
 - a. State Exclusion List;
 - b. U.S. Department of Health and Human Services, Office of Inspector General’s (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
 - c. The System of Award Management (SAM);
 - d. The Social Security Administration Death Master File (SSADMF);
 - e. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
 - f. Office of Foreign Assets Control (OFAC).
86. **Exempt Population:** Beneficiaries in Exempt Populations may voluntarily enroll in Medicaid Managed Care on an opt-in basis, if they meet other eligibility requirements for being enrolled in Medicaid Managed Care. Members of Exempt Populations are allowed to opt into Medicaid Managed Care or into NC Medicaid Direct at any time, upon request to the Enrollment Broker.
87. **Facility:** Has the same meaning as Facility in N.C. Gen. Stat. §122C—3(14).
88. **First Episode Psychosis (FEP) Programs:** Evidence-based treatment programs that address the needs of individuals ages 15-30 with early onset of serious mental illness, including psychotic disorders, utilizing the Coordinated Specialty Care (CSC) model.
89. **Fee-for-Service:** A payment model in which Providers are paid for each service provided. NC Medicaid and NC Health Choice’s Fee-for-Service program is also known as NC Medicaid Direct.
90. **Foster Care:** Has the same meaning as Foster Care as defined in N.C. Gen. Stat. § 131D-10.2(9).
91. **Grantee:** The State government entity (i.e., DHHS, DMH/DD/SAS) to which a federal grant is awarded and which is responsible and accountable for the use of the funds provided and for the performance of the grant-supported project or activity.
92. **Grievance:** As it relates to a Member, has the same meaning as Grievance as defined in 42 C.F.R. § 438.400(b).
93. **Hardship Payment:** An advanced payment from the BH I/DD Tailored Plan to a provider, the provision and amount of which are in the BH I/DD Tailored Plan’s sole discretion, to address a

situation in which the provider is experiencing a significant drop in BH I/DD Tailored Plan claims payments due to issues beyond the control of the provider, and which advance the BH I/DD Tailored Plan shall recoup by offset or repayment.

94. **Health Home:** A designated provider (including a Provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services pursuant to Section 1945 of the Social Security Act. In North Carolina’s Medicaid Managed Care program, the BH I/DD Tailored Plans will serve as the Health Homes, with approval of the federal Centers for Medicare & Medicaid Services (CMS).
95. **Health Insurance:** A contract that requires a health insurer to pay some or all of a defined beneficiary’s health care costs, sometimes in exchange for a premium.
96. **Healthy Opportunities Pilot Program (the Pilot program):** The Enhanced Case Management and Other Services Pilot Program authorized by North Carolina’s 1115 Demonstration waiver, referred to as the “Healthy Opportunities Pilot Program.” The Pilot program will evaluate the effectiveness of a set of select, evidence-based, non-medical interventions and the role of the Lead Pilot Entity on improving health outcomes and reducing healthcare costs for high-need Medicaid Members. The Healthy Opportunities Pilot Program refers to the overall Pilot program, which will encompass at least two and up to three Local Pilots
97. **Historically Marginalized Populations:** Individuals, groups, and communities that have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression. Longstanding and well documented structural marginalization has resulted in poor health outcomes, economic disadvantage, and increased vulnerability to harm and adverse social, political and economic outcomes. Historically Marginalized Populations are often identified based on their race, ethnicity, social economic status, geography, religion, language, sexual identity and disability status.
98. **Human Services Organization (HSO):** An organization that offers non-medical services to address unmet health related resource needs within one or more communities. HSOs are also known as community-based organizations or social service agencies.
99. **Implementation Plan:** Comprehensive schedule of events, tasks, deliverables, and milestones developed and executed by the BH I/DD Tailored Plan to ensure successful implementation and launch of BH I/DD Tailored Plan services.
100. **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.
101. **In-Reach:** The process of identifying individuals residing in an institutional setting or an adult care home whose service needs could potentially be met in a home or community-based setting, engaging them about their desire to transition to a home or community-based setting and referring them for transition, if appropriate.
102. **Indian Health Care Provider (IHCP):** Means an IHCP as defined by 42 C.F.R. § 438.14(a).
103. **Individual Support Plan (ISP):** A written individualized person-centered plan of care for Members with I/DD and TBI needs, including Innovations waiver and TBI waiver enrollees, that is developed using a collaborative approach led by the Member/recipient or their guardian when appropriate, incorporates the results of the care management comprehensive assessment, and identifies the Member’s/Recipient’s desired outcomes and the training, therapies, services, strategies, and formal

and informal supports needed for the Member to achieve those outcomes. For individuals enrolled in the Innovations or TBI waiver, the ISP also documents the waiver services that a Member is authorized to obtain.

104. **Innovations Waiver:** The Section 1915(c) Home and Community-Based Services (HCBS) waiver for individuals with I/DD who meet Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IDD) level of care criteria that the BH I/DD Tailored Plan operates in the geographic area covered by this Contract.
105. **Institution for Mental Disease (IMD):** Has the same meaning as IMD as defined in 42 C.F.R. § 435.1010.
106. **Interactive Purchasing System (IPS):** The State of North Carolina’s electronic system for advertising solicitations and publishing award notifications, where vendors can view and search for procurement opportunities, which can be found at the following link, accurate as of August 9, 2022: www.ips.state.nc.us.
107. **Interest:** For the purposes of claim payment or encounter submission, an amount from a BH I/DD Tailored Plan that is due to a Participating Provider for failing to timely or correctly pay a Clean Claim.
108. **Into the Mouth of Babes (IMB):** A clinical program that trains medical providers to deliver preventive oral health services to young children enrolled in North Carolina Medicaid. Services are provided from the time of tooth eruption until age 3½ (42 months), including oral evaluation and risk assessment, parent/caregiver counseling, fluoride varnish application, and referral to a dental home.
109. **Lead Pilot Entity:** The Department will procure a Lead Pilot Entity per Healthy Opportunities Pilot program region as described in *Section V.B.3.xi. Healthy Opportunities*. The Lead Pilot Entity’s role includes contracting with BH I/DD Tailored Plans to manage a network of Human Service Organizations providing Pilot services to Pilot program participants
110. **Limited English Proficient (LEP):** Has the same meaning as LEP as defined in 42 C.F.R. § 438.10(a).
111. **Limited Medicaid Managed Care:** Medicaid Managed Care for delivery of Medicaid-covered BH, I/DD, and TBI benefits only; other Medicaid-covered benefits are delivered through NC Medicaid Direct.
112. **Local Management Entity/Managed Care Organization (LME/MCO):** Has the same meaning as LME/MCO as defined in N.C. Gen. Stat. § 122C-3(20c).
113. **Long Term Service and Supports (LTSS):** LTSS includes:
 - a. Care provided in the home, in community-based settings, or in facilities;
 - b. Care for older adults and people with disabilities who need support because of age, physical, cognitive, developmental, or chronic health conditions; or other functional limitations that restrict their abilities to care for themselves; and
 - c. A wide range of services to help people live more independently by assisting with personal health care needs and activities of daily living such as:
 - i. Eating;
 - ii. Taking baths;
 - iii. Managing medications;
 - iv. Grooming;
 - v. Walking;
 - vi. Getting up and down from a seated position;
 - vii. Using the toilet;
 - viii. Cooking;
 - ix. Driving;

- x. Getting dressed; or
 - xi. Managing money.
 - d. Care management provided to individuals who, because of age, physical, cognitive, developmental or chronic health conditions or other functional limitations, are at risk of requiring formal LTSS services to remain in their communities.
114. **Maintenance of Effort (MOE):** Federal requirement that grant recipients maintain non-federal funding for activities described in their application at a level which is not less than expenditures for such activities during the fiscal year prior to receiving the grant or cooperative agreement to be eligible for full participation in federal grant funding. Public Health Service Act, Section 797(b).
 115. **Managed Care Organization (MCO):** Has the same meaning as MCO as defined in 42 C.F.R. § 438.2. Both Standard Plans and BH I/DD Tailored Plans are operated by MCOs.
 116. **Managing Employee:** Has the same meaning as Managing Employee as defined in 42 C.F.R. § 455.101. Managing Employees includes the Key Personnel required under the Contract and the Contractor’s governing board.
 117. **Mandatory Populations:** Medicaid beneficiaries who are required to enroll in Medicaid Managed Care with no option to enroll in Medicaid Direct.
 118. **Marketing:** Has the same meaning as Marketing as defined in 42 CFR 438.104(a).
 119. **Marketing Materials:** Has the same meaning as Marketing Materials as defined in 42 CFR 438.104(a).
 120. **Medicaid Direct:** Refers to the Medicaid Fee-For-Service program serving Beneficiaries who are not enrolled in a Prepaid Health Plan (PHP) or the EBCI Tribal Option.
 121. **Medicaid Direct Prepaid Inpatient Health Plan:** Refers to the benefit plan operated by a PIHP under contract with the Department, as recognized as contract number 30-2022-007-DHB.
 122. **Medicaid Enterprise System (MES):** The aggregation of technologies and applications required to operate a State Medicaid Agency (SMA).
 123. **Medicaid Managed Care (MMC):** North Carolina’s program under which contracted Managed Care Organizations arrange for integrated medical, physical, pharmacy, behavioral and other services to be delivered to Medicaid and NC Health Choice enrollees. Medicaid Managed Care will include three types of plans: (1) Standard Plans, (2) BH I/DD Tailored Plans, and (3) Statewide Foster Care Plan. The use of Medicaid Managed Care is also inclusive of EBCI Tribal Option, operating as a primary care case management entity (PCCMe).
 124. **Medicaid Managed Care Quality Rating System:** A system utilizing a rating scale designed to increase transparency and accountability for the quality of services provided by North Carolina’s health plans within Medicaid Managed Care.
 125. **Medical Claim:** A request for a payment that a healthcare provider submits to an insurer for rendered medical services.
 126. **Medical Encounter:** a record of a rendered service provided by a healthcare provider for medical services.
 127. **Medical Home Fees:** Non-visit based payments to AMH practices made in addition to fee for service payments, providing stable funding for primary care access and quality improvement at the practice level.

128. **Medically Necessary:** Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.
129. **Member and Recipient Service Line:** A service line available to both Members and Recipients for the purposes of providing convenient access to information about benefits or claims, referral assistance and access to treatment or services.
130. **Members:** Medicaid and NC Health Choice Beneficiaries specifically enrolled in and receiving benefits through the BH I/DD Tailored.
131. **National Correct Coding Initiative (NCCI):** The CMS-developed coding policies based on coding conventions defined in the American Medical Association’s Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
132. **National Provider Identifier (NPI):** Standard unique health identifier for health care Providers adopted by the Secretary of US Department of Health and Human Services in accordance with HIPAA.
133. **National Quality Forum:** A not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in healthcare.
134. **Natural Supports:** Relationships with people that include coworkers, classmates, activity individuals, neighbors, family and others. These relationships are typically developed in the community through associations in schools, the workplace and participation in clubs, organizations and community activities
135. **NCCARE360:** An electronic platform providing: (a) a robust statewide resource repository of community-based organizations and social service agencies and the services they provide, and (b) a referral platform for payers, care managers, clinicians, community health workers, social service agencies, and others to refer and connect Members directly to community resources and track the connections and outcomes through “Closed Loop Referral” capacity. The platform is being deployed as part of a public-private partnership with the Foundation for Health Leadership and Innovation.
136. **NCCI Edits:** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) medically unlikely edits, or units-of service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
137. **NCCI Methodologies:** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
138. **NCTracks:** The Department’s multi-payer Medicaid Management Information System (MMIS). NCTracks adjudicates claims for multiple NC DHHS divisions, including DHB, DMH/DD/SAS, Division of Public Health, and Office of Rural Health. NCTracks also serves as a central repository for Medicaid, NC Health Choice and State-funded Services Provider, Member and Recipient data.
139. **Network:** A group of Providers, including, without limitation, doctors, hospitals, pharmacies, and others contracted by the BH I/DD Tailored Plan to provide health care services to its Medicaid Managed Care members or State-funded Services recipients.

140. **Non-Participating Provider:** Non-participating or “non-par” Providers are physicians or other health care Providers that have not entered into a contractual agreement with the BH I/DD Tailored Plan and are not part of the BH I/DD Tailored Plan’s Network, unlike participating Providers. They may also be called out-of-network providers. Non-participating providers do not include any licensed practitioner or other healthcare provider employed by and delivering services to Members through the Participating Provider.
141. **Non-public Medicaid NCCI Edit Files:** The quarterly Medicaid NCCI Edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure Regional Information Sharing Systems (RISSNET) portal.
142. **Non-Unit Cost Reimbursement (Non-UCR) Expenditure:** Unique service or innovative project expenditures that cannot be reported through UCR/claims methodology. Non-UCR Expenditures are for State-funded Services only.
143. **North Carolina Controlled Substances Reporting System (CSRS):** The Department’s database for collecting information on dispensed controlled substance prescriptions. The system is used as a clinical tool to improve patient care and safety while avoiding potential drug interactions and identifying individuals that may be in need of referral to substance use disorder services.
144. **North Carolina Families Accessing Services through Technology (NC FAST):** The Department’s integrated case management system that provides eligibility and enrollment for Medicaid, NC Health Choice, Food and Nutrition Services, WorkFirst, Child Care, Special Assistance, Crisis Intervention Program, Low-Income Energy Assistance Program, and Refugee Assistance, and provides services for Child Welfare and Aging and Adult Services.
145. **North Carolina Health Choice (NC Health Choice):** The NC Health Choice Health Insurance Program for Low Income Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children and authorized under Social Security Act Title XXI.
146. **North Carolina Healthcare Enterprise Accounts Receivable Tracking System (HEARTS):** The primary Admission, Discharge and Transfer (ADT) and billing system used by the State’s Alcohol and Drug Abuse Treatment Centers (ADATC) and other facilities owned and/or operated by s the NC Division of State-Operated Healthcare Facilities (DSOHF).
147. **North Carolina Identity Service (NCID):** The State’s centralized Identity and access management platform provided by the Department of Information Technology. NCID is a web-based application that provides a secure environment for state agency, local government, business and individual users to log in and gain access to real-time resources, such as customer-based applications and information retrieval, which can be found at the following link, accurate as of August 9, 2022: <https://www.ncid.nc.gov>.
148. **North Carolina Immunization Registry (NCIR):** The Department’s secure, web-based clinical tool which is the official source for North Carolina immunization information.
149. **North Carolina Residency:** An established official residence within the state of North Carolina. For the purpose of this Contract and as it relates to Contractor personnel, the NC residency requirement under the Contract is satisfied if the Contractor's personnel lives no more than forty (40) miles from the North Carolina border.
150. **North Carolina Support Needs Assessment Profile (NC-SNAP):** A needs assessment tool that measures an individual’s level of intensity of need for intellectual and developmental disabilities supports and services.

151. **Nurse Line:** A service line available twenty-four (24) hours a day, seven (7) days a week, every day of the year to Members which provides medical information and advice on where to access care.
152. **Objective Quality Standard:** Means the objective standards that the Department applies during the Provider Enrollment process.
153. **Ombudsman Program:** A Department program to provide education, advocacy, and issue resolution for Medicaid Beneficiaries whether they are in the Medicaid Managed Care program or NC Medicaid Direct. This program is separate and distinct from the Long-Term Care Ombudsman Program.
154. **Ongoing Course of Treatment:** As defined in 42 C.F.R. § 438.62(b), when a member, in the absence of continued services, would suffer significant detriment to their health or be at risk of hospitalization or institutionalization.
155. **Ongoing Special Condition:** Has the same meaning as ongoing special condition defined in N.C. Gen. Stat. § 58-67-88(a)(1).
156. **Outpatient Commitment:** Occurs pursuant to N.C.G.S. § 122C, Article 5, Part 7, when a judge orders a person to receive treatment in the community for their BH condition. Before ordering Outpatient Commitment, the outpatient Provider must agree to accept the patient into treatment and serve as the responsible party for the management and supervision of the Outpatient Commitment order.
157. **Participating Provider:** Participating Provider or "par" Providers are physicians or other health care providers that have a contractual agreement with the BH I/DD Tailored Plan and are included in the BH I/DD Tailored Plan's Network. Participating Providers may also be called "in-network providers".
158. **Performance Incentive Payments:** Payments additional to fee for service, Tailored Care Management payments, and any medical home fees that are contingent upon AMH Practices, AMH+ Practices, or CMAs' reporting of and/or performance against Performance Metrics.
159. **Permanent Supportive Housing (PSH):** A program that has the same meaning as "permanent supportive housing" in 24 C.F.R. § 578.3 and offers safe and stable housing environments with voluntary and flexible supports and services to help people manage serious, chronic issues such as mental and substance use disorders. PSH is based on the following principles: 1) Choice in housing; 2) No prerequisite for housing placement; 3) Functional separation of housing and services; 4) Decent, safe, and affordable housing; 5) Housing is integrated into the community; 6) Rights of tenancy; 7) Housing access and privacy; and 8) Flexible, voluntary recovery-focused services. .
160. **Pharmacy Claim:** A request for payment that a healthcare provider submits to an insurer for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims) as well as physician-administered (professional claims) drug claims
161. **Pharmacy Encounter:** A record of a rendered service provided by a healthcare provider for pharmaceuticals or pharmacy services, including outpatient pharmacy as well as physician-administered drugs.
162. **Pharmacy Service Line:** A service line to assist pharmacies and prescribers participating in the Medicaid program with point of sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.
163. **PHP Contract Data Utility (PCDU):** A secure file transfer platform to allow for posting of Department guidance to the BH I/DD Tailored Plans and submission of key contract deliverable and reports by the BH I/DD Tailored Plans for review and approval by the Department.

164. **Post-stabilization Care Services:** Has the same meaning as post-stabilization care services as defined in 42 C.F.R. § 438.114(a).
165. **Protected Health Information (PHI):** Has the same meaning as PHI as defined by 45 C.F.R. § 160.103.
166. **Potential Member:** A beneficiary enrolled in Medicaid and eligible for enrollment in a BH I/DD Tailored Plan, but not enrolled in that BH I/DD Tailored Plan.
167. **Pregnancy Management Program:** A care program that encourages adoption of best prenatal, pregnancy, and perinatal care for Medicaid Managed Care members.
168. **Prepaid Health Plan (PHP):** Has the same meaning as Prepaid Health Plan, as defined in N.C. Gen. Stat. § 108D-1(30). A PHP is an MCO. A PHP may operate a Standard Plan or a BH/IDD Tailored Plan.
169. **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 all the Member's health care needs and to initiate and monitor referrals for specialized services, when required.
170. **Program of All-Inclusive Care for the Elderly (PACE):** A federal program that provides a capitated benefit for individuals age fifty-five (55) and older who meet nursing facility level of care. PACE features a comprehensive service delivery system and integrated Medicare and Medicaid financing.
171. **Provider:** Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. (42 C.F.R. § 438.2).
172. **Provider (For the purposes of credentialing):** Individual practitioners and facilities, hospitals, health systems, entities, organizations, atypical organizations/providers, and institutions, unless otherwise noted.
173. **Provider-based Care Management:** Care management where the care manager is affiliated with an AMH+ practice or CMA and performs care management at the site of care, in the home, or in the community through in-person and other methods of interaction between Members and Providers.
174. **Provider Contracting:** The process by which the BH I/DD Tailored Plan negotiates and secures a contractual agreement with credentialed Providers that will be included in the BH I/DD Tailored Plan's Network, or with out-of-network providers.
175. **Provider Enrollment:** The process by which a Provider is enrolled in the North Carolina's Medicaid, NC Health Choice, or State-funded Services programs with credentialing as a component of enrollment. A Provider who has enrolled in North Carolina's Medicaid or NC Health Choice programs (or both) shall be referred to as a "Medicaid Enrolled provider" or an "Enrolled Medicaid provider." A provider who has enrolled in North Carolina's State-funded Services program shall be referred to as a "State-funded Services Enrolled provider" or an "Enrolled State-funded Services provider."
176. **Provider Grievance:** Any oral or written complaint or dispute by a Provider over any aspects of the operations, activities, or behavior of the BH I/DD Tailored Plan except for any dispute over for which the Provider or related Member has appeal rights.
177. **Provider Support Service Line:** A service line available to Medicaid and State-funded Services Providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries and complaints.
178. **Qualified Health Plan (QHP):** Means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of Title 45 of the Code of Federal Regulations issued or

recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 of Title 45 of the Code of Federal Regulations. 45 C.F.R. § 155.20.

179. **Qualified Interpreter:** Has the same meaning as described in 45 C.F.R. § 92.4.
180. **Readily Accessible:** Has the same meaning as defined in 42 C.F.R. § 438.10(a).
181. **Readiness Review:** Has the same meaning as described in 42 C.F.R. § 438.66(d).
182. **Reasonable Accommodation:** A reasonable accommodation is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with disabilities to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces, or to fulfill their program obligations.
183. **Receiving Entity:** The entity (e.g., BH I/DD Tailored Plan, Standard Plan, NC Medicaid Direct) that is enrolling the transitioning Member and receiving the Member's information.
184. **Recipient:** an individual who is actively receiving a State-funded Service or State-funded function (e.g., care management or diversion).
185. **Redeterminations:** The annual review of Beneficiaries' income, assets and other information by the Department and county DSS offices to confirm eligibility for North Carolina Medicaid and NC Health Choice.
186. **Region:** The group of counties for which a BH I/DD Tailored Plan arranges for services. Also referred to as Catchment Areas.
187. **Remote Patient Monitoring:** Remote patient monitoring is the use of digital devices to measure and transmit personal health information from a patient in one location to a provider in a different location. Remote patient monitoring enables Providers to collect and analyze information such as vital signs (e.g., blood pressure, heart rate, weight, blood oxygen levels) in order to make treatment recommendations.
188. **Reprocess:** For the purposes of Claims and Encounters, the activities completed by a BH I/DD Tailored Plan to reconsider the outcome of a previously adjudicated claim.
189. **Security Assertion Markup Language (SAML):** The State's preferred standard for the implementation of identity and access management.
190. **Service Organization Control:** reports on various organizational controls related to security, availability, processing integrity, confidentiality or privacy.
191. **Settlement Agreement:** Means the court-enforceable Settlement Agreement between the United States and the State of North Carolina files with the Court on August 23, 2012 and modified in October 2017 and which created the Transitions to Community Living (TCL) program.
192. **Shadow Claim:** Refers to the claims record against non-Medicaid funds.
193. **Significant Change:** Means any change in the services offered by BH I/DD Tailored Plans, the benefits covered under the Contract, the geographic service area, and the composition of or payments to the BH I/DD Tailored Plan's network, and the enrollment of a new population in the BH I/DD Tailored Plan.
194. **Single-Stream Funding:** State-funding that is authorized by the General Assembly and disbursed to the LME/MCOs and subsequently the BH I/DD Tailored Plans to pay for State-funded BH, I/DD, and TBI services.

195. **Special Categorical State-Funds:** State-funds dedicated to members of a category defined by statute, grants, or legislation.
196. **Standard Plan or Standard Benefit Plan:** Has the same meaning as Standard Plan as defined in N.C. Gen. Stat. § 108D-1(36).
197. **State:** The State of North Carolina, the Department as an agency or in its capacity as the Using Agency.
198. **State Developmental Center:** State-operated certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) that provides residential, medical, habilitation, and other supports to individuals with intellectual and developmental disabilities who have complex behavioral challenges and/or medical conditions and for whom appropriate community-based services are not available.
199. **State Fair Hearing:** The hearing conducted at the Office of Administrative Hearings (OAH) under N.C. Gen. Stat. § 108D-15 to resolve a dispute between a Member and a BH I/DD Tailored Plan about an Adverse Benefit Determination.
200. **State-Fund Balance:** Comprised of any state-funds allocated by DMH/DD/SAS that were not expended in prior fiscal years.
201. **State-funded Services:** Refers to state and non-Medicaid federally funded services for mental health, I/DD, TBI and substance abuse.
202. **State Developmental Center:** State-operated certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) that provides residential, medical, habilitation, and other supports to individuals with intellectual and developmental disabilities who have complex behavioral challenges and/or medical conditions and for whom appropriate community-based services are not available.
203. **Subcontractor:** An entity having an arrangement with the BH I/DD Tailored Plan, where the BH I/DD Tailored Plan uses the products and/or services of that entity to fulfill some of its obligations under the Contract. Use of a Subcontractor does not create a contractual relationship between the Subcontractor and the Department, only the Contractor. Network providers are not considered Subcontractors for the Contract.
204. **Subgrantee:** The BH I/DD Tailored Plan or other legal entity to which a sub-grant is awarded or sub award is made and which is accountable to the grantee for the use of the funds provided. The terms sub grant/subgrantee and sub award/sub recipient are used interchangeably in practice.
205. **Substance Abuse Prevention and Treatment Block Grant (SAPTBG):** SAMHSA grant disbursed annually to North Carolina to provide for planning, implementing and evaluating activities that prevent and treat substance abuse and promote public health.
206. **Supplemental Evaluation Questions:** The additional questions included at *Section VIII.17. Supplemental Evaluation Questions for Empty Region(s)* that the Department will use to help select an Applicant to fill an Empty Region, if any. The Department will request responses to the Supplemental Evaluation Questions from all eligible Applicants in the event of an Empty Region.
207. **Supports Intensity Scale (SIS)[®]:** An assessment tool designed to measure the level of practical supports required by individuals with I/DD.
208. **Tailored Care Management:** The care management model for BH I/DD Tailored Plan members.
209. **Tailored Care Management Payments:** Per member per month, acuity-tiered payments made to AMH+ practices, Care Management Agencies (CMAs), and BH I/DD Tailored Plans for the provision

of Tailored Care Management. Tailored Care Management Payments will be subject to rates set by DHHS, which shall not be placed at risk.

210. **Telehealth:** Telehealth is the use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.
211. **Transitions of Care:** The process of assisting a Member to transition between BH I/DD Tailored Plans; from Standard Plans to BH I/DD Tailored Plans; between delivery systems; including transitions that result in the disenrollment from managed care. Transitions of care also includes the process of assisting a member to transition between providers upon a provider's termination from the BH I/DD Tailored Plan network.
212. **Transferring Entity:** The entity (e.g., BH I/DD Tailored Plan, Standard Plan, Medicaid Direct) that is disenrolling the transitioning Member and transferring the Member's information.
213. **Transition Entity:** Department-designated entity responsible for coordinating transition of care activities and supporting members through the transition between service delivery systems. Transition entities include BH I/DD Tailored Plans, other Tailored Plans, CCNC, Tribal Option and other designated entities.
214. **Transition Notice Date:** The date a transitioning member's anticipated enrollment change is reflected on the Tailored Plan's eligibility file.
215. **Traumatic Brain Injury Waiver (TBI Waiver):** The Section 1915(c) Home and Community-Based Services (HCBS) waiver for eligible individuals with traumatic brain injury (TBI) that the BH I/DD Tailored Plan operates in the geographic area covered by this Contract. The TBI Waiver may not operate in all geographic areas of the state. Contract requirements for the TBI Waiver apply for the BH I/DD Tailored Plan to the extent that the TBI Waiver is operational in its geographic area. <https://files.nc.gov/ncdma/documents/Approved-TBI-Waiver.pdf>
216. **Unit Cost Reimbursement (UCR):** An expenditure paid in support of services that are not supported with an approved shadow claim and are not disallowed per federal guidelines. Unit Cost Reimbursement is for State-funded Services only.
217. **Unmet Health-Related Resource Needs:** Non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, transportation and addressing interpersonal violence/toxic stress.
218. **Value-Added Services:** Services in addition to those covered under the Medicaid Managed Care benefit plan that are delivered at the BH I/DD Tailored 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.
219. **Value-Based Payment (VBP):** Payment arrangements between BH I/DD Tailored Plans and Providers that fall within Levels 2 and 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework.
220. **Vendor:** A company, firm, entity or individual, other than the Contractor, with whom the Department has contracted for goods or services.
221. **Video Remote Interpreting:** Has the same meaning as described in 28 C.F.R. § 35.104.
222. **Virtual Patient Communication:** The use of technologies other than video to enable remote evaluation and consultation support between a provider and a patient or a provider and another provider. Virtual patient communication services include: telephone conversations (audio only); virtual portal communications (e.g., secure messaging); and store and forward (e.g., transfer of data

from beneficiary using a camera or similar device that records (stores) an image that is sent by telecommunication to another site for consultation).

223. **Warm Handoff:** Time-sensitive, member-specific planning for Care-Managed members or other members identified by either the transferring or receiving entity to ensure continuity of service and care management functions. “Warm Handoffs” require collaborative transition planning between both transferring and receiving entities and, when possible, occur prior to the transition.
224. **Warm Transfer:** Occurs when a call from a Beneficiary, Member, or Provider is transferred directly from the original call center to the appropriate party during business hours without requiring the caller to make an additional call and without the BH I/DD Tailored Plan abandoning the call until the other party answers.
225. **Work First:** North Carolina’s Temporary Assistance for Needy Families (TANF) program that provides parents with short-term training and other services to help them become employed and move toward self-sufficiency.
226. **X12 Transactions:** Any EDI transaction included in the x12.org standard. This includes but is not limited to the 834 Benefit Enrollment and Maintenance, the 837 Health Care Claim, and the 277 Health Care Information Status Notification. The entire transaction set can be found at <http://www.x12.org>.

B. Abbreviations and Acronyms

1. AAP: American Academy of Pediatrics
2. ACD: Automated Call Distribution System
3. ACA: Patient Protection and Affordable Care Act
4. ACE: Adverse Childhood Experience
5. ACH: Adult Care Home
6. ADATC: Alcohol and Drug Abuse Treatment Center
7. ADL: Activities of Daily Living
8. ADT: Admission, Discharge, Transfer
9. AMH: Advanced Medical Home
10. AMH+: Advanced Medical Home Plus
11. API: Administrative Provider Identification
12. APM: Alternative Payment Method
13. ASAM: American Society for Addiction Medicine
14. ASC: Accredited Standards Committee
15. AVRS: Automated Voice Response System
16. AWOL: Absence Without Leave
17. BAA: Business Associate Agreement
18. BAHA: Bone Conduction Hearing Aids
19. BCCCP: Breast and Cervical Cancer Control Program
20. BH: Behavioral Health
21. BIP: Behavioral Intervention Plan
22. CAH: Critical Access Hospital
23. CAHPS: Consumer Assessment of Healthcare Providers and Systems Plan Survey
24. CANS: Children and Adolescents Needs and Strengths
25. CAP: Corrective Action Plan
26. CAP/C: Community Alternatives Program for Children
27. CAP/DA: Community Alternatives Program for Disabled Adults
28. CASP: Cross Area Service Program

29. CBO: Community-Based Organization
30. CCNC: Community Care of North Carolina
31. CCO: Chief Compliance Officer
32. CDC: Centers for Disease Control
33. CDSA: Children's Developmental Services Agency
34. CEO: Chief Executive Officer
35. CFAC: Consumer and Family Advisory Committee
36. CFO: Chief Financial Officer
37. CFT: Child and Family Team
38. CHIP: Children's Health Insurance Program
39. CIN: Clinically Integrated Network.
40. CIO: Chief Information Officer
41. CIP: Community Integration Plan
42. CM: Care Management
43. CMA: Care Management Agency
44. CMC: Children with Medical Complexity
45. CMO: Chief Medical Officer
46. CMP: Civil Monetary Penalty
47. CMS: Centers for Medicare & Medicaid Services
48. COD: Cost of Dispensing
49. CP: Commercial Plan
50. CPT: Current Procedural Terminology
51. CVO: Credentialing Verification Organization
52. DAAS: Division of Aging and Adult Services
53. DHB: Division of Health Benefits
54. DHHS: Department of Health and Human Services
55. DHSR: Division of Health Service Regulation
56. DID: Direct Inward Dialing
57. DIT: Department of Information Technology
58. DME: Durable Medical Equipment
59. DMH/DD/SAS: Division of Mental Health, Developmental Disabilities and Substance Abuse Services
60. DMVA: Department of Military and Veterans Affairs
61. DOI: Department of Insurance
62. DOS: Date of Service
63. DSOHF: Division of State Operated Healthcare Facilities
64. DSS: Division of Social Services
65. DUR: Drug Utilization Review
66. EB: Enrollment Broker
67. EBCI: Eastern Band of Cherokee Indians
68. ECSII: Early Childhood Services Intensity Instrument
69. EDI: Electronic Data Interchange
70. EFT: Electronic Funds Transfer
71. EHR: Electronic Health Record
72. EPS: Episodic Payment System
73. EPSDT: Early and Periodic Screening, Diagnostic and Treatment
74. EQRO: External Quality Review Organization
75. ESRD: End Stage Renal Disease
76. EUP: End User Procedures
77. EVV: Electronic Visit Verification

78. FAR: Federal Acquisition Regulation
79. FDA: Food and Drug Administration
80. FEP: First Episode Psychosis
81. FFS: Fee-for-Service
82. FFY: Federal Fiscal Year
83. FQHC: Federally Qualified Health Center
84. HCPCS: Healthcare Common Procedure Coding System
85. HEARTS: Healthcare Enterprise Accounts Receivable Tracking System
86. HHS: U.S. Department of Health and Human Services
87. HIE: Health Information Exchange
88. HIPAA: Health Insurance Portability and Accountability Act
89. HIPP: Health Insurance Premium Payment
90. HIT: Health Information Technology
91. HITECH: Health Information Technology for Economic and Clinical Health Act
92. HIV: Human Immunodeficiency Virus
93. HRSA: Health Resources and Services Administration
94. HSO: Human Service Organizations
95. I/DD: Intellectual/Developmental Disability
96. ICF: Intermediate Care Facility
97. ICF-IID: Intermediate Care Facility for Individuals with Intellectual Disabilities
98. IDG: Interdisciplinary Group
99. IDM: Identity Management
100. IEM: Inborn Errors of Metabolism
101. IEP: Individualized Education Program
102. IFSP: Individual Family Service Plan
103. IHCP: Indian Health Care Provider
104. IHP: Individual Health Plan
105. ILOS: In Lieu of Services
106. IMB: Into the Mouth of Babies
107. IMCE: Indian Managed Care Entities
108. IMD: Institution for Mental Disease
109. IPA: Independent Practice Association
110. IPS: Interactive Purchasing System
111. IRF: Inpatient Rehabilitation Facility
112. IRS: Internal Revenue Service
113. ISP: Individual Support Plan
114. ITD: Information Technology Division (DHHS)
115. LAN: Learning and Action Network
116. LCMHC: Licensed Clinical Mental Health Counselor
117. LCSW: Licensed Clinical Social Worker
118. LEA: Local Education Agencies
119. LEIE: List of Excluded Individuals/Entities
120. LEP: Limited English Proficient
121. LGBTQ: Lesbian, Gay, Bisexual, Transgender, Questioning
122. LHD: Local Health Department
123. LP: Licensed Practitioners
124. LME/MCO: Local Management Entities/Managed Care Organizations
125. LMFT: Licensed Marriage and Family Therapist
126. LPA: Licensed Psychological Associate

127. LPE: Lead Pilot Entity
128. LPN: Licensed Practical Nurse
129. LTSS: Long Term Service and Supports
130. MAC: Maximum Allowable Cost
131. MAO: Medicare Advantage Organization
132. MCAC: Medical Care Advisory Committee
133. MCO: Managed Care Organization
134. MES: Medicaid Enterprise System
135. MHPAEA: Mental Health Parity and Addiction Equity Act
136. MID: North Carolina Attorney General's Medicaid Investigations Division
137. MIMS: Medicaid Integrated Modular Solution
138. MIS: Management Information Systems
139. MLR: Medical Loss Ratio
140. MME: Morphine Milligram Equivalent
141. MMIS: Medicaid Management Information Systems
142. MOA: Memorandum of Agreement
143. NADAC: National Average Drug Acquisition Cost
144. NC: North Carolina
145. NC FAST: North Carolina Families Accessing Services through Technology
146. NCAC: North Carolina Administrative Code
147. NCCI: National Correct Coding Initiative
148. NCDPH: North Carolina Division of Public Health
149. NCGA: North Carolina General Assembly
150. NCHC: North Carolina Health Choice
151. NCID: North Carolina Identity Management Service
152. NCIR: North Carolina Immunization Registry
153. NCPDP: National Council for Prescription Drug Programs
154. NCQA: National Committee for Quality Assurance
155. NDC: National Drug Code
156. NEMT: Non- Emergency Medical Transportation
157. NIEM: National Information Exchange Model
158. NPI: National Provider Identifier
159. NPPES: National Plan and Provider Enumeration System
160. NQF: National Quality Forum
161. OAH: Office of Administrative Hearings
162. OCR: Office of Civil Rights
163. OFAC: Office of Foreign Assets Control
164. OMB: Office of Management and Budget
165. PA: Prior Authorization
166. PACE: Program of All-Inclusive Care for the Elderly
167. PBM: Pharmacy Benefit Managers
168. PCDU: PHP Contract Data Utility
169. PCP: Primary Care Provider
170. PCS: Personal Care Services
171. PDL: Preferred Drug List
172. PDM: Provider Data Management
173. PDN: Private Duty Nursing
174. PDSA: Plan-Do-Study-Act
175. PHA: Public Housing Authorities

176. PHHS: Public Health and Human Services
177. PHI: Protected Health Information
178. PHP: Prepaid Health Plan
179. PI: Program Integrity
180. PIHP: Prepaid Inpatient Health Plans
181. PIP: Performance Improvement Program
182. PLE: Provider-Led Entity
183. PMPM: Per Member Per Month
184. PRC: Purchased/Referred Care
185. PRTF: Psychiatric Residential Treatment Facility
186. PSH: Permanent Supportive Housing
187. PSO: North Carolina Department of Health and Human Services Privacy and Security Office
188. PTA: Privacy Threshold Analysis
189. QAPI: Quality Assurance and Performance Improvement
190. QHP: Qualified Health Plan
191. REOMB: Recipient Explanation of Medical Benefit
192. RFA: Request for Application
193. RHC: Rural Health Clinic
194. RN: Registered Nurse
195. ROI: Return on Investment
196. SAM: System of Award Management
197. SAMHSA: Substance Abuse and Mental Health Services Administration
198. SAML: Security Assertion Markup Language
199. SBI: North Carolina State Bureau of Investigation
200. SBIRT: Screening, Brief Intervention, and Referral to Treatment
201. SED: Serious Emotional Disturbance
202. SFTP: Secure File Transfer Protocol
203. SID: System Integration Design
204. SIP: System Integration Plan
205. SIS: Supports Intensity Scale®
206. SIU: Special Investigations Unit
207. SLA: Service Level Agreements
208. SLPA: Speech/Language Pathology Assistant
209. SMA: State Medicaid Agency
210. SMAC: State Maximum Allowable Cost
211. SMI: Serious Mental Illness
212. SNF: Skilled Nursing Facility
213. SOC: Service Organization Control
214. SP: Standard Plan
215. SPH: State Psychiatric Hospital
216. SSA: Social Security Act
217. SSADMF: Social Security Administration Death Master File
218. SUD: Substance Use Disorder
219. SUPPORT: Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
220. TBI: Traumatic Brain Injury
221. TCLI: Transition to Community Living Initiative
222. TDD: Telecommunications Device for the Deaf
223. TP: Tailored Plan

- 224. TPA: Third Party Administrator
- 225. TPL: Third party liability
- 226. TTY: Text Telephone
- 227. UM: Utilization Management
- 228. VBP: Value-based payments
- 229. VEO: Visual Evoked Potential
- 230. VFC: Vaccines for Children
- 231. VRI: Video Remote Interpreting
- 232. WCA: Web Content Accessibility Guidelines
- 233. WHCRA: Women's Health and Cancer Rights Act of 1998
- 234. WIC: Women, Infants and Children

C. Contract Term and Service Commencement

- 1. The Contract Term will be from July 26, 2021 through December 1, 2026, and shall include an implementation period and Contract Years 1 through 5 as follows:

Contract Period	July 26, 2021 through June 30, 2026.
Implementation Period	July 26, 2021 through November 30, 2022
Contract Year 1	December 1, 2022 through June 30, 2023
Contract Year 2	July 1, 2023 through June 30, 2024
Contract Year 3	July 1, 2024 through June 30, 2025
Contract Year 4	July 1, 2025 through June 30, 2026
Contract Year 5	July 1, 2026 through December 1, 2026

D. General Terms and Conditions

1. **ACCESS TO PERSONS AND RECORDS:**

- a. Pursuant to N.C. Gen. Stat. §§ 147-64.7 and 143-49(9), the Department, the State Auditor, appropriate state or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with **Paragraph 37. RECORDS RETENTION** of this Section III.D. of this Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such changes or additions.
- b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C. Gen. Stat. § 147-64.7. Nothing in this Section is intended to limit or restrict the State Auditor's rights.
- c. This term shall survive termination or expiration of the Contract.

2. **ADVERTISING:** Contractor agrees not to use the existence of this Contract or the name of the Department or State of North Carolina as part of any commercial advertising or marketing of its products or services to prospective Members, excepted as permitted under this Contract. A Contractor may inquire whether the Department is willing to act as a reference by providing information directly to other prospective customers. The Department is under no obligation to serve as a reference. Notwithstanding the foregoing, Contractor may reference the existence of this Contract and the name of the Department or State of North Carolina in communications with other audiences for non-advertising or marketing purposes associated with implementation and performance of this Contract.

3. **AMENDMENTS:** This Contract may not be amended orally or by performance. This Contract may be amended only by written amendments executed by the Department and the Contractor.

4. **ASSIGNMENT:** Except as otherwise required by law or upon written approval of the Department, no assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted.

5. **AVAILABILITY OF FUNDS:** All payments to Contractor are expressly contingent upon and subject to the appropriation, allocation, and availability of funds to the Department for the purposes set forth in the Contract. If the Contract or any purchase order issued hereunder is funded in whole or in part by federal funds, the Department's performance and payment shall be subject to and contingent upon the continuing availability of said federal funds for the purposes of the Contract or purchase order. If the term of the Contract extends into fiscal years after that in which it is approved, such continuation of the Contract is expressly contingent upon the appropriation, allocation, and availability of funds by the N.C. General Assembly for the purposes set forth in this Contract. If funds to effect payment are not available, the Department will provide written notification to the Contractor and may terminate the Contract in accordance with **Paragraph 46** of this Section III. D. of this Contract, **TERMINATION**. If the Contract is terminated, the Contractor agrees to take back any affected deliverables and software not yet delivered under the Contract, terminate any Services supplied to the Department under the Contract, and relieve the Department of any further obligation thereof. The Department shall remit payment for deliverables and Services accepted prior to the date of the previously mentioned notice in conformance with the payment terms.

6. **BACKGROUND CHECKS:** The Department reserves the right to request a criminal background check on any current or prospective employee of Contractor or its Subcontractor. The Contractor is responsible for obtaining from each prospective Contractor employee or Subcontractor employee a signed statement permitting a criminal background check. Where requested by the Department, the Contractor must obtain (at their own expense) and provide the appropriate Departmental Contract Administrator with a North Carolina State Bureau of Investigation (SBI) and/or FBI background check on all new employees prior to assignment. Neither the Contractor nor its Subcontractor may hire an employee who has a criminal record that consists of a felony unless prior written approval is obtained from the appropriate Departmental Contract Administrator. The Contractor shall keep any records related to these verifications for the life of the Contract.
7. **BENEFICIARIES:** The Contract shall inure to the benefit and be binding upon the Parties and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of the Contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Department and Contractor. Nothing contained in this Contract shall give or allow any claim or right of action whatsoever by any third person. It is the express intention of the Department and Contractor that any such other person or entity receiving services or benefits under the Contract shall be deemed an incidental Beneficiary only and not a contractual third-party Beneficiary.
8. **CHANGE IN STRUCTURE:** In cases where Contractor(s) are involved in consolidations, acquisition or mergers, the Parties may negotiate agreements for the transfer of contractual obligations and the continuance of contracts within the framework of the new structure, subject to Department approval and the terms of this Contract.
9. **CMS APPROVAL:** This Contract and subsequent contracts and amendments are subject to approval by the CMS pursuant to 42 C.F.R. § 438.806(a).
10. **COMPLIANCE WITH LAWS:**
 - a. Contractor shall comply with all laws, ordinances, codes, rules, regulations, licensing requirements, electronic storage standards concerning privacy, data protection, confidentiality, and security that are applicable to the conduct of its business and performance in accordance with this Contract, including those of federal, State, NCDHHS, and local departments and agencies having jurisdiction and/or authority.
 - b. Contractor must include in its Subcontractor agreements an attestation clause that the Subcontractor must comply with all laws, rules, regulations, and licensing requirements applicable to Contractor's performance under this Contract, including but not limited to the applicable provisions of (a) Title XIX of the Social Security Act and Titles 42 and 45 of the Code of Federal Regulations; and (b) those laws, rules, or regulations of federal and State agencies having jurisdiction over the subject matter of this Contract, whether in effect when this Contract is signed, or becoming effective during the term of this Contract.
 - c. Clean Air Act
 - i. Contractor agrees to comply to the extent practicable with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. § 7401 et seq.
 - ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the Federal Emergency Management Agency, and the appropriate Environmental Protection Agency Regional Office.
 - iii. Contractor agrees to include these requirements in each Subcontractor Agreement.
 - d. Federal Water Pollution Control Act
 - i. Contractor agrees to comply to the extent practicable with all applicable standards, orders,

or regulations issued pursuant to the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq.

- ii. Contractor agrees to report each violation(s) to the Department and understands and agrees that the Department will, in turn, report each violation as required to assure notification to the federal agency providing funds hereunder, and the appropriate Environmental Protection Agency Regional Office.
 - iii. Contractor agrees that these requirements will be included in each Subcontractor Agreement.
- e. Pandemic, Endemic and Other North Carolina State Emergencies
- i. Contractor agrees to comply with all applicable standards, Executive Orders and Department issued guidance for pandemics, endemics, and other North Carolina State emergencies.
 - ii. Notice shall be provided by the Department of the standards, orders and Department issued guidance prior to the Effective Date of the requirements, where practical.
 - iii. In the event requirements are announced and made effective immediately, such as Executive Orders, the Contractor shall adhere to such requirements.
 - iv. Contractor agrees to communicate to Subcontractors for compliance with all applicable standards, orders, and Department-issued guidance.

11. CONTRACT ADMINISTRATORS: The Contract Administrators are the persons to whom notices provided for in this Contract shall be given, and to whom matters relating to the administration of this contract shall be addressed. Either party may change its administrator or his/her address and telephone number by written notice to the other party.

For the Department

Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick Associate Director, Managed Care Contracting
Address Physical Address	820 S. Boylan Avenue Raleigh, NC 27603
Address Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7015
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Contract Administrator regarding day to day activities herein:

Name & Title	Kelsi A. Knick Deputy Director of BH I/DD Tailored Plans
Physical Address	820 S. Boylan Avenue McBryde Building Raleigh, NC 27603
Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7031
Email Address	kelsi.knick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Department’s Federal, State and the Department Compliance Coordinator for all security matters:

Name & Title	Pyreddy Reddy, DHHS CISO
Address 1	695 Palmer Drive, Raleigh, NC 27603
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

Department’s HIPAA and Policy Coordinator for all Federal, State, and Department privacy matters:

Name & Title	Ryan Eppenberger, Privacy Officer
Physical Address	1985 Umstead Drive Raleigh, NC 27603
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7747
Email Address	Ryan.Eppenberger@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

12. COOPERATION WITH OTHER STATE VENDORS: Contractor shall cooperate with applicable Department Vendors that are providing goods or services to or on behalf of the Department in relation to Medicaid Managed Care, including those Vendors providing services with respect to managed care, transition of care, system integration, encounter processing, enrollment and eligibility, Ombudsman, data analytics, and those engaged by the Department to monitor, validate, or verify Contractor’s performance. Contractor will enter into trade agreements or other agreements as necessary to allow Vendor access to Contractor’s confidential information needed in performance of Vendor’s service for the Department.

13. COPYRIGHT: The State shall own all deliverables that the Contractor is required to develop pursuant to the Contract, except as provided herein. Contractor shall not acquire any right, title, and interest in and to the copyrights for goods, all software, technical information, specifications, drawings, records, documentation, data, or derivative works thereof, or other work products provided by the Contractor and provided to the State under this Contract. The State shall, upon payment for the deliverables in full in accordance with the payment terms of the Contract, own copyrighted works first originated and prepared by the Contractor for delivery to the State. The State hereby grants Contractor a royalty-free, fully paid worldwide, perpetual, nonexclusive, irrevocable license for the Contractor’s business use, to non-confidential deliverables first originated and prepared by the Contractor for delivery to the State. Contractor shall maintain ownership of all pre-existing intellectual property that it provides to the State as part of the deliverable(s), and the State shall have a royalty-free, fully paid, worldwide, perpetual, non-exclusive, irrevocable license in all languages to use such intellectual property solely for its operations. The intellectual property terms of this Contract do not: (i) affect Contractor’s, or one of its Subcontractor’s, ownership of all other intangible intellectual property (e.g., processes, ideas, know how) that Contractor has developed in the course of performance hereunder, (ii) prevent Contractor, or one of its Subcontractors, from selling similar services elsewhere, or (iii) prevent Contractor, or one of its Subcontractors, from marketing, licensing or selling any and all intellectual property it develops hereunder to other customers, Beneficiaries, Providers, or other persons, provided no State confidential information is used or disclosed in the process or (iv) affect any ownership right, title, and interest in and to the copyrights for goods, software, technical information, specifications, drawings,

records, documentation, data, or derivative works thereof, or other work products provided by a Subcontractor to Contractor for any such deliverable required hereunder.

- 14. CULTURAL AND LINGUISTIC COMPETENCY AND SENSITIVITY:** Contractor shall make a good faith effort to recruit, train, promote, and retain a culturally and linguistically diverse governance, leadership, and workforce, who are responsive to the population in the service area, or otherwise participate in the State's efforts to promote culturally competent care in accordance with applicable federal and State law and CMS guidelines.

To support the Department's vision on diversity, equity and inclusion, Contractor shall make a good faith effort to recruit, develop and retain a diverse workforce and encourage and promote an inclusive and equitable workplace, in accordance with Federal and State law.

- 15. DISCLOSURE OF CONFLICTS OF INTEREST:** The Contractor shall disclose any known Conflicts of Interest, or perceived Conflicts of Interest, at the time they arise, as follows:

- a. Disclose any relationship to any business or associate to whom the Contractor is currently doing business that creates or may give the appearance of a Conflict of Interest related to this Contract.
- b. By signing the Contract, the Contractor certifies that it shall not knowingly take any action or acquire any interest, either directly or indirectly, that will conflict in any manner or degree with the performance of its services during the term of the Contract.
- c. Disclose prior to employment or engagement by the Contractor, any firm principal, staff member or Subcontractor, known by the Contractor to have a Conflict of Interest or potential Conflict of Interest related to this Contract.
- d. All notices required by this subsection must be provided to the Department within thirty (30) Calendar Days of Contractor becoming aware of the conflict.

- 16. DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION:** The Contractor's failure to fully and timely comply with the terms of this Section, including providing reasonable assurances satisfactory to the State, may constitute a material breach of the Contract and result in Termination for Cause.

- a. The Contractor shall notify the State, if it, or any of its Subcontractors, or their officers, directors, or key personnel who may provide services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception. The Contractor shall promptly notify the State of any criminal litigation, investigations or proceeding involving the Contractor or any Subcontractor, or any of the forgoing entities' then current officers or directors during the term of the Contract or any Scope Statement awarded to the Contractor.
- b. The Contractor shall notify the State of any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its Subcontractors during the three (3) years preceding execution of this Contract, or which may occur during the Contract term that involve (1) services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any Subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any Subcontractor hereunder violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Contractor or Subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Contractor or Subcontractor.
- c. In the event the Contractor, or an officer or governing Board member of the Contractor, is convicted of a criminal offense incident to the performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following:

embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Contractor's business integrity, and such Contractor shall be prohibited from entering into a contract for goods or services with any department, institution, or agency of the State.

- d. The Contractor shall notify the State of any legal action that could adversely affect the BH I/DD Tailored Plan's financial conditions or ability to meet the requirements of the Contract.
- e. All notices under this Section subsections a., b., c., and d. herein shall be provided in writing to the State within thirty (30) Calendar Days after the Contractor learns about any such criminal, regulatory, or civil matters or financial circumstances or material change to prior disclosures, unless such matters are governed by the other stated terms and conditions annexed to the solicitation. Details of settlements which are prevented from disclosure by the terms of the settlement shall be annotated as such. Contractor may rely on good faith certifications of its Subcontractors addressing the foregoing, which certifications shall be available for inspection at the option of the State.

17. DISCLOSURE OF OWNERSHIP INTEREST: In accordance with 42 C.F.R. § 438.608(c)(2), the Contractor and its Subcontractors shall provide to the Department written disclosures of information on Ownership and control as required under 42 C.F.R. § 455.104. The Contractor and its Subcontractors must provide the following information, as applicable, regarding ownership and control as described in 42 C.F.R. § 455.104:

- a. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Contractor (or Subcontractor), including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's (or Subcontractor's) equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor (or Subcontractor) if that interest equals at least five percent (5%) of the value of the Contractor's (or Subcontractor's) assets, is an officer or director of a Contractor (or Subcontractor) organized as a corporation, or is a partner in a Contractor (or Subcontractor) organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. C.F.R. § 455.100-104);
- b. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Contractor (or Subcontractor), including those individuals who have direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's (or Subcontractor's) equity, owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor (or Subcontractor) if that interest equals at least five percent (5%) of the value of the Contractor's (or Subcontractor's) assets, is an officer or director of a Contractor (or Subcontractor) organized as a corporation, or is a partner in a Contractor (or Subcontractor) organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. §§ 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
- c. Whether the person (individual or corporation) with an ownership or control interest in the Contractor (or Subcontractor) is related to another person with ownership or control interest in the Contractor (or Subcontractor) as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any sub-contractor of the Contractor (or Subcontractor) in which the Applicant has a five percent (5%) or more interest is related to another person with ownership or control interest in the Contractor (or Subcontractor) as a spouse, parent, child, or sibling;

- d. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity as those terms are defined in 42 C.F.R. § 455.101 in which an owner of the Contractor (or Subcontractor) has an ownership or control interest; and
- e. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee of the Contractor (or Subcontractor). The Managing Employees of the Contractor include the Contractor's governing board and Key Personnel as noted in *Section V.A.1.ix. Staffing and Facilities for Medicaid and State-funded Services* Contractor and Subcontractors must disclose the information on individuals or corporations with an ownership or control interest as described above to the Department as follows:
 - i. With the BH I/DD Tailored Plan's response to the RFA (*Section VIII. Attachment 10. Disclosure of Ownership Interest*);
 - ii. Upon effective date of the Contract;
 - iii. Upon renewal or extension of the Contractor's contract; and
 - iv. Within thirty-five (35) days after any change in the Contractor's (or Subcontractor's) ownership.

- 18. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE:** This Contract consists of the following documents incorporated herein by reference:
- a. Any amendments executed by the Parties, in reverse chronological order;
 - b. Negotiation Document #1;
 - c. Written clarifications, in reverse chronological order;
 - d. Addenda to the RFA, in reverse chronological order;;
 - e. The RFA in its entirety; and
 - f. Applicant's application.

In the event of a conflict between the Contract documents, the document in the Contract with the highest precedence shall prevail. These documents constitute the entire agreement between the Parties and supersede all prior oral or written statements or agreements.

- 19. EQUAL EMPLOYMENT OPPORTUNITY:** Contractor shall comply with all federal and State requirements and North Carolina Executive Order 24 dated October 18, 2017, concerning fair employment and employment of the disabled, and concerning the treatment of all employees without regard to discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or veteran status, sexual orientation, gender identity or expression.
- 20. FORCE MAJEURE:** Neither Party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations because of events beyond its reasonable control, including without limitation, fire, power failures, any act of war, hostile foreign action, nuclear explosion, riot, strikes or failures or refusals to perform under subcontracts, civil insurrection, earthquake, hurricane, tornado, epidemic or public emergencies, pandemic, or other catastrophic natural event or act of God.
- 21. GENERAL INDEMNITY & LIMITATION OF LIABILITY:** Subject to any limitations of liability specified in the Contract, the Contractor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or intentionally tortious acts of the Contractor. The Contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of Contractor goods and/or

services to the State. The representations and warranties in the preceding sentences shall survive the termination or expiration of this Contract. The State, Department, and/or Office of the Attorney General shall have the option to participate at their own expense in the defence of such claim(s) or action(s) filed and the State shall be responsible for its own litigation expenses if it exercises this option.

22. GOVERNING LAWS: This Contract is made under and shall be governed, construed, and enforced in accordance with the laws of the State of North Carolina, without regard to its conflict of laws or rules. This term shall survive the termination or expiration of this Contract.

23. GOVERNMENTAL RESTRICTIONS:

- a. In the event any governmental restrictions are imposed which necessitate alteration of the material, quality, workmanship, or performance of the items or services offered prior to their delivery, it shall be the responsibility of the Contractor to notify, in writing, the issuing Department immediately, indicating the specific regulation which required such alterations. The Department reserves the right to accept any such alterations, including any price adjustments occasioned thereby, or to cancel the Contract.
- b. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part of the Contract after the effective date of the loss of program authority. The Department must adjust capitation rates to remove costs that are specific to any program or activity under the Contract that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the Department paid the Contractor in advance to work on a no-longer authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the Department. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the Department included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

24. HISTORICALLY UNDERUTILIZED BUSINESS (HUBs): Pursuant to N.C. Gen. Stat. § 143-48 and Executive Order 150 (1999), the Department invites and strongly encourages participation with businesses owned by minorities, women, disabled individuals, disabled business enterprises, and nonprofit work centers for the blind and severely disabled. Contractor agrees to make a good faith effort to seek out and pursue opportunities to utilize HUBs, as defined in N.C. Gen. Stat. 143-128.4, within the scope of services of this Contract, including via the use of Subcontractors owned by HUBs.

25. INDEPENDENT CONTRACTORS: Contractor and its employees, officers and executives, and Subcontractors, if any, shall be independent Contractors and not employees or agents of the Department. The Contract shall not operate as a joint venture, partnership, trust, agency, or any other similar business relationship.

26. INSURANCE: During the term of the Contract, the Contractor, at its sole cost and expense, shall provide commercial insurance coverage of such type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, the Contractor shall provide and maintain the following coverage and limits:

- a. Worker's Compensation - The Contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with

minimum limits of \$500,000.00, covering all of Contractor's employees who are engaged in any work under the Contract. If any work is sublet, the Contractor shall require the Subcontractor to provide the same coverage for any of his employees engaged in any work under the Contract.

- b. Commercial General Liability - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$2,000,000.00 Combined Single Limit.
- c. Automobile - Automobile Liability Insurance, to include liability coverage, covering all owned, hired, and non-owned vehicles, used relating to the Contract. The minimum combined single limit shall be \$500,000.00 for bodily injury and property damage; \$500,000.00 for uninsured/underinsured motorist; and \$5,000.00 for medical payment.
- d. Requirements - Providing and maintaining adequate insurance coverage is a material obligation of the Contractor and is of the essence of this Contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The Contractor shall always comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this Contract. The limits of coverage under each insurance policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract.

27. INTELLECTUAL PROPERTY INDEMNITY: To the extent permitted by law, Contractor shall hold and save the Department, State, its officers, agents, and employees, harmless from liability of any kind, including costs and expenses, resulting from infringement of the rights of any third party in any copyrighted material, patented or unpatented invention, articles, device, or appliance delivered relating to this Contract. This term shall survive the termination or expiration of this Contract. Notwithstanding the forgoing, nothing contained in this Section shall be deemed to constitute a waiver of governmental immunity of the Contractor as a political subdivisions of the state, which immunity is hereby reserved to the Contractor as to any third party.

28. LITIGATION: If a demand is asserted, or litigation or administrative proceedings, other than those administrative proceedings related to adverse benefit determinations addressed by other provisions of the Contract, are begun against the Contractor or against the Department and Contractor jointly relating to the services being provided under this Contract, the Contractor shall notify the Department within five (5) Business Days of becoming aware of such action. To the extent no conflict of interest exists or arises, Parties may agree to joint defense and agree to cooperate fully in defense of such litigation. Department will cooperate with the Contractor fully in the defense of such litigation to the extent there is no conflict of interest.

In the event of litigation against the Department related to the Contract, Contractor's performance, or services provided under the Contract, Contractor will cooperate with Department fully in the defense of such litigation to the extent there is no conflict of interest.

Any civil or administrative settlements between the Contractor, as a delegee of the Department, and any member, or provider related to Medicaid Managed Care are public record to the extent required by law. All settlements must be reported to the Department within thirty (30) Calendar Days of an executed settlement agreement and a copy of the settlement agreement must be provided to the Department upon request.

This provision shall survive expiration or termination of the Contract.

29. MEDIA CONTACT APPROVAL AND DISCLOSURE: Contractor shall not use the name or seal of the North Carolina Division of Health Benefits, the North Carolina Department of Health and Human Services or the State of North Carolina in any media release or public announcement or disclosure relating to the

terms of this Contract without prior approval of the Department. Contractor shall not provide any information to the media regarding a recipient of services under this Contract without first receiving approval from the Department. In the event the Contractor is contacted by the media for information related to the terms of this Contract or a recipient of services under, the Contractor shall make immediate contact with the Department as soon as practical after the contact occurs. Contractor must submit any proposed media release to the Department for review and approval at least seven (7) State Business Days in advance of intended disclosure. The Department may, at its sole discretion, object to its publication or require changes to the information intended for public release. The requirements of this Section shall not apply to any information the Contractor is required by law or by any court of competent jurisdiction to disclose.

- 30. MONITORING OF SUBCONTRACTORS:** Contractor shall perform on-going monitoring of all Subcontractors and shall confirm compliance with subcontract requirements. As part of on-going monitoring, the Contractor shall identify to the Subcontractor(s) deficiencies or areas for improvement and shall require the Subcontractor(s) to take appropriate corrective action. Contractor shall perform a formal performance review of all Subcontractors at least annually.
- 31. NOTICES:** Any notices required under the Contract must be delivered to the appropriate Contract Administrator for each Party. Unless otherwise specified in the Contract, any notices shall be in writing and **delivered by email**. In addition, notices may be delivered by first class U.S. Mail, commercial courier (e.g. FedEx, UPS, DHL), or personally delivered provided the notice is also emailed to the Contract Administrator at approximately the same time.
- 32. OUTSOURCING:** Any Contractor or Subcontractor providing call or contact center services to the State of North Carolina or any of its agencies shall disclose to inbound callers the location from which the call or contact center services are being provided. If, after award of a contract, the Contractor wishes to relocate or outsource any portion of performance to a location outside the United States, or to contract with a Subcontractor for any such performance, which Subcontractor and nature of the work has not previously been disclosed to the State in writing, prior written approval must be obtained from the Department. Contractor shall give notice to the using agency of any relocation of the Contractor, employees of the Contractor, Subcontractors of the Contractor, or other persons providing performance under this Contract to a location outside of the United States.
- 33. PARTICIPATION IN REGIONAL SERVICE CONTINUITY:** In the event the Department terminates, suspends, or delays a BH I/DD Tailored Plan Contract in another Region, this Contractor agrees to meaningfully participate with the Department, all other active BH I/DD Tailored Plan Contractors, and any other entities as required by the Department in a collaborative process to identify solutions for ensuring service continuity in such a Region. Solutions identified under the process may include, but are not limited to, expanding the Contractor's service area, leveraging the Contractor's network building capabilities, and Contractor support for other operational activities, as needed.
- 34. PAYMENT AND REIMBURSEMENT:**
- a. **BH I/DD Tailored Plan Payments:** The Department will make the following payments to the Contractor, as applicable:
- i. Monthly per member per month (PMPM) capitated payments;
 - ii. Maternity event payments;
 - iii. Tailored Care Management payments;
 - iv. Additional directed payments to certain providers;
 - v. Healthy Opportunities Pilot Program payments;
 - vi. Monthly Single Stream Fund Base allocation; and
 - vii. Tailored Care Management Capacity Building Performance Incentive Payments

- b. **PMPM Capitated Payments**
 - i. The Contractor must accept capitation rates methodology developed by the Department and its actuary and approved by CMS as follows:
 - a. The Department will send the Contractor a written Notification of CMS Approved Capitation Rates (Notification of Approved Rates) within ten (10) state Business Days of receipt of CMS approval of the capitation rates for a contract year or other applicable rating period. The Notification of Approved Rates will be incorporated into the Contract as though originally set forth herein.
 - ii. Capitated payments shall be made on a PMPM, prospective basis at the first check-write of each month, unless another schedule is set by the Department.
 - iii. The Department will make PMPM capitation payments to the Contractor based on the number of members in each rate cell (as defined in the Rate Book applicable to the rating period and as determined by the monthly cutoff date in Medicaid Eligibility data system). The payment amount will be pro-rated for partial-month enrollment.
 - iv. PMPM capitation payments will be reconciled on a regular schedule to account for enrollment and eligibility changes not reflected in the initial monthly payment to the Contractor and may result in changes to a subsequent monthly capitation payment. Additional details on reconciliation can be found in *Section V.B.8. Technical Specifications*.
 - v. The PMPM capitated rates are specified in the Rate Book. However, capitated payments shall be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements at 42 C.F.R. § 438.730.
- c. **Maternity Event Payments:** As provided in *Section V.B.7. Financial Requirements*, the Contractor will be eligible to receive a separate maternity event payment. Payment will be made after the Contractor submits required documentation of an eligible delivery event to the Department. The Contractor must accept maternity event capitation rates developed by the Department and its actuary and approved by CMS.
- d. **Tailored Care Management Payments:** The Department will make payments to the Contractor to support Tailored Care Management. The Contractor will make the following payments to certified AMH+ practices and Care Management Agencies for Tailored Care Management in accordance with Section V.B.4.e. Provider Payments:
 - i. Tailored Care Management payment per member per month in which the AMH+ or CMA performed Tailored Care Management. Payment will be at a fixed rate and acuity-tiered. It will not be placed at risk.
 - ii. Performance incentive payment, if earned, based on the AMH+ and CMA metrics found in the forthcoming Department’s Technical Specifications Manual.
- e. **Additional Directed Payments for Certain Providers:** The Department will make payments to the Contractor to support additional, utilization-based, directed payments to certain providers as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) and in accordance with *Section V.B.4.iv. Provider Payments*.
- f. **Healthy Opportunities Pilot Program:** If the Contractor covers a Region that includes a Healthy Opportunity Pilot, the Contractor will receive payments from the Department, up to a BH I/DD Tailored Plan-specific capped allotment, with which to make administrative payments to LPEs and care management entities, and service payments to HSOs for delivering authorized Pilot services as provided in *Section V.B.3.x. Healthy Opportunities*. The Contractor shall make payments and manage pilot funding as required in *Section V.B.3.x. Healthy Opportunities* and as otherwise provided by Amendment.
- g. **Monthly Single Stream Fund Base allocation:** DMH/DD/SAS shall distribute to Contractor not less than one twelfth of Contractor’s Single Stream Fund (SSF) continuing allocation on a monthly basis, subject to adjustments and availability of funds allocated by the General Assembly for this purpose.

- h. **Payment in Full:**
 - i. The BH I/DD Tailored Plan shall accept BH I/DD Tailored Plan Payments under this Section as payment in full for the services provided under Contract, unless otherwise specified by the Contract.
 - ii. Members shall be entitled to receive all covered services as provided in *Section V.B.2.i. Physical Health, Behavioral Health, and I/DD Benefits Package* for the entire period for which payment has been made by the Department.
- i. **Payment Adjustments:** Payment adjustments may be initiated by the Department based on the eligibility and enrollment reconciliation or when keying errors or system errors affecting correct BH I/DD Tailored Plan Payments to the Contractor occur. Each payment adjustment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying information and the payment adjustment amount.
- j. **Overpayment and Recoupment:**
 - i. If the Contractor erroneously reports (intentionally or unintentionally), fraudulently reports, or knowingly fails to report any information affecting BH I/DD Tailored Plan Payments to the Contractor, and is consequently overpaid, the Department may request a refund of the overpayment or recoup the overpayment by adjusting payments due in any one or more subsequent months.
 - ii. The Department may also recoup erroneous overpayments made to the Contractor as a consequence of keying errors or system errors, Each recoupment transaction shall be included on the remittance advice in the month following the correction. Each transaction shall include identifying member information and the recoupment amount.
 - iii. The Department shall provide at least ten (10) days' notice to Contractor of its intent to recoup overpayments and shall offer Contractor the opportunity to contest any such alleged overpayments. If the Parties cannot come to agreement, the Contractor may utilize the Dispute Resolution process described in this Contract. The Department shall not take any collection action under this Contract, including recoupment while the dispute is pending and unresolved, unless otherwise allowed by law.
- k. **Other BH I/DD Tailored Plan Payment Terms and Conditions:**
 - i. Payment will only be made for services provided and is contingent upon satisfactory performance by the Contractor of its responsibilities and obligations under the Contract.
 - ii. Except as otherwise provided, the Department may apply withholds, monetary sanctions, liquidated damages, or other or adjustments as described in *Section V.B.5.i. Quality Management and Quality Improvement* and *Section VI. Contract Performance for Medicaid and State-funded Services* to any payment due to Contractor.
 - iii. The Contractor is responsible for all payments to its Subcontractors under the Contract. The Department shall not be liable for any purchases or Subcontracts entered into by the Contractor or any subcontracted Provider in anticipation of funding.
 - iv. All payments shall be made by electronic funds transfers. Contractor shall set up the necessary bank accounts and provide written authorization to Medicaid's Fiscal Agent to generate and process monthly payments.
 - v. Contractor shall not use funds paid under this Contract for services, administrative costs or populations not covered under this Contract related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).
 - vi. Contractor shall maintain separate accounting for revenue and expenses for payments under this Contract in accordance with CMS requirements.
- l. **Third-Party Resources:**

The capitated rates set forth in this Contract have been adjusted to account for the primary liability of third parties for some of the services rendered to members. As required in *Section V.A.3.iv.*

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

- m. **Tailored Care Management Capacity Building Performance Incentive Program Payments**
 - i. Beginning in Contract Year 1, and in accordance with 42 C.F.R. § 438.6(b)(2), the Contractor will be eligible to receive quarterly Tailored Care Management Capacity Building Performance Incentive Program payments for the achievement of certain milestones specified in *Section.V.B.7.* and aligned with the Department’s quality strategy.
 - a. Incentive payments will be separate from and in addition to the capitation payments made to the Contractor under this Contract and will be specifically identified as the “performance incentive payment” in any distribution to the Contractor.
 - b. The incentive payment is not premium revenue and will not be considered as such for purposes of calculating the Contractor’s Medical Loss Ratio or premium tax liability.
 - c. In no event will payments exceed five (5) percent of total capitation revenue that the Contractor receives during the Contract Year.
 - d. Eligibility to participate in the Performance Incentive Program is not linked to whether the Contractor is a public or private entity or whether the Contractor has provided an intergovernmental transfer to the Department.
 - e. Payments are for performance on a quarterly basis under the Contract Year in which the performance incentive arrangement is applied.
 - f. The program will not be renewed automatically, but DHHS may include the program in subsequent Contract Years. The Department will notify the Contractor ninety (90) Calendar Days prior to the start of the Contract Year whether the program will be in effect for that Contract Year.

35. PERFORMANCE BOND:

- a. The BH I/DD Tailored Plan shall furnish a performance bond to the Department within thirty (30) Calendar Days after award of the contract. This security will be in the form a surety bond licensed in North Carolina with an A.M. Best’s rating of no less than A-
- b. The amount of the performance bond shall be a minimum of \$10,000,000 adjusted upwards based on the overall population in each Region as calculated using the 2018 population data by county in which the BH I/DD Tailored Plan is awarded a Contract as set forth in the table below. If a BH I/DD Tailored Plan is awarded a Contract in multiple Regions, then BH I/DD Tailored Plan shall furnish a single bond for the total amount. The 2018 county population information can be found at https://files.nc.gov/ncosbm/demog/countytotals_2010_2019.html.

Population Range	Performance Bond
1 - 1,500,000	\$10,000,000
1,500,001 – 2,500,000	\$15,000,000
2,500,001 – 3,500,000	\$20,000,000
3,500,001 – 4,500,000	\$25,000,000
4,500,001 – 5,500,000	\$30,000,000
5,500,001 – 6,500,000	\$35,000,000
6,500,001 –7,500,000	\$40,000,000
7,500,001 – 8,500,000	\$45,000,000
8,500,001 – 9,500,000	\$50,000,000
9,500,001 – 10,500,000	\$55,000,000

- c. The following performance bond amounts are illustrative of the bond amount that would be required by Region at the time of publication of this RFA.

Region	2018 Population	Performance Bond
Region 1	1,049,463	\$10,000,000
Region 2	1,013,267	\$10,000,000
Region 3	3,157,148	\$20,000,000
Region 4	1,123,971	\$10,000,000
Region 5	1,912,914	\$15,000,000
Region 6	663,025	\$10,000,000
Region 7	1,469,360	\$10,000,000

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

36. PROHIBITION AGAINST CONTINGENT FEES AND GRATUITIES: Contractor warrants that it has not paid, and agrees not to pay, any bonus, commission, fee, or gratuity to any employee or official of the State for obtaining any Contract or award issued by the State and its Departments and other agencies or entities. The Contractor further warrants that no commission or other payment has been or will be received from or paid to any third-party contingent on the award of any Contract by the State, except as shall have been expressly communicated to the Department's Office of Procurement, Contracts and Grants in writing prior to acceptance of the Contract or award in question. The Contractor and their authorized signatory further warrant that no officer or employee of the State has any direct or indirect

financial or personal beneficial interest, in the subject matter of the Contract; obligation or Contract for future award of compensation as an inducement or consideration for making the Contract. Subsequent discovery by the State of non-compliance with these provisions shall constitute sufficient cause for termination of all outstanding contracts. Violations of this provision may result in debarment of the Contractor as permitted by 09 NCAC 06B.1206, 01 NCAC 05B.1520, or other provision of law.

37. RECORDS RETENTION: All records and data held by the Contractor as it relates to this Contract shall be retained and maintained as required by North Carolina law, federal law, State and Department Record Retention requirements and policies.

- a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer or shorter period is required by federal or State law or policy. The State policy is mandated by the State Archives of North Carolina and is located at the following link, accurate as of August 9, 2022: <https://archives.ncdcr.gov/government/retention-schedules>.
- b. Records shall not be destroyed, purged, or disposed of without the express written consent of the Department.
- c. If any litigation, claim, negotiation, audit, disallowance action or other action involving this Contract start before the expiration of the legally required retention period, the records must be retained until completion of the action and resolution of all issues which arise from it.
- d. In the event there are changes in record retention requirements or policies due to North Carolina law, federal law, State or Department record retention Policies, the Contractor shall make the necessary changes to be in compliance with all Records Retention requirements.
- e. Record Retention requirements included within the body of this RFA, subsequent contract and amendments, are intended to supplement this term. In the event of conflict, the provisions of this term are the controlling requirements.
- f. At the point the Contract terminates/expires, all data must be transitioned to the State in a format prescribed by the Department unless that data has exceeded its archive requirements. The Department may request verification from the Contractor that archive requirements are being met.
- g. BH I/DD Tailored Plan shall comply with all standards for record retention in 42 CFR 438.3(u) and the standards determined by the Department.
- h. BH I/DD Tailored Plans shall comply with all standards for record retention in 45 C.F.R. § 74.53 and the standards determined by the Department.
- i. BH I/DD Tailored Plans shall submit its BH I/DD Tailored Plan Policy for Record Retention to the Department for review. The BH I/DD Tailored Plan shall resubmit its BH I/DD Tailored Plan Policy for Record Retention to the Department if there are significant changes.
- j. Financial records and clinical records for the Innovations and TBI waivers shall be maintained by the Contractor in the manner prescribed in the clinical coverage policies for the Innovations and TBI waivers. In the absence of a policy, Contractor shall follow the requirements of this Record Retention clause.
- k. The Contractor shall maintain indirect cost rate proposals and cost allocation plans shall be retained for ten (10) years, unless otherwise required by federal or State law.
- l. This term survives termination or expiration of the Contract.

38. RESPONSE TO STATE INQUIRES AND REQUEST FOR INFORMATION: The Contractor shall prioritize requests from the Department to respond to inquiries from any Departments under the State of North Carolina, the North Carolina Legislature or other government agencies or bodies. Contractor shall respond to urgent requests from the Department within twenty-four (24) hours and according to the guidance and timelines provided by the Department. Contractor may be required to participate with and respond to inquiries from a consultant contracted with the Department regarding policies and

procedures requiring review to determine compliance.

- 39. SEVERABILITY:** If a court of competent authority holds that a provision or requirement of the Contract violates any applicable law, each such provision or requirement shall be enforced only to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of the Contract shall remain in full force and effect.
- 40. SITUS:** The place of this Contract, its situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in Contract or tort, relating to its validity, construction, interpretation, and enforcement shall be determined.
- 41. SOVEREIGN AND GOVERNMENTAL IMMUNITY:** Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of sovereign immunity that otherwise would be available to the Department and State under applicable law. Notwithstanding any other term or provision in this Contract, nothing herein is intended nor shall be interpreted as waiving any claim or defense based on the principle of governmental immunity that otherwise would be available to the Contractor under applicable law.
- 42. STATE CONTRACT REVIEW:** This Contract and subsequent contracts are exempt from the State contract review and approval requirements pursuant to N.C. Gen. Stat. § 143B-216.80(b)(4).
- 43. SUBCONTRACTORS:** Work performed under this Contract by the Contractor or its employees shall not be subcontracted without prior written approval of the Department. Acceptance of Contractor's Application includes all Subcontractor(s) specified therein. For subsequent Subcontractor requests, Contractor must submit a written request, in the form of completed *Section VII. Attachment R. Subcontractor Identification Form* for approval at least sixty (60) Calendar Days prior to the start of services by any Subcontractor.
- a. Upon request, the Contractor shall provide the Department with complete copies of any contracts made by and between the Contractor and all Subcontractors. The selected Contractor remains solely responsible for the performance of its Subcontractors. Subcontractors, if any, shall adhere to the same standards required of the selected Contractor and this Contract. Any contracts made by the Contractor with a Subcontractor shall include an affirmative statement that the Department is an intended third-party Beneficiary of the Contract; that the contract with the Subcontractor does not create a contract between the Department and Subcontractor; and that the Department shall be indemnified by the Contractor for any claim presented by the Subcontractor. Notwithstanding any other term herein, Contractor shall timely exercise its contractual remedies against any non-performing Subcontractor.
 - b. The Contractor shall neither participate with nor enter into any agreement with any individual or entity that has been excluded from participation in federal health care programs. The Contractor shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Act. [42 C.F.R. § 438.808(a); 42 C.F.R. § 438.808(b)(2); 42 C.F.R. § 431.55(h); section 1903(i)(2) of the Act; 42 C.F.R. § 1001.1901(c); 42 C.F.R. § 1002.3(b)(3); SMDL 6/12/08; SMDL 1/16/09]
 - c. Any contract(s) between the Contractor and Subcontractor(s) require:
 - i. The Subcontractor to agree that the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect its premises, any books, records, contracts, computer, or other electronic systems of the subcontractor relating to its Medicaid members, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. and in turn will make available to

the state, CMS, the DHHS Inspector General, the Comptroller General, or their designees all audit materials as described in this subsection.

- ii. The Subcontractor to agree that the right to audit by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; and
 - iii. That if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
 - iv. That the Contractor inform the Subcontractor of the sources of funding for the Contract and of any special compliance or reporting requirements associated with each funding source (e.g., block grants) and the Subcontractor to agree to accurate reporting and appropriate use of State and federal grant funds.
- d. Any contract(s) between the Contractor and Subcontractor(s) described in this Section shall include:
- i. Required activities and obligations, and related reporting responsibilities.
 - ii. Provision for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determines that the Subcontractor has not performed satisfactorily. 42 C.F.R. § 438.230(c)(1)(i) - (iii).
 - iii. Requirement to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions. 42 C.F.R. § 438.230(c)(2).

44. SURVIVAL: The expiration, termination, or cancellation of this Contract will not extinguish the rights of either Party that accrue prior to expiration, termination, or cancellation or any obligations that extend beyond termination, expiration or cancellation, either by their inherent nature or by their express terms.

45. TAXES: Any applicable taxes shall be invoiced as a separate item and in accordance with this paragraph and applicable laws.

- a. N.C. Gen. Stat. § 143-59.1 bars the Department from entering into Contracts with Contractors if the Contractor or its affiliates meet one of the conditions of N.C. Gen. Stat. § 105-164.8(b) and refuses to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under N.C. Gen. Stat. § 105-164.8(b) include: (i) Maintenance of a retail establishment or office, (ii) Presence of representatives in the State that solicit sales or transact business on behalf of the Contractor and (iii) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the application document the Contractor certifies that it and all its affiliates, (if it has affiliates), collect(s) the appropriate taxes.
- b. Contractor is a local political subdivision of the State of North Carolina and as such is exempt from local, State, and federal taxes, including but not limited to excise and transportation.
- c. Prices offered are not to include any personal property taxes, nor any sales or use tax (or fees) unless required by the North Carolina Department of Revenue.

46. TERMINATION: Any notice or termination made under the Contract shall be provided to Contractor's and Department's respective Contract Administrators.

- a. The Contractor obligations set forth in this Section shall survive the expiration or termination of this Contract and shall remain fully enforceable by Department against Contractor. .

b. Termination without Cause:

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

one hundred and eighty (180) Calendar Days notice period expires. In the event of termination without cause:

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

c. Termination for Cause:

- i. In accordance with 42 C.F.R. § 438.708, Department shall have the right to terminate this Contract with Contractor and to enroll Contractor's members in other managed Care Plans if Department determines that Contractor has failed to carry out the substantive terms of this Contract or has failed to meet applicable requirements in Sections 1905(t), 1903(m), and/or 1932 of the Social Security Act.
- ii. Upon written notification to Contractor of Department's intent to terminate this Contract, Department may give members written notice of such intent and allow the members to disenroll immediately without cause in accordance with 42 C.F.R. § 438.722.
- iii. If Department seeks to terminate this Contract pursuant to 42 C.F.R. § 438.708, Department shall provide Contractor with a pre-termination hearing as required by 42 C.F.R. § 438.710(b) and as described in this Contract.
- iv. Department shall have the right to terminate this Contract for cause when the performance of Contractor or one of its Subcontractors has systemically or repeatedly threatened to place the health or safety of any Beneficiary in jeopardy, and Contractor knew or should have known of the issue and failed to take appropriate action immediately to correct the problem;
- v. Department shall have the right to terminate this Contract for cause when Contractor becomes subject to exclusion from participation in the Medicaid program pursuant to Section 1902(p)(2) of the Social Security Act or 42 U.S.C. 1396a(p);
- vi. Department shall have the right to terminate this Contract for cause when Contractor has systemically and fraudulently misled any Beneficiary or has systemically and fraudulently misrepresented the facts or law to any Beneficiary, and Contractor failed to take appropriate action immediately to correct the problem;
- vii. Department shall have the right to terminate this Contract for cause when gratuities of any kind with the intent to influence have been offered or received by a public official, employee or agent of the State by or from Contractor, its agents or employees;
- viii. Department shall have the right to terminate this Contract for cause if Contractor loses or fails to obtain accreditation with the selected accreditation agency.
- ix. Department shall have the right to terminate this Contract for cause if Contractor declares bankruptcy.
- x. Department shall have the right to terminate this Contract as otherwise set forth in this Contract.

d. Automatic Termination:

This Contract shall immediately and automatically terminate without further Contractor obligation to Department, except as provided below in Subsection e., if:

- i. Either of the two (2) sources of reimbursement for Medical Assistance (appropriations from the North Carolina General Assembly and appropriations from the United States Congress) no longer exists; or

- ii. The sum of all contractual obligations of Department exceeds the balance of funds available to Department for a contract year in which this Contract is effective.

Written certification from the Department that one or the other or both of the conditions described above has been met shall be conclusive and binding upon the parties. Department shall attempt to provide Contractor with ten (10) Business Days' prior notice of the possible occurrence of events described above.

In the event of immediate and automatic Contract termination, Contractor shall cooperate fully with the Department in transferring any data and information or providing such other assistance as described in this Section in an expedient manner.

e. Contract Expiration, Termination, and Transition Obligations of Contractor:

Unless otherwise provided by law, at least sixty (60) Calendar Days before Contract expiration, and within thirty (30) Calendar Days of receipt of notice by Contractor of any Contract termination, Contractor shall provide notice of termination to Members. In all cases, Contractor's notification letter must be approved by Department before Contractor mails the notice to Members.

No less than ninety (90) Calendar days prior to the date of planned expiration or forty-five (45) Calendar days of planned termination of this Contract, Contractor shall:

- i. Provide Department with Contractor's plan for the transfer of all Members to other appropriate managed care entities, and make all Department required changes to said plan;
- ii. Assist Department in the implementation of the Department-approved plan for Member transition in such a manner as to ensure the continuity of services for Members;
- iii. Promptly provide Department with information about all outstanding claims, as of the date of termination, and arrange for the payment of such claims;
- iv. Arrange for the secure maintenance of all Contractor records for audit and inspection by Department, CMS, and other authorized government officials;
- v. Provide for the transfer of all data, including encounter data and records, to Department or its agents as may be requested by Department; and
- vi. Provide for the preparation and delivery of all reports, forms and other documents to Department as may be required pursuant to this Contract or any applicable policies and procedures of Department.

47. TIME IS OF THE ESSENCE: Time is of the essence in the performance of this Contract and all provisions that specify a time for performance.

48. TITLES AND HEADINGS: Titles and headings in this RFA, and in any subsequent Contract, are for convenience only and shall have no binding force of effect.

49. USE OF THIRD PARTY ADMINISTRATOR: If Contractor uses the services of a Third Party Administrator (TPA) to adjust or settle claims for members, then the Contractor shall do all of the following:

- a. Ensure the TPA has a current license issued by, and is in good standing with DOI, as required by N.C. Gen. Stat. §§ 58-56-2(5) and 58-56-51;
- b. Have a written agreement with the TPA that is compliant with Article 56 of Chapter 58 of the General Statutes, as applicable, and includes a statement of the duties the TPA is expected to perform on behalf of the Contractor, as specified in N.C. Gen. Stat. § 58-56-6;
- c. Establish the rules, in accordance with this Contract, pertaining to claims payment and shall provide the TPA with the rules in accordance with N.C. Gen. Stat. § 58-56-26; and
- d. Submit to the Department an attestation that the Contractor understands it is solely responsible to provide for competent administration of its claims under the Contract, as provided in N.C. Gen. Stat. § 58-56-26.

50. **WAIVER:** The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance.
51. **SUBSTANCE USE DATA (42 CFR Part 2):** Contractor is fully bound by the provisions of 42 CFR Part 2 upon receipt of data from DHB that includes Patient Identifying Information (PII) regarding substance use disorder, as those terms are defined by 42 CFR 2.11. Contractor shall implement appropriate safeguards to prevent the unauthorized uses and disclosures of data protected under 42 CFR Part 2. Contractor shall report any unauthorized uses, disclosures, or breaches of data subject to this term and condition, to the Contract Administrators for DHB within three (3) business days of the unauthorized use, disclosure, or breach. This notice is in addition to any other notice requirement regarding unauthorized disclosure of PII or PHI required by the Contract. Information disclosed to Contractor is limited to that which is necessary for the Contractor to perform its duties under the Contract. Contractor shall not re-disclose information to a third party unless that third party is a contract agent of the Contractor or subcontractor, helping to provide services described in the contract and only if the subcontractor only further discloses the information back to the contractor or lawful holder from which the information originated.

E. Confidentiality, Privacy and Security Protections

1. The requirements of this Section shall survive expiration or termination of the Contract except the requirements to protect the privacy and security of State-owned data, which shall survive so long as Contractor holds State-owned data.
2. Confidential Information
 - a. The Contractor, its agents, and its Subcontractors shall maintain the privacy, security and confidentiality of all data information, working papers, and other documents related to the performance of the Contract, including information obtained through its performance under the Contract, that meets the conditions for confidentiality under NCGS 132-1.2, is otherwise protected by law or applicable policy as confidential, or is identified by the Department as embargoed, confidential, or not for release; i.e. confidential information. Any use, sale, or offer of confidential information associated with the performance of the Contract except as contemplated under the Contract or approved in writing by the Department shall be a violation of the Contract. Any such violation will be considered a material breach of the Contract. Contractor specifically warrants that it, its officers, directors, principals, employees, any Subcontractors, and approved third-party contractors shall hold confidential information received from the Department during performance of the Contract in the strictest confidence and shall not disclose the same to any third party except as contemplated under the Contract or approved in writing by the Department.
 - b. Contractor warrants that all its employees, Subcontractors, and any approved third-party Contractors are subject to a non-disclosure and/or confidentiality agreement or provisions that is/are enforceable in North Carolina and sufficient in breadth to include and protect confidential information related to the Contract. The Contractor shall, upon request by the Department, verify and produce true copies of any such agreements/provisions. Production of such agreements by the Contractor may be made subject to applicable confidentiality, non-disclosure, or privacy laws, provided that the Contractor produces satisfactory evidence supporting exclusion of such agreements from disclosure under the North Carolina Public Records laws in N.C. Gen. Stat. § 132-1 et. Seq. The Department may, in its sole discretion, provide a non-disclosure and confidentiality agreement satisfactory to the Department for the Contractor's execution. The Department may exercise its rights under this paragraph as necessary or proper, in its discretion, to comply with applicable security regulations or statutes, including but not limited to 26 U.S.C. 6103, SSA, and IRS

Publication 1075 (Tax Information Security Guidelines for Federal, State, and Local Agencies and Entities), HIPAA, and implementing regulation in the Code of Federal Regulations and any future regulations imposed upon the Department of Information Technology Services or the North Carolina Department of Revenue pursuant to future statutory or regulatory requirements.

- c. The Department, State auditors, State Attorney General, federal officials as authorized by federal law or regulations, and State officials as authorized by State law or regulations, as well as the authorized representatives of the foregoing, shall have access to confidential information in accordance with the requirements of State and federal laws and regulations. No other person or entity shall be granted access to confidential information unless State and federal laws and regulations allow such access. The Department has the sole authority to determine if and when any other person or entity has properly obtained the right to have access to any confidential information and whether such access may be granted. Use or disclosure of confidential information shall be limited to purposes directly connected with the administration of the Contract.
- d. The Contractor warrants that without prior written approval of the Department, the Contractor shall not incorporate confidential or proprietary information of any person or entity not a Party to the Contract into any materials furnished to the Department, nor without such approval shall the Contractor disclose to the Department or induce the Department to use any confidential or proprietary information of any person or entity not a Party to the Contract.
- e. The foregoing confidentiality provisions do not prevent the Contractor from disclosing information that (i) at the time of disclosure by the Department is already known by the Contractor without an obligation of confidentiality other than under this Contract, (ii) is publicly known or becomes publicly known through no act of the Contractor other than an act that is authorized by the Department or applicable law, (iii) is rightfully received by Contractor from a third party and Contractor has no reason to believe that the third party's disclosure was in violation of an obligation of confidence to the Department, (iv) is independently developed by the Contractor without use of the Department's confidential information, (v) is disclosed without similar restrictions to a third party by the Department, or (vi) is required to be disclosed pursuant to a requirement of law or a governmental authority, so long as the Contractor, to the extent possible provides the Department with timely prior notice of such requirement and coordinates with the State in an effort to limit the nature and scope of such required disclosure.

3. HIPAA and HITECH

- a. The Department has declared itself to be a hybrid entity under HIPAA with the DHB being a covered health care component. As such, this Contract and related activities are subject to HIPAA and HITECH. Contractor shall comply with HIPAA and HITECH requirements and regulations, as amended, including:
 - i. Compliance with the Privacy Rule, Security Rule, and Notification Rule;
 - ii. The development of and adherence to applicable Privacy and Security Safeguards and Policies;
 - iii. Timely reporting of violations regarding the access, use, and disclosure of PHI; and
 - iv. Timely reporting of privacy and/or security incidents at the following link, accurate as of August 9, 2022: <https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security>
- b. Contractor will be performing functions on behalf of the Department that make Contractor a business associate for purposes of HIPAA regulations. Accordingly, Contractor and this Contract are subject to the terms and conditions of *Section VIII. Attachment Q.12. First Revised and Restated Business Associate Agreement*.

- c. Contractor shall cooperate and coordinate with the Department and its privacy officials and other compliance officers as mandated by HIPAA and HITECH and accompanying regulations, or as requested by the Department, during performance of the Contract so that both Parties are in compliance with HIPAA and HITECH.
 - d. In addition to federal law and regulation, Contractor shall comply with State rules and regulations regarding protected information and Department and State policies including State IT Security Policy and standards. State and Department policies may be revised from time to time, with at last thirty (30) Calendar Days' notice to Contractor and the Contractor shall comply with all such revisions following the notice period as soon as practicable upon written notification of such revision(s).
4. North Carolina Identity Theft Protection Act and Other Protections
- Certain data and information received, generated, maintained or used by Contractor may be classified as "identifying information" within the meaning of N.C. Gen. Stat. § 14-113.20(b) or "personal information" within the meaning of N.C. Gen. Stat. § 75-61(10). Contractor is subject to the North Carolina Identity Theft Protection Act requirements, N.C. Gen. Stat. §§ 132-1.10 and 75-65 and must protect such identifying information and personal information as required by law, Department and State policy, and the terms of this Contract. Contractor shall report security incidents and breaches of all protected information, whether PHI, identifying information, or personal information as required in these Confidentiality, Privacy, and Security provisions.
5. Information Technology
- a. Contractor shall comply with and adhere to all applicable federal and North Carolina laws, regulations, policies, and guidelines, including but not limited to HIPAA, CMS and State IT Security Policy and Standards; Department Privacy and Security Policies; and the most recent Information Security and Privacy guidance shared by CMS. State and Department policies may be revised periodically, with at last thirty (30) Calendar Days' notice to Contractor and Contractor shall comply with any revisions following the notice period as soon as practicable upon written notification of such revision(s). The State Security Manual is available at the following link, accurate as of August 9, 2022: https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf and the Department security manual is available at <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>.
 - b. Contractor's information technology systems shall meet all State and federal statutes, rules and regulations governing information technology (including but not limited to 26 U.S.C. 6103, SSA, IRS Publication 1075, and HIPAA) and the policies of the NC Department of Information Technology, including NIST 800-53, as outlined in the State's Information Security Manual which can be found at the following links, accurate as of August 9, 2022. *See e.g.*, <https://it.nc.gov/statewide-resources/policies>; https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf and <https://it.nc.gov/document/statewide-data-classification-and-handling-policy>.
 - c. Enterprise Architecture Standards: The North Carolina Statewide Technical Architecture standards are located at the following link, accurate as of August 9, 2022: <https://it.nc.gov/services/it-architecture/statewide-architecture-framework>. This provides a series of domain documents describing objectives, principles and best practices for the development, implementation and integration of business systems.
 - d. Modifications, Updates or Fixes to the Contractor's Information Technology Systems: The Contractor will adhere to the Department's Change Management and control policies and procedures for all modifications to systems that contain electronic protected health information. The Contractor shall not modify, update, or fix any IT system that shares information with (or interfaces with) the Department's Information Technology systems without the Department's

prior written approval, unless Contractor identifies the need to perform a security emergency change. The Contractor's request for approval must be communicated to the Department one hundred twenty (120) Calendar Days prior to the change, or immediately after an emergency change, and contain a detailed description of the changes proposed or taken by the Contractor. The Contractor must supplement its request with all clarifications and additional information requested by the Department. The Contractor shall not place any modification, upgrade, or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade, or fix to ensure that it does not impair the operation of the Department's IT systems. The Department reserves the right to delay Contractor's system implementation if it perceives a risk to its operations.

- e. Modifications, Updates, and Fixes Requested by the Department: The Contractor shall promptly modify, upgrade, or fix any part of its Information Technology System that shares information with (or interfaces with) the Department's Information Technology Systems as requested by the Department. The Contractor shall not place any such modification, upgrade or fix into a production environment without first giving the Department an opportunity to test the modification, upgrade or fix to ensure that it does not impair the operation of the Department's Information Technology Systems. The Contractor may not unilaterally refuse to make a modification, update or fix requested by the Department. In the event the Contractor disagrees with the Department on modification, update or fix requests, the Contractor must follow the Change Management and control policies and procedures for resolution. If the Parties cannot come to agreement, the Contractor may utilize the Dispute Resolution process described in this Contract.
- f. Patch Management: As soon as practicable upon receipt of written notification of the need to do so, the Contractor will apply patches based on State requirements on or to any Information Technology Systems or platforms that share information with (or interfaces with) the Department's Information Technology Systems or which may impact the delivery of services to the Department's members, provided that the patches do not disrupt Contractor operations. The State requirements are located at the following link, accurate as of August 9, 2022:
https://files.nc.gov/ncdit/documents/files/Statewide-Information_Security_Manual.pdf
The Contractor will coordinate patching activity with the Department to be sure any dependent patching that needs to be implemented on Department Information Technology Systems or platforms is completed in the conjunction with Contractor patching. The requirement to apply the patch may come from the Contractor, the Department, or an external organization such as <https://www.us-cert.gov/>
- g. Changes to Department Information Technology Systems: The Department anticipates changes to its Information Technology Systems. As soon as practicable upon receipt of written notification of the need to do so, the Contractor will update its Information Technology Systems to conform with any updates to the Departments' Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file or overall file size in bytes). The Department will provide test environments to allow adequate testing time.
- h. The Department's Rejection of the Contractor's Modifications, Updates or Fixes to the Contractor's IT Systems: The Department reserves the right to reject any modification, update or fix that does not meet the Department's Information Technology standards or could impair the operation of the Department's Information Technology Systems.
- i. Cost of Modifications, Updates, Fixes, and Patches to the Contractor's IT Systems: The cost of all modifications, updates, fixes, and patches to the Contractor's Information Technology Systems

(whether proposed by the Contractor or required by the Department) shall be borne solely by the Contractor.

- j. State LAN/Wan: The Contractor shall not connect any of its own equipment to a State-owned or operated LAN/WAN without prior written approval by the Department. The Contractor shall complete all necessary paperwork as directed and coordinated by the Department's appropriate Contract Administrator to obtain the required written approval by the Department to connect Contractor-owned equipment to a State LAN/WAN.
 - k. Connectivity: The Contractor shall be responsible for providing connectivity to the Department's network and systems as required by the Department. This includes any network, connectivity, licensing, or hardware associated with complying with the State's and the Department's policy for securing data. This applies to all communication between the Contractor and the Department, and also includes the Department's current and future Contractors' networks.
 - l. Web / Internet Presence: Where necessary, any web presence that is required to complete the terms of this agreement will comply with the Department's, the State's, and federal standards including but not limited to those required for accessibility (Web Content Accessibility Guidelines (WCAG) 2.0 and the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Sec. 508 of the Rehabilitation Act of 1973 as amended January 2017). The Department will make these standards available as needed.
 - m. Architecture Framework: The Contractor shall follow the North Carolina Statewide Information Architecture Framework (located at following link, accurate as of August 9, 2022: <https://it.nc.gov/services/it-architecture/statewide-architecture-framework>), and any Department derivatives of these documents. The Contractor shall provide documentation as requested by the Department to assess the security of the Contractor's facilities and systems. The security review is part of the overall readiness and noncompliance may be subject to Contract Termination for Cause.
6. Continuous Monitoring
- a. The Contractor shall adhere to the mandate for a Continuous Monitoring Process and work with the Department to implement a risk management program that continuously monitors risk through assessments, risk analysis and data inventory. The requirements are based on NIST 800-37, Continuous Monitoring Process and originates from N.C. Gen. Stat. § 143B-1376, located online at the following link, accurate as of August 9, 2022: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_143B.html, which requires the North Carolina State CIO to annually assess each agency and each agency's contractors' compliance with enterprise security standards.
 - b. The Contractor shall assist the Department with risk assessment and security assessment of the Contractor's critical systems and infrastructure.
 - i. The Contractor shall perform the required assessments, either through a third-party or a self-assessment, on a three-year cycle (with a third-party assessment mandated every third year).
 - ii. All findings identified in the assessment shall be provided, through DHB to the North Carolina Department of Information Technology within thirty (30) Calendar Days of assessment completion and a plan to remediate each finding.
 - iii. The Contractor shall provide a risk assessment for its cloud-hosted providers or off-site hosting service providers. Contractor shall provide all findings identified in these risk assessments to the Department and NC DIT within thirty (30) Calendar Days of assessment completion, also including a corrective action plan documenting how each finding will be remediated.
 - c. Assessment of agency cloud-hosted providers or off-site hosting services.

- i. The Contractor will provide attestation to their compliance and an industry recognized, third party assessment report performed annually. Types of these reports include: Federal Risk and Authorization Management Program (FedRAMP) certification, SOC 2 Type II, SSAE 18 or ISO 27001.
- ii. Departments and their divisions/offices are required to review these reports, assess the risk of each Contractor, and provide annual certification of their compliance to the State CIO.
- iii. Contractor shall cooperate with the Department in completing a data inventory of all public cloud hosted services as required and performed through completion of a Privacy Threshold Analysis (PTA) documenting the data classification and data fields hosted within the cloud, offsite or vendor hosted environment. The PTA shall be reviewed and updated annually by the Parties and when changes have been made to the data being collected. The Department's PTA form is available at the following link, accurate as of August 9, 2022: <https://ncconnect.sharepoint.com/sites/ESRMO-PTA/Lists/PTATracker/NewForm.aspx>

7. Secure Integration Services

- a. The Contractor's systems shall be able to transmit, receive and process data in HIPAA-compliant or Department-specific formats and methods, including but not limited to Secure File Transfer Protocol (SFTP) over encrypted connections such as a SSL (Secure Sockets Layer) or SSH (Secure Shell).
- b. As soon as practicable upon receipt of written notification of the need to do so, the Contractor shall work with the Department and Department vendors to implement data exchanges that comply with the Department, State's security policies, as defined by the North Carolina Department of Information Technology. The State's preferred method of exchanging data with other applications in the Medicaid Enterprise System (MES) is through synchronous real-time web services and/or asynchronous queue-based messaging, when ready.
- c. The Contractor shall have the ability to exchange files through secure protocols with other systems.

8. Service Organization Control (SOC) reports

All SOC 1 and SOC 2 Type II reports, and associated SOC 2 corrective action plans, must be submitted annually to the DHHS Privacy and Security Office in a format to be specified by the State. The Department will accept ISO 27001 certification for security controls in lieu of a SOC 2 Type II report. Reports must be submitted within thirty (30) days of completion unless another timeframe is approved by the Department.

9. Security

a. State of NC Security Standards and DHHS Privacy and Security Standards

- i. Contractor shall comply with all security standards including those published in the State of North Carolina Statewide Information Security Manual, the Department PSO Standards, and any federal regulations and requirements (found at the following link, accurate as of July 1, 2022: <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>). The State of North Carolina Statewide Information Security Manual is available at the following URL, accurate as of August 9, 2022: <https://it.nc.gov/statewide-information-security-policies>. The Department will work with the Contractor to validate compliance with the PSO standards.
- ii. The Contractor's systems and processes shall comply with all current and future federal, State, and Department requirements for privacy and security and data exchange within one hundred twenty (120) Calendar Days of the implementation of that standard.

b. Physical Security

- i. Each person who is an employee or agent of Contractor or Subcontractor must always display an appropriate State badge and his or her company ID badge while on State

premises. Upon request of Department personnel, each such employee or agent must also provide additional photo identification.

- ii. At all times at any State facility, Contractor's personnel shall cooperate with State site requirements, including being prepared to be escorted, providing information for badging, and wearing the badge in a visible location.

- c. State of NC Data Classification and Handling

The State of North Carolina Data Classifications as published in the North Carolina Department of Information Technology Data Classification and Handling Policy guide and the related handling procedures will apply to all data held in Contractor's IT systems on behalf of the Department, and in the execution of this Contract. The guide is available at the following URL, accurate as of August 9, 2022: <https://files.nc.gov/ncdit/documents/files/Statewide-Data-Class-Handling.pdf>

10. Privacy and Security Incidents and Breaches

- a. Contractor shall cooperate with the Department regarding any privacy and security incident or breach.
- b. Contractor shall report significant privacy and security incidents (whether confirmed or suspected) and any breaches to the Department's PSO Incident Website at the following link, accurate as of August 9, 2022: <https://www.ncdhhs.gov/about/administrative-divisions-offices/office-privacy-security> within twenty-four (24) hours after the incident is first discovered. If a Social Security number has been compromised, the incident must be reported to the Department's PSO within sixty (60) minutes after the incident is discovered.
- c. Contractor, in coordination with the Department PSO, shall also report any breaches of personal information to the North Carolina Department of Justice Consumer Protection Division as well as to the three major consumer reporting agencies. NCDOJ information is available here: <https://ncdoj.gov/protecting-consumers/protecting-your-identity/protect-your-business-from-id-theft/security-breach-information/>
- d. If any applicable federal, State, or local law, regulation or rule requires the Department or the Contractor to give persons written notice of a privacy and/or security breach arising out of the Contractor's performance under this Contract, the Contractor shall bear the cost of the notice and any other costs related to or resulting from the breach.
- e. Contractor shall notify the Department's PSO and the appropriate Contract Administrator of any contact by the federal Office for Civil Rights (OCR) received by the Contractor. This term survives termination or expiration of the Contract, as it relates to contact by OCR related to this Contract.

F. Public Records and Trade Secrets Protections

1. Pursuant to N.C. Gen. Stat. § 132-1, et seq., this Contract and information or documents provided to the Department under the Contract are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute. Any proprietary or confidential information which conforms to exclusions from public records as provided by Chapter 132 of the General Statutes must be clearly marked as such with each page containing the trade secret or confidential information identified with bold face as "**CONFIDENTIAL.**" Any material labeled as confidential constitutes a representation by the Contractor that it has made a reasonable effort in good faith to determine that such material is, in fact, a trade secret under N.C. Gen. Stat. § 66-152(3). Under no circumstances shall price information be designated as confidential. Contractor is urged and cautioned to limit the marking of information as trade secret or confidential so far as is possible.
2. Regardless of what Contractor may label as a trade secret, the determination of whether it is or is not entitled to protection will be made in accordance with N.C. Gen. Stat. § 132-1.2 and N.C. Gen. Stat. § 66-152(3). If any challenge, legal or otherwise, is made related to the confidential nature of

information redacted by the Contractor, the Department will provide reasonable notice of such action to Contractor, and Contractor shall be responsible for the cost and defense of, or objection to, release of any material. The Department is not obligated to defend any challenges as to the confidential nature of information identified by the Contractor as being trade secret, proprietary, and otherwise confidential. The Department shall have no liability to Contractor with the respect to disclosure of Contractor's confidential information ordered by a court of competent authority pursuant to N.C. Gen. Stat. § 132-9 or other applicable law.

3. A redacted copy of this Contract and any subsequent amendments, documents, or materials relating to or provided as part of this Contract, shall be provided to the Department within thirty (30) days of execution. Redacted copies must clearly indicate where information has been redacted. For the purposes of this Contract, redaction means to edit the document by obscuring information that is considered confidential and proprietary **and** meets the definition of Confidential Information set forth in N.C. Gen. Stat. § 132-1.2. In lieu of redacting information by obscuring, Contractor may replace the information, paragraphs or pages with the word "Redacted." By submitting a redacted copy, the Contractor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions marked Confidential and/or Redacted meet the requirements of Chapter 132 of the General Statutes. Redacted copies provided by Contractor to the Department may be released in response to public record requests without notification to the Contractor. Information submitted by Contractor that is not marked "Confidential" or "Trade Secret" will become a public record.

G. Dispute Resolution for Contract Compliance

1. Disputes that arise out of this Contract shall be promptly investigated by the Department's Contract Administrator. If either Party identifies a dispute or potential problem with contract compliance, the Department's Contract Administrator shall first obtain all information regarding the issue from the BH I/DD Tailored Plan Contract Administrator and/or relevant Department staff, review all the facts in conjunction with the requirements and terms and conditions of this Contract and confer with Department leadership, if necessary, to determine the appropriate course of action.
2. If BH I/DD Tailored Plan alleges the dispute or potential problem is the fault of the Department or any of its Divisions, agents, employees or subcontractors, the Department Contract Administrator shall investigate the BH I/DD Tailored Plan's allegations, take immediate steps to cure the problem if substantiated by the Department and shall notify the BH I/DD Tailored Plan Contract Administrator in writing of its investigative findings and the timeline for resolution, if any, within five (5) Business Days of such determination.
3. If the Department alleges the dispute or potential problem, including but not limited to contested over or under payments, recoupments, penalties or adjustments pursuant to this Contract, is the fault of BH I/DD Tailored Plan or its agents, employees or subcontractors, the BH I/DD Tailored Plan Contract Administrator shall investigate the Department's allegations, take immediate steps to cure the problem if substantiated by BH I/DD Tailored Plan and shall notify the Department Contract Administrator in writing of its investigative findings and the timeline for resolution, if any, within five (5) Business Days of such determination.
4. If the dispute is not resolved pursuant to *Section III. G.2,3* and is the result of a conflict or lack of clarity within this Contract, the Parties will negotiate in good faith an Amendment to this Contract to resolve the dispute.
5. If the unresolved dispute appears to impact more than one BH I/DD Tailored Plan operating under the 1915(b)/(c) Waiver, the Department Contract Administrator shall notify Department leadership, who will develop a plan of action with multiple BH I/DD Tailored Plans for resolving the dispute. The goal of

the resolution process shall be to resolve all problems before they escalate to the next level. The Department and BH I/DD Tailored Plan Contract Administrators shall schedule telephone or face to face meetings as necessary in order to achieve resolution without conflict where possible.

6. If BH I/DD Tailored Plan or Department is not satisfied with the results of the above-described resolution process decision, BH I/DD Tailored Plan or Department may invoke any legal or administrative remedy available to it under State and Federal law. Pending appeal, both parties shall proceed diligently with the performance of this Contract, unless a court of competent jurisdiction issues a stay.

IV. First Revised and Restated Minimum Qualifications

The Department has defined Minimum Qualifications that the Applicant is required to meet to be considered and have its response evaluated as defined in *Section II.G. Evaluation Process and Contract Award. Section IV. Table 1: Minimum Qualifications* below defines the Department’s Minimum Qualifications. The Applicant must complete *Section VIII. Second Revised and Restated Attachment Q.2. First Revised and Restated Minimum Qualifications Response* and provide the appropriate details to support each requirement as part of *Section VIII. Second Revised and Restated Attachment Q. Application Response* and Completed Attachments.

Section IV. First Revised and Restated Table 1: Minimum Qualifications	
Qualification	
1.	The Applicant is a local political subdivision of the State and operates as an LME/MCO, as that term is defined in N.C. Gen. Stat. § 122C-3(20c), at the time of application. The Applicant is applying only for the Region in which it was operating as an LME/MCO as of the issue date of this RFA; the Applicant acknowledges that there may be an opportunity to respond to Supplemental Evaluation Questions to be considered to fill an Empty Region.
2.	The Applicant agrees to all of the terms and conditions, including confidentiality, privacy and security protections and public records and trade secrets protections, specified herein.
3.	The Applicant agrees to comply with the Conflict of Interest requirements within this RFA, as outlined in <i>Section III.D.15. Disclosure of Conflicts of Interests and Section V.A.1.ix.(xiii) Conflict of Interest</i> .
4.	The Applicant agrees to comply with the Performance Bond requirements within this RFA, as outlined in <i>Section III.C.37 Performance Bond</i> .
5.	The Applicant certifies the Applicant is not located outside of the United States in accordance with 42 C.F.R. § 438.602(i).

V. Scope of Services

VI. Contract Performance for Medicaid and State-funded Services

VII. RFA Attachments

The following Attachments to the Contract are incorporated herein by reference and shall be completed and signed as required under the Contract.

1. Second Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions
2. First Revised and Restated Attachment B. Summary of Medicaid and NC Health Choice Covered Services and Clinical Coverage Policies
3. First Revised and Restated Attachment C. Approved Behavioral Health In Lieu of Services
4. First Revised and Restated Attachment D. Anticipated Contract Implementation Schedule
5. First Revised and Restated Attachment E. Required BH I/DD Tailored Plan Quality Metrics
6. First Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards
7. Second Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts
8. Second Revised and Restated Attachment H. Addendum for Indian Health Care Providers (IHCPs)
9. Second Revised and Restated Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers
10. First Revised and Restated Attachment J. Reporting Requirements for Medicaid and State-funded Services
11. First Revised and Restated Attachment K. Risk Level Matrix
12. First Revised and Restated Attachment L. Managed Care Terminology Provided to the BH I/DD Tailored Plan for Use with Members Pursuant to 42 C.F.R. § 438.10
13. Attachment M. Policies
 - First Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care Enrollment Policy
 - First Revised and Restated Attachment M. 2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
 - First Revised and Restated Attachment M. 3. AMH+ Practice and CMA Certification Policy
 - Attachment M. 4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members
 - Attachment M. 5. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
 - First Revised and Restated Attachment M. 6. Reserved
 - First Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy
 - First Revised and Restated Attachment M. 8. Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members

- Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients
 - First Revised and Restated Attachment M. 10. Reserved
 - First Revised and Restated Attachment M. 11. Tribal Payment Policy
 - Attachment M. 12. Healthy Opportunities Screening Questions
14. First Revised and Restated Attachment N. Division of State Operated Healthcare Facilities Policy for Medicaid Members and State-Funded Recipients
 15. First Revised and Restated Attachment O. Reserved.
 16. First Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages
 17. Attachment R. Subcontractor Identification Form
 18. Attachment S: National Correct Coding Initiative Confidentiality Agreement
 19. Attachment T: BH I/DD Tailored Plan Catchment Areas

VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments

Second Revised and Restated Attachment Q. is located in a separate document titled ***RFA 30-2020-052-DHB Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments***. This includes the following sub attachments that are part of the Application Response and Completed Attachments.

- Section VIII. 1. Instructions
- Section VIII. 2. First Revised and Restated Minimum Qualifications Response
- Section VIII. 3. First Revised and Restated Applicant's Response to Evaluation Questions
- Section VIII. 4. Use Care Scenarios
- Section VIII. 5. BH I/DD Tailored Plan Key Personnel
- Section VIII. 6. Contractor's Contract Administrators
- Section VIII. 7. Certification of Financial Condition
- Section VIII. 8. Disclosure of Litigation and Criminal Conviction
- Section VIII. 9. Disclosure of Conflicts of Interest
- Section VIII. 10. Disclosure of Ownership Interest
- Section VIII. 11. Subcontractor Identification
- Section VIII. 12. First Revised and Restated Business Associate Agreement
- Section VIII. 13. Reserved.
- Section VIII. 14. First Revised and Restated State Certifications
- Section VIII. 15. First Revised and Restated Federal Certifications
- Section VIII. 16. Request for Proposed Modifications to the Terms and Conditions

IX. Medicaid Tailored Plan Rate Book

The Medicaid Tailored Plan Rate Book shall be incorporated into this Contract in a future amendment and applies to the services provided under this Contract.

The Medicaid PIHP Rate Book, which applies to the services provided under Contract #30-2020-052-DHB, is located at **Contract #30-2022-007-DHB, Section VII. Medicaid PIHP Rate Book.**

**First Revised and Restated Request for Application 30-2020-052-DHB
 BH I/DD Tailored Plan
 Section V. Scope of Services, Section VI. Contract Performance**

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V. Scope of Services

A. Unified

1. Administration and Management
 - i. Medicaid Program and State-funded Services Administration
 - (i) In the State of North Carolina, the Department is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance and the single state authority for the SAMHSA Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant. The Division of Health Benefits (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) 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 both the Medicaid and NC Health Choice programs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is designated with the administration of State-funded mental health, developmental disability, TBI and substance use services.
 - (ii) In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland and SAMHSA monitors North Carolina's block grant-funded activities.
 - (iii) The Department has the authority to administer the program in the way outlined in this RFA under the terms of the State's waiver under Section 1115 of the Social Security Act and various Medicaid State Plan Amendments.
 - (iv) The Department will remain responsible for all aspects of the North Carolina Medicaid, NC Health Choice programs and State-funded Services system, and will delegate the direct management of certain health services, including physical health, BH, I/DD, pharmacy, LTSS, and TBI services, and financial risks to the BH I/DD Tailored Plan as defined in the Contract. Certain functions delegated to the BH I/DD Tailored Plan pursuant to this Contract are the duty and responsibility of the Department as the grantee of federal grant funds. Nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Department to perform any of the duties assigned to the Department or its Secretary by the North Carolina General Statutes, the terms and conditions of the federal funds and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by the Department to reimburse the BH I/DD Tailored Plan for any of its duties under this Contract. The BH I/DD Tailored Plan will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the BH I/DD Tailored Plan has an adequate Network, delivers high quality care, and operates a successful Medicaid Managed Care program and State-funded Services system.
 - (v) The BH I/DD Tailored Plan shall work cooperatively with the Department to be good stewards of funds and to ensure effective administration of the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.
 - (vi) In partnership with the Department, the BH I/DD Tailored Plan shall develop processes and procedures to ensure the BH I/DD Tailored Plan is soliciting stakeholder input, including, but not limited to, input from members and recipients, as applicable, and providers, to drive policy development and continual improvement in the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.

- (vii) The BH I/DD Tailored Plan shall provide certification by the Contractor’s Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting to either the CEO or CFO duly authorized to submit the certification concurrently with the submission of all data, documentation, or information requiring such certification under federal and state law and under this Contract to the Department that such information is accurate, complete and truthful. For Medicaid Managed Care, the BH I/DD Tailored Plan shall provide such certification in accordance with 42 C.F.R. § 438.606.
 - (viii) The BH I/DD Tailored Plan shall cooperate with the Department in the administration of North Carolina’s federal Medicaid waivers (e.g., Section 1115, 1915(c), and other active waivers) including providing reporting and data, engaging with the Department’s External Evaluators, and supporting waiver-required stakeholder engagement.
 - (ix) The BH I/DD Tailored Plan shall comply with the following Department policies and any other Department policy as directed. The Department may amend policies and shall provide updated versions to the BH I/DD Tailored Plan at least sixty (60) Calendar Days prior to its intended effective date or the date defined by the Department. The BH I/DD Tailored Plan shall have the opportunity to review and provide feedback prior to finalization. The following is a non-exhaustive list of policies for which the Department will provide a notice and comment period as described in this subsection:
 - (a) North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy;
 - (b) Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members;
 - (c) AMH+ Practice and CMA Certification Policy;
 - (d) Pregnancy Management Program Policy for Medicaid and NC Health Choice Members;
 - (e) Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members;
 - (f) Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members;
 - (g) Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice and State-funded Providers;
 - (h) Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members;
 - (i) 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 Policy;
 - (j) NC Non-Emergency Medical Transportation Managed Care Policy;
 - (k) PCP Assignment Requirements Policy; and
 - (l) Tribal Payment Policy.
 - (x) When reasonable, under these unified provisions, State-funded Services for which federal regulations do not apply, Contract reference to such regulation sets a requirement standard for State-funded services that must be met by the Contractor regardless of regulatory applicability.
- ii. Entity Requirements for Medicaid and State-funded Services
- (i) Operational Authority & Licensure
 - (a) Except where expressly stated, the BH I/DD Tailored Plan shall be permitted to utilize the same staff committees, advisory boards, Subcontractors, policies, procedures, Call Center service lines, systems, processes, training, training materials, and other business materials and operations for both PIHP and BH I/DD Tailored Plan Contract.
 - (b) A BH I/DD Tailored Plan operating a contract with the Department for the provision of Medicaid Managed Care and State-funded BH, I/DD and TBI services must be a local political subdivision of the State and operate as a LME/MCO, as that term is defined in N.C. Gen. Stat. § 122C-3(20c), at the time of application and as required by the Contract.

- (c) Contingent on a change in state law, the BH I/DD Tailored Plan must, at least ninety days (90) before the end of Contract Year 3, be licensed as a Prepaid Health Plan (PHP) set forth by the North Carolina Department of Insurance (DOI), as outlined in Article 93 of Chapter 58 of the N.C. General Statutes.
 - (1) A PHP license is not required as a condition of award.
 - (2) At the discretion of the Department, failure to obtain a license shall result in termination of the Contract between the BH I/DD Tailored Plan and the Department.
 - (3) Upon request by the Department, the BH I/DD Tailored Plan shall share with the Department any information related to its Medicaid business that was provided to the DOI.
 - (4) Upon obtaining a PHP license and upon request by the Department, the BH I/DD Tailored Plan shall share with the Department a copy of the license and any information related to its State-funded BH, I/DD, and TBI services business that was provided to the DOI.
- (ii) BH I/DD Tailored Plan Governance and Operations for Medicaid and State-funded Services
 - (a) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, compensation, and maintenance of the entity's governing board, which governs all aspects of BH I/DD Tailored Plan operations, including both Medicaid and State-funded Services
 - (b) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, and support of the Consumer and Family Advisory Committee (CFAC), which advises the BH I/DD Tailored Plan on the planning and management of the local public mental health, intellectual/ developmental disabilities, and substance use services system , including both Medicaid and State-funded Services pursuant to N.C.G.S. §122C-170(a).
 - (c) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the establishment and maintenance of any other required advisory boards, including both Medicaid and State-funded Services.
- (iii) BH I/DD Tailored Plan Operating Plan
 - (a) The Department seeks the most qualified BH I/DD Tailored Plans to serve within the North Carolina Medicaid Managed Care program and to manage State-funded BH, I/DD and TBI services with whom the Department may entrust the care of its members and recipients.
 - (b) The BH I/DD Tailored Plan shall develop and maintain an up-to-date BH I/DD Tailored Plan Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid and State-funded Services operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care and State-funded Services. As long as the BH I/DD Tailored Plan Operating Plan clearly states that it applies to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan Operating Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (1) Core Medicaid and State-funded operations include:
 - i. Managing Medicaid Managed Care member lives including Member services and the administration of clinical benefits and services;
 - ii. Managing member and recipient services, including utilization management and the administration of clinical benefits and services;
 - iii. Managing the provider network;
 - iv. Performing care management and care coordination functions, other than AMH+ and CMAs;
 - v. Performing quality management and data reporting;
 - vi. Processing and paying claims;

- vii. Managing single stream funding and other non-Medicaid funds for State-funded Services; and
- viii. Assuming risk through a capitated contract for Medicaid services.
- (2) Entities included in the Operating Plan shall include Subcontractors, business partners, and any other entities involved in core Medicaid and State-funded operations.
- (3) The BH I/DD Tailored Plan Operating Plan shall:
 - i. Identify each entity by corporate or other legal entity name, address, and telephone number;
 - ii. Describe generally the roles, responsibilities and functions that the entity performs;
 - iii. Describe the BH I/DD Tailored Plan's legal or contractual relationship with each entity;
 - iv. Describe how the BH I/DD tailored Plan trains vendor staff; and
 - v. Describe how the BH I/DD Tailored Plan manages and oversees each entity and ensures compliance with the standards described in the Contract.
- (4) For Department review and approval, after the first year and annually thereafter provide a Delegation report for each core Medicaid operations entity and State-funded Services, 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.
- (5) The Tailored Plan shall be permitted to combine its oversight activities over a Subcontractor that is common between the BH I/DD Tailored Plan and PIHP.
- (6) The BH I/DD Tailored Plan shall respond to any additional requests for information pursuant to this subsection as directed by the Department.
- (c) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Operating Plan to the Department for review and approval:
 - (1) Within thirty (30) days after Contract Award;
 - (2) Annually, on June 30 of the calendar year; and
 - (3) Within three (3) Business Days after request from the Department.
- (d) The BH I/DD Tailored Plan must provide written notice to the Department within ten (10) Business Days of any material changes, as determined by the BH I/DD Tailored Plan, to the BH I/DD Tailored Plan Operating Plan.
 - (1) Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
 - (2) At the Department's discretion, the BH I/DD Tailored Plan will be subject to a reevaluation and Readiness Review prior to approval of the amended BH I/DD Tailored Plan Operating Plan.
- (e) The BH I/DD Tailored Plan shall provide the information necessary in response to any additional requests for information pursuant to this subsection as directed by the Department.
- iii. National Committee for Quality Assurance (NCQA) Accreditation
 - (i) The BH I/DD Tailored Plan shall achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3. To the extent allowable by law and NCQA policy, the Department will assist the BH I/DD Tailored Plan in providing support and information to NCQA necessary for BH I/DD Tailored Plan to obtain and maintain NCQA accreditation within the timelines contained herein.
 - (a) The BH I/DD Tailored Plan shall submit accreditation information to the Department, including:
 - (1) Accreditation status;
 - (2) Accreditation level;
 - (3) Accreditation survey type, if applicable;

- (4) Accreditation results (corrective action plans, summaries of findings), if applicable; and
 - (5) Accreditation expiration date.
 - (ii) In accordance with 42 C.F.R. § 438.322, the BH I/DD Tailored Plan shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO.
- iv. Third Party (Subcontractor) Contractual Relationships
- (i) The BH I/DD Tailored Plan shall contract with a PHP.
 - (a) Consistent with N.C. Gen. Stat. § 108D-60(5), LME/MCOs operating a BH I/DD Tailored Plan must contract with “an entity that holds a PHP license and that covers the services required to be covered under a Standard Benefit Plan contract.” These contracts will be subject to the contractual requirements outlined in this section.
 - (b) The BH I/DD Tailored Plan shall meaningfully leverage PHP expertise to support and strengthen BH I/DD Tailored Plan capabilities to ensure readiness and ability to manage all applicable aspects of the Contract.
 - (c) Consistent with *Section V.A.1.ii Entity Requirements for Medicaid and State-funded Services*, the BH I/DD Tailored Plan Operating Plan must detail the role(s), responsibilities, function(s), and qualifications of any PHP involved in core Medicaid and State-funded Services operations.
 - (ii) The BH I/DD Tailored Plan must demonstrate its ability to manage Subcontractors and ensure integrated approaches to plan operations and member or recipient’s care, as applicable. Accordingly, the BH I/DD Tailored Plan shall comply with the following operational requirements:
 - (a) The BH I/DD Tailored Plan must ensure that care managers delivering the Tailored Care Management model coordinate across a member’s whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy, and unmet-health related resource needs. See *Section V.B.3.ii. Tailored Care Management* for more information on the Tailored Care Management model.
 - (b) The BH I/DD Tailored Plan must provide a single phone line for member- and recipient-facing services, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement. See applicable requirements throughout *Section V.B. Medicaid* and *Section V.C. State-funded Services* for more information on requirements for operational services.
 - (c) The BH I/DD Tailored Plan must provide a single phone line for provider-facing services, including utilization management, claims payments, provider relations, and provider-facing plan operations, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement. The BH I/DD Tailored Plan is encouraged to implement other provider-facing operational solutions to align processes across service types and reduce the administrative burden on providers. Such solutions may include, but are not limited to, provider contracting. See applicable requirements in *Section V.B.4. Providers*, *Section V.B.6. Claims and Encounter Management*, and elsewhere throughout *Section V.B. Medicaid* and *Section V.C. State-funded Services* for more information on other operational services.
 - (d) The utilization management process must support an integrated, holistic look at a member’s physical health, BH, I/DD, TBI, pharmacy, and LTSS needs, noting that standard utilization protocols or guidelines may not be appropriate in light of a member’s complete clinical and other support needs. See *Section V.B.2.i.(v) Utilization Management* for more information.
 - (e) The Medicaid member appeals processes must follow Department policy and must be centralized, regardless of service type. See *Section V.B.1.vi. Member Grievances and Appeals* for more information.

- (f) The State-funded Services recipient appeals processes must be centralized, regardless of service type. See *Section V.C.1.e. Recipient Complaints and Appeals* for more information.
- (g) The BH I/DD Tailored Plan is required to have a single Medicaid and NC Health Choice Provider Network directory, encompassing all providers regardless of service type, available in both electronic and paper versions. See *Section V.B.4.ii. Provider Network Management* and *Section V.B.8.v. Provider Directory* for more information.
- (iii) The BH I/DD Tailored Plan shall comply with the following financial requirements for all third party subcontracting contracts:
 - (a) A BH I/DD Tailored Plan and Subcontractor may not split physical and BH risk or savings in a way that is inconsistent with integrated care.
 - (1) A BH I/DD Tailored Plan and Subcontractor may not segregate risk based on type of service or percent of premium allocated to service type. For example, a BH I/DD Tailored Plan may not enter a contract with a PHP that sub-capitates all physical health services and holds the PHP accountable for the risk associated with those services.
 - (2) Limited scope sub-capitation arrangements (e.g., for primary care services or bundled payments) are permitted.
 - (b) A BH I/DD Tailored Plan and Subcontractor may enter a contract under which the two plans share savings from reduced medical expenditures, however:
 - (1) Any savings must be shared across the total cost of care of both physical and behavioral health (including I/DD and TBI services); and
 - (2) Physical and behavioral health cannot be divided into separate budgets.
- v. Implementation for BH I/DD Tailored Plan Services
 - (i) The BH I/DD Tailored Plan shall have a fully assembled implementation team ready to begin work immediately following Contract Award. The team shall include an implementation manager and separate implementation resources for, at a minimum, the following workstreams:
 - (a) Administration & Management;
 - (b) Members and Recipients;
 - (c) Benefits and Services (including contact for transition of care and utilization management);
 - (d) Care Management;
 - (e) Providers;
 - (f) Quality and Value;
 - (g) Stakeholder Engagement & Community Partnerships;
 - (h) Program Operations;
 - (i) Claims and Encounter Management;
 - (j) Financial Requirements;
 - (k) Compliance; and
 - (l) Technological Specifications.
 - (ii) Additional resources to support the implementation of all workstreams identified as part of the services and requirements of the Contract shall be added to the implementation team no later than twenty (20) Calendar Days after the Contract Award unless an exception has been made by the Department in writing.
 - (iii) The BH I/DD Tailored Plan shall be responsible for developing business requirements documents, implementation plan and test plans for each workstream. The Department shall review and approve these documents.
 - (iv) The BH I/DD Tailored Plan shall provide to the Department an updated, draft implementation plan fourteen (14) Calendar Days after Contract Award that defines the tasks necessary to develop the following capabilities or milestones for Medicaid and State-funded Services as applicable. As long as the Implementation Plan clearly states that it applies to the BH I/DD Tailored Plan, the

implementation Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP:

- (a) Network development, including provider education, training and contracting;
 - (b) Member and recipient engagement, including educational materials, welcome and enrollment materials, and community outreach;
 - (c) Service line operations;
 - (d) Utilization management development and implementation;
 - (e) Care and case management program development and implementation;
 - (f) PCP assignment;
 - (g) Transition of Care data exchange;
 - (h) Quality management infrastructure;
 - (i) Member, recipient and provider enrollment systems;
 - (j) Claims and encounter systems;
 - (k) Required system interfaces;
 - (l) Design, development, and testing activities; and
 - (m) Other administrative supports.
- (v) To support Medicaid Managed Care and State-funded Services implementation and operations, the BH I/DD Tailored Plan shall perform the following testing and technology operations:
- (a) Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable.
 - (b) End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting.
 - (c) Production defect resolution and testing of production incidents.
- (vi) The Department maintains the discretion to require the BH I/DD Tailored Plan to establish additional implementation teams, plans and testing requirements, including distinct environments to support testing and implementation, on an ongoing basis as new program requirements are implemented or prior to the BH I/DD Tailored Plan effectuating, for example, a material program, operational or technical change.
- vi. Readiness Review Requirements
- (i) The Department is committed to ensuring the BH I/DD Tailored Plan is prepared and able to serve as a good administrator of Medicaid Managed Care and State-funded BH, I/DD and TBI services. The Department will engage in a thorough Readiness Review of the following functions immediately after Contract Award through at least the first six (6) months, or a different period as determined by the Department and shall include all areas identified in 42 C.F.R. § 438.66 and others to be identified by the Department. To the greatest extent possible, the Department shall use best efforts to combine components of the Readiness Review for the PIHP and BH I/DD Tailored Plan.
 - (ii) The Department and its partners will conduct a Readiness Review to verify the BH I/DD Tailored Plan, its staff, providers, Subcontractors and other individuals and organizations are prepared to provide Medicaid Managed Care and State-funded BH, I/DD and TBI services on behalf of the Department, consistent with the terms of the Contract and at the Department's discretion.
 - (iii) The BH I/DD Tailored Plan shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a Readiness Review; the Department may require multiple rounds of Review.
 - (a) The BH I/DD Tailored Plan shall participate in Readiness Review(s) conducted by the Department to review the BH I/DD Tailored Plan's readiness to begin and sustain operations throughout the term of the Contract.

- (1) The requirements covered within the Readiness Review shall be determined by the Department and communicated to the BH I/DD Tailored Plan at least fifteen (15) Calendar Days prior to the Readiness Review.
 - (2) The Department may determine, at its discretion, the frequency and intensity of the Readiness Review requirements and may tailor the particular Readiness Review to a specific issue or BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan must meet these Readiness Review requirements and Contract requirements in the time frame specified by the Department.
 - (b) Readiness Reviews may include, but are not limited to, onsite reviews, desktop reviews, policy reviews, financial reviews, system demonstrations, staff interviews and self-audit evaluations.
 - (c) Readiness Reviews will also consider the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* to the degree a Subcontractor relationship applies.
 - (iv) The Department maintains the discretion to conduct Readiness Reviews on an ongoing basis as new program requirements are implemented or prior to the BH I/DD Tailored Plan effectuating, for example, a material program, operational or technical change.
 - (v) Readiness Reviews are different and distinct from program integrity, program audits, quality reviews, routine oversight or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.
 - (vi) Based upon results of the Readiness Review(s), the Department reserves the right to:
 - (a) Offer acceptance to allow the BH I/DD Tailored Plan to commence full operations;
 - (b) Offer conditional acceptance to allow the BH I/DD Tailored Plan to commence operations if the BH I/DD Tailored Plan is found not to meet certain requirements of the Readiness Review(s), so long as the BH I/DD Tailored Plan develops and executes a Department-approved corrective action plan describing how it will meet Readiness Review criteria within the timeframe specified by the Department;
 - (c) Offer limited acceptance to limit the BH I/DD Tailored Plan's level of participation in Medicaid Managed Care and State-funded BH, I/DD and TBI services based on the results of the Readiness Review and any resulting corrective action plans;
 - (d) Determine a remedy consistent with the terms of this RFA, including corrective action, liquidated damages or sanctions; or
 - (e) Terminate this Contract in accordance with *Section III, B.46. TERMINATION*.
 - (vii) Prior to allowing a BH I/DD Tailored Plan to be assigned Medicaid Managed Care members or to manage State-funded Services for recipients under this Contract, the BH I/DD Tailored Plan shall demonstrate compliance with the Department's solvency requirements specified in *Section V.B.7.iii.(vii) Financial Viability* and *Section V.C.7.i. Financial Viability*. If the BH I/DD Tailored Plan uses the services of a TPA, the TPA shall be licensed. A copy of the TPA license shall be due no later than ninety (90) Calendar Days after Contract Award. As long as the TPA License clearly states that it applies to the BH I/DD Tailored Plan, the TPA License may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (viii) As part of Readiness Review, the BH I/DD Tailored Plan shall submit to the Department all required reports for approval prior to commencing operations or performing services according to the terms of this Contract.
 - (ix) The BH I/DD Tailored Plan shall submit to the Department all policies and procedures that require review and/or approval or as requested by the Department within this RFA and defined in the Contract.
- vii. Non-discrimination for Medicaid and State-funded Services

- (i) The BH I/DD Tailored Plan shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:
 - (a) Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
 - (b) Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identify and national origin;
 - (c) Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
 - (d) Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
 - (e) The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
 - (f) Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
 - (g) The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
 - (h) Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;
 - (i) The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;
 - (j) The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;
 - (k) The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and
 - (l) Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017 by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran’s status, sexual orientation, and gender identity or expression.
- (ii) The BH I/DD Tailored Plan shall not discriminate against members, recipients, providers, or employees in the provision of services or administration of the program.
- (iii) The BH I/DD Tailored Plan shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3)
- (iv) The BH I/DD Tailored Plan shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.
 - (a) At a minimum, the Non-Discrimination Policy shall include:
 - (1) The definition of discrimination under federal law and regulation, as amended;
 - (2) How the BH I/DD Tailored Plan will collaborate with all of the Department’s thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (example: Division of Services for the Deaf and Hard of Hearing);
 - (3) How the BH I/DD Tailored Plan’s policy will apply to clinical, marketing, and care management programs offered to members and recipients;

- (4) The BH I/DD Tailored Plan’s internal complaint process for members, recipients, and employees including [penalties](#);
 - (5) The legal recourse, investigative, and complaint process available for members and recipients through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and
 - (6) Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.
- (b) The BH I/DD Tailored Plan shall make the Non-discrimination Policy available for Department review, upon request.
 - (c) The BH I/DD Tailored Plan shall make updates to its Non-discrimination Policy as necessary, and, at a minimum, the BH I/DD Tailored Plan shall review its Non-discrimination Policy for updates annually.
 - (d) The BH I/DD Tailored Plan shall make the Non-discrimination Policy available to members, recipients, and employees of the BH I/DD Tailored Plan. Posting on Contractor’s public-facing website shall be considered an acceptable means of making the Non-discrimination Policy available
- viii. Advance Directives for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall comply with all state and federal laws and regulations related to Advance Directives (including advance instructions for mental health treatment), including Article 23 of Chapter 90 of the General Statutes and Part 2 of Article 3 of Chapter 122C of the General Statutes.
 - (ii) The BH I/DD Tailored Plan shall maintain and implement written policies and procedures on Advance Directives for all adult members and recipients receiving care arranged by the BH I/DD Tailored Plan. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a); Part 2 of Article 3 of Chapter 122C of the General Statutes. As long as the Advance Directives Policy clearly states that it applies to the BH I/DD Tailored Plan, the Advance Directives Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (iii) The BH I/DD Tailored Plan shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) days after the effective date of the change. 42 C.F.R. § 438.3(j)(4)
 - (iv) The BH I/DD Tailored Plan shall be prohibited from conditioning the provision of care or otherwise discriminating against a member based on whether or not the Member or Recipient has executed an Advance Directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).
 - (v) The BH I/DD Tailored Plan shall educate staff concerning their policies and procedures on Advance Directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).
 - (vi) The BH I/DD Tailored Plan shall provide adult members and recipients with written information on Advance Directives (including advance instructions for mental health treatment), including the following:
 - (a) Member and Recipient rights under State law;
 - (b) BH I/DD Tailored Plan policies with respect to the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives;
 - (c) Information on the advance directive policies of the BH I/DD Tailored Plan;
 - (d) Each member’s and recipient’s right to file a Grievance with the State Certification and Survey Agency for fully licensed services and the BH I/DD Tailored Plan for unlicensed services concerning any alleged noncompliance with the advance directive law. Each member or recipient has the right to file a Grievance with other applicable agencies such as Disability Rights North Carolina, licensing boards, etc.; and

- (e) Option to register his or her Advance Directive with the Secretary of State's Office so the Advance Directive can be available to medical professionals.
 - (f) The state shall supply to the BH I/DD Tailored Plan a model enrollee handbook including provisions for members on how to exercise an Advance Directive. The BH I/DD Tailored Plan's communications to adult members on the topic, as described above, must align with the information contained in the enrollee handbook.
- ix. Staffing and Facilities for Medicaid and State-funded Services
- (i) Personnel required to perform the functions described in this section are not required to be dedicated solely to either PIHP or BH I/DD Tailored Plan. These functions shall be permitted to be performed by both entities, unless otherwise noted.
 - (ii) The BH I/DD Tailored Plan shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The BH I/DD Tailored Plan shall provide qualified persons in numbers appropriate to the BH I/DD Tailored Plan's size of enrollment and consistent with the requirements to successfully operate the BH I/DD Tailored Plan for Medicaid Managed Care and State-funded Services.
 - (iii) Unless otherwise specified, the BH I/DD Tailored Plan may combine or split the listed responsibilities across Medicaid and State-funded Services populations and among the BH I/DD Tailored Plan's personnel if the BH I/DD Tailored Plan demonstrates that the responsibilities are being met. The BH I/DD Tailored Plan shall also be permitted to utilize the same staff for both its PIHP and Behavioral Health I/DD Tailored Plan. In such instance, the BH I/DD Tailored Plan shall demonstrate upon request by the Department that responsibilities under this Contract are being met. Similarly, the BH I/DD Tailored Plan may contract with a third-party (Subcontractor) to perform one or more of these responsibilities as outlined in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*. In a format to be specified by the Department, the BH I/DD Tailored Plan shall identify proportion of responsibilities across Medicaid and State-funded Services fulfilled by key personnel to allow for appropriate cost allocation across Medicaid and State-funded Services.
 - (iv) The BH I/DD Tailored Plan shall be responsible for screening all employees and Subcontractors to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
 - (a) The BH I/DD Tailored Plan shall not employ or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610 (a) and (b)].
 - (v) To support the Department's vision on diversity, equity and inclusion, Contractor shall make a good faith effort to recruit, develop and retain a diverse workforce and encourage and promote an inclusive and equitable workplace, in accordance with Federal and State law.
 - (vi) Key BH I/DD Tailored Plan Personnel
 - (a) The BH I/DD Tailored Plan shall hire Key Personnel (defined in *Section V.A.1. Second Revised and Restated Table 1 Key Personnel Requirements*) to be assigned, unless otherwise indicated, exclusive to the North Carolina Medicaid and State-funded Services market, and shall ensure these Key Personnel positions are filled for the duration of this Contract. Key Personnel shall be identified and mapped to the Staffing Roles provided in *Section V.A.1.ix.(iv) Key BH I/DD Tailored Plan Personnel*. The BH I/DD Tailored Plan shall include the name of the proposed individual to perform each role as part of the Applicant's Application.
 - (b) Key Personnel shall be directly employed by the BH I/DD Tailored Plan unless an exception request has been submitted and approved by the Department.

- (c) Key Personnel that may be shared for both this Contract and the PIHP include the following as identified in *Section V.A.1. Second Revised and Restated Table 1 Key Personnel Requirements*.
- (d) For Key Personnel positions that require the employee to reside in North Carolina, the BH I/DD Tailored Plan shall adhere to North Carolina Residency requirements as defined in *Section III. First Revised and Restated Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections, A. Definitions, North Carolina Residency*.
- (e) Key Personnel include the following as identified in *Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements*:

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements			
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who has clear authority over the general administration and day-to-day business activities of this Contract.	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must hold a Master’s degree from an accredited college or university
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for accounting and finance operations, including financial audit activities.	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years’ of progressive accounting experience, of which three (3) years are supervisory

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
<p>3. Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training.</p>	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor’s degree from an accredited college or university • Minimum of seven (7) years’ experience in a managed care organization
<p>4. Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.</p>	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must be a primary care physician or psychiatrist, fully licensed to practice in NC and in good standing. • Minimum of five (5) years of experience in a health clinical setting and five (5) years’ experience in managed care • If a primary care physician, clinical experience with child/adolescent and adult populations is preferred. If individual does not have experience with all populations, direct medical staff reports must have experience. • If a psychiatrist, clinical experience with child mental health or addiction/SUD is preferred. (If individual

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience)
5.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and manages all fraud, waste, and abuse and compliance activities.
<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor’s degree from an accredited college or university 		
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected.
<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor’s degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years’ experience in health care 		
7.	Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances.
Individual reports to the CMO.	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries 	

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	
		<ul style="list-style-type: none"> • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred 	
8.	<p>Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and the peer review functions of related member appeals.</p> <p>Individual reports to the CMO.</p>	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT)
9.	<p>Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for providers services and provider relations, including all network development and management issues.</p> <p>Individual reports to the CMO.</p>	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of combined network operations, provider relations, and management experience
10.	<p>Deputy Chief Medical Officer of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual who oversees and is responsible for activities as assigned by the CMO including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for</p>	<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years' experience in a health clinical setting and two (2)

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>supporting CMO in ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.</p> <p>Individual reports to the CMO.</p>	<p>years' experience in managed care</p> <ul style="list-style-type: none"> • If the CMO is a psychiatrist: <ul style="list-style-type: none"> ○ Must be a primary care physician fully licensed to practice in NC and in good standing. ○ Minimum of five (5) years clinical experience and two (2) years' experience in managed care ○ Clinical experience with child/adolescent and adult populations is preferred. If individual does not have child/adolescent and adult populations experience, direct medical staff reports must have experience with these populations. • If the CMO is a primary care physician: <ul style="list-style-type: none"> ○ Must be a psychiatrist fully licensed to practice in NC and in good standing ○ Minimum of five (5) years' experience in a BH and/or I/DD clinical setting and two (2) years' experience in managed care

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	
		<ul style="list-style-type: none"> ○ Clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, at least one direct medical staff report must have experience) 	
11.	<p>I/DD and TBI Clinical Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and BH benefits.</p> <p>Individual reports to the CMO.</p>	<ul style="list-style-type: none"> ● Must meet North Carolina residency requirements under this Contract ● Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI ● Minimum of seven (7) years of utilization review, care management, and/or rehabilitative and case management experience in I/DD care
12.	<p>Director of Population Health and Care Management of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including oversight of care management provided by AMH+, State-funded case management providers, and care management agencies and care management delivered by Local Health Departments.</p> <p>Individual reports to the CMO.</p>	<ul style="list-style-type: none"> ● Must meet North Carolina residency requirements under this Contract ● Minimum of five (5) years of demonstrated care management/population health experience in a healthcare organization serving Medicaid beneficiaries, including

Section V.A.1. Second Revised and Restated Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		experience with BH and I/DD populations <ul style="list-style-type: none"> • North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT)
13.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the BH I/DD Tailored Plan pharmacy benefits and services. Individual reports to the CMO.
		<ul style="list-style-type: none"> • Must meet North Carolina residency requirements under this Contract • Must be a North Carolina-registered pharmacist with a current NC pharmacist license • Minimum of three (3) working years of Medicaid pharmacy benefits management experience

(vii) The BH I/DD Tailored Plan shall:

- (a) Ensure that Key Personnel hold no more than one (1) position that is required by the Contract, with time limited exceptions for vacancies; as specified above all Key Personnel positions may be shared between the BH I/DD Tailored Plan and PIHP Contract The Department may specify in future guidance a deadline for all Key Personnel positions to be filled.
- (b) Ensure all Key Personnel meet the Key Personnel role and minimum certification and/or credentialing requirements.

(viii) Key Personnel shall be available to meet during normal Business Hours at the Department’s requested location within one business day’s notice from the Department unless they are able to provide good cause exceptions.

(ix) The Department may, at its sole discretion, notify Contractor that a Key Personnel providing services under this Contract is not meeting Department requirements, and request that Contractor remove the individual from the Key Personnel position. The notice shall include a detailed basis for the Department’s determination, which must satisfy the definition of “just cause” established under the North Carolina State Human Resources Act, Chapter 126 of the North Carolina General Statutes, and implementing rules at Title 25 of the North Carolina Administrative Code, Subchapter 11, Service to Local Government. If the Key Personnel is the Chief Executive Officer, the notice shall be directed to the Chair of Contractor’s Board of Directors and the Chief Compliance Officer. Contractor shall have fifteen (15) Calendar Days to respond to the Department’s request and indicate whether it agrees with the just cause determination and accepts or declines to remove the individual from the Key Personnel position. The Department understands, agrees and

acknowledges that if Contractor consents to remove the individual from a Key Personnel position, such removal shall constitute a demotion or dismissal as those terms are defined in Title 25 of the North Carolina Administrative Code, Subchapter 1I, and may be appealed by the individual pursuant to N.C.G.S. § 126-35(a). In such case, the Department agrees to cooperate with Contractor if the removed individual challenges the removal by filing a petition at the Office of Administrative Hearings, such cooperation to include, but not be limited to, providing supporting documentation and testimony.

- (x) The BH I/DD Tailored Plan shall not permanently substitute Key Personnel without prior written approval by the Department. The BH I/DD Tailored Plan shall inform the Department in writing within seven (7) Calendar Days of staffing changes in Key Personnel positions, including vacancies. The BH I/DD Tailored Plan shall extend offers of employment for Key Personnel roles with permanent qualified replacements within ninety (90) Calendar Days of the departure of the former staff member. At no time, however, shall a Key Personnel Role be vacant. It is the BH I/DD Tailored Plan's responsibility to keep the role filled until the Department approves a substitution. The Department shall not withhold or delay such approval without good cause, which it must relay to the BH I/DD Tailored Plan as soon as is practicable.
- (xi) Upon filling a Key Personnel vacancy, the BH I/DD Tailored Plan shall demonstrate that BH I/DD Tailored Plan staff proposed as Key Personnel have the proper credentials and experience to perform all duties and responsibilities of that role. The BH I/DD Tailored Plan shall provide the following to the Department for each position:
 - (a) Name;
 - (b) Role;
 - (c) Experience relevant to the services to be provided under this Contract;
 - (d) Resume;
 - (e) North Carolina Residency; and
 - (f) Any certifications, licenses or credentials for the role where requested by the Department.
- (xii) If the BH I/DD Tailored Plan is unable to find a candidate for a Key Personnel Position that meets the required credentials, or a permanent qualified replacement, the BH I/DD Tailored Plan may submit an exception request for the Department's approval. The exception request shall include the proposed candidate and mitigation and reporting strategy to fulfill the full requirements of the Contract. The Department reserves the right to provide input on the mitigation and reporting strategy, specify conditions for approval, and request documentation and provide feedback on performance of the candidate.
- (xiii) Organization Roles and Positions
 - (a) The BH I/DD Tailored Plan shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Section VII. Second Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*.
 - (b) Member and Recipient Services Staffing
 - (1) The BH I/DD Tailored Plan shall adequately staff and operate its Member and Recipient Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related with Medicaid Managed Care and State-funded Services for the populations covered by the BH I/DD Tailored Plans.
 - (2) The BH I/DD Tailored Plan shall ensure that unlicensed Member and Recipient Services staff are prohibited from providing health-related advice to members requesting clinical information and instead shall triage/refer such requests to licensed staff with appropriate clinical expertise in treating the member's or recipient's condition or disease.

- i. Annually, all unlicensed Member and Recipient Services staff and Member and Recipient Services management will submit an attestation that the staff and management understand and adhere to the requirements of the prohibition.
- (c) Fraud, Waste and Abuse Staffing
 - (1) The BH I/DD Tailored Plan shall establish a single point of contact to serve as a liaison with the Department, including DHB and DMH/DD/SAS program integrity staff, and Medical Investigation Division (MID) and to facilitate timely response to Department requests for information, including claims data. This individual may be the same person who serves as the liaison for the PIHP.
 - (2) The BH I/DD Tailored Plan shall establish a custodian of records, who may be the same person who serves as the custodian of records for the PIHP to authenticate the business records of the BH I/DD Tailored Plan, provide the business records of the BH I/DD Tailored Plan to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:
 - i. Made at or near the time of the events by a person with knowledge;
 - ii. Kept in the normal course of regularly conducted business activity; and
 - iii. Made in the regular practice of the BH I/DD Tailored Plan's business activity.
- (d) The BH I/DD Tailored Plan shall submit resumes for any employee or subcontracted employee upon request by the Department.
- (e) The BH I/DD Tailored Plan shall provide an updated Business Continuity Plan with a detailed staffing contingency plan in the event of public health emergencies, natural disasters, sudden and unexpected increases in enrollment, and service area expansions, with a description on how the plan shall be implemented and coordinated with the Department, upon request by the Department. As long as the Business Continuity Plan clearly states that it applies to the BH I/DD Tailored Plan, the Business Continuity Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (f) The BH I/DD Tailored Plan shall provide staffing levels, hiring, layoff activity, and plans upon request by the Department.
- (g) BH I/DD Tailored Plan staff with prior professional experience providing diversion, in-reach or transition services under TCLI who do not meet the minimum credentials for "Transition Coordinator" or "Diversion Specialist" as defined in *Section VII. Second Revised and Restated Attachment A. Second Revised and Restated Table 1: BH I/DD Tailored Plan Organization Roles and Positions* shall be permitted to fill the "Transition Coordinator" or "Diversion Specialist" role.
- (h) Personnel required to perform the functions described in this Section are not required to be dedicatedly solely to the BH I/DD Tailored Plan and shall be permitted to perform functions for the PIHP, unless otherwise noted, provided that such personnel comply with requirements imposed under this Contract.
- (xiv) Physical Presence in North Carolina
 - (a) The BH I/DD Tailored Plan shall have a physical presence in North Carolina by having one or more offices located in the BH I/DD Tailored Plan's region.
 - (b) The BH I/DD Tailored Plan shall establish an office in North Carolina within ninety (90) Calendar Days after Contract Award that shall be maintained for the duration of the Contract.
 - (c) The BH I/DD Tailored Plan shall begin implementing call center(s) within ninety (90) Calendar Days after Contract Award and ensure for call center(s) are established for Readiness Review.
 - (d) The Department requires the BH I/DD Tailored Plan establish an office that serves to support in care management functions and member, recipient, provider and stakeholder engagement requirements of the Contract by BH I/DD Tailored Plan launch within one hundred fifty (150)

Calendar Days of Contract award. This may be the same office as that described in *Section V.A.1.6.xiii.b.*

- (e) Additionally, the following personnel and roles, at a minimum, shall be located in and operate from within the State of North Carolina (as found in *Section VII. Second Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*). All BH I/DD Tailored Plan personnel, regardless of residence must be fully able to fulfill their scope of work as outlined in the contract. All personnel approvals and exceptions issued by the Department to any BH I/DD Tailored Plan for BH I/DD Tailored Plan contract operations shall apply equally to the PIHP Contract:

- (1) Implementation and Readiness Review Staff;
- (2) Supervising Care Managers;
- (3) State-funded BH Care Management Coordinator;
- (4) Care Managers;
- (5) Care Management Housing Specialist(s);
- (6) Transition Supervisor(s);
- (7) Transition Coordinator(s);
- (8) Peer Support Specialist(s);
- (9) In-Reach Specialist(s) for Medicaid;
- (10) Diversion Specialist(s) for State-funded Services;
- (11) System of Care Family Partner(s);
- (12) System of Care Coordinator(s);
- (13) DSOHF Admission Through Discharge Managers;
- (14) Member and Recipient Appeal Coordinator;
- (15) Member and Recipient Complaint and Grievance Coordinator;
- (16) Member and Recipient Complaint and Grievance Staff;
- (17) Member and Recipient Appeal Staff;
- (18) Member and Recipient Services and Service Line Staff;
- (19) Provider Relations and Service Line Staff;
- (20) Provider Network Relations Staff;
- (21) Provider Complaint, Grievance, and Appeal Coordinator;
- (22) I/DD and TBI Utilization Management Staff;
- (23) Pharmacy Benefit Manager (PBM) Liaison;
- (24) Tribal Provider Contracting Specialist;
- (25) Reserved;
- (26) Liaison between the Department and the MID;
- (27) Special Investigations Unit Lead;
- (28) Special Investigations Unit Staff;
- (29) Liaison to the DSS; and
- (30) Waiver Contract Manager.

(xv) Conflict of Interest

- (a) The BH I/DD Tailored Plan shall verify that its employees, directors, and Subcontractors comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C.
- (b) The BH I/DD Tailored Plan shall undertake reasonable actions to verify that employees or Subcontractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the North Carolina Medicaid or NC Health Choice programs, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.

- (c) The BH I/DD Tailored Plan and its employees and directors shall:
 - (1) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee (or such employee's spouse or minor child) if such Department employee participated personally and substantially in the procurement of the BH I/DD Tailored Plan's contract or the oversight of such contract as a Department employee.
 - (2) Not promise or give a gift to any Department employee or any family member of a Department employee.
 - (3) Fully and completely disclose to the Department any situation that may present a conflict of interest.
 - (4) Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.
 - (5) Not solicit or obtain from the Department any non-public information relating to the Department's criteria or processes for evaluating bids to enter into or renew a BH I/DD Tailored Plan contract.
- (d) The BH I/DD Tailored Plan shall ensure that financial considerations do not influence decisions to provide Medically Necessary care.
- (e) The BH I/DD Tailored Plan shall validate that all its employees, directors, Subcontractors or owners who are fully licensed providers abide by their professional obligations to their members and recipients and shall not take any actions which conflict with such obligations.
- (f) The BH I/DD Tailored Plan shall not serve as a legal guardian or representative payee for any of its members or recipients.
- (g) No official or employee of the BH I/DD Tailored Plan shall acquire any personal interest, direct or indirect, in any provider or vendor contracted with State or Federal funds that would be considered a conflict of interest under this Contract.
- (h) The BH I/DD Tailored Plan Board of Directors, advisory committees, employees, volunteers, agents, and contractors shall not participate in clinical or administrative activities or decision in which there is or may be a conflict of interest.
- (i) As required by N.C. Gen. Stat. § 143B-139.6C, the BH I/DD Tailored Plan shall not use a former Department employee, director, or contractor in the administration of its BH I/DD Tailored Plan contract for six (6) months after such person's employment or contract with the Department is terminated, if such person personally participated in the following activities:
 - (1) The award of the Contract to the BH I/DD Tailored Plan;
 - (2) An audit, decision, investigation, or other action affecting the BH I/DD Tailored Plan; or
 - (3) Regulatory or licensing decisions that applied to the BH I/DD Tailored Plan.
- (j) The BH I/DD Tailored Plan shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices. The BH I/DD Tailored Plan shall submit its written Conflict of Interest Policy for its employees to the Department for review upon request. As long as the Conflict of Interest Policy clearly states that it applies to the BH I/DD Tailored Plan, the Conflict of Interest Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

2. Program Operations

i. Service Lines for Medicaid and State-funded Services

- (i) The BH I/DD Tailored Plan may utilize the same staff and service lines as it does for the PIHP to perform the operations described in this Section.
- (ii) All service lines shall be staffed with personnel specifically trained on the requirements, policies and procedures of the North Carolina market and can resolve an applicable inquiry or issue in "one-touch."

- (iii) The BH I/DD Tailored Plan shall establish the following service lines as part of its call center:
- (a) **Member and Recipient Service Line:** To enable members and recipients to conveniently access information about benefits or claims, referral assistance and access to treatment or services.
 - (b) **Provider Support Service Line:** To assist Medicaid and State-funded Services providers with enrollment, service authorization, contracting, or reimbursement questions or issues, and resolve provider questions, comments, inquiries and complaints
 - (c) **Behavioral Health Crisis Line:** To provide members and recipients with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year which is confidential, toll free, and provides emergency referral with immediate access to trained, skilled, licensed BH professionals who provide assistance for any type of BH issue the member may be experiencing, and offers assistance in linking members and recipients to supportive available community resources. In addition to accessing call recordings in real time, the BH I/DD Tailored Plan shall maintain a record of telephonic crisis line calls, including date of the call, type of call, and disposition and make available to the Department upon request.
 - (d) For Medicaid program, only:
 - (1) **Pharmacy Service Line:** To assist pharmacies and prescribers with point of sale claims questions and pharmacy prior authorizations and clinical coverage criteria, resolve claims payment and adjudication issues, and address general provider questions.
 - (2) **Nurse Line:** To provide members with a service which is available twenty-four (24) hours a day, seven (7) days a week, every day of the year for medical information and advice on where to access care.
 - (3) **Non-Emergency Medical Transportation (NEMT) Member and Provider Service Lines:** To assist callers in scheduling coordinated, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid -enrolled Providers.
- (iv) The BH I/DD Tailored Plan shall adhere to the Department’s hours of operations, location, and staffing and member ID requirements for each service line as described in *Section V.A.2.a. First Revised and Restated Table 1: Member, Recipient and Provider Support Call Center Operations*. The BH I/DD Tailored Plan shall adhere to hours of operations regardless of holidays.

Section V.A.2.a. First Revised and Restated Table 1: Member, Recipient, and Provider Support Call Center Operations				
Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
1. Member and Recipient Service Line for Medicaid and State-funded Services	<ul style="list-style-type: none"> a. Non-emergency member and recipient issues: Monday – Saturday: 7AM – 6PM ET, including State holidays for member and recipient questions and additional hours as required by the Department during times of expected high volume (e.g., BH I/DD Tailored Plan launch) b. Emergency member and recipient issues: open twenty-four (24) 	Yes	Yes	At the beginning of Tailored Plan Marketing

	hours per day/seven (7) days per week			
2. Provider Support Service Line for Medicaid and State-funded Services	a. Monday – Saturday: 7AM – 6PM ET, including State holidays	Yes	Yes	At the beginning of Tailored Plan Marketing
3. Behavioral Health Crisis Line for Medicaid and State-funded Services	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	Yes	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
4. Pharmacy Service Line for Medicaid Program	a. Monday – Saturday: 7AM – 6PM ET, including State holidays b. Prescriber prior authorization services available to meet 24-hour review requirements as defined in <i>Section V.B.2.iii. Pharmacy Benefits</i>	Yes	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
5. Nurse Line for Medicaid Program	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	No	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
6. Non-Emergency Medical Transportation (NEMT) Member Service Line for Medicaid Program	a. Monday – Saturday: 7AM – 6PM ET, including State holidays	No	No	At least forty-five (45) Calendar Days prior to BH I/DD Tailored Plan Launch
7. Non-Emergency Medical Transportation (NEMT) Provider Service Line for Medicaid Program	a. Twenty-four (24) hours per day / seven (7) days per week / three hundred sixty-five (365) days per year	No	No	At least forty-five (45) Calendar Days prior to BH I/DD Tailored Plan Launch

(v) The BH I/DD Tailored Plan service lines shall be accessible via a toll-free telephone line. The BH I/DD Tailored Plan shall establish and maintain a direct inward dialing (DID) number for each required service line to allow for Warm Transfers between the BH I/DD Tailored Plan, the Department and other Department vendors.

(vi) The BH I/DD Tailored Plan services lines shall have capacity to handle:

- (a) All inbound and outbound telephone calls during the hours of operation as defined in this Section;
- (b) Calls from members, recipients, and providers with limited English proficiency, as well as members, recipients, and providers with communications impairments, including individuals with hearing and/or speech disabilities;

- (c) Technology needed to receive calls from deaf, hard of hearing and Deaf-Blind callers to include TTY, captioned phones and amplified phones;
- (d) After-hours calls for Member and Recipient Services Line, Provider Support Service Line, and Pharmacy Service Line, including:
 - (1) Accepting, recording or providing instruction in response to incoming calls during non-business hours;
 - (2) Allowing option to leave a message and request for call back for all lines with the exception of the BH Crisis Line;
 - (3) If a request for a call back is made, the return phone call shall be made the following Business Day during normal hours of operations; and
 - (4) Department approval of the after-hours message.
- (e) An Automated Voice Response System (AVRS) which:
 - (1) Interacts with the member through voice and numeric prompts and allows members and recipients to perform self-service activities and resolve simple inquiries without the need to interact with a live person;
 - (2) May prompt callers to enter their Medicaid identification number or an alternative identifier as defined by the Department to identify the member prior to the call being distributed to a call center representative;
 - i. The AVRS must have the capability of allowing non-enrolled individuals and providers to access service line staff.
 - (3) Offers user-friendly options that are easily understood by Medicaid members, State-funded Services recipients and authorized representatives (including a decision tree illustrating AVRS system); and
 - (4) Works in conjunction with an Automated Call Distributor (ACD) which intelligently routes and effectively manages all calls to appropriate and available staff:
 - i. When a member or recipient desires to speak with a live person; and
 - ii. Based on unique member or recipient needs (i.e., caller language needs).
- (f) Ensures adequate staffing and capacity to meet the service line performance standards defined in the Contract.
- (vii) The BH I/DD Tailored Plan shall have an overflow, secondary call centers, or Department approved mitigation strategy to meet capacity requirements or to augment services provided as defined in this Section. All call centers required hereunder shall be held to the same service line performance standards as defined within this Contract, unless the Department has approved an exception as provided in this Section.
- (viii) The BH I/DD Tailored Plan shall be permitted to provide educational messages or other messages that improve the customer experience (e.g., announcement of new program changes or reminders) while callers are on hold, as recommended or approved by the Department. Callers to the Behavioral Crisis Line shall not be placed on hold.
- (ix) All BH I/DD Tailored Plan services lines, with the exception of the NEMT Member and Provider service lines, shall be able to transfer calls via Warm Transfer to the Department's NC Medicaid Direct provider and beneficiary call centers, Enrollment Broker, Ombudsman, county DSS or EBCL Public Health & Human Service (PHHS) offices, Standard Plans, and BH I/DD Tailored Plans when appropriate and without impacting the capacity to handle inbound calls simultaneously.
 - (a) The Warm Transfer is required only during the operational hours of the entities listed above in *Section V.A.2.a. Table 1: First Member, Recipient, and Provider Support Call Center Operations*.
 - (b) If the service line is attempting to connect a member or recipient to another entity that is closed, the BH I/DD Tailored Plan shall provide the information on how the caller may contact the entity directly during their operating hours.

- (x) All BH I/DD Tailored Plan services lines, with the exception of the NEMT Member and Provider service lines, shall be able to transfer calls via Warm Transfer to all other BH I/DD Tailored Plan service lines, when appropriate.
- (xi) The BH I/DD Tailored Plan shall digitally record and store one hundred percent (100%) of incoming and outgoing calls for quality assurance purposes for a period of no less than twelve (12) months from the date of the call including Subcontractors. The calls must be searchable via call recording metadata including at least service line, caller phone number, time and date.
- (xii) The BH I/DD Tailored Plan shall ensure the service lines are staffed with professionals who have sufficient training and knowledge, as defined in *Section V.A.2.iii. Staff Training for Medicaid and State-funded Services*, on North Carolina Medicaid, NC Health Choice and State-funded Services as defined within this Contract.
- (xiii) The BH I/DD Tailored Plan shall acquire the necessary phone number(s) to support the requirements of this section within sixty (60) Calendar Days of the Contract Award.
 - (a) The BH I/DD Tailored Plan shall relinquish ownership of the toll-free number(s), with the exception of the NEMT Member and Provider service line numbers, upon Contract termination or expiration, at which time the Department shall take title of these telephone numbers.
 - (b) All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, penalties or fines shall be the sole obligation of the BH I/DD Tailored Plan and shall be paid prior to the Department taking title.
- (xiv) The BH I/DD Tailored Plan shall develop service line scripts for use by BH I/DD Tailored Plan staff when talking with members, recipients, authorized representatives, and providers.
 - (a) All service line scripts shall be clear and easily understandable and reflect the specific requirements, policies and procedures of the North Carolina market.
 - (b) The BH I/DD Tailored Plan shall submit to the Department for approval a listing of topics which scripts will address, and shall modify the script topics as required by the Department. Topics for scripts shall include, but not be limited to:
 - (1) Member Medicaid Managed Care resources, education and assistance to understand Medicaid and NC Health Choice benefits;
 - (2) Recipient resources, education and assistance to understand State-funded Services;
 - (3) Information to contact the Enrollment Broker for Medicaid members;
 - (4) BH I/DD Tailored Plan Medicaid benefits and State-funded Services;
 - (5) Medicaid and State-funded Services Network;
 - (6) Service prior authorization process and status for Medicaid and State-funded Services;
 - (7) Member and recipient Grievances, Complaints and Appeals processes, including information on available member and recipients supports;
 - (8) Care Management for Medicaid and State-funded Services;
 - (9) Unmet Health-Related Resource Needs and the NCCARE360 resource for Medicaid and State-funded Services;
 - (10) Provider contracting for Medicaid and State-funded Services;
 - (11) Provider claim submission and adjudication issues for Medicaid and State-funded Services;
 - (12) AMH+ and CMA certification for Medicaid;
 - (13) Medicaid member pharmacy lock-in program;
 - (14) Ombudsman program for Medicaid;
 - (15) Transitions of Care for Medicaid; and
 - (16) Other topics as identified by the Department.
 - (c) All service line scripts shall be made available to the Department upon request, and all Member and Recipient Service Line, Nurse Line, NEMT Member Service Line and Behavioral Health Crisis

Line scripts shall be approved by the Department prior to use or when Significant Changes are made.

- (xv) The BH I/DD Tailored Plan shall document all call center interactions with members, recipients authorized representative and providers. The record of contact must include:
 - (a) Current or potential member's or recipient's name;
 - (b) Medicaid/NC Health Choice/State-funded Services identification number (preferred);
 - (c) Channel of interaction/Service Line;
 - (1) Phone number; and emergency or alternative number, if needed;
 - (d) Notes summary of current or potential member or recipient's interaction (e.g., summary of issue, if issue was resolved or addressed, what information was provided by the BH I/DD Tailored Plan's representative);
 - (e) Record of the time and date of interaction;
 - (f) Contact agent;
 - (g) Resolution and/or if additional follow-up is or was required; and
 - (h) Interpreter requests and the language requested.
- (xvi) The BH I/DD Tailored Plan shall develop and maintain a Call Center and Service Line Policy that defines how the BH I/DD Tailored Plan will meet and maintain the requirements of the Contract. As long as the Call Center and Service Line Policy clearly states that it applies to the BH I/DD Tailored Plan, the Call Center and Service Line Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP. The Call Center and Service Line Policy shall be made available to the Department, upon request.
 - (a) The Call Center and Service Line Policy shall include at a minimum:
 - (1) Service line process flows and call-tree routing options;
 - (2) Service line script topics;
 - (3) Staffing and licensure requirements;
 - (4) Quality assurance and monitoring approach;
 - (5) Member, recipient, and provider issue tracking and resolution process; and
 - (6) Incorporation of member, recipient, and provider issues into broader BH I/DD Tailored Plan QI activities.
- (xvii) Member and Recipient Service Line:
 - (a) Emergency member issues shall be defined as a member or recipient having an Emergency Medical Condition or in need of emergency services.
 - (1) The Member and Recipient Services Line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined in *Section V.B.1.iii. Member Engagement and Section V.C.1.b. Recipient Engagement*.
 - (2) Notwithstanding the preceding Warm Transfer requirements in *Section V.A.2.i.(viii)*, the BH I/DD Tailored Plan Member and Recipient Service Line must be able to connect to the BH I/DD Tailored Plan Behavioral Health Crisis Line via a Warm Transfer twenty-four (24) hours per day, seven (7) days per week.
- (xviii) The Nurse Line shall integrate with the BH I/DD Tailored Plan's overall care management program.
 - (a) Within forty-eight (48) hours of a member call, the Nurse Line shall follow up with the member's care manager or organization providing Tailored Care Management to share relevant clinical and follow up information.
- (xix) Pharmacy Service Line:
 - (a) The Service Line Policy shall include standards to meet twenty-four (24) hour prior authorization requirement as defined in *Section V.B.2.iii. Pharmacy Benefits*.
- (xx) Behavioral Health Crisis Line:

- (a) Must The BH I/DD Tailored Plan Behavioral Health Crisis Line must be staffed with licensed BH professionals.
- (b) Must be able to address mental health, SUD, I/DD, and TBI-related crisis events.
- (c) Must immediately connect to the crisis response systems.
- (d) Must have patch capabilities to 911 and any other crisis emergency services lines. In instances where there is immediate danger to self or others, the BH I/DD Tailored Plan shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
- (e) Must follow up with the member's care manager or organization providing Tailored Care Management to share relevant clinical and follow up information.
- (f) Must not:
 - (1) Allow members or recipients to receive a busy signal;
 - (2) Allow Member or recipient calls to be answered by an automated response;
 - (3) Allow Members or recipients to leave messages and receive a call back;
 - (4) Shift calls to an overflow system during high volume call times; or
 - (5) Allow maximum call duration limits.
- (xxi) In all communications with Members, recipients, and their families, the BH I/DD Tailored Plan shall comply with HIPAA and all other applicable confidentiality provisions set forth in State and federal law. The BH I/DD Tailored Plan shall:
 - (a) Respond appropriately to inquiries by Members, recipients, and their family members (including those with limited English proficiency);
 - (b) Connect Members, recipients, family members, and stakeholders to crisis services, when clinically appropriate, twenty-four hours (24) per day, seven (7) days per week, 365 days per year;
 - (c) Provide information to members, recipients, and their family members on where and how to access BH services; and
 - (d) Train its staff to recognize third-party insurance issues and member or recipient complaints, grievances, and appeals and to route these issues to the appropriate individual or BH I/DD Tailored Plan department.
- (xxii) The Department may allow certain exceptions from service line performance standards as defined by the Contract for secondary call centers. The BH I/DD Tailored Plan is required to submit a request to the Department for review and approval for a call center used by the BH I/DD Tailored Plan, or its Subcontractor, to be deemed a secondary call center and for any exceptions from the service line performance or Contract requirement standards defined by the Contract. The BH I/DD Tailored Plan shall not be allowed to request, for Department review and approval, any exceptions for overflow call centers.
- (xxiii) The NEMT service line shall adhere to logistical, informational, and accessibility requirements defined in *Section V.B.1.iii. Member Engagement* .
- (xxiv) Gross Customer Abuse
 - (a) The BH I/DD Tailored Plan shall prohibit gross customer abuse by call center agents across its service lines. Gross customer abuse includes any of the following actions performed by a call center agent, as determined by the Department:
 - (1) Use of profanity or vulgar language;
 - (2) Yelling or screaming at callers;
 - (3) Intentional disconnection with the caller; and
 - (4) Negligent or willful misconduct.
 - (b) As part of its call center quality assurance and monitoring approach, the BH I/DD Tailored Plan shall monitor its service lines for gross customer abuse and report any identified incidents to

the Department. Any complaints received by the BH I/DD Tailored Plan from a caller claiming gross customer abuse shall be reported to the Department. The BH I/DD Tailored Plan shall report incidents of gross customer abuse to the Department within two (2) Business Days after the incident is reported to or discovered by the BH I/DD Tailored Plan, in a format and manner defined by the Department.

- (c) The Department will monitor service lines for gross customer abuse during call center quality assurance procedures such as call report reviews listening observations or investigating external complaints.
- ii. Forensic Evaluator Program for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall maintain the Forensic Evaluator Program as described in 10A NCAC 27H .0205.
- iii. Staff Training for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall meet the Department's goals and objectives of providing support and services to meet member, recipient, and provider needs by training and educating BH I/DD Tailored Plan staff and contractors on the requirements, policies and procedures of Medicaid Managed Care, State-funded Services and the unique needs of Medicaid Managed Care members and State-funded Services recipient, or by contracting with a qualified training entity (as described in this section and in other sections in the RFA). The BH I/DD Tailored Plan and PIHP may combine its training modules to the extent the training goals and objectives are substantially similar.
 - (ii) As long as the training clearly states that it applies to the BH I/DD Tailored Plan, the training may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (iii) The BH I/DD Tailored Plan shall participate in Department initiatives to educate members, recipients, and providers about implementation activities, including but not limited to:
 - (a) Assistance with the development of call center scripts;
 - (b) Participation in Department-sponsored educational activities; and
 - (c) Integration of Department developed implementation-related content into member- and recipient-facing and provider-facing educational materials.
 - (iv) The BH I/DD Tailored Plan shall ensure that staff and contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under the Contract. Staff members having contact with members, recipients, or providers, or with the Department or the county Departments of Social Services staff shall receive training regarding the appropriate identification and handling of questions and concerns.
 - (v) The BH I/DD Tailored Plan shall begin training new staff to the North Carolina Medicaid Program and State-funded Services within seven (7) Calendar Days of their start date and complete within sixty (60) Calendar Days, unless otherwise approved by the Department.
 - (vi) The BH I/DD Tailored Plan shall conduct due process training at least annually for all relevant staff.
 - (vii) The training program shall include distinct training for:
 - (a) Member and recipient services staff and contractors;
 - (b) Provider relations staff and contractors;
 - (c) Staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators; and
 - (d) Staff and contractors whose work integrates with the Department.
 - (viii) The BH I/DD Tailored Plan shall be responsible for ensuring training directed toward member and recipient services staff and contractors include, but are not limited to:
 - (a) Overall understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals; and

- (2) BH I/DD Tailored Plan eligibility, benefits, and services, including State-funded Services and waiver services.
- (b) Services which the BH I/DD Tailored Plan is required to make available to all members;
- (c) Awareness of:
 - (1) All supports and services that may be appropriate for the member or recipient;
 - (2) Unique needs of the member and recipient populations;
 - (3) Stakeholders who may interact with members and recipients;
 - (4) Other programs that serve distinct populations;
 - (5) The role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to members' and recipients' health and health care needs; and
 - (6) Benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI.
- (d) Awareness of and sensitivity to:
 - (1) Different cultural health beliefs and practices;
 - (2) Low-socioeconomic individuals and/or families;
 - (3) Individuals with disabilities;
 - (4) Learning preferences to receiving information;
 - (5) Health disparities for Historically Marginalized Populations; and
 - (6) Individuals with trauma.
- (e) Ability to communicate appropriately with individuals in need of communication and language assistance.
 - (1) Use of interpreters, sign language interpreters both in-person and through video remote interpreting, Relay Video Conferencing Captioning, video relay services, 711 relay services, TTY machines, or assertive communication devices;
- (f) Member and recipient rights and responsibilities;
- (g) Member and recipient Grievances, Complaints, and Appeals processes, including State Fair Hearing Process;
- (h) The BH I/DD Tailored Plan's Medicaid and State-funded Services provider networks;
- (i) Overcoming barriers to accessing medical care for Medicaid members and for State-funded Services recipients (to the degree those resources are available and known by the BH I/DD Tailored Plan);
- (j) Linking members and recipients to other state and local programs or assistance, including but not limited to social services, state-funded BH services, law enforcement and the criminal justice system;
- (k) Fraud, waste, and abuse detection, investigation, and prevention;
- (l) Process for offering suggestions to improve the member, recipient, or provider experience;
- (m) Unique needs, experiences of members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:
 - (1) The significance of extended families including an understanding that the definition of extended families is different than non-native families;
 - (2) The potential services available for family members of enrolled members in EBCI or other federally recognized tribes;
 - (3) Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish); and
 - (4) Respect for traditions where gender and age may play an important role;
 - (5) Elders have a highly respected status due to their life experiences;
 - (6) Elders tend to be non-verbal;

- (7) Pregnant individuals; and
- (8) Veterans.
- (n) The different service types and benefit plans available through the EBCI Tribal Option; and
- (o) HIPAA and the Department's privacy and security requirements.
- (p) Differences between the PIHP and BH I/DD Tailored Plan, including who is eligible for each.
- (ix) The BH I/DD Tailored Plan shall be responsible for training care managers and supervising care managers as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements*.
- (x) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards provider relations staff and contractors include, but are not limited to:
 - (a) Understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
 - (2) BH I/DD Tailored Plan eligibility and services, including State-funded Services and waiver services;
 - (3) Unique needs of Member and Recipient populations; and
 - (4) Learning preferences to receiving information.
 - (b) Awareness of:
 - (1) All supports and services that enhance the provider experience;
 - (2) Stakeholders who may interact with providers; and
 - (3) Other programs that serve distinct populations.
 - (c) Awareness and sensitivity to:
 - (1) Different cultural health beliefs and practices; and
 - (2) Individuals with trauma.
 - (d) Covered Medicaid and State-funded Services;
 - (e) EPSDT criteria for members;
 - (f) Provider rights and responsibilities;
 - (g) Fraud, waste, and abuse detection, investigation, and prevention;
 - (h) Use of interpreters, sign language interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, or assistive communication devices;
 - (i) Unique needs and requirements of Indian Health Care Providers;
 - (j) HIPAA and the Department's privacy and security requirements; and
 - (k) Disaster or emergency situations that result in a major failure or disruption in care (e.g., fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic infectious disease) according to available guidance from the Department or federal government such as from the Centers for Disease Control and Prevention.
- (xi) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators include, but are not limited to:
 - (a) Overall understanding of Medicaid Managed Care and State-funded Services, including program eligibility, benefits, services, cost sharing, key initiatives and priorities, and program goals;
 - (b) Overall understanding of BH I/DD Tailored Plan eligibility and services, including State-funded Services and waiver services;
 - (c) Overall understanding of the unique needs of member and recipient populations;
 - (d) Awareness of member and recipient supports and services;
 - (e) Member and recipient rights and responsibilities;
 - (f) Member and recipient Grievances, Complaints, and Appeals processes;

- (g) Awareness of other programs that serve distinct populations;
 - (h) Fraud, waste, and abuse detection, investigation, and prevention; and
 - (i) HIPAA and the Department's privacy and security requirements.
- (xii) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the Department includes topics identified for all other training programs as described above, including, but not limited to:
- (a) Overall understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals; and
 - (2) BH I/DD Tailored Plan eligibility, benefits, and services, including State-funded Services and waiver services.
- (xiii) Submission and Approval
- (a) No later than ninety (90) Calendar Days after Contract Award, the BH I/DD Tailored Plan shall submit a training and evaluation program to the Department.
 - (1) The training program shall comply with all state and federal provisions, and should utilize Department resources where available.
 - (2) Each training program shall be approved by the Department before use with BH I/DD Tailored Plan staff and contractors.
 - (3) The BH I/DD Tailored Plan shall initiate training within five (5) Calendar Days of approval by the Department.
 - (4) As long as the Staff Training and Evaluation Program clearly states that it applies to the BH I/DD Tailored Plan, the Staff Training and Evaluation Program may apply to other LME/MCO operations, including, without limitation, the PIHP.
 - (b) Training materials shall include, but are not limited to:
 - (1) Training policies and procedures;
 - (2) Training plan;
 - (3) Training curriculum; and
 - (4) Evaluation methodology.
 - (c) The BH I/DD Tailored Plan shall update the training materials and conduct training of its staff and contractors annually, as changes are made to Medicaid Managed Care or State-funded Services, in response to improving the member and recipient experience, improving the provider experience, improving staff and contractor performance, and/or as requested by the Department.
 - (1) The BH I/DD Tailored Plan shall submit material updates and changes to the Department for review and approval before use with BH I/DD Tailored Plan staff and contractors.
- (xiv) The BH I/DD Tailored Plan must collaborate with the Department on providing training to Department, county DSS staff, the EBCI, the Ombudsman program and Enrollment Broker.
- (a) Training must:
 - (1) Be completed at least ninety (90) Calendar Days prior to BH I/DD Tailored Plan launch;
 - (2) Be hosted at multiple locations as defined by the Department or be held virtually;
 - (3) Contain information on the role of the BH I/DD Tailored Plan;
 - (4) Describe the relationship and integration of the BH I/DD Tailored Plan with the Department, Enrollment Broker, county DSS staff, the EBCI PHHS, and the Ombudsman program; and
 - (5) Describe how to navigate the public facing websites.
 - (b) Materials for the training must be provided to the Department no later than thirty (30) days prior to scheduled events for review. Training events may take place in person, virtually, using

an on-demand recorded webinar, through distributed materials, or any other vehicle in which the BH I/DD Tailored Plan is able to communicate its content to staff and contractors.

- (xv) No later than fourteen (14) Calendar Days after identification, the BH I/DD Tailored Plan shall update any materials publicly posted on the BH I/DD Tailored Plan's website that are inconsistent with the terms of this subsection or inconsistent with any trainings provided by the Department.
 - (xvi) The BH I/DD Tailored Plan shall require all staff to complete implicit bias training, inclusive of race, ethnicity, and religion in health care, gender and class bias.
 - (xvii) In support of the Department's health equity goals, the BH I/DD Tailored Plan shall establish and maintain a Health Equity Council that reports to the CEO no less than quarterly. The council members shall be reflective of the diverse populations served by the BH I/DD Tailored Plan and at a minimum:
 - (a) Identify and analyze health disparities through review of utilization and quality data;
 - (b) Address stakeholder representation and engagement improvements;
 - (c) Identify areas for improving diversity of staff, especially those in leadership positions, serving NC Medicaid members;
 - (d) Develop new initiatives that would address health disparities; and
 - (e) Examine existing policies that can be amended to improve health equity and reduce health disparities.
 - (xviii) As long as the Health Equity Council clearly covers BH I/DD Tailored Plan operations, the Council may also be used to meet requirements for other operations, including without limitation the PIHP contract.
- iv. Reporting for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall comply with all the reporting requirements established by the Contract for Medicaid and State-funded Services.
 - (ii) The Department shall provide the BH I/DD Tailored Plan with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
 - (iii) The Department may, at its discretion, change the content, format or frequency of reports or require the BH I/DD Tailored Plan to submit additional reports both ad hoc and recurring. The Department shall provide written notice of the proposed change at least thirty (30) days' in advance of the change's effective date through posting on the PCDU. As applicable, all notices should include the updated reporting template and any sample data requests for the BH I/DD Tailored Plan to send to its staff, contractors, contracted providers, or any other entity as appropriate.
 - (a) If the Department requests any revisions to the reports already submitted, the BH I/DD Tailored Plan shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.
 - (iv) The BH I/DD Tailored Plan shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.
 - (v) The BH I/DD Tailored Plan shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.
 - (vi) Except as otherwise specified, all reports shall be specific to each Region covered by this Contract.
 - (vii) The BH I/DD Tailored Plan shall provide all necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements including in the administration of North Carolina's 1115 and 1915(c) waivers and SPAs, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Community Mental Health Block Grant (CMHBG) by supporting the Department in monitoring BH I/DD Tailored Plan progress towards clinical quality and outcomes goals and maximizing federal match of state funds.

- (viii) Upon request, the BH I/DD Tailored Plan shall provide the Department with all underlying data required to produce reports required under the Contract for Medicaid and State-funded Services.
- v. BH I/DD Tailored Plan Policies for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall develop policy documents outlining key business processes, procedures and staffing requirements as required in this Contract for Medicaid and State-funded Services.
- (ii) Each policy document shall include:
- (a) Processes and procedures;
- (b) Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
- (c) Define required BH I/DD Tailored Plan and Department systems;
- (d) Role of Subcontractors; and
- (e) Describe BH I/DD Tailored Plan's continuous improvement approach to update policies.
- (iii) All required BH I/DD Tailored Plan policies are outlined in the Contract. The BH I/DD Tailored Plan shall submit policy documents for Medicaid and State-funded Services to the Department for review and approval as defined in the Contract.
- (iv) After initial approval, the BH I/DD Tailored Plan shall submit any material modifications, additions, or deletions of all Medicaid and State-funded Services policies to the Department at least thirty (30) Calendar Days prior to implementation, unless another time frame has been specified in the Contract.
- vi. Business Continuity for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall develop and maintain a Business Continuity Plan for Medicaid and State-funded Services that is acceptable to the Department, and demonstrate the adequacy of the Plan at the Department's request. The BH I/DD Tailored Plan shall adhere to all applicable published Department privacy and security policies, (located at <https://it.nc.gov/documents/statewide-information-security-manual> and <https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security/manuals>) and all other requirements set forth in the Contract.
- (ii) As long as the Business Continuity Plan clearly states that it applies to the BH I/DD Tailored Plan, the Business Continuity Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (iii) The BH I/DD Tailored Plan shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following the occurrence of a natural or manmade disaster or state of emergency. The BH I/DD Tailored Plan shall meet recognized industry standards for security and disaster recovery requirements.
- (iv) The BH I/DD Tailored Plan shall identify disaster or emergency situations that can result in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic.
- (v) As part of the BH I/DD Tailored Plan's business continuity planning, the BH I/DD Tailored Plan shall identify and review all federal or state disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Award to inform future disaster or emergency planning.
- (vi) The BH I/DD Tailored Plan shall provide disaster or emergency-related care coordination for high-risk Medicaid members who are obtaining care management as described in *Section V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations* (e.g., high-risk pregnant women, dialysis patients, medically frail, hemophiliacs, long-term care population,

individuals receiving Medication Assisted Treatment) during three (3) emergency timeframes, as applicable:

- (a) Pre-Emergency:
 - (1) Incorporate disaster planning in the care planning process; and
 - (2) Increase member outreach to ensure that members and recipients have adequate shelter, access to support to address their Unmet Health Related Resource Needs, access to back-up equipment and/or caretaker training if equipment fails.
- (b) During an Emergency:
 - (1) Continue to check-in on high-risk members and recipients to ensure safety and access to supports to address their Unmet Health-Related Resource Needs.
- (c) Post-Emergency:
 - (1) Check-in on high-risk members to ensure they were able to shelter safely and identify any behavioral or medical needs or Unmet Health-Related Resource Needs.
- (vii) The BH I/DD Tailored Plan shall comply with any additional requirements released by the Department to ensure continuity of care during an epidemic or pandemic, including those related to care coordination, care management, and supports to address their Unmet Health-Related Resource Needs.
- (viii) BH I/DD Tailored Plans shall comply with any additional guidance released by the Department during any type of disaster or emergency, including guidance on provider payments.
- (ix) When directed by the Department during a disaster or emergency, the BH I/DD Tailored Plan shall ensure continuity for Medicaid members and State-funded Services recipients by:
 - (a) Offering extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries.
 - (b) Removing and/or reducing required prior authorizations and concurrent review for Medicaid and State-funded Services;
 - (c) Providing emergency physical health to Medicaid members and BH services to Medicaid members and State-funded Services recipients residing in shelters;
 - (d) Providing all Medicaid members and State-funded Services recipients with access to out-of-network and Telehealth providers; and
 - (e) Increasing Medicaid member access to medications by removing maximum dosage limits for required medication, including medication assisted treatment (MAT), antipsychotics, and insulin.
- (x) The BH I/DD Tailored Plan shall support the Department's priorities for state-wide and local disaster or emergency planning and response including:
 - (a) Participation in the development of community disaster emergency response plans;
 - (b) Collaboration with other State department vendors to align efforts, as needed;
 - (c) Appointment of at least one representative to the statewide disaster or emergency planning and response efforts; and
 - (d) Recruitment and training for in-network Medicaid and State-funded BH providers to staff disaster shelters; and
 - (e) Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.
- (xi) Within thirty (30) Calendar Days of the Contract Award, the BH I/DD Tailored Plan shall submit its Business Continuity Plan for all requirements specified in the Contract, including:
 - (a) The preventive measures that would be instituted to minimize impact;
 - (b) The back-up, off-site storage, and other pre-disaster or emergency safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:

- (1) Descriptions of the controls for back-up processing, including how frequently backups occur;
 - (2) Documented back-up procedures;
 - (3) The location of data that has been backed up (off-site and on-site, as applicable);
 - (4) Identification and description of what is being backed up as part of the back-up plan;
 - (5) Any change in back-up procedures in relation to the BH I/DD Tailored Plan's technology changes;
 - (6) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and
- (c) Approach for providing care coordination activities to high risk Medicaid members in accordance with *Section V.A.2.vi.(v)*;
 - (d) Approach for ensuring continuity of care during an emergency for Medicaid members and State-funded Services recipients in accordance with *Section V.A.2.vi.(viii)*;
 - (e) Approach for supporting the Department's priorities for statewide and local disaster or emergency planning in accordance with *Section V.A.2.vi.(ix)*;
 - (f) Processes to provide information and resources to Medicaid members and State-funded Services recipients on how to protect themselves during a disaster or emergency and assist members and recipients with understanding how and when to access Medicaid benefits and State-funded Services;
 - (g) Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a member;
 - (h) Processes to ensure that providers deliver all necessary care to members during a disaster or emergency;
 - (i) Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
 - (j) Approach to supporting providers in the event of provider revenue disruptions;
 - (k) Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
 - (l) The tasks that would be involved in implementing the Business Continuity Plan, and identify by job description or title the BH I/DD Tailored Plan's staff and the Department's staff involvement;
 - (m) Current contact information for all critical staff and relevant personnel;
 - (n) The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternate worksite locations;
 - (o) The timeframe required to accomplish full recovery from the point of interruption;
 - (p) A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
 - (q) The procedures for coordinating with the Department in the event of a disaster or emergency;
 - (r) Notification procedures (call trees);
 - (s) Employee training and awareness detailing activation process;
 - (t) Document recovery time results;
 - (u) Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results; and
 - (v) The procedures for notifying the Department, Enrollment Broker, members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.

- (xii) The Business Continuity Plan should be marked as follows: “Confidential information – Not subject to public disclosure under G.S. §132” to prevent such document from being produced in a response to public record’s request.
- (xiii) The BH I/DD Tailored Plan shall update the Business Continuity Plan as necessary, every six (6) months at minimum.

3. Compliance

i. Compliance Program for Medicaid and State-funded Services

- (i) The BH I/DD Tailored Plan may utilize the same staff and services as it does for the PIHP to perform the operations described in this Section.
- (ii) The BH I/DD Tailored Plan shall implement a comprehensive Compliance Program for Medicaid and State-funded Services focused on ensuring the BH I/DD Tailored Plan is in compliance with all applicable federal and state laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.
- (iii) The BH I/DD Tailored Plan’s Compliance Program shall comply with 42 C.F.R. § 438.608, and must include for Medicaid and State-funded Services:
 - (a) Written policies, procedures, and standards of conduct that articulate the BH I/DD Tailored Plan’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:
 - (1) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a Network provider's circumstances that may affect the Network provider's eligibility to participate in the Medicaid Managed Care program or State-funded Services, including termination of the provider agreement with the BH I/DD Tailored Plan. 42 C.F.R. § 438.608(a)(4)
 - (2) Retention policies for the treatment of recoveries of all overpayments from the BH I/DD Tailored Plan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i).
 - (3) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the BH I/DD Tailored Plan is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii).
 - (4) Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).
 - (5) Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network providers were received by members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5).
 - (6) Process for providers to report and promptly return overpayments within sixty (60) days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2).
 - (b) The designation of a Chief Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract for Medicaid and State-funded Services and who reports directly to the Chief Executive Officer and the Board of Directors.
 - (c) The establishment of a Regulatory Compliance Committee of the Board of Directors for Medicaid and State-funded Services and at the senior management level charged with overseeing the BH I/DD Tailored Plan's Compliance Program and its compliance with the requirements under the Contract.

- (d) A system for training and education for the Compliance Officer, the BH I/DD Tailored Plan's senior management, and the BH I/DD Tailored Plan's employees on the federal and state standards and requirements under the Contract.
 - (e) Effective lines of communication between the Compliance Officer and the BH I/DD Tailored Plan's employees.
 - (f) Enforcement of standards through well-publicized disciplinary guidelines.
 - (g) Identification of potential and actual compliance risks.
 - (h) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.
- (iv) The BH I/DD Tailored Plan shall develop a Compliance Plan which defines the BH I/DD Tailored Plan's Compliance Program for Medicaid and State-funded Services. As long as the Compliance Plan clearly states that it applies to the BH I/DD Tailored Plan, the Compliance Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP
- (a) The BH I/DD Tailored Plan shall provide the Compliance Plan to the Department:
 - (1) As part of the Implementation Plan, during Readiness Review;
 - (2) Annually thereafter; and
 - (3) Upon request by the Department.
 - (b) The BH I/DD Tailored Plan shall revise the BH I/DD Tailored Plan's Compliance Plan as requested by the Department.
 - (c) The BH I/DD Tailored Plan shall submit any requested document within five (5) Calendar Days of the Department's request to review the BH I/DD Tailored Plan's Compliance Plan, and any other policy or procedures governing the BH I/DD Tailored Plan's compliance activities for Medicaid and State-funded Services.
 - (d) Annually, the BH I/DD Tailored Plan shall develop monitoring and auditing work plan(s) for the upcoming year for Medicaid and State-funded Services.
 - (1) The BH I/DD Tailored Plan shall submit a Compliance Program report for Medicaid and State-funded Services describing the work plans for the upcoming year.
 - (2) The report shall be submitted ninety (90) days prior to BH I/DD Tailored Plan launch.
 - (3) Following Contract Year 1 of BH I/DD Tailored Plan, the Compliance Program report shall include proposed work plan(s) for the upcoming year and summarize of the status of the previous year's work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.
 - (e) Compliance with federal and state requirements for State-funded Services
 - (1) The BH I/DD Plan's Compliance Program shall address how it will ensure that the BH I/DD Tailored Plan staff and its Subcontractors shall fully comply with all requirements and restrictions of all state and federal grant programs, and their accompanying State-fund Maintenance of Effort (MOE) requirements in all BH I/DD Tailored Plan expenditures and reimbursements using state and federal funds, and in all BH I/DD Tailored Plan subcontracting with entities that are eligible to receive these funds.
 - (2) The Department shall apprise the BH I/DD Tailored Plan in writing of the requirements and restrictions of these funding sources.
 - (3) The BH I/DD Tailored Plan shall notify all staff and Subcontractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.

- (4) The BH I/DD Tailored Plan staff and contractors shall fully comply with the monitoring and auditing activities of the Department as instructed.
- ii. Program Integrity (PI) for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan may utilize the same staff and services as it does for the PIHP to perform the operations described in the Section.
- (ii) To ensure the effective use and management of public resources in the delivery of services to Medicaid Managed Care members and State-funded Services recipients, the BH I/DD Tailored Plan shall also increase awareness within its organization and across its provider Network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the BH I/DD Tailored Plan shall comply with all applicable federal and state laws and regulations including, but not limited to Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.
- (iii) To promote PI, the BH I/DD Tailored Plan shall adhere to the following program standards, at a minimum:
- (a) Validation of Exclusion List Status for Medicaid and State-Funded Services
- (1) The BH I/DD Tailored Plan shall, prior to contracting, check the exclusion status of all providers against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal funds to excluded persons or entities.
- (2) The BH I/DD Tailored Plan shall disclose to the Department within thirty (30) Calendar Days of BH I/DD Tailored Plan's knowledge any disciplinary actions that have been imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.
- (3) The BH I/DD Tailored Plan shall check, at least every month, the exclusion status of persons with an ownership or controlling interest in the BH I/DD Tailored Plan (as applicable), agents and managing employees of the BH I/DD Tailored Plan, network providers, delegated entities, and Subcontractors against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal or state funds to excluded persons or entities. The BH I/DD Tailored Plan shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).
- (4) The BH I/DD Tailored Plan shall take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities or Subcontractor appears on one or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
- (5) The BH I/DD Tailored Plan shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
- i. The name(s) of the Excluded Person(s);
- ii. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
- iii. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.
- (b) Prohibited Relationships for Medicaid and State-funded Services
- (1) In accordance with 42 C.F.R. § 438.610, the BH I/DD Tailored Plan shall not knowingly have a relationship with any of the following:
- i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued

- under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
- ii. An individual or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person.
 - iii. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
- (2) For the purposes of this Section, a “relationship” means any of the following:
- i. A director, officer, governing board member, or partner of the BH I/DD Tailored Plan;
 - ii. A Subcontractor of the BH I/DD Tailored Plan, as governed by 42 C.F.R. § 438.230;
 - iii. A person with beneficial ownership of five percent (5%) or more of the BH I/DD Tailored Plan’s equity; or
 - iv. A network provider or person with an employment, consulting or other arrangement with the BH I/DD Tailored Plan for the provision of items and services that are significant and material to the BH I/DD Tailored Plan’s obligations under this Contract.
- (3) If the Department learns that the BH I/DD Tailored Plan has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the BH I/DD Tailored Plan has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the BH I/DD Tailored Plan unless the United States Secretary of the Department of Health & Human Services directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the BH I/DD Tailored Plan unless the United States Secretary of the Department of Health & Human Services provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.
- (c) Suspensions and Withholds for Payments to Providers for Program Integrity for Medicaid and State-funded Services
- (1) The BH I/DD Tailored Plan shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold for Medicaid and State-funded Services providers.
 - (2) The BH I/DD Tailored Plan shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold for Medicaid and State-funded Services providers.
 - (3) When the Department notifies the BH I/DD Tailored Plan that payments to a provider have been suspended or are being withheld, the BH I/DD Tailored Plan shall suspend payments to or withhold payments from the provider in accordance with the Department’s instructions within one (1) Business Day of receipt of the notice or as otherwise instructed. The BH I/DD Tailored Plan shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
 - (4) The BH I/DD Tailored Plan shall commence a payment suspension or withhold in accordance with the Department’s instructions and such suspension or withhold shall continue until the BH I/DD Tailored Plan receives notice from the Department to lift the suspension or withhold.

- (5) The BH I/DD Tailored Plan shall lift the suspension or withhold within three (3) Business Days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
- (6) The BH I/DD Tailored Plan shall obtain the Department's written approval of the suspension prior to suspending payments to any provider due to suspected fraud or abuse. The BH I/DD Tailored Plan shall initiate such suspension within one (1) Business Day of receipt of the approval if the Department approve the suspension of payment.
- (7) The BH I/DD Tailored Plan shall provide the following information to the Department to request a suspension or withhold of payment to any provider:
 - i. Name of the Network provider or non-contract provider and NPI;
 - ii. The nature of the suspected fraud;
 - iii. Basis for the suspension/withhold;
 - iv. Desired date for the suspension/withhold to begin;
 - v. Proposed length of the suspension/withhold;
 - vi. Proposed percentage of the withhold, if applicable; and
 - vii. If applicable, the good cause rationale for imposing a partial payment suspension.
- (d) Coordination of Provider Monitoring and Auditing for Medicaid and State-Funded Services
 - (1) The BH I/DD Tailored Plan may conduct an audit of a provider or accept a self-disclosure from a provider even when the Department or MID conducted an audit of the same provider or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period with prior permission from the Department.
 - (2) The BH I/DD Tailored Plan shall comply with any Department directive not to conduct an audit of a provider.
- (e) The BH I/DD Tailored Plan shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services, the Inspector General of the US DHHS, and the Comptroller General, Members, and Recipients a description of transactions between the BH I/DD Tailored Plan and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
 - (1) Any sale or exchange, or leasing of any property between the BH I/DD Tailored Plan and such a party;
 - (2) Any furnishing for consideration of goods, services (including management services), or facilities between the BH I/DD Tailored Plan and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
 - (3) Any lending of money or other extension of credit between the BH I/DD Tailored Plan and such a party. Section 1903(m)(4)(A) of the Social Security Act.
- (f) Deficit Reduction Act (DRA) Reporting for Medicaid
 - (1) The BH I/DD Tailored Plan shall have a policy and procedure which complies with the requirements of the DRA of 2005, which requires entities that make or receive annual Medicaid payments of five million (\$5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal penalties for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
 - (2) The BH I/DD Tailored Plan shall submit annually to the Department, in the format prescribed by the Department, policies and procedures in accordance with the DRA.
- (g) Providers and Subcontractors

- (1) The BH I/DD Tailored Plan shall require Subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the DRA of 2005 requirements.
 - (2) The BH I/DD Tailored Plan shall provide its Network providers and Subcontractors with training materials regarding fraud, waste, and abuse prevention.
 - (3) The BH I/DD Tailored Plan shall annually certify that no payments are made for services or items provided to a provider, Subcontractor, or financial institution located outside of the United States.
 - (4) In accordance with federal regulations, the BH I/DD Tailored Plan shall require Network providers and non-contract providers to have and implement a policy recognizing Medicaid as the payer of last resort.
- (h) Prohibited Payments for Medicaid and State-funded Services
- (1) The BH I/DD Tailored Plan shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
 - i. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
 - ii. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
 - iii. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
 - (2) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
 - (3) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.
- (i) Notice of Certain Reporting and Audit Requirements for State-Funded Services
- (1) In accordance with the Federal Funding Accountability and Transparency Act (FFATA), BH I/DD Tailored Plans that receive a sub award of more than \$25,000 in federal financial assistance (through block grants or other federal grants, exclusive of Medicaid) are required to obtain a DUNS number at <http://fedgov.dnb.com/webform> and to register in the System for Award Management (SAM) at www.sam.gov.
 - (2) The BH I/DD Tailored Plan shall send proof of the DUNS number prior to the initiation of the contract and the receipt of any sub award payments to the Department.
 - (3) The BH I/DD Tailored Plan shall use or expend the funds available under this Contract only for the purposes for which they were appropriated by the General Assembly or received by the State.
 - (4) State funds include federal grant funds that flow through the State.
 - (5) In addition, specific state funds allocated to the BH I/DD Tailored Plan by the Department must be used in accordance with the requirements set out in the allocation letters which accompany those funds, to the extent that such requirements are not inconsistent with the terms and conditions of this Contract. The BH I/DD Tailored Plan is subject to the

requirements of 2 CFR Part 200, known as the OMB Super Circular, and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.

- (6) The BH I/DD Tailored Plan shall furnish to the State Auditor, upon his/her request, all books, records, and other information that the State Auditor needs to fully account for the use and expenditure of state funds in accordance with N.C.G.S. §147-64.7.
- (j) Post-Payment Clinical and Administrative Reviews for State-Funded Services
 - (1) The BH I/DD Tailored Plan shall conduct post-payment reviews of state-funded BH and I/DD services to monitor whether services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Records Management and Documentation Manual; the DMH/DD/SAS State-funded Enhanced Mental Health and Substance Abuse Services Manual and the DMH/DD/SAS Service Definitions; the Person-Centered Planning Instruction Manual; DMH/DD/SAS policies; and the NC General Statutes, as applicable.
 - (2) In accordance with 42 USC 300x-5 and 300x-31 and 42 USC 300x-55, the BH I/DD Tailored Plan shall:
 - i. Develop and implement a policy and/or procedure mandating that the federal program requirements are conveyed to intermediaries and providers of block grant services.
 - ii. Cooperate with the Department monitoring activities of the BH I/DD Tailored Plan's appropriate use of block grant and State funds, including:
 - iii. Budget review;
 - iv. Claims payment adjudication;
 - v. Expenditure report analysis;
 - vi. Compliance reviews;
 - vii. Recipient level encounter/use/performance analysis data; and
 - viii. Audits.
 - (3) The BH I/DD Tailored Plan shall implement payment method controls to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
- iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services
 - (i) To promote integrity in all BH I/DD Tailored Plan activities and combat fraud, waste, and abuse, the BH I/DD Tailored Plan shall:
 - (a) Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (members, providers, Subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid Managed Care and State-funded Services;
 - (b) Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits for Medicaid members or the disbursement of funds for State-funded Services recipients;
 - (c) Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
 - (d) Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
 - (e) Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
 - (f) Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;

- (g) Refer all allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department;
 - (h) Define the quality and data integrity standards maintained by the BH I/DD Tailored Plan to produce accurate clinical quality metrics and reporting to the Department; and
 - (i) Have an identified individual(s) testify to the potential financial loss due to fraud, waste, and abuse upon request by the Department.
- (ii) Fraud, Waste, and Abuse Investigation Staffing
- (a) The BH I/DD Tailored Plan may utilize the same staff and services as it does for the PIHP to perform the operations described in this Section.
 - (b) The BH I/DD Tailored Plan shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the BH I/DD Tailored Plan in preventing and detecting fraud, waste and abuse.
 - (c) The BH I/DD Tailored Plan shall establish a Special Investigations Unit (SIU) sixty (60) Calendar Days prior to BH I/DD Tailored Plan launch, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan inclusive of Medicaid and non-Medicaid funding. The BH I/DD Tailored Plan shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.
 - (1) The SIU will consist of dedicated staff members who are located in North Carolina.
 - (2) The BH I/DD Tailored Plan's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
 - (3) The BH I/DD Tailored Plan shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law or criminal justice, or have at least three (3) years of relevant experience.
 - (4) The BH I/DD Tailored Plan shall require that the staff of its SIU, as well as its Chief Compliance Officer, or designee, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training or similar training from the Health Care Compliance Association.
- (iii) Investigation Coordination
- (a) The BH I/DD Tailored Plan shall refer **all** allegations of fraud for Medicaid and State-funded Services, including instances involving the BH I/DD Tailored Plan's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) days of making the determination.
 - (b) Once **an** allegation of fraud has been referred to the Department, until further written notice by the Department, the BH I/DD Tailored Plan shall not take any further action including the following:
 - (1) Contacting the subject of the investigation about any matters related to the investigation;
 - (2) Continuing the investigation into the matter;
 - (3) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
 - (4) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
 - (c) The BH I/DD Tailored Plan shall cooperate with all appropriate State and federal agencies, including MID, the DMH/DD/SAS Financial Audit and Program Integrity teams and/or federal OIG, in investigating fraud and abuse.

- (d) The BH I/DD Tailored Plan shall provide data or information requested by the Department including the DMH/DD/SAS Financial Audit and Program Integrity teams or MID, as relevant, in the standardized format within five (5) Calendar Days of receiving the request.
- (e) The BH I/DD Tailored Plan shall cooperate with the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID, as relevant, to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.
- (f) If the BH I/DD Tailored Plan is directed to complete the investigation into potential instances of fraud, then the BH I/DD Tailored Plan shall report to the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID, as relevant, in a specified format, its finding within ten (10) Calendar Days of the conclusion of the investigation.
- (g) The BH I/DD Tailored Plan shall report new information related to a previously referred potential instance of fraud where PI, the DMH/DD/SAS Financial Audit and Program Integrity teams and MID did not intervene in the investigation to the Department. The BH I/DD Tailored Plan shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) Calendar Days of receiving or identifying the new information.
- (h) The BH I/DD Tailored Plan cannot take action, such as termination or suspension, or withhold of payment, related to potential findings of fraud without approval of the Department including the DMH/DD/SAS Financial Audit and Program Integrity teams and/or MID. Any such action taken after BH I/DD Tailored Plan has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.
- (i) Action by the BH I/DD Tailored Plan shall not preclude the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams or MID from conducting an audit or accepting a self-disclosure from a provider even if the BH I/DD Tailored Plan has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.
- (j) The BH I/DD Tailored Plan must participate in:
 - (1) Monthly calls with the Department regarding fraud, waste, and abuse;
 - (2) Quarterly in-person or virtual meetings with the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID regarding fraud and abuse; and
 - (3) Ad hoc calls or meetings as requested by the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID.
- (iv) Whistleblower Protections
 - (a) The BH I/DD Tailored Plan shall develop and maintain a Whistleblower Policy related to whistleblower protections for Medicaid and State-funded Services and submit to the Department for review ninety (90) days after Contract Award.
 - (b) As long as the Whistleblower Policy clearly states that it applies to the BH I/DD Tailored Plan, the Whistleblower Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (c) The BH I/DD Tailored Plan shall include fraud, waste, and abuse policies and procedure information in the BH I/DD Tailored Plan's employee handbook with reference to and description of the applicable federal and State fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the BH I/DD Tailored Plan's compliance policies and how to access those policies.
- (v) Fraud Prevention Plan
 - (a) The BH I/DD Tailored Plan shall develop and maintain a Fraud Prevention Plan for Medicaid and State-funded Services subject to Department review and approval. The BH I/DD Tailored Plan shall submit the Plan to the Department:

- (1) Ninety (90) days after Contract Award;
 - (2) Annually thereafter;
 - (3) When substantive or material changes are made to the Fraud Prevention Plan; and
 - (4) Upon request by the Department.
- (b) The BH I/DD Tailored Plan shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the BH I/DD Tailored Plan to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the BH I/DD Tailored Plan's Fraud Prevention Plan.
- (c) As long as the Fraud Prevention Plan clearly states that it applies to the BH I/DD Tailored Plan, the Fraud Prevention Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (d) The Fraud Prevention Plan shall include the following:
- (1) The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2 and *Section III.A. Definitions*;
 - (2) Name of the Chief Compliance Officer;
 - i. The Chief Compliance Officer, or designee, shall be responsible for making the decisions on which fraud, waste, or abuse cases to refer to the Department.
 - (3) Description of the SIU, the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care and/or State-funded Services;
 - (4) Description of other staff assigned to fraud, waste, and abuse functions;
 - (5) Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
 - (6) Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
 - (7) Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
 - (8) Processes and procedures that address Medicaid and State-funded network provider and BH I/DD Tailored Plan staff terminations related to suspected or confirmed fraud and abuse;
 - (9) Processes and procedures by which the BH I/DD Tailored Plan avoids fraud, waste and abuse engaged in by out-of-network Medicaid and State-funded providers;
 - (10) Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by members or recipients;
 - (11) Training procedures for directors, officers, employees, delegated entities, and subcontractor education on federal and state laws, as well as BH I/DD Tailored Plan practices for detection, identification, reporting and prevention of fraud, waste and abuse;
 - (12) Processes and procedures for ensuring in and out-of-network providers, members and recipients know and understand fraud, waste and abuse obligations;
 - (13) Processes and procedures for putting a provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate. The policy shall be included in the BH I/DD Tailored Plan's Provider Manual;
 - (14) Description of the BH I/DD Tailored Plan's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
 - i. A list of automated pre-payment claims edits;
 - ii. A list of automated post-payment claims edits;

- iii. A list of desk audits on post-processing review of claims planned;
 - iv. A list of reports on Medicaid and State-funded network provider and out-of-network provider profiling used to aid program and payment integrity review;
 - v. The methods the BH I/DD Tailored Plan will use to identify high-risk claims and the BH I/DD Tailored Plan's definition of "high-risk claims;"
 - vi. Visit verification procedures and practices, including sample sizes and targeted providers types or locations;
 - vii. A list of surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Medicaid, waiver, Pilot, or State-funded Services;
 - viii. Policies and procedures used by the BH I/DD Tailored Plan designed to prevent, detect, and report known or suspected fraud, waste and abuse for Medicaid and State-funded Services;
 - ix. A list of references in provider and member and recipient material regarding fraud and abuse referrals (e.g. on member EOB);
 - x. Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly; and
 - xi. The process by which the SIU shall monitor the BH I/DD Tailored Plan's marketing representative activities to ensure that the BH I/DD Tailored Plan does not engage in inappropriate activities, such as provision of inducements.
- (15) Assurance that the identities of individuals reporting violations by the BH I/DD Tailored Plan are protected and that there is no retaliation against such persons;
 - (16) Description of criminal background and Exclusion List screening processes for its owners, agents, delegated entities, employees, Network providers and subcontractors; and
 - (17) Process and procedures for working and coordinating with the Department, including its state and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.
- iv. Third Party Liability (TPL) for Medicaid
 - (i) The BH I/DD Tailored Plan shall be responsible for actively seeking and identifying third party resources for the purposes of the following:
 - (a) Cost avoidance;
 - (b) Credit balance;
 - (c) Commercial health insurance;
 - (d) Medicare disallowance;
 - (e) Casualty insurance; and
 - (f) Liability insurance.
 - (ii) Cost Avoidance
 - (a) The BH I/DD Tailored Plan shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
 - (1) Policy number;
 - (2) Policyholder's name;
 - (3) Group Policy number;
 - (4) Group Policy name;
 - (5) Identification of whether the policyholder is the non-custodial parent;
 - (6) Member Medicaid/NC Health Choice ID;
 - (7) Member relationship to policy holder;
 - (8) The begin date of insurance coverage; and
 - (9) The end date of insurance coverage.

- (iii) The BH I/DD Tailored Plan shall engage in third party resource recovery and cost avoidance for all other types of recovery. BH I/DD Tailored Plan shall not use State-funded Services or Pilot services to cost avoid.
- (iv) The BH I/DD Tailored Plan shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless of whether the start date began prior to the member becoming Medicaid eligible or enrolled with the BH I/DD Tailored Plan.
- (v) The BH I/DD Tailored Plan shall report cost recovery and cost adjustments through the encounter process, including denials.
- (vi) The BH I/DD Tailored Plan shall make every reasonable effort to determine the liability of third parties to pay for services rendered to members and to cost avoid and/or cost recover such liability from the third party.
- (vii) The BH I/DD Tailored Plan shall treat all funds recovered by the BH I/DD Tailored Plan from third party resources as income to the BH I/DD Tailored Plan. Further, the Department will include the revenue as a reduction in claims expense (numerator only) and not included as revenue in the denominator of the BH I/DD Tailored Plan's Medical Loss Ratio calculation.
- (viii) TPL Recovery
 - (a) The BH I/DD Tailored Plan shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
 - (b) The BH I/DD Tailored Plan shall open a new case upon receipt of a TPL Accident Information Report form from the member's attorney or other reliable leads that indicate third party recovery might be possible.
 - (c) The BH I/DD Tailored Plan shall be responsible for identifying and communicating with attorneys retained by Members for tort action, through contact with the Members, Participating Providers, and the Department for seeking and identifying third party resources.
 - (d) The Department shall review the effectiveness of the BH I/DD Tailored Plan's TPL recovery programs annually and may revoke TPL activities from a BH I/DD Tailored Plan if the BH I/DD Tailored Plan's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the BH I/DD Tailored Plan's TPL recovery programs may include:
 - (1) A comparison to annual Medicaid Fee-for-Service recovery averages to BH I/DD Tailored Plan recovery averages per beneficiary.
 - (2) The percentage of recoveries over total spend.
 - (3) The percentage of cost avoidance over total spend.
 - (4) The average turnaround time from the remittance to recovery.
 - (5) The average number of policy adds in comparison to historical Medicaid Fee-for-Service policy adds on a monthly basis.
 - (6) Quarterly audits on BH I/DD Tailored Plan encounter data.
 - (e) The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.
- (ix) Identification of Other Forms of Insurance
 - (a) The BH I/DD Tailored Plan shall notify the Department within five (5) Calendar Days if it has identified that a member has another form of insurance.
 - (b) The BH I/DD Tailored Plan shall load and submit to the Department updates and additions on other forms of insurance into its system within thirty (30) Calendar Days of matching and verification.
 - (c) The BH I/DD Tailored Plan shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been

updated in the BH I/DD Tailored Plan's system or submitted by the BH I/DD Tailored Plan to the Department for Medicaid Managed Care members.

- (d) The BH I/DD Tailored Plan shall ensure that the information on member's other forms of insurance is accurately tracked and maintained within the member record. The BH I/DD Tailored Plan must correct all errors made in its submission of other forms of insurance to the Department within five (5) Business Days of becoming aware of the other forms of insurance and must provide proof of such corrections upon request from the Department.
- (e) The BH I/DD Tailored Plan shall review paid claims to determine which paid claims should have been paid by the member's other forms of insurance instead of by the BH I/DD Tailored Plan.
- (f) The BH I/DD Tailored Plan shall notify the Department of overpayments paid to the BH I/DD Tailored Plan from an insurance carrier for recovery claims billed by the BH I/DD Tailored Plan for members with other forms of coverage.
- (g) The BH I/DD Tailored Plan shall bill the applicable insurance carriers for Medicaid Managed Care members' major medical, prescription drug and dental claims within thirty (30) Calendar Days of matching the claims to TPL segments pertaining to members' active insurance policies for commercial insurance direct billing.
 - (1) The BH I/DD Tailored Plan shall adhere to the billing requirements of each commercial insurance carrier.
 - (2) In instances where the carrier will not accept the claim without supporting medical records, the BH I/DD Tailored Plan shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) Calendar Days of becoming aware of the need for medical records by the commercial insurance to bill.
- (h) Within ten (10) Business Days after receipt of a direct claim billing denial or other types of denials, the BH I/DD Tailored Plan shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the BH I/DD Tailored Plan's IT system; and resubmit the claim to the appropriate insurance carrier.
- (x) Subrogation Cases
 - (a) Pursuant to 42 C.F.R. § 438.608, the BH I/DD Tailored Plan agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
 - (b) The BH I/DD Tailored Plan lien in each subrogation case shall be equal to the payments made by the BH I/DD Tailored Plan.
 - (c) The BH I/DD Tailored Plan shall identify the BH I/DD Tailored Plan paid medical claims amounts for each subrogation case using data from the paid claims file.
 - (d) Relevant information in the subrogation case at the time of closure shall include:
 - (1) Settlement sheet listing all providers with medical subrogation rights.
 - (2) Original lien amount of each entity with subrogation right.
 - (3) The BH I/DD Tailored Plan recovered amount.
 - (4) The amount disbursed to each entity involved.
 - (e) The BH I/DD Tailored Plan shall review the diagnosis code and member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
 - (f) A subrogation case shall be closed with recovery after the BH I/DD Tailored Plan lien has been satisfied to the statutory limits, as referenced in N.C. Gen. Stat. § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery only after the BH I/DD Tailored Plan provides relevant and adequate documentation supporting the reason for case closure without recovery. The BH I/DD Tailored

Plan shall obtain and record all relevant information in the subrogation case at the time of closure.

- (g) In accordance with N.C. Gen. Stat. § 108A-57(a1), the BH I/DD Tailored Plan shall collect the amount of the BH I/DD Tailored Plan lien or up to one-third (1/3) of the amount of the member's gross recovery in the personal injury or wrongful death case, whichever is less.
 - (h) The BH I/DD Tailored Plan shall coordinate collection of the settlement amount with the Member or the Member's attorney.
 - (i) The BH I/DD Tailored Plan shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the BH I/DD Tailored Plan's claim to any part of the proceeds of any settlement.
 - (j) The BH I/DD Tailored Plan shall not compromise, waive or reduce the BH I/DD Tailored Plan's lien without written authorization from the Department or its designated legal counsel.
 - (k) The BH I/DD Tailored Plan shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.
 - (l) The BH I/DD Tailored Plan shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.
 - (xi) The BH I/DD Tailored Plan shall develop and maintain a TPL Policy for review and approval by the Department. As long as the TPL Policy clearly states that it applies to the BH I/DD Tailored Plan, the TPL Policy clearly may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (a) The TPL Policy shall include the following:
 - (1) Cost avoidance activities;
 - (2) Payment recovery activities;
 - (3) Identification of other forms of insurance processes and procedures; and
 - (4) Subrogation, including:
 - i. Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
 - (b) The BH I/DD Tailored Plan shall submit the TPL Policy:
 - (1) Ninety (90) days after Contract Award;
 - (2) Annually thereafter; and
 - (3) Upon request by the Department.
- v. TPL for State-funded Services
- (i) The BH I/DD Tailored Plan shall require its providers to pursue all applicable first and third-party payments for services, including Medicaid funding and the Division of Vocational Rehabilitation (DVRS) funding for Supported Employment, in order to minimize the usage of State resources.
 - (ii) In the event that a recipient has third party coverage, the BH I/DD Tailored Plan shall coordinate benefits so that costs for services otherwise payable by non-Medicaid funds are avoided or recovered from any liable third-party payers.
 - (iii) The BH I/DD Tailored Plan's claims system shall include appropriate edits for coordination of benefits and first and third-party liability.
 - (iv) The BH I/DD Tailored Plan shall develop and implement monitoring of provider compliance with first and third-party requirements.
- vi. Medicaid Service Recipient Explanation of Medical Benefit (REOMB) for Medicaid
- (i) The BH I/DD Tailored Plan shall create the REOMB using the previous month's claims for North Carolina Medicaid (i.e. February claims comprise March REOMB sample).

- (ii) The BH I/DD Tailored Plan shall include the following in the REOMB:
 - (a) List of services provided and billed to the BH I/DD Tailored Plan;
 - (b) The name of the provider administering the service;
 - (c) The date(s) on which the service was administered;
 - (d) The paid and unpaid services; and
 - (e) The reason a service was not paid.
 - (iii) The BH I/DD Tailored Plan shall exclude those claims that include sensitive information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB. Sensitive information shall be defined as any procedures for allergies, newborn treatment and care, and any treatment for a member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, sterilization, and substance abuse disorder information protected by 42 C.F.R. Part 2.
 - (iv) The BH I/DD Tailored Plan shall exclude sensitive information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with N.C. General Statutes Chapter 48A.
 - (v) The BH I/DD Tailored Plan shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month, for both PIHP and BH I/DD Tailored Plan claims, whichever is less. (Excluded claims include those in referenced in this Section).
 - (vi) The BH I/DD Tailored Plan shall send the REOMB via US mail to randomly selected Members. The BH I/DD Tailored Plan shall collect responses from the REOMB mailing.
 - (vii) The BH I/DD Tailored Plan shall use a Department approved sampling method to determine the population to receive the REOMB and include it in the BH I/DD Tailored Plan's annual Fraud Prevention Plan.
 - (viii) The BH I/DD Tailored Plan shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.
 - (ix) The BH I/DD Tailored Plan shall provide a REOMB to a Member upon request.
4. Stakeholder Engagement and Community Partnerships
- i. Engagement with Tribes for Medicaid Only
 - (i) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of all tribal members and other individuals eligible to receive Indian Health Services, including North Carolina's federally recognized tribe (the Eastern Band of Cherokee Indians) and state-recognized tribes.
 - (ii) As specified in N.C. Gen. Stat. § 160-40(a)(5) and (5a), members of federally recognized tribes are exempt from mandatory enrollment in Medicaid Managed Care, and the Department will seek statutory authorization to exempt from mandatory enrollment in Medicaid Managed Care other individuals eligible to receive Indian Health Services, consistent with federal law. Members of state-recognized tribes are required to enroll in Medicaid Managed Care unless they are Members of otherwise excluded populations.
 - (iii) The Department is collaborating with the EBCI to develop the EBCI Tribal Option that considers and addresses the unique cultural, physical/medical behavioral, and social determinants of health needs of federally recognized tribal members and other individuals eligible to receive Indian Health Services.
 - (iv) Federally recognized tribal members and other individuals eligible to receive Indian Health Services will be enrolled in the Tribal Option if they live in the five western counties of Swain, Jackson, Haywood, Cherokee, and Graham counties. Individuals will have the ability to opt out of the Tribal Option if they reside in those five counties and participate in Medicaid Managed Care (either a Standard Plan or BH I/DD Tailored Plan, as applicable) or NC Medicaid Direct.

- (v) The BH I/DD Tailored Plan shall establish an ongoing meaningful partnership and collaboration with any state- and federally-recognized Tribes located within the service area of the BH I/DD Tailored Plan. All BH I/DD Tailored Plans are required to establish a partnership with the Eastern Band of the Cherokee as they manage and operate the IHCPs in NC in which all federally recognized tribal members are entitled to access regardless of location or geography.
- (vi) The BH I/DD Tailored Plan shall implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health and behavioral and I/DD care and supports for the individual, family, or community members of both state- and federally-recognized tribes. The Strategy should adapt individual engagement interventions unique to the Tribe's respective culture, address access to programs, and policies that target health and social determinant disparities, demonstrate Cultural and Linguistic Competency, respect and honor and fit the historical and cultural context of the individual, family, or community members of Tribes. The Strategy should clearly articulate differences (e.g., Medicaid enrollment options, federal payment and funding allowances, etc.) for members of state- and federally-recognized tribes. The engagement strategy should outline the impact of tribal history on the issues facing native Americans in today's environment as it relates to their health status.
- (vii) The Tribal Engagement Strategy shall include:
 - (a) A proposal of an administrative, clinical and operating model intended to meet the needs of tribal members in the service area of the BH I/DD Tailored Plan;
 - (b) A proposal to access IHCP services for federally recognized tribal members regardless of location of the BH I/DD Tailored Plan;
 - (c) Culturally and Linguistically Competent, proactive, innovative methods for engaging and communicating with tribal members and tribal leadership;
 - (d) A proposal and strategy to improve communication through the utilization of the state or regional health information exchange (e.g., Health Connex) to improve coordination of care and health outcomes for tribal members and reduce duplication and administration as a result of multiple IT systems;
 - (e) A description of how the BH I/DD Tailored Plan's care management and quality strategies take into consideration the needs of tribal members and working with tribal providers, utilizing those quality measures already in place for Standard Plans or with the Tribal Option;
 - (f) A description of the proposed relationship with the Tribal AMH/AMH+;
 - (g) A description of how the plan will coordinate with the EBCI Family Safety Office, the Tsali Public Health Agency and other programs within EBCI;
 - (h) A description of how the BH I/DD Tailored Plan will integrate with and coordinate with tribal organizations or agencies (e.g., community-based organizations, services or entities) serving tribal members in the service area of the BH I/DD Tailored Plan or that have the right to access IHCPs;
 - (i) Medicaid Managed Care education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may lead to health disparities, create barriers to health care, provider access and service delivery; and
 - (j) A description of how the BH I/DD Tailored Plan will coordinate with tribal organizations to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities managed and operated by the Tribe. The plan shall address both tribal operated and county operated services that are accessed by Tribal members.
- (viii) The Tribal Engagement Strategy shall be submitted to the Department for review and approval within ninety (90) Calendar Days of Contract Award. The Strategy shall be updated annually, with consultation with the Tribe and resubmitted to the Department for review. As long as the Tribal

Engagement Strategy clearly states that it applies to BH I/DD Tailored Plans, the Tribal Engagement Strategy may apply to LME/ MCO operations, including, without limitation, the PIHP.

- (ix) The BH I/DD Tailored Plan shall consult with the Indian Tribes and Tribal Organizations, in a manner agreed upon by the individual Tribes regarding Medicaid Managed Care initiatives impacting tribal populations or providers.
 - (x) The BH I/DD Tailored Plan shall collaborate with the Tribes in the service area of the BH I/DD Tailored Plan to facilitate, in a manner agreed upon by the individual Tribes, meetings and forums with tribal leaders and IHCPs that serve tribal members.
 - (xi) The BH I/DD Tailored Plan shall collaborate with the Tribes in developing any member education and training materials. The manner for such collaboration shall be outlined in the Tribal Engagement Strategy and must be approved by the Tribes.
 - (xii) The BH I/DD Tailored Plan shall make member education and training material available to licensed and unlicensed physical and BH personnel who work with Tribal members, upon request by such personnel.
 - (xiii) The BH I/DD Tailored Plan shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract, to the extent such requirements are applicable and the DHHS Tribal Payment Policy.
 - (xiv) The BH I/DD Tailored Plan shall provide and maintain a single point of contact for IHCP billing issues to the Department and with the Tribe.
 - (xv) The BH I/DD Tailored Plan shall ensure its staff, materials, and resources adhere to the requirements described in *Section V.B.1.iii. Member Engagement*.
 - (xvi) Annually, the BH I/DD Tailored Plan shall train its staff regarding the BH I/DD Tailored Plan's Tribal Engagement Strategy and in providing Culturally and Linguistically Competent and consumer-specific supports to the tribal population as referenced in *Section V.A.2.iii. Staff Training for Medicaid and State-funded Services*. Training materials used referencing federally recognized tribes shall be reviewed by the EBCI prior to training. Reasonable time for review shall be established as part of the Tribal Engagement Strategy.
- ii. Engagement with Community and County Organizations for Medicaid and State-Funded Services
- (i) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of North Carolina's local communities to help guide and support delivery of services to members and their families in their Catchment Area, including engagement with:
 - (a) County agencies (e.g., county mental health associations, local Department of Social Services, Area Agency on Aging, Local Education Agencies, housing authorities, county commissioners, children's developmental services agencies, local systems of care programs, law enforcement, justice and judicial agencies such as sheriff departments, police departments, pre and post-trial release programs, reentry councils, county magistrates)
 - (b) County and community based organizations (e.g., homeless shelters, continuums of care, homelessness and housing providers, faith-based organizations, food pantries, domestic violence agencies, consumer and peer run organizations to help guide and support the delivery of services to members, recipients and their families in their Catchment Area.
 - (ii) The BH I/DD Tailored Plan shall engage with CFACs as required by N.C. Gen. Stat. §§ 122C-170 and 122C-171, non-profits, county and community-based organizations (CBOs) to understand the potentially unique resources and needs of each community.
 - (iii) The BH I/DD Tailored Plan shall include strategies within the Local Community Collaboration and Engagement Strategy to effectively integrate its model of care and eliminate service access barriers within the local communities it serves. The BH I/DD Tailored Plan shall establish an ongoing partnership with the Department and North Carolina County Agencies ("County Agencies"), CFACs, nonprofits, and CBOs in the Region that the BH I/DD Tailored Plan is contracted to cover with the

primary goals of getting feedback from members, families and advocates to improve service delivery, access, and outcomes.

- (a) This shall include providing support staff to local or regional CFACs with the goals of assisting CFACs in performing their statutory duties as outlined in NC G.S. 122C-170 and all relevant statutory provisions with the primary goals of working to address service barriers, identify system gaps, and assess policies impacting service delivery and access.
- (iv) The BH I/DD Tailored Plan shall develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with County Agencies, CFACs and CBOs and build partnerships at the local level to improve the health of their members and recipients. As long as the Local Community Collaboration and Engagement Strategy clearly states that it applies to the BH I/DD Tailored Plan, the Local Community Collaboration and Engagement Strategy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (a) The Local Community Collaboration and Engagement Strategy shall address how the BH I/DD Tailored Plan will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs (e.g. transportation, food insecurity, housing) and local continuums of care.
 - (1) The strategy shall include:
 - i. An approach to understand the unique needs of the counties and communities the BH I/DD Tailored Plan serves;
 - ii. Methods of collaborative outreach and engagement with county agencies, CBOs, and other community partners;
 - iii. Measures of successful engagement and collaboration;
 - iv. Measures to foster community inclusion supporting BH I/DD Tailored Plan members and recipients;
 - v. Reporting of outcomes to County Agencies, CFACs, CBOs, and other community partners;
 - vi. Contracting status with each provider identified in each local area crisis services plan and other key crisis providers identified by the Department within their regions; and
 - vii. Information on how the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.
 - (b) The BH I/DD Tailored Plan shall submit the Local Community Collaboration and Engagement Strategy to the Department for review and approval ninety (90) days following BH I/DD Tailored Plan Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.
 - (v) The BH I/DD Tailored Plan shall consult with the County Agencies, county executives and/or the county commissioners' association quarterly regarding Medicaid Managed Care and State-funded Services initiatives impacting counties and community organizations.
 - (vi) The BH I/DD Tailored Plan shall facilitate, at least semi-annually, meetings and forums with the County Agencies, county executives and/or the county associations to report on progress of Local Community Collaboration and Engagement Strategy.
 - (vii) The BH I/DD Tailored Plan shall support local collaboratives that are focused on addressing the unique needs of the populations they serve.
 - (a) The BH I/DD Tailored Plan shall staff city or county Community Collaboratives, work to address service barriers, identify system gaps, and develop cross system training plans for children receiving services in their areas as referenced in *Section V.B.3.vii. System of Care*; and
 - (b) The BH I/DD Tailored Plan shall participate in local crisis collaboratives as detailed in *Section V.A.4.v. Community Crisis Services Plan for Medicaid and State-funded Services*.

- (viii) The BH I/DD Tailored Plan is encouraged to organize and participate in other local and regional collaboratives, including those focused on the adult and juvenile justice-involved populations, seniors and aging adults.
 - (ix) For State-funded Services recipients only: The BH I/DD Tailored Plan shall work with County Agencies, CFACs and CBOs to increase the availability of natural, community and recovery supports available to BH I/DD Tailored Plan recipients. The BH I/DD Tailored Plan shall work with other county and DHHS agencies and CBOs to connect recipients to housing, free and low-cost prescriptions, supported employment, and other social services that promote community inclusion principles and are funded through other sources. The BH I/DD Tailored Plan is encouraged to use NCCARE360 to connect recipients to natural, community, and recovery supports.
- iii. Integration with Other Department Partners for Medicaid and State-Funded Services
- (i) The Department seeks a BH I/DD Tailored Plan with the ability to seamlessly integrate with key Medicaid and State-Funded Services partners, including, but not limited to: Department divisions, Standard Plans, the Enrollment Broker, Ombudsman Program and local county DSS offices to support beneficiaries and recipients through on-going implementation of BH I/DD Tailored Plans. To achieve this goal, the BH I/DD Tailored Plan shall:
 - (a) Engage in joint community-based education events and activities with the staff of the Enrollment Broker, Ombudsman Program and other key Department partners as requested by the Department, including but not limited to health education and promotion fairs, forums, town halls and other community events.
 - (b) For Medicaid members only: Provide educational materials described in *Section V.B.1.iii. Member Engagement* in hard copy and electronic format for distribution to local DSS offices and to members who may utilize the Ombudsman Program for assistance.
 - (c) Coordinate efforts with the Department, the Enrollment Broker and the Ombudsman Program to improve the member and recipient experience by incorporating member feedback into the BH I/DD Tailored Plan education campaign strategy by modifying, updating, removing, changing, or adding materials, call center scripts, website content, education materials, presentations, or other administrative or operational processes.
 - (d) Collaborate with county DSS offices, PHHS offices, community based and advocacy organizations and the Ombudsman Program to understand and incorporate the needs of members and recipients into the BH I/DD Tailored Plan's members and recipients education strategy.
 - (ii) The BH I/DD Tailored Plan shall collaborate with other Department and Division partners to ensure that members' and recipients' unique needs are met, including the Department of Public Instruction, the Department of Public Safety, the North Carolina Housing Financing Agency, the Division of Health Services Regulation, the Division of Public Health, the Division of Adult and Aging Services and the Division of Social Services.
 - (iii) The BH I/DD Tailored Plan shall work with the Department and DVRS to improve employment outcomes for members and consumers aligning with Employment First principles and best practices for recovery, self-determination, and full community inclusion.
 - (iv) The BH I/DD Tailored Plan shall also foster relationships with its local VR offices, Workforce Development boards, Department of Public of Instruction (DPI) post-secondary transition partners, and the NC Business Leadership Network to increase access to employment opportunities for members and recipients.
- iv. Development of Housing Opportunities for Medicaid Members and State-funded Services Recipients
- (i) The Department expects that BH I/DD Tailored Plans will play an integral role in the Department's supportive housing approach and community integration for individuals with mental illness, I/DD, TBI and/or SUDs.

- (ii) The BH I/DD Tailored Plan shall work in collaboration with the Department and with other public agencies, local, regional and statewide housing and homeless populations' service providers and Department housing staff to support the expansion of supportive housing opportunities available to persons with mental illness, I/DD, TBI and/or SUDs.
- (iii) The BH I/DD Tailored Plan shall develop and annually update a BH I/DD Tailored Plan Regional Housing Plan for its members and recipients that reflects the unique aspects of each Region, is parallel to the goals that will be outlined within the Statewide Housing Plan to reduce homelessness, increase entry into and sustain supportive housing, promote independence for people with disabilities, improve an individual's health and help individuals retain employment; and will be due to the Department as determined upon the adoption of the Statewide Housing Plan. As long as the Regional Housing Plan clearly states it applies to the BH I/DD Tailored Plan the Regional Housing Plan may apply to other LME/ MCO operations, including without limitation the PIHP.
 - (a) The Department is in the process of developing a Statewide Housing Plan for the broader North Carolina population that will inform the BH I/DD Tailored Plan's Regional Housing Plan.
- (iv) The BH I/DD Tailored Plan Regional Housing Plan shall:
 - (a) Incorporate housing inventory data from existing local housing stock in the BH I/DD Tailored Plan's Region for persons with mental illness, SUDs, I/DD and/or TBI;
 - (b) Include strategies for implementation of housing objectives, milestones/goals, including to: reduce homelessness, increase entry into and sustain supportive housing, promote independence for members and recipients with disabilities, improve members' and recipients' health, help members and recipients retain employment, increase landlord engagement to increase available units for members;
 - (c) Identify and address gaps in housing programs and infrastructure, including to: offer rapid rehousing services and/or partner with local agencies to build local capacity; and
 - (d) Be updated, submitted to and reviewed by the Department no less than quarterly.
- (v) The BH I/DD Tailored Plan shall employ care management housing specialists to act as experts on supportive housing for members and organizations providing Tailored Care Management as referenced in *Section V.B.3.ii. Tailored Care Management*.
 - (a) The housing staff shall have the knowledge, expertise and experience to support and oversee affordable and supportive housing programs in local municipalities and local geographic areas including census tracts.
- (vi) The BH I/DD Tailored Plan's care management housing specialist(s) shall attend the four (4) quarterly meetings and any ad hoc meetings of Housing Specialists that are facilitated by the Department.
- (vii) Education and Outreach
 - (a) The BH I/DD Tailored Plan shall provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable and supportive housing, and on negotiating reasonable accommodations.
 - (b) The BH I/DD Tailored Plan shall:
 - (1) Collaborate with Department professionals and their vendors along with other stakeholders to identify and secure housing as referenced in *Section V.B.3.ii. Tailored Care Management*.
 - (2) Make available in multiple venues where service providers convene information to identify housing resources, expand knowledge of eligibility requirements for different housing programs, how to access affordable housing resources, including information on, for example: the Fair Housing Act, Landlord and Tenant Rights, barriers associated with

Not In My Back Yard (NIMBY), and information to reduce stigma associated with mental illness, I/DD, TBI and SUDs.

- (c) Provide technical support to service providers on accessing housing, landlord engagement, and the process of making a Reasonable Accommodation request.
- (d) Provide and/or appropriately link consumers to additional supports when housing is at risk of becoming destabilized.

(viii) Collaborative Relationships

- (a) The BH I/DD Tailored Plan shall develop a memorandum of understanding establishing a working relationship with each local public housing authority (PHA), and HUD Section 8/Housing Choice Voucher administrating agency, local and state-wide Continuum of Care committees as defined in *Section III.A. Definitions*. Topics covered must include local coordinated entry processes, and any other pertinent local, regional, or statewide homeless/housing organizations, to improve access and increase the supply of these resources, through the following means:
 - (1) Regularly, strategically seek out means of establishing/formalizing partnerships with PHAs and other relevant housing assistance organizations
 - (2) Gain knowledge of and seek out ways to support PHAs' administrative plans and collaborate on preferences for individuals with BH, I/DD and TBI needs.
 - (3) Stay abreast of and attend at least one (1) public meeting annually at a PHA in the Catchment Area with a particular focus on increasing affordable and supportive housing opportunities for individuals with BH, I/DD and TBI needs.
 - (4) Participate in local, regional and statewide housing and homelessness planning and plan creation.
- (b) The BH I/DD Tailored Plan shall also use best efforts to establish partnerships with other local, affordable housing and BH, TBI and I/DD advocates and stakeholders to improve access to supportive housing, increase the supply of resources for BH and I/DD consumers, coordinate supportive services for eligible populations, identify and secure housing, and support/collaborate on service funding opportunities from private, city/county, state, and federal sources through the following means:
 - (1) Meet with property managers and provide training opportunity for landlords on supportive housing for members and recipients with BH, I/DD and TBI needs.
 - (2) Employ landlord engagement strategies to create more landlord partnerships for members and recipients.
 - (3) Maintain regular communication with area housing agencies, and supportive housing advocates.
 - (4) Gain knowledge of and strive to work collaboratively with local non-profits, developers, Departmental stakeholders such as NC Oxford House to encourage and support development of new supportive housing for members and recipients with BH, I/DD and TBI needs.
 - (5) Gain knowledge of and strive to work collaboratively with local advocates and stakeholders to encourage and support development of new supportive housing (participating jurisdiction, affordable housing providers, local Coalition, Center for Independent Living, etc.).
 - (6) Work with partners and stakeholders to establish additional resources for supportive housing (i.e. additional vouchers, housing opportunities, and programs).
 - (7) Identify potential housing development partners (e.g., DSS, city officials, faith community, public housing agencies, jails, prisons, psychiatric hospitals, homeless shelters, mental

- health, substance abuse, I/DD and TBI professionals and advocates) and collaborate to creating opportunities for supportive housing.
- (8) Strive to enhance working knowledge of funding sources and how to successfully secure and utilize to increase the supply of supportive housing.
 - (9) Provide technical assistance and support to identified agencies applying for state and federal funding opportunities for supportive housing (e.g., justification of need, providing data and information as it relates to available support services) as resources allow.
- (ix) For State-funded Services, the BH I/DD Tailored Plan shall provide housing subsidy administration services in accordance with the Professional Services Agreement Between the Department, the North Carolina Housing Finance Agency and the BH I/DD Tailored Plan.
- v. Community Crisis Services Plan for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall implement the community crisis services plan as defined in N.C. General Statutes § 122C-202.2. As long as the community crisis service plan clearly states that it applies to the BH I/DD Tailored Plan, the community crisis service plan may apply to other LME/MCO operations, including , without limitation, the PIHP.
 - (ii) The community crisis services plan defined in the statute, shall cover the BH I/DD Tailored Plan’s entire Region and shall be comprised of one or more local area crisis plans.
 - (iii) The BH I/DD Tailored Plan shall submit an updated community crisis services plan to the Department at least every two years and when there are Significant Changes as defined by the Department.
 - (iv) The BH I/DD Tailored Plan shall include in the Crisis Planning Committee all affected agencies, including all Standard Plans that cover any of the counties covered in the local area crisis plan when updating the community crisis services plan.
 - (v) The community crisis services plan shall not be considered complete by the Department unless all affected agencies have signed and agreed to each local area crisis plan.
 - (vi) The BH I/DD Tailored Plan shall coordinate with Standard Plans and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each community crisis services plan and alternatives to involving law enforcement in behavioral health crisis response.
 - (vii) The BH I/DD Tailored Plan shall participate in local or regional crisis collaboratives with local magistrates, law enforcement, county commissioners, crisis providers, and hospitals, to meet and regularly share information on improvements to the crisis continuum.

B. Medicaid

1. Members

- i. Eligibility and Enrollment for BH I/DD Tailored Plans
 - (i) Department Roles and Responsibilities
 - (a) Pursuant to Article 4. of Chapter 108D of the N.C. General Statutes, the Department was directed to transition certain North Carolina Medicaid and NC Health Choice populations, including populations eligible for BH I/DD Tailored Plans from a Medicaid Fee for Service structure to a Medicaid Managed Care structure. The Department shall maintain authority in determining North Carolina Medicaid and NC Health Choice eligibility and defining populations to be transitioned into Medicaid Managed Care consistent with Article 4. of Chapter 108D of the N.C. General Statutes.
 - (b) The Department shall maintain sole authority for performing, managing, and maintaining all Medicaid eligibility, BH I/DD Tailored Plan eligibility, enrollment and cost sharing

determinations. The BH I/DD Tailored Plan shall be responsible for adhering to Medicaid eligibility, enrollment and cost sharing determinations made by the Department. It is the responsibility of the Enrollment Broker, the BH I/DD Tailored Plan and other partners of the Department operating within Medicaid Managed Care to adhere to the determinations made by the Department. The Department reserves the right to modify the eligibility criteria and populations eligible to enroll in a BH I/DD Tailored Plan, for all or a limited package of benefits, as authorized under current or future state law.

- (c) The Department shall be responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt or mandatory at any point in time.
 - (d) The Department shall be responsible for determining if a beneficiary is BH I/DD Tailored Plan eligible and will conduct regular data reviews over a defined lookback period to identify beneficiaries who are BH I/DD Tailored Plan eligible.
 - (e) The Department will review requests to enroll in a BH I/DD Tailored Plan submitted by, or on behalf of, beneficiaries who are not identified as BH I/DD Tailored Plan eligible based upon available data.
 - (f) The Department shall be responsible for transmitting to the BH I/DD Tailored Plan all information related to North Carolina Medicaid and NC Health Choice eligibility and cost sharing via the Medicaid Managed Care eligibility file format.
 - (g) Consistent with 42 C.F.R. § 438.810, the Department may contract with an Enrollment Broker to:
 - (1) Educate beneficiaries on Medicaid Managed Care;
 - (2) Provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives who want to select a Standard Plan or BH I/DD Tailored Plan or a primary care provider (PCP); and
 - (3) Transmit enrollment selections and approved disenrollment requests to the Standard Plan or BH I/DD Tailored Plan to effectuate.
- (ii) BH I/DD Tailored Plan Eligible Populations
- (a) In accordance with N.C. Gen. Stat. § 108D-40(a)(12), and other applicable law, the following populations who are not otherwise excluded from Medicaid Managed Care as described in *Section V.B.1.i.(iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care* are eligible and shall be enrolled in BH I/DD Tailored Plans upon their launch:
 - (1) Individuals with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or traumatic brain injury (TBI).
 - (2) Individuals with a developmental disability as defined in N.C. Gen. Stat. § 122C-3(12a).
 - (3) Individuals with a mental illness diagnosis who also meet any of the following criteria:
 - i. Individuals with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living Initiative (TCL) settlement agreement.
 - ii. Individuals with two (2) or more psychiatric hospitalizations or readmissions within the prior eighteen (18) months.
 - iii. Individuals who have had two (2) or more visits to the emergency department for a psychiatric problem within the prior eighteen (18) months and are assessed by the Department as eligible for the BH I/DD Tailored Plan.
 - iv. Individuals known to the Department or an LME/MCO to have had one (1) or more involuntary treatment episodes within the prior eighteen (18) months.
 - (4) Individuals who, regardless of diagnosis, meet any of the following criteria:

- i. Individuals who have had two (2) or more episodes using BH crisis services within the prior eighteen (18) months and are assessed by the Department as eligible for the BH I/DD Tailored Plan.
 - ii. Individuals receiving any of the BH, I/DD, or TBI services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered by a Standard Plan in accordance with N.C. Gen. Stat. § 108D-35(1).
 - iii. Individuals who are receiving or need to be receiving BH, I/DD, or TBI services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
 - iv. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina.
 - v. Children aged zero (0) to three (3) years old with, or at risk for, developmental delay or disability.
 - vi. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department.
- (iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care
- (a) The following populations shall be excluded from Medicaid Managed Care:
 - (1) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
 - (2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
 - (3) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
 - (4) Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations or TBI waivers¹;
 - (5) Presumptively eligible beneficiaries, during the period of presumptive eligibility;
 - (6) Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations or TBI waivers²;
 - (7) Beneficiaries enrolled under the Medicaid Family Planning program;
 - (8) Beneficiaries who are inmates of prisons;
 - (9) Beneficiaries being served through CAP/C;
 - (10) Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice);
 - (11) Beneficiaries with services provided through the PACE³; and

¹ Because the Innovations and TBI waivers will only be offered by the BH I/DD Tailored Plans upon their launch, Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

² Because the Innovations and TBI waivers will only be offered by the BH I/DD Tailored Plans upon their launch, Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

³ The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to N.C. Gen. Stat. § 108D-35(3), which excludes all PACE program services from Medicaid Managed Care.

- (12) Beneficiaries enrolled in the Optional COVID-19 (MCV) Testing Program⁴
- (b) Because the Innovations and TBI waivers shall only be offered by the BH I/DD Tailored Plans upon their launch, the Department has authority under N.C. Gen. Stat. § 108D-40(b) to enroll beneficiaries enrolled in the Innovations or TBI waiver in BH I/DD Tailored Plans, regardless of whether they otherwise are part of a group that is delayed or excluded from managed care.
- (1) All provisions of this contract shall apply to BH I/DD Tailored Plan members who are enrolled in the Innovations or TBI waiver unless otherwise noted. BH I/DD Tailored Plans that do not offer the TBI waiver will not be subject to provisions of this contract that apply to the TBI waiver.
 - (2) Beneficiaries who are enrolled in the Innovations or TBI waiver and are also medically needy or participants in the NC HIPP program shall enroll in a BH I/DD Tailored Plan at BH I/DD Tailored Plan launch for all Medicaid-covered services.
- (c) In accordance with N.C. Gen. Stat. § 108D-40(a)(5) and (5a), the following population shall be exempt from Medicaid Managed Care, including BH I/DD Tailored Plans:
- (1) Beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are exempt from Medicaid Managed Care. These beneficiaries will default to the Tribal Option or NC Medicaid Direct depending on their county of residence, but will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible). More details of these options can be found in *Section V.B.4.i.(iii)(c) Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)*.
 - (2) Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).
- (d) In accordance with N.C. Gen. Stat. § 108D-40(a)(13), the following populations are temporarily excluded, for a period not to exceed five (5) years from the date Standard Plan contracts begin, and shall be treated as excluded until the Department includes them in Medicaid Managed Care, including BH I/DD Tailored Plans:
- (1) Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA. If an individual enrolled in a BH I/DD Tailored Plan resides in a nursing facility for ninety (90) days or more, such an individual shall be disenrolled from the BH I/DD Tailored Plan on the first day of the month following the ninetieth (90th) day of the stay and enrolled in NC Medicaid Direct.
 - i. The Department considers beneficiaries residing in or determined eligible for and transferred to a state-owned Neuro-Medical Center operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) or a Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) to be temporarily excluded until the beneficiary is discharged and determined eligible for Medicaid Managed Care.
 - ii. For members of the BH I/DD Tailored Plan determined eligible for and transferred for treatment to a DSOHF Neuro-Medical Center or state-owned Veterans Home after BH I/DD Tailored Plan implementation, the Department shall disenroll the member in accordance with the *Section VII. First Revised and Restated Attachment M.1. North*

⁴ The Department is seeking a change in State law to clarify that individuals enrolled in the Optional COVID-19 (MCV) Testing Program, authorized under Section 4.5 of S.L. 2020-4, are also excluded from Medicaid Managed Care, if the coverage is still available at the launch of Managed Care.

Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy and the Contract.

- (2) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding beneficiaries served through CAP/DA and beneficiaries enrolled in the Innovations or TBI waivers⁵.
- (3) Recipients who are enrolled in the foster care system, receiving Title IV-E adoption assistance, under the age of twenty-six (26) and formerly were in the foster care system, or under the age of twenty-six (26) and formerly received adoption assistance.
- (e) Pursuant to N.C. Gen. Stat. § 108D-40(b), populations excluded from Medicaid Managed Care or populations who have been temporarily excluded from Medicaid Managed Care may be enrolled at any time, as determined by the Department, if eligible to receive a service that is not available in NC Medicaid Direct but is offered by the BH I/DD Tailored Plan.
- (f) At any time during the Contract Term, the Department reserves the right to amend the contract based on an increase or decrease in covered populations included in the Medicaid Managed Care program based on federal or state law or regulatory changes, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes or BH I/DD Tailored Plan eligibility criteria. The Department shall provide written notice to each BH I/DD Tailored Plan of such change no later than sixty (60) days prior to the effective date of such change, unless shorter notice period is required by a federal or state law or regulatory change, with the Parties executing a Contract Amendment to incorporate such modifications.
- (iv) The Department believes that certain groups of beneficiaries meeting one or more of the BH I/DD Tailored Plan eligibility criteria who are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The following legislative changes will impact eligibility or coverage of services by a BH I/DD Tailored Plan upon becoming law:
 - (a) The Department is seeking a change in State law to allow Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing are eligible to enroll in a BH I/DD Tailored Plan at BH I/DD Tailored Plan launch for Medicaid-covered BH, I/DD, and TBI services if they meet one of the BH I/DD Tailored Plan eligibility criteria. They will receive all other Medicaid-covered services through NC Medicaid Direct.
 - (b) The Department is exploring seeking a change in State law to allow Beneficiaries who are medically needy, participate in the NC HIPP program, or are enrolled in the CAP/C or CAP/DA waivers if they meet one of the BH I/DD Tailored Plan eligibility criteria to enroll in a BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI services. They would receive all other Medicaid-covered services through NC Medicaid Direct.
- (v) Medicaid Managed Care Enrollment and Disenrollment
 - (a) BH I/DD Tailored Plan Roles and Responsibilities
 - (1) The BH I/DD Tailored Plan must adhere to BH I/DD Tailored Plan eligibility decisions made by the Department and enroll or disenroll beneficiaries in accordance with those decisions and this Contract.

⁵ Because the Innovations and TBI waivers will only be offered by the BH I/DD Tailored Plans upon their launch, Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

- (2) The BH I/DD Tailored Plan shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1).
 - (3) The BH I/DD Tailored Plan shall have staff with sufficient knowledge about the North Carolina Medicaid and NC Health Choice programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.
 - (4) The BH I/DD Tailored Plan shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect the member's Medicaid or NC Health Choice eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).
 - (5) The BH I/DD Tailored Plan shall ensure automatic reenrollment of a member who is disenrolled solely because he or she loses North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).
 - (6) The BH I/DD Tailored Plan shall only process enrollment for beneficiaries who are eligible for BH I/DD Tailored Plan coverage.
 - (7) The BH I/DD Tailored Plan shall notify the Department in a format defined by the Department of the receipt of enrollment information for any beneficiary who is ineligible for BH I/DD Tailored Plan within five (5) Business Days.
 - (8) The BH I/DD Tailored Plan shall adhere to the Department's Medicaid Managed Care enrollment approach, including but not limited to BH I/DD Tailored Plan enrollment format and processes, as defined in *Section VII. First Revised and Restated Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and consistent with federal regulations
 - (9) The BH I/DD Tailored Plan shall direct the member to the NC FAST online portal or perform a Warm Transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.); this requirement does not apply to the choice of Standard Plan or BH I/DD Tailored Plan, PCP or, if applicable, prescriber.
 - (10) The BH I/DD Tailored Plan shall, if a member contacts the BH I/DD Tailored Plan to change to a Standard Plan or another BH I/DD Tailored Plan (e.g., if they change Regions), perform a Warm Transfer to the Enrollment Broker.
 - (11) The BH I/DD Tailored Plan shall ensure as outlined in *Section V.A.2. Program Operations* that its telephone system will have the functionality to transfer beneficiaries and authorized representatives from the call center to local DSS office without disconnecting the call.
 - (12) If a member's demographic information is not updated during the next member reconciliation cycle with the BH I/DD Tailored Plan and the Department, the BH I/DD Tailored Plan shall follow up with members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.
- (b) Beneficiary Disenrollment
- (1) The BH I/DD Tailored Plan shall adhere to the Department's Medicaid Managed Care disenrollment approach as defined in *Section VII. First Revised and Restated Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
 - i. Member disenrollment requests; and

- ii. Department disenrollment requests.
 - (2) The BH I/DD Tailored Plan shall accept and process all BH I/DD Tailored Plan enrollments and disenrollments within twenty-four (24) hours of receipt of the standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
 - (3) The BH I/DD Tailored Plan shall comply with the Department's membership reconciliation process as defined in *Section V.B.8. Technical Specifications*.
 - (4) The BH I/DD Tailored Plan shall develop and maintain a Member Enrollment and Disenrollment policy. No later than ninety (90) days after the Contract Award the policy shall be submitted to the Department for review and approval. The BH I/DD Tailored Plan shall submit to the Department for review any updates to the policy at least ninety (90) Calendar Days prior to implementation. As long as the Member Enrollment and Disenrollment Policy clearly states that it applies to the BH I/DD Tailored Plan, the Member Enrollment and Disenrollment Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- ii. Transitions of Care
 - (i) Ongoing Requirements
 - (a) The BH I/DD Tailored Plan shall develop policies, processes and procedures to support members transitioning between BH I/DD Tailored Plans, from Standard Plans to BH I/DD Tailored Plans, BH I/DD Tailored Plans to Standard Plans, BH I/DD Tailored Plans to Medicaid Direct, other types of plans established by the Department (e.g., Tribal Option or Statewide Specialized Foster Care Plan) or between delivery systems (e.g., from NC Medicaid Direct to a BH I/DD Tailored Plan).
 - (b) As long as the Transition of Care Policy clearly states that it applies to the BH I/DD Tailored Plan, the Transition of Care Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (c) Sixty days (60) following Contract Award, the BH I/DD Tailored Plan shall provide the Department with a contact person who will coordinate Transitions of Care for newly enrolling members on behalf of the BH I/DD Tailored Plan, including for the initial transition to BH I/DD Tailored Plan. This may be the same individual identified as the contact person for Transitions of Care for the PIHP.
 - (d) The BH I/DD Tailored Plan shall accept and transfer member's claims/encounter history, prior authorizations and transition file content, as described in *Section V.B.1.ii.(i) Transitions of Care: Ongoing Requirements*, between BH I/DD Tailored Plans, Standard Plans and other authorized Department Business Associates in accordance with the Department's data transfer protocols and related privacy and security requirements. The BH I/DD Tailored Plan shall adhere to the Department's Transition of Care Policy for newly enrolling members and members transitioning between BH I/DD Tailored Plans, or between the BH I/DD Tailored Plan and Medicaid Direct or the Tribal Option. The BH I/DD Tailored Plan shall at a minimum:
 - (1) Identify enrolled or disenrolled members, as defined in *Section VII. First Revised and Restated Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*, who are transitioning from another BH I/DD Tailored Plan, Standard Plan, other plan established by the Department, or other delivery system such as NC Medicaid Direct. Protocols shall be made available to the Department, upon request.
 - (2) Provide for the transfer and receipt of relevant member information, including a summary page narrative of member-specific circumstances that are time-sensitive or potentially impact continuity of care, a summary listing of the member's providers, treatment

records that would encompass both physical and BH, care management records, open service authorizations, prescheduled appointments, NEMT, historic claims and encounter data, and other pertinent materials, to the transitioning member's receiving entity (the entity, such as the BH I/DD Tailored Plan, Standard Plan, other type of plan established by the Department, or NC Medicaid Direct, that is enrolling the transitioning member and receiving the member's information) upon notification of the transition. Transferred information described here is collectively referred to as the transition file content.

- i. The BH I/DD Tailored Plan shall facilitate the transfer of a Member's claims/encounter history and Prior Authorization data between BH I/DD Tailored Plans and other authorized Transition Entities and Department Business Associates following requirements established and published by the Department.
 - ii. If the BH I/DD Tailored Plan is contacted by another BH I/DD Tailored Plan or other receiving entity, such as a Standard Plan, other plan established by the Department, or designated entity within NC Medicaid Direct, requesting relevant Member information, the BH I/DD Tailored Plan shall provide such data to the entity within five (5) Business Days of receiving the request, unless otherwise governed by established technical requirements.
 - iii. The BH I/DD Tailored Plan shall engage in pre-transition planning discussions and knowledge transfer with other Transition Entities as required in the NC DHHS Transition of Care Policy or as requested by another Transition Entity . .
 - iv. If the BH I/DD Tailored Plan receives notice of an enrollment and has not received the applicable TOC data file or Enrollee's Transition File within five (5) business days of the transition notice date, the Tailored Plan will contact the applicable Transition entity on the following business day to request transition information, as needed. Additionally, as needed, the Department will support the BH I/DD Tailored Plan in obtaining all applicable transition materials from the Transition entity in a timely manner. needed.
 - v. Within five (5) business days of the BH I/DD Tailored Plan receiving notice that a member will disenroll, the BH I/DD Tailored Plan shall ensure the member's transition data files and member's transition file are transferred utilizing process and schedule established in applicable technical requirements.
- (3) The BH I/DD Tailored Plan shall ensure that any member enrolling into the BH I/DD Tailored Plan is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.
- (4) The BH I/DD Tailored Plan shall allow a member to complete an existing service authorization period for a Medicaid-covered State Plan or waiver service established by their previous Standard Plan, BH I/DD Tailored Plan, another plan established by the Department or NC Medicaid Direct.
- i. If applicable, the BH I/DD Tailored Plan shall assist the member in transitioning to an in-network provider at the end of the service authorization period established by their previous Standard Plan, BH I/DD Tailored Plan or NC Medicaid Direct.
- (5) In instances in which a member transitions into a BH I/DD Tailored Plan from NC Medicaid Direct, a Standard Plan, another BH I/DD Tailored Plan, another type of plan established by the Department or another type of health insurance coverage, and the member is in an ongoing course of treatment or has an Ongoing Special Condition, the BH I/DD Tailored Plan shall permit the member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g), and as otherwise required by the Contract. A member's I/DD, mental health

diagnosis, substance use disorder or TBI shall be considered a special condition under N.C. Gen. Stat § 58-57-88(a)(1). In lieu of the transitional period established in N.C. Gen. Stat. § 58-67-88(d), the BH I/DD Tailored Plan shall honor a transitional period of a minimum of ninety (90) Calendar Days for all out-of-network Providers serving a transitioning Tailored Plan Members at the time of transition, treating out-of-network Providers the same as in-network Providers regarding both reimbursement and prior authorization requirements.

- (6) The BH I/DD Tailored Plan shall allow pregnant members to continue to receive services from their BH treatment provider or obstetrician, without any form of prior authorization, until the birth of the child, the end of the pregnancy, or loss of Medicaid eligibility during the pregnancy, whichever is later.
- (7) The BH I/DD Tailored Plan shall bear the financial responsibility for the non per diem diagnosis-related group (DRG) based inpatient facility claims of an enrolled member who is admitted to an inpatient facility or prior in the case of a member who is inpatient on their first day of enrollment in the BH I/DD Tailored Plan if there is no prior Medicaid Managed Care or NC Medicaid Direct coverage for inpatient services. If the member was already inpatient on their first day of enrollment in the BH I/DD Tailored Plan and was previously not eligible for Medicaid, the BH I/DD Tailored Plan shall bear the financial responsibility for the full amount of the DRG-based inpatient facility claims.
- (8) For facilities paid a per diem rate, the BH I/DD Tailored Plan shall only be responsible for the days the member resides in the facility and is also enrolled with the BH I/DD Tailored Plan.
 - i. The BH I/DD Tailored Plan's financial responsibility shall not extend beyond the date of disenrollment.
 - ii. Post-discharge care shall be coordinated prior to discharge in accordance with *Section V.B.3. Care Management*.
- (9) The BH I/DD Tailored Plan shall establish a written Transition of Care Policy.
 - i. The BH I/DD Tailored Plan Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and include processes and procedures for coordinating care for:
 - a) Members who have an ongoing special condition;
 - b) Members transitioning to the BH I/DD Tailored Plan from another BH I/DD Tailored Plan, Standard Plan, other types of plans established by the Department or NC Medicaid Direct, including processes and procedures specific to Standard Plan members transitioning to the BH I/DD Tailored Plan to obtain services only available in the BH I/DD Tailored Plans as detailed in *Section VII. First Revised and Restated Attachment M.1 North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*;
 - c) Members transitioning from the BH I/DD Tailored Plan into another BH I/DD Tailored Plan, Standard Plan, other type of plan established by the Department or NC Medicaid Direct.
 - d) Members covered by the Management of Inborn Errors of Metabolism (IEM) Program, as defined in *Section V.B.3.ix. Prevention and Population Health Programs*;
 - e) Services delivered through other delivery systems including NC Medicaid Direct; and
 - f) Other requirements as defined in this Section and the Department's Transition of Care Policy as revised.

- (10) Transition of Care Requirements for Members Actively Engaged in Care Management and Members Disenrolling from the BH I/DD Tailored Plan:
 - i. The BH I/DD Tailored Plan's Transition of Care Policy shall integrate processes and procedures for managing the transition of members actively engaged in care management and of members transitioning between delivery systems.
 - ii. Processes and procedures shall be consistent with the Department's Transition of Care Policy and ensure:
 - a) Timely Warm Handoffs as defined in *Section III.A. Definitions* with the other transition entity.
 - b) Proactive communication with the other transition entity (e.g., Standard Plan, other BH I/DD Tailored Plans, NC Medicaid Direct) throughout the transition process;
 - c) Population and service-specific coordination with other entities to ensure the member's continuity of care.
- (11) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Transition of Care Policy to the Department for review and approval ninety (90) Calendar Days after Contract Award.
- (e) Transition of Care with Change of Providers
 - (1) The BH I/DD Tailored Plan shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated from or otherwise leaves the BH I/DD Tailored Plan's network.
 - i. The BH I/DD Tailored Plan shall develop policies, process and procedures that include supporting Members transitioning between providers when a provider is terminated from or otherwise leaves the BH I/DD Tailored Plan's network. The Provider Transition of Care Policy shall include at a minimum, the requirements of this Section.
 - ii. In instances in which a provider is terminated or leaves the BH I/DD Tailored Plan's network for expiration or nonrenewal of the contract and the member is in an ongoing course of treatment or has an ongoing special condition, the BH I/DD Tailored Plan shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).
 - iii. In instances in which a provider is terminated or leaves the BH I/DD Tailored Plan's network for reasons related to quality of care or Program Integrity, the BH I/DD Tailored Plan shall notify the Member in accordance with this Section's requirements and shall assist the member in transitioning to an appropriate in-network provider that can meet the member's needs. The Department shall support the BH I/DD Tailored Plan in facilitating a timely transition.
 - (2) Member Notification of Provider Termination
 - i. Within fifteen (15) Calendar Days of providing notice of termination to the provider, the BH I/DD Tailored Plan shall provide written notice of termination of a network provider to all Members who have received or are scheduled to receive services consistent with *Section VII. Second Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* from the terminated provider within the twelve (12) month period immediately preceding the date of notice of termination, except if a terminated provider is a primary care provider (PCP), Advanced Medical Home Plus (AMH+) or care management agency (CMA) for a member. 42 C.F.R. § 438.10(f)(1).

- ii. If a terminated provider is a PCP, AMH+ or CMA for a Member, the BH I/DD Tailored Plan shall notify the Member by the later of thirty (30) Calendar Days prior to the effective date of the termination or fifteen (15) Calendar Days after the receipt or issuance of a provider termination notice of the following:
 - a) Procedures for selecting an alternative PCP, AMH+ or CMA.
 - b) That the member will be assigned to a PCP, AMH+ or CMA if they do not actively select one within thirty (30) Calendar Days.
 - iii. If a terminated provider is a PCP, AMH+ or CMA for a member, the BH I/DD Tailored Plan shall ensure that the member selects or is assigned to a new PCP, AMH+ or CMA within thirty (30) Calendar Days of the date of notice to the member and notify the member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.
 - iv. The BH I/DD Tailored Plan shall use a member notice consistent with the Department-developed model member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).
- (3) The BH I/DD Tailored Plan shall hold the member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.
- (4) The BH I/DD Tailored Plan shall establish a Provider Transition of Care Policy that is consistent with the Department’s Transition of Care Policy and this Contract.
- i. The Provider Transition of Care Policy shall include processes and procedures for coordinating care for members who:
 - a) Have an ongoing special condition as defined in N.C. Gen. Stat. § 58-67-88(a)(1);
 - b) Are discharged from a residential or institutional setting;
 - c) Are obtaining services from a provider that leaves the BH I/DD Tailored Plan’s network;
 - d) Must select a new PCP after a provider termination; and
 - e) Other requirements as identified by the Department.
- (5) The BH I/DD Tailored Plan shall submit the Provider Transition of Care Policy to the Department for review and approval one hundred fifty (150) Calendar Days after the Contract Award.
- (e) The BH I/DD Tailored Plan shall provide encounter, provider and Member data at least monthly, or more frequently in order to support transitions of care requirements or as requested by the Department.
- (ii) Crossover Population
- (a) The BH I/DD Tailored Plan shall comply with the requirements listed above in *Section V.B.1.ii.(i) Ongoing Requirements* to support members transitioning during the Cross-over Period.
 - (b) The BH I/DD Tailored Plan shall implement strategies to minimize the disruption of benefits at BH I/DD Tailored Plan implementation by adhering to additional prior authorization requirements, including resetting the number of visits that do not require prior authorization, continuing to honor current authorizations for ongoing benefits and complying with Department-defined protocols for streamlining prior authorization requests.
 - (c) The BH I/DD Tailored Plan shall have the capacity to accept, ingest and utilize claims, encounter, prior authorization data files and care plans from other authorized Department Business Associates related to Crossover activities.
 - (d) The BH I/DD Tailored Plan shall participate in Department led implementation preparation activities including but not limited to:
 - (1) Time-limited “stand up” meetings with the Department on a schedule to be determined by the Department;

- (2) Testing related to data file transfers on a schedule and under a protocol determined by the Department.
- (3) Time-limited, rapid cycle solutions process related to data transfer issues and member disruption in care.
- (e) The BH I/DD Tailored Plan shall complete and submit any established crossover status reports and data reconciliation to the Department on a weekly basis.
- (f) The BH I/DD Tailored Plan shall participate in “Warm Handoffs” for beneficiaries transitioning to the BH I/DD Tailored Plan who were previously receiving services through CCNC, Standard Plan or care coordination services through another BH I/DD Tailored Plan or LME/MCO.
- (g) The BH I/DD Tailored Plan must honor existing and active medical prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans minimally for the first ninety (90) Calendar Days after BH I/DD Tailored Plan implementation (Medicaid Managed Care Launch) or until the end of the authorization period, whichever occurs first to ensure continuity of care for members. For service authorizations managed by an LME/MCO and impacted by 42 C.F.R. Part 2, the BH I/DD Tailored Plan shall deem authorizations submitted directly by impacted Providers as covered under this requirement. For the first ninety (90) Calendar Days after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network Providers equal to that of in network Providers. To ensure that Providers fully understand each BH I/DD Tailored Plan’s prior authorization requirements during the transition the BH I/DD Tailored Plan will still process and pay for services rendered during this Crossover transition period if:
 - (1) A Provider fails to submit prior authorization prior to the services being provided and submits prior authorization after the date of service, or
 - (2) A provider submits for retroactive prior authorizations.

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

iii. Member Engagement

- (i) Members, their families, and caregivers may need support during the initial transition to Medicaid Managed Care and on-going as members in the Medicaid Managed Care program. To the extent possible due to law and funding, the BH I/DD Tailored Plan will be responsible, individually and in partnership with the Department and other entities identified by the Department, for assisting members and their families with understanding Medicaid Managed Care, navigating the health care system, improving overall member health through various avenues, including maintaining a Member Services department, conducting member and community outreach, and providing education before, during, and after Medicaid Managed Care implementation. The Department strongly encourages the BH I/DD Tailored Plan to develop innovative approaches, including the use of electronic mechanisms for member education and outreach.
- (ii) The BH I/DD Tailored Plan shall be responsible for engaging with members and their authorized representatives to help them understand Medicaid Managed Care and their rights and responsibilities and accessing available benefits and services in-person, by telephone, by mail, and online/electronically. 42 C.F.R. § 438.10(c)(7).
- (iii) The BH I/DD Tailored Plan shall utilize various engagement strategies and communication mediums to engage, educate, and assist members. The engagement strategy shall include the operation of a dedicated Member Services Department which, at a minimum, shall:

- (a) Maintain a member call center and a member services website;
 - (b) Engage with the Department engagement and customer service offices, as well as local community and county organizations;
 - (c) Provide written and verbal educational materials, activities and programs;
 - (d) Collaborate with other entities operating within the Medicaid Managed Care delivery system; and
 - (e) Comply with the requirements of *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* if BH I/DD Tailored Plan delegates any of the requirements to a Subcontractor.
- (iv) The BH I/DD Tailored Plan shall use standard managed care terminology in all communications with members and potential members as defined in *Section VII. First Revised and Restated Attachment L. Managed Care Terminology Provided to BH I/DD Tailored Plans pursuant to 42 C.F.R. § 438.10.*
- (v) Unless otherwise stated, all written communications, call center scripts, websites or other communications directed to Members or potential Members must adhere to the requirements in this Contract and receive prior approval from the Department before the material is disseminated. The Department may require changes to previously approved communications, at its sole discretion.
- (vi) Member Services Department
- (a) The BH I/DD Tailored Plan may utilize the same staff, systems and policies and procedures to perform the operations described in this section for both BH I/DD Tailored Plan and Medicaid Direct. The BH I/DD Tailored Plan shall have and implement Member Services policies and procedures that address the needs of potential members, members, those individuals who support and care for members and address all Member Services activities.
 - (b) The BH I/DD Tailored Plan shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
 - (c) The Member Services staff shall be responsible, at a minimum, for the following functions:
 - (1) Explaining operation of the BH I/DD Tailored Plan, including the role of the PCP and what to do in an emergency, disaster or urgent medical situation;
 - (2) Assisting with arranging non-emergency medical transportation for members;
 - (3) Assisting members in selecting or changing PCP and Tailored care management entity;
 - (4) Educating and assisting members with obtaining services under Medicaid Managed Care, including out-of-network services;
 - (5) Explaining transition of care requirements and care management services offered by the BH I/DD Tailored Plan;
 - (6) Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
 - (7) Fielding and responding to members' questions and complaints;
 - (8) Clarifying information in the Member Handbook;
 - (9) Advising members of and assisting members with the Appeals, Grievances, and State Fair Hearing processes;
 - (10) Referring members to the Department's Enrollment Broker if an individual requests information regarding how to enroll in or select a BH I/DD Tailored Plan, Standard Plan, or NC Medicaid Direct; and
 - (11) Referring members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues.

- (d) The BH I/DD Tailored Plan shall operate and maintain the following four (4) member facing Service Lines:
 - (1) Member and Recipient Service Line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*);
 - (2) Behavioral Health Crisis Line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*);
 - (3) Nurse Line; and
 - (4) Non-Emergency Medical Transportation (NEMT) Member Service Line
- (e) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Member Services Department via member surveys and internal audits of departments to ensure member satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - (1) Member surveys shall be made available after each web, call center (with exception of Behavioral Health Crisis Line) or in-person interaction.
 - (2) Surveys and internal audits are intended to measure member’s overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
 - (3) Reports, including the results of provider surveys and the BH I/DD Tailored Plan’s evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- (vii) Member Services Website
 - (a) The Department encourages the BH I/DD Tailored Plan to utilize processes, procedures and technology to improve the member experience and effectively reduce or ease administrative burdens on the member.
 - (b) The BH I/DD Tailored Plan shall develop and maintain a dedicated, interactive North Carolina Medicaid and NC Health Choice member services website that, at a minimum, has the functionality to allow the member to search for in-network providers and search the drug formulary. The website may be shared across and inclusive of this product and the BH I/DD Tailored Plan, which links to dedicated webpages for the Medicaid Direct health plan and the BH I/DD Tailored Plan.
 - (c) Within two (2) “clicks” from the homepage, the BH I/DD Tailored Plan shall also include on its website at a minimum:
 - (1) An up-to-date copy of the Member Handbook, Innovations Member and Family Handbook, and, if applicable, TBI Handbook;
 - (2) Information on hours of operation;
 - (3) How to contact the Member Services staff and care managers;
 - (4) How to access BH I/DD Tailored Plan services;
 - (5) Appeals, Grievances, and State Fair Hearing policies and processes;
 - (6) Information regarding the Ombudsman program;
 - (7) Health promotion and educational materials;
 - (8) Any specific prevention, population health, or care management programs offered by the BH I/DD Tailored Plan;
 - (9) Information relevant to any disasters or states of emergency affecting the BH I/DD Tailored Plan region; and
 - (10) Other information the BH I/DD Tailored Plan believes would support the member and natural supports.

- (d) The BH I/DD Tailored Plan shall meet the same literacy standards identified for written materials in any materials made available electronically.
 - (e) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
 - (f) The BH I/DD Tailored Plan website shall be accessible via mobile devices.
 - (g) The BH I/DD Tailored Plan website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's MMIS that impact the ability for the website to operate correctly.
 - (1) The BH I/DD Tailored Plan shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
 - (2) The BH I/DD Tailored Plan shall notify the Department of unscheduled downtime within one (1) hour of the BH I/DD Tailored Plan becoming aware and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the BH I/DD Tailored Plan.
- (viii) Communications with Members and Potential Members
- (a) The BH I/DD Tailored Plan shall ensure all contacts with members or authorized representatives are Culturally and Linguistically Competent and provide effective communication to the member, with deference to the method requested by the member, including sign language interpreters, and occur in a timely manner that protects the privacy and independence of the individual with a disability.
 - (b) The BH I/DD Tailored Plan shall ensure that members and potential members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and N.C. Gen. Stat. § 58-3-191(b)(5) in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
 - (c) The BH I/DD Tailored Plan shall address the following in the development of member materials:
 - (1) The population size and geographic/regional needs and differences throughout each of the BH I/DD Tailored Plan's Region;
 - (2) Language proficiencies;
 - (3) Types of disabilities;
 - (4) Literacy levels;
 - (5) Cultural needs of the member population;
 - (6) Age and age-specific or other targeted learning skills or capabilities; and
 - (7) Ability to access and use technology.
 - (d) The BH I/DD Tailored Plan shall be permitted to provide information required to be communicated to members and potential members in the following manner:
 - (1) Mailing a printed copy of the information to the member's mailing address is the default absent an explicit preference stated by a member or their authorized representative;
 - (2) Emailing the information, after receiving the member's or potential member's express consent to receive information via email and obtaining a valid, up to date email address. The BH I/DD Tailored Plan may email information unencrypted if the Member or potential Member explicitly requests that emails are not encrypted and signs a waiver acknowledging the risk of unencryption;
 - (3) Posting the information on the BH I/DD Tailored Plan's website and advising the member or potential member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a member may request communication accommodations; and

- (4) Providing the information by any other method that can reasonably be expected to result in the member receiving the information. 42 C.F.R. § 438.10(g)(3).
- (e) The BH I/DD Tailored Plan shall not construe requirement herein to limit or alleviate the BH I/DD Tailored Plan's obligation to communicate directly with the member, a member's authorized representative, parent or guardian, or potential member as required under the Contract or under federal or state law or regulation.
- (f) The BH I/DD Tailored Plan shall provide information in the member's preferred format upon request at no cost (e.g., a member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
- (g) The BH I/DD Tailored Plan shall comply with guidelines promulgated by the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.
- (ix) Written and Verbal Member Materials
 - (a) The BH I/DD Tailored Plan shall provide member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which address information requirements related to written and verbal information provided to members.
 - (b) The BH I/DD Tailored Plan shall provide all written materials to members and potential members consistent with the following:
 - (1) Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).
 - (2) Use a sans serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.
 - (3) Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.
 - (4) Include a tagline that is sufficiently conspicuous and visible (sans serif font type and font size no smaller than 12 points) for Members or potential Members to see and read the information on how to request auxiliary aids and services, including materials in alternative formats. The font type and size shall be appropriate to the audience. 42 C.F.R. § 438.10(d).
 - i. Taglines are required on materials that are critical for potential members and members to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, member handbooks, appeal and grievance notices, and denial and termination notices. 42 C.F.R. § 438.10(d).
 - (5) Written in accordance with the most recent Associated Press Style guidance and NC Medicaid Style Guide or Department provided template..
 - (6) Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
 - (7) Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the BH I/DD Tailored Plan's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:
 - i. Spanish,
 - ii. Chinese (Mandarin Simplified),
 - iii. Vietnamese,

- iv. Korean,
 - v. French,
 - vi. Arabic,
 - vii. Hmong,
 - viii. Russian,
 - ix. Tagalog,
 - x. Gujarati,
 - xi. Mon-Khmer (Cambodia),
 - xii. German,
 - xiii. Hindi,
 - xiv. Laotian, and
 - xv. Japanese.
- (c) The BH I/DD Tailored Plan shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to members in their original format.
- (d) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
- (e) The BH I/DD Tailored Plan shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on various platforms, such as website and mobile devices.
- (x) Mailing Materials to Members
- (a) The BH I/DD Tailored Plan shall verify addresses against a United States Postal Service approved product or service on all members enrolled in the BH I/DD Tailored Plan prior to mailing materials, at no additional cost to the Department or the member.
- (1) The BH I/DD Tailored Plan shall make all reasonable attempts to identify the correct mailing address and mail information to the member within applicable timeframes, as required under the Contract.
 - (2) The BH I/DD Tailored Plan shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
 - (3) The BH I/DD Tailored Plan shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
- (b) The BH I/DD Tailored Plan shall notify the Department, or the local DSS office as directed by the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.
- (c) If the BH I/DD Tailored Plan identifies a new, updated address, the BH I/DD Tailored Plan shall resend only member specific information at no additional cost to the Department or the Member.
- (d) All materials mailed to potential members, members, and, when applicable, authorized representatives, shall be sent via first class mail.
- (e) The BH I/DD Tailored Plan shall consider cost-effective methods for controlling postage costs when producing member materials for mailing.
- (f) The BH I/DD Tailored Plan shall develop a Member and Recipient Mailing Policy, subject to Department review and approval. The BH I/DD Tailored Plan shall submit to the Department ninety (90) days after Contract Award. As long as the Member and Recipient Mailing Policy clearly states that it applies to the BH I/DD Tailored Plan, the Member and Recipient Mailing Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

- (xi) Translation and Interpretation Services
- (a) The BH I/DD Tailored Plan shall make interpretation services available to all potential members and members. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).
 - (b) The BH I/DD Tailored Plan shall notify its members of the availability of interpretation services and inform them of how to access such services, including providing the following information:
 - (1) That verbal information is available for any language and written translation is available in prevalent languages free of charge to each member. 42 C.F.R. § 438.10(d)(4); and
 - (2) That auxiliary aids and services are available upon request and at no cost for members with disabilities. 42 C.F.R. § 438.10(d)(5).
 - (c) The BH I/DD Tailored Plan shall offer qualified interpreter services available for verbal contacts with members and authorized representatives whose primary language is not English.
 - (d) The BH I/DD Tailored Plan shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
 - (e) The BH I/DD Tailored Plan shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with member audiences.
 - (f) The BH I/DD Tailored Plan shall make interpretation services available free of charge to each member. 42 C.F.R. § 438.10(d)(4).
 - (g) The BH I/DD Tailored Plan shall staff member facing service lines with enough fluent Spanish speakers to converse with members who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the member or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department.
 - (h) Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:
 - (1) Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
 - (2) Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
 - (i) The BH I/DD Tailored Plan shall notify the Department in writing within five (5) Business Days each time the BH I/DD Tailored Plan or its Subcontractor charges a member, potential member, authorized representative or guardian for interpreter or translation services.
 - (j) The BH I/DD Tailored Plan shall notify the Department of any change in the language preference for members in an electronic format and frequency as defined by the Department.
- (xii) Member Welcome Packet
- (a) During Contract Year 1, the BH I/DD Tailored Plan shall send a Welcome Packet to the member within eight (8) Calendar Days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment with confirmation of the Member's PCP assignment. Beginning in Contract Year 2, the BH I/DD Tailored Plan shall send a Welcome Packet to the Member within six (6) Calendar Days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department.
 - (b) The BH I/DD Tailored Plan shall include the following in the initial member Welcome Packet and upon redetermination:
 - (1) A welcome letter that notifies the member of their enrollment in the BH I/DD Tailored Plan and provides:

- i. The effective date from which the BH I/DD Tailored Plan shall assume health coverage for the member;
 - ii. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
 - iii. Information on how to change to a Standard Plan or NC Medicaid Direct;
 - iv. The toll-free service line numbers which a member may call for the Member and Recipient Service Line, Behavioral Health Crisis Line, and Nurse Line;
 - v. Information on care management services, assigned Tailored care management entity, how to change a Tailored care management entity, why a member might be auto assigned to a Tailored care management entity and information on opting out;
 - vi. The role of a PCP in Medicaid Managed Care;
 - a) How to select or change a PCP;
 - b) Why a member might be auto-assigned a PCP;
 - vii. How to arrange for non-emergency medical transportation (NEMT);
 - viii. An offer of assistance in arranging initial visit to his or her PCP; and
 - ix. Contact information for the Ombudsman Program.
- (2) Member identification card; and
 - (3) A current Member Handbook.
 - (4) The BH I/DD Tailored Plan may opt to send the ID card or handbooks separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
- (c) The BH I/DD Tailored Plan shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within ninety (90) Calendar Days of Contract Award, and then annually thereafter. The Department may require changes to the Member Welcome Packet and other communications, at its sole discretion.
 - (d) All materials mailed to potential members, and when applicable, authorized representatives, shall be sent via first class mail, unless otherwise approved by the Department or permitted by the Member and Recipient Mailing Policy.
- (xiii) Member Identification Cards
- (a) The BH I/DD Tailored Plan is required to generate an identification card for each Member enrolled in the BH I/DD Tailored Plan with the following printed information:
 - (1) The Member's North Carolina Medicaid or NC Health Choice identification number
 - i. The Member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and
 - ii. The Member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the BH I/DD Tailored Plan.
 - (2) The BH I/DD Tailored Plan's name, mailing address and Member Portal.
 - (3) The Member's PCP name, physical address and phone number.
 - (4) The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
 - (5) Indicator if Member is NC Medicaid or NC Health Choice.
 - (6) The MID, fraud, waste and abuse hotline with the following language:
 - i. If you suspect a doctor, clinic, hospital, home health service or any other kind of health provider is committing Medicaid fraud, report it. Call (919) 881-2320.
 - (b) A replacement identification card shall be provided at least once every twelve (12) months, or upon request by the Member or the Member's authorized representative or upon PCP change, at no charge to the Member.

- (c) The BH I/DD Tailored Plan shall submit the Member identification card to the Department for review and approval ninety (90) Calendar Days after Contract Award, at the direction of the Department, or when changes are made to the card layout or content.
 - (d) The BH I/DD Tailored Plan may send a Certificate of Coverage in lieu of a Member identification card for Members who have a coverage termination date prior to notification of enrollment to the BH I/DD Tailored Plan via the standard enrollment file layout, if approved by the Department.
- (xiv) Member Handbook, Innovations Member and Family Handbook, and TBI Handbook
- (a) The BH I/DD Tailored Plan shall use the Department’s model BH I/DD Tailored Plan Member Handbook as guidance in the development of the BH I/DD Tailored Plan’s Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii).
 - (b) Consistent with the mailing requirements for the Member Welcome Packet, the BH I/DD Tailored Plan shall provide each Member a Member Handbook.
 - (c) Consistent with the mailing requirements for the Member Welcome Packet, the BH I/DD Tailored Plan shall send each existing waiver enrollee and new waiver enrollee their respective waiver handbook, Innovations Member and Family Handbook or a TBI Handbook.
 - (d) The BH I/DD Tailored Plan shall ensure that all Member Handbook, Innovations Member and Family Handbook, and TBI Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
 - (e) The BH I/DD Tailored Plan shall ensure that the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook includes sufficient information that enables the member to understand how to effectively use Medicaid Managed Care. This information shall include at a minimum:
 - (1) Covered benefits provided by the BH I/DD Tailored Plan, including:
 - i. Waiver services and supports where applicable; and
 - ii. Care management, including how to select and change care managers or care management entities.
 - (2) For BH I/DD Tailored Plans in selected Pilot regions—Information on the Healthy Opportunities Pilot program and how to access its services, including through Tailored Care Management.
 - (3) Member Enrollment and Disenrollment Policy, including Information on the member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract.
 - (4) How and where to access any benefits provided by the Department, including carved out services.
 - (5) As applicable to the BH I/DD Tailored Plan as a governmental entity, list of counseling or referral services that the BH I/DD Tailored Plan does not cover because of moral or religious objection, instructions for how the member can obtain information from the Department about how to access those services, and notification that the BH I/DD Tailored Plan’s failure to cover a service based on moral or religious objection.
 - (6) The amount, duration, and scope of benefits available under the BH I/DD Tailored Plan in sufficient detail to ensure that members understand the benefits to which they are entitled.
 - (7) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member’s PCP.

- (8) Information on the EPSDT benefits, for Medicaid Managed Care members under the age of twenty-one (21), including:
 - i. The benefits of preventive health care;
 - ii. Populations eligible for EPSDT;
 - iii. Services available under the EPSDT program and where and how to obtain those services;
 - iv. That EPSDT services are not subject to cost sharing; and
 - v. That BH I/DD Tailored Plan will provide scheduling and transportation assistance for EPSDT services upon request by the member.
- (9) The extent to which, and how, after-hours and emergency coverage are provided, including:
 - i. What constitutes an emergency medical condition and emergency services;
 - ii. The fact that prior authorization is not required for emergency services; and
 - iii. The fact that, subject to 42 C.F.R. § 438.10, the member has a right to use any hospital or other setting for emergency care.
- (10) Any restrictions on the member's freedom of choice among in-network providers and out-of-network providers.
- (11) The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the BH I/DD Tailored Plan cannot and shall not require a member to obtain a referral before choosing a family planning provider.
- (12) Cost sharing, if any, imposed on North Carolina Medicaid or NC Health Choice beneficiaries.
- (13) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract.
- (14) The process of selecting and changing the member's PCP, including, but not limited to:
 - i. Information on the two (2) annual without cause PCP changes; and
 - ii. The with cause reasons for switches beyond the two (2) without cause changes.
- (15) Grievance, Appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
 - i. The right to file Grievances and Appeals;
 - ii. The requirements and timeframes for filing a Grievance or Appeal or Request for a State Fair Hearing;
 - iii. The availability of assistance in the filing process;
 - iv. The right to request a State Fair Hearing after the BH I/DD Tailored Plan makes a decision on the member's Appeal which is adverse to the member; and
 - v. The fact that, when requested by the member, benefits that the BH I/DD Tailored Plan seeks to reduce or terminate will continue if the member files a request within the timeframes specified for filing and that the member may be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the member.
- (16) How to exercise an Advance Directive.
- (17) An overview of its continuation of benefits policy and define when, why and how a member or a member's authorized representative may file for a continuation of benefits.
- (18) How to access auxiliary aids and services, including additional information in alternative formats or languages.
- (19) The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Support Service Line, and Prescriber Service Line.

- (20) Information on how to report suspected fraud, waste or abuse.
 - (21) Information about Opioid Misuse Prevention and Treatment Program and the Tobacco Cessation Program.
 - (22) Information on the BH I/DD Tailored Plan Transition of Care Policy.
 - (23) Information about the BH I/DD Tailored Plan's prevention and population health programs.
 - (24) Contact information for beneficiary support systems, including the Ombudsman Program and the Enrollment Broker.
- (f) The BH I/DD Tailored Plan shall ensure that the Innovations Member and Family Handbook and the TBI Handbook include monitoring requirements and participant responsibilities for the respective waiver and information on the respective waiver advisory group.
 - (g) The BH I/DD Tailored Plan shall provide the Department for review any changes to the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook sixty (60) Calendar Days prior to the intended effective date of the change.
 - (h) The BH I/DD Tailored Plan shall notify each member, using Department-developed templates, of any Significant Change to the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook at least thirty (30) Calendar Days before the intended effective date of the change.
- (xv) Member Education and Outreach
 - (a) The BH I/DD Tailored Plan shall provide education and outreach to members and potential members, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department, the Enrollment Broker, Ombudsman Program and/or local health departments may be present. The BH I/DD Tailored Plan may provide education and outreach about other products, including without limitation the PIHP contract, at the same health awareness events, community events and health fairs.
 - (b) The BH I/DD Tailored Plan shall develop educational materials to be used by the Enrollment Broker to support BH I/DD Tailored Plan, PCP, and care management agency selection. The BH I/DD Tailored Plan shall provide information to be used by the Enrollment Broker to the Department for review and approval after Contract Award and annually thereafter.
 - (c) The BH I/DD Tailored Plan shall provide information regarding its planned member education efforts to the Department for review and approval sixty (60) Calendar Days after Contract Award and annually thereafter.
 - (d) The BH I/DD Tailored Plan shall provide Innovations and TBI waiver education and training for members and families in the manner prescribed in the Innovations and TBI waivers.
 - (e) Any outreach or education related to the proposed Member Incentive Program as described in *Section V.B.1.iii.(xx) Member Incentive Program* must be approved by the Department through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not be approved.
 - (f) In support of the Department's health equity goals, the BH I/DD Tailored Plan shall develop a Member Engagement and Marketing Plan for historically marginalized populations for review by the Department. The plan shall include the BH I/DD Tailored Plan's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. As long as the Member Engagement and Marketing Plan for Historically Marginalized Populations clearly states that it applies to the BH I/DD Tailored Plan, the Member Engagement and Marketing Plan for Historically Marginalized Populations may apply to other LME/ MCO operations, including, without limitation, the PIHP. The plan shall be submitted to the Department no later than November 1, 2022, and annually thereafter.
 - (xvi) Engagement with Consumers

- (a) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of its Members. To that end, the BH I/DD Tailored Plan shall establish and maintain mechanisms to communicate with and obtain advisement from consumer groups.
 - (b) Specifically, the BH I/DD Tailored Plan shall establish a Consumer and Family Advisory Committee (CFAC) and comply with applicable provisions of N.C. Gen. Stat. § 122C regarding the composition, meeting schedule, training, and support of the governing board, as outlined in *Section V.A.1.ii. Entity Requirements for Medicaid and State-funded Services*.
 - (c) One (1) CFAC is statutorily required for the LME/MCO as a whole, but shall serve as the Member Advisory Committee for both the BH I/DD Tailored Plan and the PIHP.
 - (d) The BH I/DD Tailored Plan shall seek input and advice regarding the BH I/DD Tailored Plan's programs and policies from the CFAC. Topics for discussion and consultation shall include but should not be limited to:
 - (1) Medical, pharmacy, BH, I/DD, and TBI benefits;
 - (2) Healthy Opportunities priority domains;
 - (3) Care management; and
 - (4) Healthy Opportunities Pilots (if applicable).
- (xvii) Engagement with Beneficiaries Utilizing Long Term Services and Supports
- (a) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. The BH I/DD Tailored Plan shall establish a LTSS Member Advisory Committee that garners stakeholder input and advice regarding the LTSS covered under the BH I/DD Tailored Plan contract, and meets all provisions noted in 42 C.F.R. § 438.110.
 - (b) The BH I/DD Tailored Plan shall provide reports to Committee that will enable the Committee to review member experience and quality of care to serve as an early warning system for the BH I/DD Tailored Plan on emerging issues.
 - (c) The BH I/DD Tailored Plan shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by BH I/DD Tailored Plan.
 - (d) The BH I/DD Tailored Plan shall provide quarterly reports quality measure data, appeals and grievance, critical incident reporting, Member satisfaction surveys and ad hoc feedback from Providers to the LTSS Member Advisory Committee that will enable the LTSS Member Advisory Committee to review member experience and quality of care to serve as an early warning system for the BH I/DD Tailored Plan on emerging issues.
 - (e) The BH I/DD Tailored Plan shall designate an existing staff member as a single point of contact who will be responsible for reporting concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to the State's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program as applicable.
 - (f) The BH I/DD Tailored Plan shall help coordinate resolution of concerns within 30 days related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's authorized family member(s), the Office of the State Long-Term Care Ombudsman in the Division of Aging and Adult Services, Medicaid Managed Care Ombudsman Program, and/or Member Advisory Committee as appropriate.
 - (g) The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the BH I/DD Tailored Plan or their representatives and include:
 - (1) Members accessing LTSS;
 - (2) Representatives of LTSS members (e.g., authorized representatives);

- (3) LTSS providers;
 - (4) Care managers from AMH+ practices and CMAs serving members with LTSS needs; and
 - (5) BH I/DD Tailored Plan staff involved in the authorization of LTSS and/or care management of LTSS members.
- (h) The BH I/DD Tailored Plan shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.
 - (i) The BH I/DD Tailored Plan shall designate a single point of contact who will be responsible for reporting concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to the state's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, Consumer and Family Advisory Committee (CFAC), as applicable.
 - (j) The BH I/DD Tailored Plan shall require care managers and other member services and provider relations staff to report concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to a single point of contact designated by the BH I/DD Tailored Plan.
 - (k) The BH I/DD Tailored Plan shall help coordinate resolutions to quality of care concerns related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's family, the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or CFAC, as appropriate.
- (xviii) Engagement with Innovations and TBI Waiver Members
- (a) The BH I/DD Tailored Plan shall develop stakeholder group(s) consisting of Innovations waiver members, families, advocates, and providers to provide recommendations regarding implementation and operation of Innovations waiver services and policies.
 - (1) The BH I/DD Tailored Plan shall meet with this stakeholder group(s) at least on a quarterly basis.
 - (2) The BH I/DD Tailored Plan shall keep meeting minutes and attendance records for each of these stakeholder meetings. BH I/DD Tailored Plan shall make these records available for review by Department and shall report on these efforts during the regular sessions between the BH I/DD Tailored Plan and the Department. These records should be submitted on a regular basis as defined by the Department.
 - (b) The BH I/DD Tailored Plan shall develop stakeholder group(s) consisting of TBI waiver members, families, advocates, and providers to provide recommendations regarding implementation of TBI waiver services and policies.
 - (1) The BH I/DD Tailored Plan shall meet with this stakeholder group(s) at least on a quarterly basis.
 - (2) The BH I/DD Tailored Plan shall keep meeting minutes and attendance records for each of these stakeholder meetings. BH I/DD Tailored Plan shall make these records available for review by the Department and shall report on these efforts at IMT meetings.
 - (3) This subsection only applies to those BH I/DD Tailored Plans with TBI waiver members.
- (xix) Health Education and Promotion Programs
- (a) The BH I/DD Tailored Plan shall develop member health education and promotion programs that address prevention, wellness, and early intervention of illness and disease. The BH I/DD Tailored Plan may provide health education and promotion in coordination with other products, including without limitation the PIHP contract, at the same health awareness events, during the same health education and promotion programming.
 - (b) The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.

- (c) The BH I/DD Tailored Plan shall make the health education and promotion programs available to members through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
 - (d) The Department may select additional specific educational and health promotion topics for the BH I/DD Tailored Plan to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- (xx) Member Incentive Program
- (a) The BH I/DD Tailored Plan may offer healthy behavior incentive programs to members, provided that the following criteria are met:
 - (1) The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy.
 - (2) The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
 - (3) The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed \$75.00.
 - (b) Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
 - (c) Prior to implementation, the BH I/DD Tailored Plan shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the Quality Assurance and Performance Improvement (QAPI) program.
- (xxi) The BH I/DD Tailored Plan shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (i) the program meets the requirements of 1112 of the Social Security Act; and (ii) the program meets the criteria determined by the Department.
- iv. Marketing
- (i) The Department views BH I/DD Tailored Plan marketing activities as a method to help publicize Medicaid Managed Care and educate potential members about health plan options, while ensuring the protection of members from coercive or misleading practices.
 - (ii) The BH I/DD Tailored Plan shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the BH I/DD Tailored Plan to ensure that members receive accurate verbal and written information to make an informed decision on whether to enroll or reenroll in the BH I/DD Tailored Plan.
 - (iii) The BH I/DD Tailored Plan shall submit its marketing plan to the Department for review and approval on an annual basis.
 - (iv) The BH I/DD Tailored Plan shall not market nor distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i). Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
 - (v) The BH I/DD Tailored Plan shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud members or the Department. 42 C.F.R. § 438.104(b)(2).
 - (vi) The BH I/DD Tailored Plan shall establish and maintain a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented, shall be the responsibility of the BH I/DD Tailored Plan.
 - (vii) If the BH I/DD Tailored Plan chooses to market, the BH I/DD Tailored Plan shall distribute marketing materials to the entire Region served by the BH I/DD Tailored Plan. 42 C.F.R. 438.104(b)(1)(ii).

- (viii) The BH I/DD Tailored Plan shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- (ix) The BH I/DD Tailored Plan shall ensure that all marketing materials and marketing strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy. In addition, the BH I/DD Tailored Plan shall not discriminate against members or potential members who may:
 - (a) Live or receive health care in rural or underserved areas; or
 - (b) Experience income disparities.
- (x) The BH I/DD Tailored Plan shall assign a unique marketing code provided by the Department to all marketing materials distributed to members.
- (xi) Marketing Materials and Activities
 - (a) Permissible Marketing Activities
 - (1) The BH I/DD Tailored Plan may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
 - (2) The BH I/DD Tailored Plan may participate in community-based marketing events or activities (e.g., health fairs, community events).
 - (3) The BH I/DD Tailored Plan may sponsor outreach activities and events, including as a financial sponsor.
 - (4) The BH I/DD Tailored Plan may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
 - (5) The BH I/DD Tailored Plan may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
 - (b) Prohibited Statements, Claims, and Activities (Written or Verbal)
 - (1) The BH I/DD Tailored Plan shall not assert that a member must enroll in the BH I/DD Tailored Plan to obtain benefits or to not lose benefits. However, the BH I/DD Tailored Plan may inform the member that certain benefits are available only through enrollment in a BH I/DD Tailored Plan (e.g., BH I/DD Tailored Plan-only services, Innovations waiver services, TBI waiver services, and State-funded services) so that the member may make an informed decision. 42 C.F.R. § 438.104(b)(2)(i).
 - (2) The BH I/DD Tailored Plan shall not claim that the BH I/DD Tailored Plan is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).
 - (3) The BH I/DD Tailored Plan shall not use the Department or State logo or other proprietary material in marketing.
 - (4) The BH I/DD Tailored Plan shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
 - (5) The BH I/DD Tailored Plan shall not reference competing BH I/DD Tailored Plans, Standard Plans, or other contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department, Standard Plans, or other BH I/DD Tailored Plans in any of its marketing materials.
 - (6) The BH I/DD Tailored Plan shall not cross-market with a Standard Plan.
 - (7) The BH I/DD Tailored Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).

- (8) The BH I/DD Tailored Plan shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.
 - (9) The BH I/DD Tailored Plan shall not market materials or activities that are discriminatory or that target potential members based on health status, geographic residence, location of the provision of possible services or income.
 - (10) The BH I/DD Tailored Plan shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
 - (11) The BH I/DD Tailored Plan shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
 - (12) The BH I/DD Tailored Plan shall not engage in activities that seek to target members currently enrolled in other BH I/DD Tailored Plans, Standard Plans, NC Medicaid Direct, the Tribal Option, or the Statewide Specialized Foster Care Plan.
 - (13) The BH I/DD Tailored Plan shall not offer choice counseling or seek to enroll potential members in the BH I/DD Tailored Plan. This is the sole responsibility of the Department and the Enrollment Broker.
 - (14) The BH I/DD Tailored Plan shall not send Request for Tailored Plan eligibility forms to potential members without prior approval from the Department on the target population and associated algorithms.
 - (15) The BH I/DD Tailored Plan shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
 - (16) The BH I/DD Tailored Plan shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
- (c) References to Studies and Statistics
- (1) The BH I/DD Tailored Plan shall not use irrelevant facts or inaccurate or misleading statistical information in any marketing materials and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
 - (2) If references to a study or statistics are included in any marketing material, the BH I/DD Tailored Plan shall provide reference information (e.g., publication, date, page number) and information about the BH I/DD Tailored Plan's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.
- (d) Nominal Gifts
- (1) The BH I/DD Tailored Plan may conduct giveaways and distribute nominal gifts to members and potential members.
 - (2) The BH I/DD Tailored Plan shall ensure the following for nominal gifts offered by the BH I/DD Tailored Plan:
 - i. The gifts do not exceed ten dollars (\$10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
 - ii. The gifts are made available to the public and are not in any way connected to enrollment.
 - iii. The gifts are distributed via in-person contacts only (e.g., community events).
- (e) Marketing of Multiple Lines of Business

- (1) The BH I/DD Tailored Plan shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.
 - (2) The BH I/DD Tailored Plan shall be permitted to co-market QHPs and Medicaid products, to the extent the BH I/DD Tailored Plan is participating in both markets in the State and within the scope authorized for BH I/DD Tailored Plans under State law.
 - (3) The BH I/DD Tailored Plan shall be permitted to provide information about a QHP to potential members who could enroll in such a plan as an alternative to Medicaid Managed Care due to a loss of Medicaid eligibility.
- (xii) Department Approval of Marketing Materials
- (a) The BH I/DD Tailored Plan shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.
 - (b) If the BH I/DD Tailored Plan makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the BH I/DD Tailored Plan must resubmit the materials, in accordance with this Section, for Department review and approval.
- (xiii) The BH I/DD Tailored Plan may engage in marketing activities beginning eight (8) weeks prior to open enrollment and shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the BH I/DD Tailored Plan's marketing activities in accordance with *Section VI.A. Contract Violations and Noncompliance for Medicaid and State-funded Services*.
- v. Member Rights and Responsibilities
- (i) The Department expects the BH I/DD Tailored Plan to treat members with dignity and respect, to protect members' rights, to inform members of their responsibilities as members of the plan, and ensure each member is not subject to any unlawful discrimination in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any Network provider of the BH I/DD Tailored Plan.
 - (ii) The BH I/DD Tailored Plan shall establish and maintain written policies and procedures that are designed to protect the rights of members and describe the responsibilities of each member. The BH I/DD Tailored Plan shall develop and submit to the Department for review a Member and Recipient Rights and Responsibilities Policy ninety (90) Calendar Days after Contract Award. As long as the Member and Recipient Rights and Responsibilities Policy clearly states that it applies to the BH I/DD Tailored Plan, the Member and Recipient Rights and Responsibilities Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (iii) The BH I/DD Tailored Plan shall include a written description of the rights and responsibilities of members in the Member Welcome Packet and the Member Handbook.
 - (iv) The BH I/DD Tailored Plan shall provide a copy of its Member and Recipient Rights and Responsibilities Policy to all BH I/DD Tailored Plan employees and network providers.
 - (v) In accordance with 42 C.F.R. § 438.100(b), the BH I/DD Tailored Plan shall ensure its written policies and procedures, at a minimum, afford members the right to:
 - (1) Receive information in accordance with 42 C.F.R. § 438.10;
 - (2) Be treated with respect and with due consideration for his or her dignity and privacy;
 - (3) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
 - (4) Participate in decisions regarding his or her health care, including the right to refuse treatment and Advance Directives under *Section V.A.1.viii. Advance Directives for Medicaid and State-funded Services*;

- (5) Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - (6) If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
 - (7) Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.
- (vi) The BH I/DD Tailored Plan shall not attempt to influence, limit, or otherwise interfere with the member's decision to exercise their rights as provided in this Contract.
 - (vii) The BH I/DD Tailored Plan shall ensure that members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the BH I/DD Tailored Plan or its Network providers treat the member. 42 C.F.R. § 438.100(c).
 - (viii) The BH I/DD Tailored Plan shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against members in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any network provider of the BH I/DD Tailored Plan. 42 C.F.R. § 438.100(d).
 - (ix) The BH I/DD Tailored Plan shall not avoid costs for services covered in its Contract by referring NC Health Choice beneficiaries to publicly supported health care resources. 42 C.F.R. § 457.1201(p).
- vi. Member Grievances and Appeals
- (i) The Department is committed to ensuring that members understand and can freely exercise their Appeal and Grievance rights and resolve issues efficiently with minimal burden to the member or their authorized representative. The BH I/DD Tailored Plan shall educate the member on their rights and provide reasonable assistance with understanding and navigating the Appeals and Grievances processes.
 - (ii) Member Grievances and Appeals General Requirements
 - (a) The BH I/DD Tailored Plan shall establish and maintain a Grievance and Appeals system for reviewing and resolving member Grievances and Appeals. Components of the system shall include a Grievance process, a plan-level Appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F. The BH I/DD Tailored Plan shall ensure the Grievance and Appeals system aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, to the degree a subcontractor relationship applies.
 - (b) The BH I/DD Tailored Plan shall, while adhering to the required Utilization Management Program, employ strategies to resolve Grievance and Appeals at the lowest level of escalation that meets a member's needs and in a manner that does not discourage members from exercising their rights.
 - (c) The BH I/DD Tailored Plan shall provide members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section V.A.4.iii. Integration with other Department Partners*, *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*, and *Section V.B.1.iii. Member Engagement*.
 - (d) The BH I/DD Tailored Plan shall provide members reasonable assistance in completing forms and taking other procedural steps related to a plan Grievance or Appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a).
 - (e) The BH I/DD Tailored Plan shall ensure that the individuals making decisions on Grievances and Appeals:

- (1) Acknowledge receipt of Grievances and Appeals (including verbal Appeals), unless the member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
 - (2) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).
 - (3) If deciding an Appeal of a denial is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues, are individuals who have the appropriate clinical expertise in treating the member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).
 - (4) Take into account all comments, documents, records, and other information submitted by the member or their authorized representative for the service authorization request or payment denial at issue without regard to whether such information was submitted or considered in the initial adverse benefit determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).
- (f) The BH I/DD Tailored Plan shall allow an authorized representative (including providers) or legal guardian, with the member's written consent, to request an Appeal or file a Grievance on behalf of a member. 42 C.F.R. § 438.402(c)(ii).
 - (g) The BH I/DD Tailored Plan shall not retaliate if a member, authorized representative, or legal guardian requests an Appeal or files a Grievance.
 - (h) The BH I/DD Tailored Plan shall use Department developed templates for all member notices related to the member Grievance and Appeals processes that meet applicable notification standards, including but not limited to, the notice of adverse benefit determination, the plan Appeal request form, the State Fair Hearing Appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii).
 - (i) The Department shall provide such templates in a timely fashion and agrees to provide the BH I/DD Tailored Plan with ninety (90) Calendar Days' advance notice of the issuance of new templates before the templates' proposed effective date. The Department shall not issue new templates more than once a year unless required by regulatory changes. The Department shall allow the BH I/DD Tailored Plan the right to provide comment and feedback on proposed template modifications, which the Department shall consider before the templates are finalized.
 - (j) The BH I/DD Tailored Plan shall define an Appeal, adverse benefit determination, and Grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400.
 - (k) The BH I/DD Tailored Plan shall provide the information specified in 42 C.F.R. §§ 438.10(g)(xi) on its Grievance, Appeals, and State Fair Hearing procedures to all providers and applicable subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.
 - (l) The BH I/DD Tailored Plan shall comply with Chapter 108D of the North Carolina General Statutes for all Appeals and Grievance proceedings.
 - (m) The BH I/DD Tailored Plan shall adhere to the NC DHHS Transition of Care Policy's guidance for managing Appeals in effect during the Member's transition.
- (iii) Member Grievance Process
 - (a) The BH I/DD Tailored Plan shall develop and submit to the Department for review a Member Grievance Policy one hundred twenty (120) Calendar Days after Contract Award.
 - (b) The BH I/DD Tailored Plan shall allow a member or authorized representative to file a Grievance with the BH I/DD Tailored Plan, verbally or in writing, at any time. 42 C.F.R. §§, 438.408; 438.402(c)(2)(i), and 438.402(c)(3)(i).

- (c) The BH I/DD Tailored Plan shall use the Department-developed Notice of Acknowledgement of Receipt of Grievance template to notify the member of receipt of the Grievance.
 - (d) The BH I/DD Tailored Plan's member Grievance process shall include acknowledgement, in writing, within five (5) Calendar Days of receipt of each Grievance. 42 C.F.R. § 438.406(b)(1).
 - (e) Reserved.
 - (f) If a Grievance relates to the denial of an expedited Appeal request, the BH I/DD Tailored Plan shall resolve the Grievance and provide notice to the member and, as applicable, the member's authorized representative within five (5) Calendar Days from the date the BH I/DD Tailored Plan receives the Grievance. 42 C.F.R. § 438.408(b)(1).
 - (g) The BH I/DD Tailored Plan shall provide written notice of resolution of the Grievance to the member and, as applicable, the member's authorized representative within thirty (30) Calendar Days from the date the BH I/DD Tailored Plan receives the Grievance. 42 C.F.R. § 438.408(b)(1).
 - (h) Consistent with 42 C.F.R. § 438.408(c)(1)(i) - (ii), the BH I/DD Tailored Plan may extend the timeframes for resolution of a Grievance by up to fourteen (14) Calendar Days if:
 - (1) The member requests the extension or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest.
 - (2) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - i. Make reasonable efforts to give the member verbal notice of the delay;
 - ii. Within two (2) Calendar Days, provide written notice and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - iii. Resolve the Grievance as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
 - (3) The BH I/DD Tailored Plan shall notify members of their opportunity to submit a complaint with the Department if the member is dissatisfied with the BH I/DD Tailored Plan's resolution of a Grievance.
- (iv) Notice of Adverse Benefit Determination
- (a) The BH I/DD Tailored Plan shall give the member and provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.404.
 - (b) The BH I/DD Tailored Plan shall issue a member a Notice of Adverse Benefit Determination with due process rights for any decision to deny, reduce, terminate, or suspend:
 - (1) A member's Innovations waiver or TBI waiver program participation;
 - (2) Placement on a Registry of Unmet Needs;
 - (3) ICF-MR Level of Care determination; or
 - (4) Qualification for an emergency Innovations waiver slot.
 - (c) Each Notice of Adverse Benefit Determination shall conform with 42 C.F.R. § 431.210, contain and explain:
 - (1) The Adverse Benefit Determination the BH I/DD Tailored Plan has made or intends to take. 42 C.F.R. § 438.404(b)(1);
 - (2) The reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);
 - (3) The member's right to file an Appeal, including information on exhausting the BH I/DD Tailored Plan's one (1) level of Appeal and the right to request a State Fair Hearing if the Adverse Benefit Determination is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);

- (4) Procedures for exercising member's rights to file a Grievance or Appeal. 42 C.F.R. § 438.404(b)(4);
 - (5) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
 - (6) The member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).
- (d) The BH I/DD Tailored Plan shall use the Department-developed template for the Notice of Adverse Benefit Determination.
 - (e) The BH I/DD Tailored Plan shall provide the member with a Department-developed Appeal request form in conjunction with the Notice of Adverse Benefit Determination.
 - (f) Timing of the Notice of Adverse Benefit Determination.
 - (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the BH I/DD Tailored Plan shall give written notice to the member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date of the adverse benefit determination is to take effect, except as provided in this Section. 42 C.F.R. § 438.404(c)(1).
 - (2) For termination, suspension, or reduction of previously authorized Medicaid-covered services the BH I/DD Tailored Plan shall provide written notice as expeditiously as possible and no later than five (5) Calendar Days before the date of the Adverse Benefit Determination take effect if:
 - i. The BH I/DD Tailored Plan has facts indicating that action should be taken because of probable fraud by the member; and
 - ii. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).
 - (3) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the BH I/DD Tailored Plan shall provide written notice no later than by the date of the action when any of the following occurs:
 - i. The BH I/DD Tailored Plan has factual information confirming the death of the member;
 - ii. The BH I/DD Tailored Plan receives a signed, written statement from the member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
 - iii. The member is admitted to an institution where he or she is ineligible under the plan for further services;
 - iv. The member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
 - v. The BH I/DD Tailored Plan establishes that the member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
 - vi. A change in the level of medical care is prescribed by the member's physician. 42 C.F.R. §§ 431.213 and 438.404(c).
 - (4) For denial of payment, the BH I/DD Tailored Plan shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 CFR 438.404(c)(2).
 - (5) For denial of placement on or removal from a Registry of Unmet Needs or termination from or denial of participation in the Innovations Waiver program or TBI waiver program, the BH I/DD Tailored Plan shall give written notice to the member, and when applicable,

an authorized representative at least ten (10) calendar days before the date that the adverse decision is to take effect.

- (6) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the BH I/DD Tailored Plan shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).
 - (7) If the member's address is unknown and mail directed to him/her has no forwarding address, the BH I/DD Tailored Plan shall have a contingency plan to provide an Adverse Benefit Determination notification to the member or legally responsible person regarding termination or reduction of previously authorized Medicaid-covered services no later than the date of the benefit determination
- (g) Internal Plan Appeals
- (1) The BH I/DD Tailored Plan shall have an established internal member Appeal process for standard and expedited resolution of Appeals requests.
 - (2) The BH I/DD Tailored Plan shall have only one level of Appeal for members. 42 C.F.R. § 438.402(b).
 - (3) The BH I/DD Tailored Plan shall include the member and his or her representative or the legal representative of a deceased member's estate as parties to the Appeal. 42 C.F.R. § 438.406(b)(6).
 - (4) The BH I/DD Tailored Plan shall provide members a reasonable opportunity by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the Appeal. For requests for expedited resolution, the BH I/DD Tailored Plan shall inform the member of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)
 - (5) The BH I/DD Tailored Plan shall provide members and his or her authorized representative, to the extent permitted by law, the member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the BH I/DD Tailored Plan (or at the direction of the BH I/DD Tailored Plan) in connection with the Appeal. The BH I/DD Tailored Plan shall provide the information to the member free of charge and within five (5) calendar days for standard appeals and within two (2) calendar days for expedited appeals. . 42 C.F.R. § 438.406(b)(5).
 - (6) The BH I/DD Tailored Plan shall consider all comments, documents, records, and other information submitted by the member or, his or her authorized representative, during the appeal without regard to whether such information was submitted or considered in the initial adverse benefit determination.
 - (7) The BH I/DD Tailored Plan shall require members to exhaust the internal Appeal process before requesting a State Fair Hearing. However, if the BH I/DD Tailored Plan fails to adhere to the notice and timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, members will be deemed to have exhausted the BH I/DD Tailored Plan's internal Appeal process and can request a State Fair Hearing. 42 C.F.R. § 438.402(c)(1).
- (8) Request for Plan Appeals
- i. The BH I/DD Tailored Plan shall allow members, or an authorized representative, sixty (60) Calendar Days from the date on the Notice of Adverse Benefit Determination to file a request, verbally or in writing, for an Appeal with the BH I/DD Tailored Plan. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).
 - ii. The BH I/DD Tailored Plan shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing,

receipt of each standard Appeal request, whether received verbally or in writing, within five (5) Calendar Days of receipt of the request. 42 C.F.R. § 438.406(b)(1).

iii. Standard resolution of Appeals

- a) The BH I/DD Tailored Plan shall provide written notice of resolution of the Appeal to the member and/or authorized representative as expeditiously as the member's health condition requires and no later than thirty (30) Calendar Days after receipt of a standard Appeal request. 42 C.F.R. § 438.408(b)(2).
- b) The BH I/DD Tailored Plan shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing Appeal request form consistent with. 42 C.F.R. § 438.408(e).

iv. Extension of standard resolution of Appeal

- a) The BH I/DD Tailored Plan may extend the timeframes for standard resolution of an Appeal request by up to fourteen (14) Calendar Days if:
 - 1) The member requests the extension, or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
- b) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - 1) Make reasonable efforts to give the Member verbal notice of the delay;
 - 2) Within two (2) Calendar Days, provide written notice using the Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - 3) Resolve the Appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).
- c) The Notice of Extension of Timeframe for Standard Appeal Resolution shall include:
 - 1) The timeframe for extension;
 - 2) The reason for extension;
 - 3) A statement on the member's right to file a Grievance if he or she disagrees with the extension; and
 - 4) A statement regarding the availability of assistance with the Appeals process and the ability to call the BH I/DD Tailored Plan with questions. 42 C.F.R. § 438.10(c)(4)(ii).
- d) The BH I/DD Tailored Plan shall provide written notice of the resolution of the Appeal, which shall include the date completed and reasons for the determination in easily, understood language. The BH I/DD Tailored Plan shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).

(h) Expedited Resolution of Plan Appeals

- (1) The BH I/DD Tailored Plan shall establish, maintain and communicate to members an expedited Appeal resolution process for plan Appeals for use when there is an immediate need for health services because a standard Appeal could jeopardize the member's life,

physical or mental health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).

- (2) The BH I/DD Tailored Plan shall allow members or an authorized representative to file an expedited Appeal resolution request either verbally or in writing within sixty (60) Calendar Days of the date on the adverse benefit determination notice.
- (3) The BH I/DD Tailored Plan shall not require any additional written follow-up for verbal requests for expedited Appeal resolution requests. 42 C.F.R. § 438.406(b)(3).
- (4) In accordance with NC.G.S. § 108D-14(a) and 42 C.F.R. § 438.410(a), for expedited appeal requests made by a network provider acting as an authorized representative of the Member on behalf of a Members, the BH I/DD Tailored Plan shall presume an expedited appeal resolution is necessary and grant the request for expedited resolution. The BH I/DD Tailored Plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a Member's appeal. 42 C.F.R. § 438.410(b).Fe
- (5) If the BH I/DD Tailored Plan denies the request for an expedited plan Appeal, it shall do the following:
 - i. Immediately transfer the Appeal to the timeframes for standard resolution timeframe and
 - ii. Make reasonable efforts to give the Member or an authorized representative oral notice of the denial and follow up with a written notice, of the denial of the expedited resolution request within two (2) Calendar Days of the denial of the expedited appeal. 42 C.F.R. 438.410(c) and 438.408.(c)(2)(ii).
- (6) For expedited resolution of Appeals, the BH I/DD Tailored Plan shall make a determination as expeditiously as the member's health condition requires but shall provide written notice, and make reasonable effort to provide verbal notice, of resolution no later than seventy-two (72) hours of receipt of the expedited Appeal request. 42 C.F.R. § 438.408(a) and 42 C.F.R. § 438.408(b)(3).
- (7) BH I/DD Tailored Plan shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing Appeal request form.
- (8) Extension of expedited Appeal resolution
 - i. The BH I/DD Tailored Plan may extend the timeframes for expedited resolution of an Appeal request by up to fourteen (14) Calendar Days if:
 - a) The member requests the extension, or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest.
 - b) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - 1) Make reasonable efforts to give the member verbal notice of the delay;
 - 2) Within two (2) Calendar Days, provide written notice and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - 3) Resolve the Appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(iii); 42 C.F.R. § 438.408(b)(1).
 - ii. The BH I/DD Tailored Plan shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
 - a) The timeframe for extension;
 - b) The reason for extension;

- c) A statement on the member’s right to file a Grievance if he or she disagrees with the extension; and
 - d) A statement on the availability of assistance with the Appeals process and the ability to call the BH I/DD Tailored Plan with questions. 42 C.F.R. § 438.10(c)(4)(ii).
- (v) Continuation of Benefits
 - (a) Timely Request for Continuation of Benefits: The BH I/DD Tailored Plan shall continue and pay for the member’s benefits during the pendency of the plan Appeal and State Fair Hearing if all of the following occur:
 - (1) The member, or the member’s authorized representative, files the request for an Appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
 - (2) The plan Appeal involves the termination, suspension, or reduction of previously authorized services, including removal from a Registry of Unmet Needs, Innovations waiver program, or TBI waiver program;
 - (3) The services were ordered by an authorized provider;
 - (4) The period covered by the original authorization has not expired; and
 - (5) The member timely files for continuation of benefits within ten (10) Calendar Days of the BH I/DD Tailored Plan sending the notice of the adverse benefit determination (or before), or on the intended effective date of the BH I/DD Tailored Plan’s proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(b).
 - (b) If the BH I/DD Tailored Plan continues the member’s benefits while the Appeal is pending, the benefits must be continued until one (1) of the following occurs:
 - (1) The member withdraws the Appeal or State Fair Hearing request, in writing;
 - (2) The member does not request a State Fair Hearing and continuation of benefits within ten (10) Calendar Days from when the BH I/DD Tailored Plan mails an adverse BH I/DD Tailored Plan decision regarding the member’s BH I/DD Tailored Plan Appeal; or
 - (3) A State Fair Hearing decision adverse to the member is made.
 - (c) The BH I/DD Tailored Plan shall not allow a provider to request continuation of benefits on behalf of a member. 42 C.F.R. § 438.402(c)(1)(ii).
 - (d) Reserved.
 - (e) Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
 - (1) The BH I/DD Tailored Plan shall be permitted to recover the cost of services furnished to the member during the pendency of the plan Appeal and the State Fair Hearing if:
 - i. The BH I/DD Tailored Plan notified the member of the potential for recovery;
 - ii. The BH I/DD Tailored Plan furnished benefits to the member solely because of the requirement for continuation of benefits; and
 - iii. The final resolution of the plan Appeal or the State Fair Hearing is adverse to the member (i.e., upholds the BH I/DD Tailored Plan’s adverse benefit determination). 42 C.F.R. § 438.420(d). For purposes of recovering cost of services furnished during the pendency of the Appeal, the BH I/DD Tailored Plan shall consider a final resolution to be adverse to the member when all the following occur:
 - a) The member timely requests benefits to continue during the plan appeal or the State Fair Hearing;
 - b) The BH I/DD Tailored Plan upholds its initial decision in its notice of resolution to the member following the plan appeal; and
 - c) The Office of Administrative Hearings issues a final decision in accordance with N.C. Gen. Stat. § 150B-34 that upholds the BH I/DD Tailored Plan’s Adverse Benefit Determination that gave rise to the appeal.

- (2) If the BH I/DD Tailored Plan chooses to seek to recover the cost of services provided to members during the pendency of the plan Appeal or the State Fair Hearing, the BH I/DD Tailored Plan shall do the following:
 - i. Develop a member hardship exemption process; and
 - ii. Obtain prior approval from the Department for each instance in which the BH I/DD Tailored Plan seeks to recover the costs of benefits provided to members under this Section which includes an explanation of the services provided to the member, the amount the BH I/DD Tailored Plan is seeking to recover and a detailed explanation for why the BH I/DD Tailored Plan is seeking recovery.
- (vi) State Fair Hearing Process
- (a) BH I/DD Tailored Plan shall comply with Chapter 108D and Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
 - (b) The BH I/DD Tailored Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.
 - (c) The BH I/DD Tailored Plan shall allow members or, an authorized representative, one hundred and twenty (120) Calendar Days from the date on the Notice of Resolution issued by the BH I/DD Tailored Plan upholding, in whole or in part, the Adverse Benefit Determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f).
 - (d) The parties to the State Fair Hearing shall include the BH I/DD Tailored Plan and the member or, when applicable, the member's authorized representative. 42 C.F.R. § 438.408(f)(3).
 - (e) The BH I/DD Tailored Plan shall designate a mailing and email address with the OAH for all fair-hearing-related communications from OAH and any party to the State Fair Hearing.
 - (f) Mediation
 - (1) The BH I/DD Tailored Plan shall notify members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
 - (2) The BH I/DD Tailored Plan shall inform members that mediation is voluntary and that the member is not required to request a mediation to receive a State Fair Hearing with OAH.
 - (3) The BH I/DD Tailored Plan shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
 - (g) Effectuation of Reversed Appeal Resolutions
 - (1) If the BH I/DD Tailored Plan, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the BH I/DD Tailored Plan shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).
 - (2) If the BH I/DD Tailored Plan, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the member received the disputed services while the Appeal was pending, the BH I/DD Tailored Plan shall pay for those services in accordance with the terms of the Contract. 42 C.F.R. § 438.424(b).
- (vii) Appellate Responsibilities
- (a) The BH I/DD Tailored Plan shall notify the Department within five (5) Calendar Days of being served notice of a member's request for judicial review, or other Appeal, following an adverse ruling in a State Fair Hearing.

- (b) The BH I/DD Tailored Plan is responsible for responding to the request for judicial review, or other Appeal, as well as BH I/DD Tailored Plan's attorney's fees and costs.
 - (c) If Department is also a party, the Department is responsible for its response to the request for judicial review. The BH I/DD Tailored Plan will cooperate fully with Department in its response and defense. To the extent no conflict of interest exists or arises, the BH I/DD Tailored Plan and Department may agree to joint defense.
 - (d) The BH I/DD Tailored Plan is responsible for satisfying any judgement, including, payment of benefits, that result from a court's ruling or order in favor of the member and against the BH I/DD Tailored Plan. The Department will seek indemnification in accordance with the terms of this Contract for any ruling against the Department.
- (viii) NC Health Choice Beneficiary Grievances and Appeals
- (a) The BH I/DD Tailored Plan shall allow members who are NC Health Choice beneficiaries enrolled in the BH I/DD Tailored Plan to file Grievances in the same manner as members who are North Carolina Medicaid beneficiaries as specified in this Contract. 42 C.F.R. § 457.1260.
 - (b) In accordance with 42 C.F.R. §§ 457.1260 and 457.1130(b), the BH I/DD Tailored Plan shall allow members who are NC Health Choice beneficiaries enrolled in the plan to file Appeals in the same manner as members who are North Carolina Medicaid beneficiaries as specified in this Contract, except that the BH I/DD Tailored Plan shall not provide continuation of benefits to members who are NC Health Choice beneficiaries during the pendency of an Appeal. 42 C.F.R. § 457.1260.
 - (c) Notwithstanding requirements within this Section, if the sole basis for the BH I/DD Tailored Plan's decision to delay, deny, reduce, suspend, or terminate health services, in whole or in part, is a provision in the NC Health Choice State Plan or in federal or North Carolina law requiring an automatic change in coverage under the health benefits package that affects all members or a group of members without regard to their individual circumstances, the BH I/DD Tailored Plan shall not be required to provide the member with an opportunity for review of the matter. 42 C.F.R. § 457.1130(c).
- (ix) Appeals and Grievances Recordkeeping and Reporting
- (a) The BH I/DD Tailored Plan shall maintain records of all member Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's Quality Strategy. 42 C.F.R. § 438.416(a).
 - (b) The record of each Grievance and Appeal shall contain, at a minimum, the following:
 - (1) The name of the person for whom the Appeal or Grievance was filed;
 - (2) A general description of the reason for the Appeal or Grievance;
 - (3) The date received;
 - (4) The date of each review or, if applicable, review meeting;
 - (5) Resolution at each level of the Appeal or Grievance, if applicable;
 - (6) Date of resolution at each level, if applicable;
 - (7) Date of Appeal decision and mail date of Appeal decision;
 - (8) Whether the Appeal was an expedited request, if applicable;
 - (9) Who conducted the review of the Appeal or Grievance and made the determination; and
 - (10) Whether an extension of Appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b).
 - (c) The BH I/DD Tailored Plan shall maintain accurate records in a manner accessible to the Department and available upon request to CMS. 42 C.F.R. § 438.416(c).
 - (d) The BH I/DD Tailored Plan shall retain Appeal and Grievance records consistent with the record retention terms of the Contract following the final decision or the close of the Appeal or Grievance. If any litigation, claims negotiation, audit, or other action involving the records has

been started before the expiration of the retention period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular period, whichever is later.

- (e) Appeals and Grievance Reporting
 - (1) In accordance with 42 C.F.R. § 438.416, the Department will monitor the BH I/DD Tailored Plan to ensure compliance with all applicable laws and rules pertaining to member Appeals and Grievances.
 - (2) To support the Department's monitoring efforts, the BH I/DD Tailored Plan shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
 - i. Each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan; and
 - ii. Each Notice of Resolution issued by the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall provide a report on all Appeals and Grievances received by the BH I/DD Tailored Plan from members, or an authorized representative, in a form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
- (x) Additional Due Process Principles under the NC Innovations waiver and TBI waiver: In addition to the appeals and notice requirements set forth above, BH I/DD Tailored Plan shall comply with the following due process principles as they relate to members who are participants in the Innovations waiver or TBI waiver, including but not limited to development of the member's individual budget and ISP:
 - (a) NC Innovations Waiver: The BH I/DD Tailored Plan shall utilize a Department-approved template to notify the member or authorized representative of the results of any new Supports Intensity Scale® (SIS®) evaluation and to inform the member or authorized representative in writing of the opportunity and process for raising concerns regarding SIS® evaluations and results. The process for raising concerns shall include an opportunity to discuss the results of the SIS® evaluation with the BH I/DD Tailored Plan and the potential for results to be adjusted if it is determined that particular support needs of the individual were not accurately captured, as well as the opportunity to file a Grievance regarding SIS® evaluations and results. The failure to request a Grievance shall not waive the Innovations waiver member's ability to argue that the results of the SIS® are incorrect in requesting services, or during reconsideration review or the State fair hearing
 - (b) If the BH I/DD Tailored Plan authorizes a requested service for a duration less than the duration requested in the ISP, the BH I/DD Tailored Plan shall provide written notice with Appeal rights and clinical reasons for the decision at the time of the limited authorization.
 - (c) If the BH I/DD Tailored Plan denies a request for authorization of services by a member, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of service, BH I/DD Tailored Plan shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404:
 - (1) An Appeal filed by a member must not prevent any authorized services from being provided pending the outcome of the Appeal. BH I/DD Tailored Plan must not prevent the member from making a new request for services during a pending Appeal.
 - (d) The BH I/DD Tailored Plan shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all members from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to Appeal the denial, reduction, or termination of a service. BH

I/DD Tailored Plan shall not attempt to influence, limit, or interfere with a member's right or decision to file or pursue a Grievance or request an Appeal.

- (e) ISP: The BH I/DD Tailored Plan shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver or TBI waiver member and that such desires are reflected in the Innovations waiver or TBI waiver member's ISP, including the desired type, amount, and duration of services.
- (f) The BH I/DD Tailored Plan shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to the Innovations/TBI waivers and other trainings relevant to due process procedures, whether related to the waiver or otherwise.

vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs)

(i) Advanced Medical Home Contracting

(a) Background and General Requirements

- (1) The majority of primary care practices serving Medicaid beneficiaries are participating in the Advanced Medical Home (AMH) program in Tiers 1-3. All AMH practices additionally receive a Medical Home Fee.
- (2) Under BH I/DD Tailored Plans, AMH practices will act as primary care providers (PCPs) for BH I/DD Tailored Plan members. The BH I/DD Tailored Plan shall pay AMH practices serving as the PCP for Members the Medical Home Fee paid to AMH practices. *Section V.B.4.iv.(xvii) Payments of Medical Home Fees to Advanced Medical Homes.*
- (3) Different from Standard Plans, AMH practices ready to take primary responsibility for care management under BH I/DD Tailored Plans must become certified as AMH+ practices as described in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs.* The Department will establish a fixed Tailored Care Management payment for AMH+ practices certified to provide Tailored Care Management as described in *Section III.D.36. Payment and Reimbursement.*
- (4) The BH I/DD Tailored Plan shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices as described in *Section VII. First Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members.*
- (5) The BH I/DD Tailored Plan shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the AMH practice and the BH I/DD Tailored Plan.
- (6) The BH I/DD Tailored Plan shall incorporate any new Department guidance, policy, operational manuals and other program-specific requirements into BH I/DD Tailored Plan operations and AMH contracts, as applicable, and within Department-specified timelines.

(b) Advanced Medical Home Quality Metrics

- (1) Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for BH I/DD Tailored Plans, the BH I/DD Tailored Plan shall compile and calculate each of the AMH quality metrics for each AMH practice.
- (2) The BH I/DD Tailored Plan shall provide feedback on quality scoring results to each AMH practice.
- (3) The Department will provide the BH I/DD Tailored Plan with the AMH measure set and reporting schedule prior to implementation as described in *Section VII. First Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members.*

- (c) For AMH practices that are not certified as AMH+ practices, the BH I/DD Tailored Plan may, but is not required to, develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics. Performance Incentive Payments must be accounted for and reported to the Department separately from Medical Home Fees and Care Management Fees.
- (d) Advance Medical Home Oversight
 - (1) The BH I/DD Tailored Plan shall monitor AMH practices' performance against Tier-specific AMH requirements reflected in their contracts with AMH practices, and against other mutually agreed upon contract terms.
 - (2) In the event of underperformance by an AMH practice or CIN/other technology partner, the BH I/DD Tailored Plan shall send a notice of underperformance to the AMH practice/CIN/other technology partner and copy the Department.
 - (3) The BH I/DD Tailored Plan shall provide the AMH practice/CIN/other technology partner a minimum of thirty (30) Calendar Days to remediate noncompliance with Tier-specific AMH requirements and any other mutually agreed upon contract terms prior to the BH I/DD Tailored Plan moving to downgrade a Tier status (for AMH practices) or cease to make payments (AMH practices or CINs/other technology partners).
 - (4) The BH I/DD Tailored Plan shall not automatically change the Tier of any affiliated AMH Tier 3 practices as a result of a Corrective Action Plan or other compliance action imposed at the CIN/other partner level.
 - (5) In the event of continued underperformance (i.e. non-adherence to contract standards, quality of care concerns) by an AMH that is not corrected, the Department shall permit the BH I/DD Tailored Plan to stop paying the Care Management Fee and/or Medical Home Fee (as applicable based on Tier status) and downgrade the Tier status of the AMH for that BH I/DD Tailored Plan, only.
 - (6) In the event that the BH I/DD Tailored Plan notifies an AMH practice that it will no longer pay the practice the Care Management Fee and/or Medical Home Fee that would otherwise be required by the Department, the BH I/DD Tailored Plan shall notify the Department that it has downgraded the Tier status for the practice. The Department reserves the right to specify the timing and format of this notification.
 - (7) In the event a practice is downgraded from Tier 3 to Tier 2, the BH I/DD Tailored Plan shall ensure that there are no gaps in care management functions for Members assigned to the practice.
 - (8) Within ninety (90) Calendar Days of contract execution with the provider, the BH I/DD Tailored Plan shall share with each AMH practice a description of the oversight process it will use to monitor practices' performance against Tier-specific AMH requirements. The oversight process shall contain a process for Corrective Action Plans, or equivalent, as a mechanism to allow practices to remediate compliance problems. For AMH practices affiliated with a CIN/other partner, the description shall include the process that the BH I/DD Tailored Plan will employ to monitor performance at the CIN/other partner level, including how Corrective Action Plans will apply at the CIN/other partner level and how the BH I/DD Tailored Plan will keep AMH practices informed in the event that a Corrective Action Plan is imposed at the CIN/other partner level.
 - (9) In the case of any corrective actions imposed at the CIN/other technology partner level, the BH I/DD Tailored Plan shall provide notice to each AMH practice affiliated with that CIN/other technology partner within sixty (60) Calendar Days that the corrective action has been imposed. The BH I/DD Tailored Plan shall provide individual AMH practices affiliated with the CIN/other technology partner notice of their options, which shall include contracting directly with the BH I/DD Tailored Plan as an AMH Tier 3, contracting with another CIN/other technology partner as an AMH Tier 3, or reverting to AMH Tier 2.
- (e) Required Data and Information Sharing to Support Care Management

- (1) In cases where the Department establishes a standard file format for data sharing reports, the BH I/DD Tailored Plan shall utilize the file format as specified by the Department.
- (2) In order to support care management activities, the BH I/DD Tailored Plan shall provide the following data to AMH+ practices and CMAs (or their designated CINs or other technology partners):
 - i. Member Assignment Files:
 - a) For AMH practices and CMAs or their designated CINs or other technology partners, Member assignment and pharmacy lock-in data applicable to their populations using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department and published on the Department's website.
 - b) Member Assignment files including:
 - 1) Point in time assignment, on at least a monthly basis;
 - 2) Projected assignment information by the following month (to the extent information is available);
 - 3) Information about newly-assigned Members to the BH I/DD Tailored Plan, within seven (7) Business Days of enrollment (more rapid notification may be required for assignment of newborns); and
 - 4) Notifications of any ad-hoc changes in assignment as they occur, within seven (7) Business Days of each change.
 - ii. Claims and Encounter data (applicable to AMH+ practices and CMAs or their designated CINs or other technology partners):
 - a) Current and historical Medical-encounter data and Pharmacy claims and encounter data applicable to their populations, ~~uber~~ upon member assignment in Tailored Care Management using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department.
 - b) After initiation of care management, BH I/DD Tailored Plans will be required to provide updated encounter, provider, and member data at least monthly and updated pharmacy data at least weekly to AMH+ practices and CMAs (or more frequently as requested by the Department).
 - iii. Initial Care Needs Screening Information (applicable to all AMH+ practices).
 - a) Results of all available Initial Care Needs Screenings, within seven (7) Business Days of the end of the screening window or seven (7) Business Days of assignment of a new PCP or AMH, whichever is earlier.
 - iv. Acuity Tiering and Risk Stratification information
 - a) BH I/DD Tailored Plan must furnish up-to-date acuity tiering results for each member and any other risk scoring/stratification the BH I/DD Tailored Plan has conducted.
 - b) The BH I/DD Tailored Plan is encouraged to explain the types or categories of inputs to its risk stratification model (e.g. frequent hospital utilization) and any clinically relevant information identified through the risk score development process that can inform specific actions by the AMH+ practice or CMA.
 - v. Quality measure performance information at the practice level.
 - a) The BH I/DD Tailored Plan shall provide feedback on quality scoring results to each AMH+ practice and CMA on both an annual and an interim basis as specified by the Department.
- (3) The BH I/DD Tailored Plan shall successfully implement all mandatory program integrations with all its contracted AMH+ practices and CMAs (or their designated CINs/other technology partners) prior to Medicaid BH I/DD Tailored Plan launch, or for any new AMH+ practice or CMA, within one hundred twenty (120) Calendar Days of provider contract execution with the BH I/DD Tailored Plan. Successful integration

completion requires both the BH I/DD Tailored Plan and its contracted AMH+ practices and CMAs (or their designated CINs/ other technology partners) to fully complete design, development, testing and deployment activities aligned with all the requirements and respective interface specifications specified by the Department and published on the Department's website.

- i. The BH I/DD Tailored Plan shall complete testing and implementation of the interface and integration for required data sharing with each AMH+ practice or CMA (or its designated CIN or other technology partners), in accordance with the Department's published Tailored Care Management Care Management data system guidance and data specifications and within the following timeframes:
 - a) Ninety (90) Calendar Days, for provider contracts signed one hundred twenty (120) Calendar days or more prior to Medicaid BH I/DD Tailored Plan launch;
 - b) Thirty (30) Calendar Days, for any provider contracts signed less than one hundred twenty (120) Calendar Days prior to Medicaid BH I/DD Tailored Plan launch.
 - ii. At a frequency and in a format determined by the Department in its report/file specifications for such report, the BH I/DD Tailored Plan shall transmit integration status reports that include information on the BH I/DD Tailored Plan's testing and implementation of the interface and integration for required data sharing with each AMH+ practice and CMA (or designated CIN/ other technology partners), including identification of at-risk file transmissions and reasons for any non-completion of activities within the required timeframes.
- (4) The BH I/DD Tailored Plan shall participate in the Data Subcommittee of the Tailored Care Management Technical Advisory Group to contribute to data sharing planning and improvements to support AMH+ practices and CMAs.
- (5) In order to support care management activities, the B/H Tailored Plans shall provide the following data to CMARC/CMHRP technology vendor for Local Health Departments (LHDs) providing care management of high-risk pregnancy and at-risk children:
- i. Member assignment data applicable to their populations using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department and published on the Department's website.
 - ii. Claims and Encounter data: current and historical Medical and Pharmacy claims and encounter data applicable to their populations, using the standard format, frequency, file layout, transmission type and transmission method, and with supporting notifications, as specified by the Department.
 - iii. Risk Stratification information:
 - a) BH I/DD Tailored Plan furnished risk scoring results,
 - b) Notification when Members fall into required Department priority population categories.
 - c) The BH I/DD Tailored Plan is encouraged to explain the types or categories of inputs to its risk stratification model with LHDs (e.g. frequent hospital utilization) that can inform specific actions by the LHD.
 - d) Quality measure performance information at the LHD level. The B/H Tailored Plans shall provide feedback on quality scoring results to each LHD on both an annual and an interim basis as specified by the Department.
- (6) The BH I/DD Tailored Plan shall successfully implement all mandatory LHD program integrations with state selected CMARC/CMHRP technology vendor. Successful integration completion requires both the BH I/DD Tailored Plan and LHD platform vendor to fully complete design, development, testing and deployment activities aligned with all the requirements and respective interface specifications specified by the Department and published on the Department's website.

- (7) The BH I/DD Tailored Plan shall develop a strategy to share data with Members, in a format that is secure, takes into account varying levels of health literacy, and promotes member engagement in care.
- (ii) PCP Choice and Assignment
- (a) Consistent with 42 C.F.R. § 438.3(l), the BH I/DD Tailored Plan shall ensure that each member has a choice of PCP.
 - (b) The BH I/DD Tailored Plan shall assign every Member to a PCP for general primary care services prior to their assignment to a care management approach as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (c) The BH I/DD Tailored Plan shall, in instances in which a Member does not select a PCP at the time of enrollment, assign the Member to a PCP within twenty-four (24) hours of their enrollment in BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall allow PCPs to set limits on panel size and shall have a process for PCPs to do so.
 - (d) The BH I/DD Tailored Plan's methodology for assigning members to a PCP shall include the following components, in this order, to the extent that such information is available.
 - (1) Prior PCP assignment;
 - (2) Member's claims history;
 - (3) Family member's PCP assignment;
 - (4) Family member's claims history;
 - (5) Geographic proximity;
 - (6) Special medical needs;
 - (7) Language/cultural preference;
 - (8) AMH+ status; and
 - (9) AMH status (Tiers 2 and 3).
 - (e) The Department reserves the right to adjust the PCP methodology for assigning each Member to a PCP as defined in this Contract and to audit the BH I/DD Tailored Plan's PCP auto-assignment logic upon request.
 - (f) When applicable, the BH I/DD Tailored Plan shall notify Members when they have been assigned to a PCP.
 - (g) Members can change their PCP without cause twice per year. Members shall be given thirty (30) Calendar Days from receipt of notification of their PCP assignment each year to change their PCP without cause (1st instance) and shall be allowed to change their PCP without cause up to one (1) time per year thereafter (2nd instance). Members of federally recognized tribes may change their PCP without cause at any time.
 - (h) In addition, Members shall be allowed to change their PCP with cause at any time.
 - (i) The Department shall consider the following as appropriate "cause" for member PCP changes:
 - (1) The Provider has failed to furnish accessible and appropriate medical care, services or supplies to which the member is entitled under the terms of the contract under which the BH I/DD Tailored Plan has agreed to provide services. This includes, but is not limited to, the failure to:
 - i. Provide primary care services;
 - ii. Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
 - iii. Arrange for consultation appointments;
 - iv. Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
 - v. Arrange for services with qualified licensed or certified Providers;

- vi. Coordinate the Member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;
 - vii. The Member disagrees with a treatment plan;
 - viii. The Member and Provider are not able to communicate due to a language barrier or other impediment to communication;
 - ix. The Provider is not able to reasonably accommodate the Member's special needs;
 - x. There is a change in the Provider's practice, including but not limited to the following:
 - a) The Provider moves to a location that is not convenient for the Member;
 - b) There is a Significant Change in the hours the Provider is available, and the Member cannot reasonably make appointments during the new hours;
 - c) The Provider no longer has hospital access.
 - xi. The Member and the Provider agree that a change would be in the best interest of the Member; or
 - xii. The Provider leaves the Network.
- (j) The BH I/DD Tailored Plan shall allow PCPs to request removal of a Member from their panel and must submit to the Department their process for reviewing and approving such removal requests.
 - (k) The BH I/DD Tailored Plan shall allow Members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such Members direct access to a specialist as appropriate to the Member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).
 - (l) The BH I/DD Tailored Plan shall follow the requirements on the PCP Assignment Requirements Policy, as they develop the PCP assignment algorithm.

2. Benefits

- i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package
 - (i) Throughout the term of this Contract, the BH I/DD Tailored Plan shall promptly provide, arrange, purchase or otherwise make available all medically necessary services required under this Contract to all its members enrolled in the BH I/DD Tailored Plan. Services shall be delivered within the standard of care and meet Department quality standards and expectations or otherwise communicated to the B I/DD Tailored Plan.
 - (a) Physical health benefits are inclusive of physical health and State Plan LTSS services, including nursing facility services, home health services, private duty nursing services, personal care services, and hospice services.
 - (b) BH benefits are inclusive of mental health and SUD services.
 - (c) I/DD benefits refer to services targeted towards individuals with an I/DD, including intermediate care facilities for individuals with intellectual disabilities (ICF-IID), Innovations waiver services, and other home and community-based services.
 - (d) TBI benefits refer to services targeted toward individuals with a TBI, including TBI waiver services and other home and community-based services.
 - (ii) The BH I/DD Tailored Plan shall:
 - (a) Cover all services in the North Carolina Medicaid and NC Health Choice State Plans with the exception of services carved out of Medicaid Managed Care under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract;
 - (b) Use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;
 - (c) Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the member's diagnosis, type of illness or condition;

- (d) Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2);
 - (e) Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i);
 - (f) Develop a comprehensive Utilization Management Program inclusive of a subset of NC Medicaid Direct clinical coverage policies as defined in this Contract; and
 - (g) Implement and adhere to all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policies and protocols as defined in *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* for Medicaid members.
 - (h) Not impose aggregate lifetime limits or annual dollar limits, as defined in 42 CFR 438.900, on the total amount of specified benefits that may be paid under the PHP.
- (iii) Covered Medicaid and NC Health Choice services:
- (a) The BH I/DD Tailored Plan shall cover all services as defined in the Medicaid and NC Health Choice State Plans with the exception of services carved out under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid and NC Health Choice State Plan covered services are described in *Section VII. First Revised and Restated Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid and NC Health Care State Plan); the BH I/DD Tailored Plan shall not be responsible for providing carved out services to members as defined in *Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care*.
 - (b) Consistent with N.C. Gen. Stat. §§ 108D-60 and 108D-35, the BH I/DD Tailored Plan shall be responsible for covering BH, I/DD and TBI services that are defined as *Section V.B.2. Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans*, including 1915(c) Innovations and TBI waiver services, as well as any services that the Department obtains authority through a SPA or waiver to cover and adds to the BH I/DD Tailored Plan benefit package (e.g., supported employment).
 - (1) A crosswalk of the SUD services covered under the Medicaid and NC Health Choice State Plans to national clinical standards is provided in *Section V.B.2 Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*.
 - (c) The BH I/DD Tailored Plan shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.

Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care⁶
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan

⁶ N.C. Gen. Stat. § 108D-35.

Dental services defined as all services billed as dental using the American Dental Association’s Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the “Into the Mouths of Babes” (IMB)/Physician Fluoride Varnish Program
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract) ⁷
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Section V.B.2. Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced BH services are <i>italicized</i>	
<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment</i>⁸ • <i>Ambulatory detoxification</i> • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization</i> • Early and periodic screening, diagnostic and treatment (EPSDT) services 	<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Residential treatment facility services • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • Psychiatric residential treatment facilities (PRTFs) • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)</i>⁹ • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services

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

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

⁹ CST includes tenancy supports.

Section V.B.2. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Inpatient BH services
Office-based opioid treatment	Office-based opioid treatment ¹⁰	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

(d) The Department will allocate a specific number of Innovations and TBI waiver slots to each BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall manage access to its allotted waiver slots, including reserved capacity slots except for Military Transfers, and maintain a Registry of Unmet Needs (waiting list) for members who are determined eligible for waiver funding but for

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

whom funding is not available at the time of their waiver eligibility determination. The BH I/DD Tailored Plan shall report on the status of the use of waiver slots and reserved capacity as required by the Department.

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

Section V.B.2. Table 4: Innovations Waiver Services¹¹	
<ul style="list-style-type: none"> • Assistive Technology Equipment and Supplies • Community Living and Support • Community Navigator¹² • Community Networking • Community Transition • Crisis Services • Day Supports • Financial Support Services • Home Modifications • Individual Goods and Services 	<ul style="list-style-type: none"> • Natural Supports Education • Residential Supports • Respite • Supported Employment • Specialized Consultation • Supported Living • Supported Living - Periodic • Supported Living – Transition • Vehicle Adaptations

Section V.B.2. Table 5: TBI Waiver Services¹³	
<ul style="list-style-type: none"> • Adult Day Health • Assistive Technology • Cognitive Rehabilitation • Community Networking • Community Transition • Crisis Support Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education 	<ul style="list-style-type: none"> • Occupational Therapy • Personal Care • Physical Therapy • Remote Supports • Residential Supports • Respite • Resource Facilitation • Speech Language Therapy • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

- (f) The Department currently covers a subset of BH services under its 1915(b)(3) waiver, which will sunset upon BH I/DD Tailored Plan launch. The Department plans to seek authority to cover most of the current 1915(b)(3) services through 1915(i) authority. The Department is also considering seeking federal authority to provide Medicaid coverage for select home and community-based services that are currently covered under the state-funded I/DD service

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

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

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

array. Prior to BH I/DD Tailored Plan launch, the Department will release additional information on additional services it is seeking to cover through BH I/DD Tailored Plans.

- (g) The BH I/DD Tailored Plan shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.
- (h) The BH I/DD Tailored Plan shall, in accordance with the federal Women’s Health and Cancer Rights Act of 1998 (WHCRA), provide protections to members who choose to have breast reconstruction relating to a mastectomy, including coverage of:
 - (1) All stages of reconstruction of the breast on which the mastectomy has been performed;
 - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (3) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.
- (i) The BH I/DD Tailored Plan shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).
- (j) The BH I/DD Tailored Plan shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a member enrolling in the BH I/DD Tailored Plan.
- (k) The BH I/DD Tailored Plan shall encourage primary care providers who serve members under age nineteen (19) to participate in the Vaccines for Children (VFC) program, which allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).
 - (1) The BH I/DD Tailored Plan shall require that primary care providers administer vaccines consistent with the American Academy of Pediatrics (AAP)/Bright Future periodicity schedule.
 - (2) For Medical Benefits, the BH I/DD Tailored Plan shall reimburse the Provider for only the administration fee for VFC eligible beneficiaries.
 - (3) Vaccines provided for children enrolled in Medicaid should go through the VFC, when the VFC program includes the vaccine.
 - (4) Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. The BH I/DD Tailored Plan shall reimburse the Provider for both the vaccine and administration fee for NC Health Choice beneficiaries.
 - (5) The BH I/DD Tailored Plan shall adhere to additional VFC requirements as defined in *Section V.B.3.ix. Prevention and Population Health Programs*.
- (l) Pursuant to 42 C.F.R. § 457.410(b)(1), the BH I/DD Tailored Plan shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
 - (1) Routine physical examinations as recommended and updated by the AAP “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents” including:
 - i. Screening for developmental delay at each visit through the 5th year;
 - ii. Screening for Autistic Spectrum Disorders per AAP guidelines;
 - iii. Comprehensive unclothed physical examination;
 - iv. All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
 - (2) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
 - (3) Health education and anticipatory guidance for both the child and caregiver.
- (m) Changes to Covered Benefits

- (1) The BH I/DD Tailored Plan shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans and consistent with any approved Medicaid waivers, except to the extent the service is carved out of Medicaid Managed Care.
- (n) Institutions for mental disease (IMD) SUD Services
 - (1) Under North Carolina's 1115 waiver authority, the BH I/DD Tailored Plan shall provide coverage for substance use disorder services for members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.
 - (2) The BH I/DD Tailored Plan shall provide the Department with a weekly report on members who are residing or have resided in an IMD for SUD treatment as defined in *Section VII. First Revised and Restated Attachment J. Reporting Requirements* to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.
- (o) For members newly enrolled in the BH I/DD Tailored Plan with no immediately prior period of Medicaid Managed Care enrollment or NC Medicaid Direct enrollment with inpatient coverage, the BH I/DD Tailored Plan shall be responsible for any diagnosis-related group based inpatient facility claims if the member's first day of BH I/DD Tailored Plan enrollment is during the hospital stay.
- (iv) Medical Necessity
 - (a) The BH I/DD Tailored Plan shall cover all medically necessary services for its enrolled members in accordance with *Section V.B.2. Benefits*.
 - (b) The BH I/DD Tailored Plan shall provide medically necessary services to all enrolled members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or BH, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment for Medicaid Members*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.
 - (c) The BH I/DD Tailored Plan may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.B.2.i.(v) Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.
 - (d) The BH I/DD Tailored Plan shall work with providers to ensure that providers identify an appropriate new level of care for a member who no longer meets the medical necessity criteria for an existing service.
 - (e) The BH I/DD Tailored Plan shall determine whether a service is medically necessary on a case by case basis.
 - (f) For Medicaid Managed Care members under the age of twenty-one (21), the BH I/DD Tailored Plan shall not issue adverse determinations on requests for a medical service coverable under 42 U.S.C. § 1396d(a), (§1905(a) of the Social Security Act) unless the decision is made following a medical necessity review per EPSDT federal standards.
 - (g) Consistent with 42 C.F.R. 438.210(a)(5)(ii), the BH I/DD Tailored Plan shall provide medically necessary services that address:
 - (1) The prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder that results in health impairments and/or disability.
 - (2) The ability for a Member to achieve age-appropriate growth and development.
 - (3) The ability for a Member to attain, maintain, or regain functional capacity.

- (4) The opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.
- (v) Utilization Management
- (a) The BH I/DD Tailored Plan shall develop a utilization management (UM) program for medical, BH, I/DD, LTSS, and pharmacy services that is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies. The BH I/DD Tailored Plan shall ensure the UM program aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, to the degree a subcontractor relationship applies.
- (b) UM Program Policy
- (1) The BH I/DD Tailored Plan shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review one hundred fifty (150) Calendar Days after Contract Award. As long as the UM Policy clearly states that it applies to the BH I/DD Tailored Plan, the UM Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (2) The UM Program Policy, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
- i. Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
 - ii. Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting Provider;
 - iii. Mechanisms to assess whether Members are receiving the appropriate level of care corresponding to their clinical information;
 - iv. Authorization of State Plan LTSS based on a Member's current needs assessment and consistent with the person-centered service plan;
 - v. Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
 - vi. Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;
 - vii. Protecting Members from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to Appeal the denial or reduction or termination of a service;
 - viii. Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization;
 - ix. Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the BH I/DD Tailored Plan;
 - x. Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Members. Section 1903(i) of the Social Security Act;
 - xi. Dissemination of guidelines to all affected providers and, upon request, to members and potential members; and
 - xii. Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any member.

- (3) The BH I/DD Tailored Plan shall submit a signed attestation to the Department to confirm compliance with the UM and clinical coverage requirements in the Contract, in a format and frequency specified by the Department. Minimally, the BH I/DD Tailored Plan shall submit the attestation required by this Section annually, by June 30th, unless otherwise directed by the Department.
 - i. Nothing in this Section shall be construed to limit or interfere with the Department's right to individually review and approve any BH I/DD Tailored Plan UM or clinical coverage policy to ensure compliance with the Contract.
- (4) The BH I/DD Tailored Plan shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.
- (5) The BH I/DD Tailored Plan shall post the UM Program Policy on their publicly available website for providers and members, or in other forms as requested by the provider or member, at no cost. The BH I/DD Tailored Plan shall include a prominent reference to the web address of the UM Program Policy in both its Provider Manual and Member Handbooks, including Innovations and TBI Waiver Handbooks.
- (6) The BH I/DD Tailored Plan shall provide training and education to providers including prescribers on changes to the UM Program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.B.4.iii. Provider Relations and Engagement*.
- (7) The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §438.3(e)(1)(ii), 42 C.F.R. § 438.905, and 438.910(b)-(d).
 - i. Annually, the BH I/DD Tailored Plan shall submit a completed standardized parity analysis workbook, developed by the Department and provided upon award, to demonstrate compliance.
- (c) The BH I/DD Tailored Plan shall have the option of using the Department's NC Medicaid Direct clinical coverage policies as the basis for the UM program or developing its own for all covered services with the exception of those listed in *Section V.B.2. Table 6: Required Clinical Coverage Policies*.
- (d) The UM process must support an integrated, holistic look at an enrollee's physical health, LTSS, BH, and I/DD needs, noting that alternative treatments or supports may be appropriate in light of a beneficiary's complete clinical and other support needs.
- (e) The Clinical Practice Guidelines shall:
 - (1) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
 - (2) Consider the needs of members;
 - (3) Be adopted in consultation with contracting health professionals;
 - (4) Be reviewed and updated periodically as appropriate;
 - (5) Be utilized for decisions for utilization management, Member education, coverage of services, and other areas to which the guidelines apply; and
 - (6) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation with LTSS distinction set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. § 438.236(b).
- (f) The Department will allow "proprietary" UM policies under limited circumstances, with prior approval by the Department.

- (g) A chart of all North Carolina Medicaid and NC Health Choice clinical coverage policies is found in *Section VII. First Revised and Restated Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies.*
- (h) For a limited number of services, the BH I/DD Tailored Plan shall incorporate existing NC Medicaid Direct, NC Health Choice, and State-funded clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.B.2. Table 6: Required Clinical Coverage Policies.*
- (i) The Department reserves the right to require the BH I/DD Tailored Plan to follow additional NC Medicaid Direct clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.B. First Revised and Restated Table 6: Required Clinical Coverage Policies	
Service	Scope
BH and I/DD Services: For these policies, BH I/DD Tailored Plans shall have the flexibility to be less restrictive with regard to Prior Authorization requirements.	
<i>Medicaid State Plan BH Services</i>	Row Reserved
<i>Medicaid State Plan I/DD Services</i>	Row Reserved
<i>1915(c) Home and Community-Based Services (HCBS) Waivers</i>	<i>8P: North Carolina Innovations</i>
Other Services	
<i>Auditory Implant External Parts</i>	<i>13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair</i> <i>13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair</i>
<i>Obstetrics and Gynecology</i>	<i>1E-7: Family Planning Services</i>
<i>Physician Services</i>	<i>1A-4: Cochlear and Auditory Brainstem Implants</i> <i>1A-23: Physician Fluoride Varnish Services</i> <i>1A-36: Implantable Bone Conduction Hearing Aids (BAHA)</i> <i>1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions</i>
<i>Pharmacy</i>	As defined in <i>Section V.B.2.iii. Pharmacy Benefits</i>

- (j) The BH I/DD Tailored Plan shall make the CMO or designee available to discuss and report on the UM Program, as requested by the Department.
- (k) The BH I/DD Tailored Plan shall use a standardized prior authorization request form developed by the Department.
- (l) The BH I/DD Tailored Plan shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.
 - (1) Providers and members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (Supports Needs Assessment Profile) or SIS[®] score or other clinical assessment.
 - (2) Material misinformation to or intimidation of providers or members who has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH Appeals is prohibited. The care management process shall not be used to improperly influence, change or prevent a request for a prior approval.
 - (3) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.
- (m) The BH I/DD Tailored Plan shall not terminate a service authorization after the services, supplies, or other items have been provided, except as provided in N.C. Gen. Stat. § 58-3-200(c).
- (n) The BH I/DD Tailored Plan shall not terminate a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).
- (o) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the member's medical, BH, I/DD, TBI, or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).
- (p) As part of the UM program, the BH I/DD Tailored Plan shall adhere to the following prior authorization requirements.
 - (1) To effectively manage the care of its members, the BH I/DD Tailored Plan shall establish and maintain a referral and prior authorization process that is centered on the member's primary care provider (PCP).
 - (2) The BH I/DD Tailored Plan shall conduct prior authorization reviews using current clinical documentation and must consider the comprehensive range of the member's physical health, LTSS, BH, I/DD and TBI needs, noting that alternative treatments or supports may be appropriate in light of a member's complete clinical and other support needs.
 - (3) The BH I/DD Tailored Plan may require a referral for any medical services not provided by the PCP except where specifically prohibited in the Department-BH I/DD Tailored Plan contract and in federal and state statute and regulations.
 - (4) The BH I/DD Tailored Plan shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the LEA, unless required by the applicable NC Medicaid Clinical Coverage Policy. However, the BH I/DD Tailored Plan may consider the IEP to contain evidence to support a determination that a Member may require active treatment.
 - (5) Consistent with 42 C.F.R. § 438.206, the BH I/DD Tailored Plan shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:

- i. Emergency services
 - a) In accordance with 42 C.F.R. § 438.114, the BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization before receiving emergency services.
 - b) The BH I/DD Tailored Plan shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
 - c) The BH I/DD Tailored Plan shall not refuse to cover emergency services, including ambulance services, based on the provider of such services, the hospital, or the fiscal agent not notifying the member's PCP or BH I/DD Tailored Plan of the member's screening and treatment within ten (10) Calendar Days of presentation for emergency services.
 - d) The BH I/DD Tailored Plan shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in the BH I/DD Tailored Plan's Network.
 - e) The BH I/DD Tailored Plan shall not hold a member with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - f) The BH I/DD Tailored Plan shall not deny payment for treatment obtained due to an emergency medical condition or as a result of the member having been instructed by a representative of the BH I/DD Tailored Plan to seek emergency services. For purposes of this section, the term "representative" shall not include a contracted provider of the BH I/DD Tailored Plan.
- ii. Family planning services
 - a) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for family planning services and supplies and reproductive health services and supplies. 42 C.F.R. § 438.206(b)(3).
 - b) The BH I/DD Tailored Plan shall not restrict the member's free choice of family planning services and supplies providers. 42 C.F.R. § 431.51(b)(2).
 - c) The BH I/DD Tailored Plan shall not hold members liable for payment for family planning services or supplies that are not in the BH I/DD Tailored Plan's network.
 - d) The BH I/DD Tailored Plan shall not require members to obtain referrals for services provided by women's health specialists in accordance with 42 C.F.R. § 438.206(b)(2) and N.C. Gen. Stat. § 58-51-38.
 - e) The BH I/DD Tailored Plan shall not require female members to obtain a referral or prior authorization to women's health specialists within the network for covered care necessary to provide women's routine and preventive health care services.
 - f) The BH I/DD Tailored Plan shall not require providers to obtain prior approval for any obstetrical ultrasound.
 - g) Women's routine and preventive health care services may include but are not limited to: initial and follow-up visits for services unique to women such as mammograms, pap smears, prenatal and maternity care, and for services to treat genitourinary conditions such as vaginal and urinary tract infections and sexually transmitted infections.
- iii. BH services
 - a) For Medicaid State Plan BH and I/DD services, the BH I/DD Tailored Plan shall require providers to use the following BH or other Department approved level-of-care determination and screening as part of the BH I/DD Tailored Plan's UM

program. The Department reserves the right to change, in writing, these required screening tools:

- 1) Substance Use: American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through six (6); The BH I/DD Tailored Plan shall use EPSDT criteria when evaluating requests for services for all children;
- b) Mental Health:
 - 1) Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department
- c) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for the first mental health or substance use assessment completed in a twelve (12) month period.
- d) The BH I/DD Tailored Plan shall make available to all members a complete listing of its participating mental health and SUD providers. The listing should specify which provider groups or practitioners specialize in children's mental health services.
- iv. Screening services for children and youth under age 21:
 - a) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for children's screening services.
 - b) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for Local Health Department services.
- v. Primary care services: the BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for primary care services.
- vi. School-based clinic services: The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for services rendered at school-based clinics.
- (6) The BH I/DD Tailored Plan shall ensure members have and are aware of having direct access to services for which the Department does not allow the BH I/DD Tailored Plan to require referral or prior authorization, as defined in this Section.
- (q) Service Authorization and Noticing Requirements
 - (1) The BH I/DD Tailored Plan shall provide written notice, using the Department-developed template, to members on adverse decisions related to authorization of services. The written notice shall include the following:
 - i. The basis for such decisions; and
 - ii. Sufficient details that inform members of the decision, which will provide them with information necessary to determine if they wish to Appeal as noted in *Section V.B.1.vi. Member Grievances and Appeals*.
 - (2) For standard authorization decisions, the BH I/DD Tailored Plan shall provide notice as expeditiously as the member's condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).¹⁴
 - (3) The BH I/DD Tailored Plan may receive a possible extension of service authorization decision of up to fourteen (14) Calendar Days if the member requests the extension or

¹⁴ 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.

- the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the member's interest.
- (4) If the BH I/DD Tailored Plan extends the timeframe beyond fourteen (14) Calendar Days, the BH I/DD Tailored Plan shall provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.
 - (5) For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the BH I/DD Tailored Plan shall provide notice no later than seventy-two (72) hours after receipt of the request for service.¹⁵
 - (6) The BH I/DD Tailored Plan may extend the seventy-two (72) hour time period for service authorization decisions by up to fourteen (14) Calendar Days if the member requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the member's interest.
 - (7) If the BH I/DD Tailored Plan extends the timeframe beyond seventy-two (72) hours, the BH I/DD Tailored Plan shall provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.
- (r) UM policy for Innovations and TBI waiver services
- (1) For Innovations waiver members only:
 - i. The BH I/DD Tailored Plan shall use the NC Innovations level of care assessment tool to determine whether a member meets the level of care required by the Innovations waiver.
 - ii. The BH I/DD Tailored Plan shall utilize a NC Medicaid-approved template to notify members enrolled in the Innovations waiver of the results of any new SIS[®] evaluation and to inform members in writing of the opportunity and process for:
 - a) Raising concerns regarding SIS[®] evaluations and results, and
 - b) Filing a Grievance regarding SIS[®] evaluations and results.
 - iii. The process for raising concerns shall include an opportunity to discuss the results of the SIS[®] evaluation with the BH I/DD Tailored Plan and the potential for the results to be adjusted if it is determined that the particular needs of the individual were not accurately captured.
 - iv. The failure to request a Grievance shall not waive the Innovations waiver member's ability to argue that the results of the SIS[®] evaluation are incorrect in requesting of services, or during reconsideration review or the State Fair Hearing.
 - v. The BH I/DD Tailored Plan shall ensure that the SIS[®] is used to guide the development of the ISP, and that the results of the SIS[®], or any other similar evaluation, are not the sole basis for limiting the services requested or approved. The BH I/DD Tailored Plan may use the SIS[®] in conjunction with other information to reduce or deny requested services.
 - (2) The BH I/DD Tailored Plan shall ensure that the TBI waiver level of care tool is used to determine whether a member meets the level of care required for the TBI waiver.
 - (3) The BH I/DD Tailored Plan shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver or TBI waiver

¹⁵ 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.

member and that such desires are reflected in the Innovations or TBI waiver member's ISP, including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver* for additional details.

- i. The member's care manager based in a BH I/DD Tailored Plan, AMH+ or CMA shall discuss with the member the duration of the services expected by the member and shall ensure that proposed ISP request authorization for each service at the duration requested by the member during the contract year.
 - ii. The member's care manager based in a BH I/DD Tailored Plan, AMH+ or CMA shall assist the member in developing an ISP and shall explain options regarding the services available to the member.
- (4) The BH I/DD Tailored Plan shall inform Innovations and TBI waiver members that they may make a new request for services at any time by requesting an updated ISP.
- (5) Care managers based in a BH I/DD Tailored Plan, AMH+ or CMA may not exercise prior authorization authority over the ISP.
- (6) BH I/DD Tailored Plans shall issue prior authorizations for all BH and I/DD services covered under the 1915(c) waivers and any forthcoming 1915(i) SPAs according to the requirements set forth in the service definitions that will be established by the Department.
- (7) The BH I/DD Tailored Plan may act to terminate a member from participation in the Innovations or TBI waiver based upon the following circumstances:
 - i. The member's or member's personal representative's failure to comply with the requirements set forth in the Innovations or TBI waiver approved by CMS
 - ii. The member no longer meets the Level of Care criteria stipulated in the Innovations or TBI Waiver.
 - iii. For other reasons explicitly authorized in the Innovations or TBI waiver approved by CMS.
- (8) Prior to the termination of a member from the Innovations or TBI waiver, the BH I/DD Tailored Plan must discuss the termination with the Department. Termination of Innovations or TBI waiver participation is considered an adverse benefit determination.
- (s) UM Policy for DSOHF facilities
 - (1) The BH I/DD Tailored Plan shall comply with the authorization and admission requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and *Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the BH I/DD Tailored Plan shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with IDD, TBI or dementia.
 - (2) 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. Gen. Stat. § 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a State psychiatric hospital.

- (3) 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. Gen. Stat. § 122C-261(e)(4).
 - (4) 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.
- (vi) Telehealth, Virtual Patient Communications and Remote Patient Monitoring
- (a) The BH I/DD Tailored Plan shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid and NC Health Choice beneficiaries as an alternative service delivery model where clinically appropriate in compliance with all state and federal laws, including HIPAA and record retention requirements.
 - (b) The services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).
 - (c) The BH I/DD Tailored Plan may use Telehealth, Virtual Patient Communications and Remote Patient Monitoring as tools for facilitating access to needed services in a clinically appropriate manner that are not available within the BH I/DD Tailored Plan's network.
 - (d) The BH I/DD Tailored Plan shall not require a member to seek the services through Telehealth and must allow the member to access an in-person service through an out-of-network provider, if the member requests.
 - (e) As part of the UM Program Policy, the BH I/DD Tailored Plan shall develop and submit a Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department. As long as the Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy clearly states that it applies to the BH I/DD Tailored Plan, the Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP. The Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy shall include:
 - (1) Eligible providers who may perform Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
 - (2) Modalities covered by the BH I/DD Tailored Plan;
 - (3) Modalities not covered by the BH I/DD Tailored Plan;
 - (4) Requirements for and limitations on coverage;
 - (5) Description of each covered modality, including:
 - i. Compliance with local, state and federal laws, including HIPAA; and
 - ii. Process to ensure security of protected health information.
 - (6) Reimbursement mechanism (i.e. flow of funds from BH I/DD Tailored Plan to all relevant providers and facilities) for each covered modality; and
 - (7) Billing guidance for providers.
 - (f) The BH I/DD Tailored Plan shall submit a revised Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy to the Department whenever there is a material change to the Policy.
 - (1) The BH I/DD Tailored Plan shall pay at least the in-person rate for the same service delivered via Telehealth (i.e. payment parity).

- (2) For all services provided through Telehealth, the BH I/DD Tailored Plan shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.
 - (3) As long as the Telehealth and Virtual Patient Communications Coverage Policy applies to the BH I/DD Tailored Plan, the Telehealth and Virtual Patient Communications Coverage Policy may apply to other LME/MCO operations, including without limitation the PIHP contract
 - (g) The BH I/DD Tailored Plan shall pilot new approaches to Telehealth, Virtual Patient Communications and Remote Patient Monitoring and Value-Based Payment and shall support providers in optimizing the use of these services in their practices. For purposes of any pilot, the BH I/DD Tailored Plan may propose, for the Department's review and approval, a waiver of payment parity requirements.
- (vii) In Lieu of Services (ILOS)
- (a) The BH I/DD Tailored Plan may use ILOS, services or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plans, but are a medically appropriate, cost-effective alternative to a State Plan covered service. 42 C.F.R. § 438.3(e)(2)i-iv.
 - (b) The BH I/DD Tailored Plan shall submit the Department's standardized ILOS Service Request Form, prior to implementation to the Department for approval.
 - (1) In no instance shall the BH I/DD Tailored Plan reduce or remove ILOS service without approval by the Department within a Contract Year.
 - (2) If changes, reduction, or removal of ILOS services is approved, the BH I/DD Tailored Plan shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.
 - i. The BH I/DD Tailored Plan shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.
 - (3) If the BH I/DD Tailored Plan wishes to offer an ILOS previously approved by the Department as outlined in *Section VII. First Revised and Restated Attachment C. Approved Behavioral Health In Lieu of Services for Medicaid*, the BH I/DD Tailored Plan must still submit the Department's standardized ILOS Service Request Form for approval.
 - (4) Upon approval by the Department, the BH I/DD Tailored Plan shall post ILOS policies on its publicly available Member and Provider websites no later than thirty (30) Calendar Days prior to the effective date of change.
 - (5) The BH I/DD Tailored Plan shall monitor the cost-effectiveness of each approved ILOS by tracking utilization and expenditures on an annual basis or more frequently upon request of the Department (see *Section VII. First Revised and Restated Attachment J. Reporting Requirements* for more detailed requirements).
 - (6) The BH I/DD Tailored Plan shall not require the member to utilize an ILOS.
- (viii) Value-Added Services
- (a) The BH I/DD Tailored Plan may offer Value-Added Services as approved by the Department. For each value-added service, the BH I/DD Tailored Plan shall submit to the Department for approval, in the Department developed standardized template, the following information:
 - (1) Definition and description of the value-added service, including if prior authorization is required;
 - (2) Definition of the criteria to be eligible for proposed value-added service;
 - (3) Types of providers eligible to provide the Value-Added Services;

- (4) Description of how and when providers and members will be notified about the availability of the proposed value-added service;
- (5) Duration for which Value-Added Services will be provided; and
- (6) Description of if, and how, the services will be identified in encounter data.
- (b) The BH I/DD Tailored Plan shall submit to the Department for approval any changes to Value-Added Services.
- (c) In no instance may the BH I/DD Tailored Plan reduce or remove Value-Added Services without approval by the Department during a Contract Year.
 - (1) If changes, reduction, or removal of Value-Added Services is approved, the BH I/DD Tailored Plan shall notify all members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.
- (d) Value-Added Services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).
- (ix) Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements
 - (a) The BH I/DD Tailored Plan shall work with the Department and the member's nursing facility to coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120 for members admitted to nursing facilities.
 - (b) The BH I/DD Tailored Plan shall ensure the provision of Specialized Services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this contract as listed in *Section V.B.2.i.(iii) Covered Medicaid and NC Health Choice Services*.
 - (1) The BH I/DD Tailored Plan shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.
- (x) Cost Sharing
 - (a) The BH I/DD Tailored Plan shall impose the same cost sharing amounts as specified in North Carolina's Medicaid and NC Health Choice State Plans which are displayed in *Section V.B.2. Table 7 Medicaid Managed Care Cost Sharing* below.
 - (b) The BH I/DD Tailored Plan shall not require members to pay for any covered services other than the copayment amounts required under the State Plans.
 - (c) The BH I/DD Tailored Plan shall not hold members responsible for any of the following:
 - (1) BH I/DD Tailored Plan's debts in the event of BH I/DD Tailored Plan insolvency;
 - (2) Covered services provided to the member for which:
 - i. The Department does not pay the BH I/DD Tailored Plan, or
 - ii. The Department, or BH I/DD Tailored Plan, does not pay the health care provider that furnished the services under a contractual referral or other arrangement.
 - (3) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the BH I/DD Tailored Plan covered the services directly. 42 C.F.R. § 438.106.
 - (d) The BH I/DD Tailored Plan shall track cost sharing obligations of each member and provide to the Department using the Department developed standardized template.
 - (e) Exceptions for cost sharing:
 - (1) Pursuant to 42 C.F.R. § 457.505(d)(1), all NC Health Choice members receive well-child visits and age-appropriate immunizations at no cost to their families.

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

Section V.B.2. First Revised and Restated Table 7: Medicaid Managed Care Cost Sharing			
Income Level	Annual Enrollment Fee	Service	Copay
Medicaid			
<i>All Medicaid beneficiaries</i>	<i>None</i>	Physician services Outpatient services Podiatrists Generic and brand prescriptions Chiropractic services Optical services/supplies Optometrists Non-emergency ER visit	\$4/visit \$4/visit \$4/visit \$4/script \$4/visit \$4/visit \$4/visit \$4/visit
NC Health Choice			
<i>NC Health Choice beneficiaries with family incomes <159% FPL</i>	<i>None</i>	Office visits Generic prescriptions Brand prescriptions when no generics available Brand prescriptions when generics available Over-the-counter medications Non-emergency ER visit	\$0/visit \$1/script \$1/script \$3/script \$1/script \$10/visit
<i>NC Health Choice beneficiaries with family incomes >159% and <211% FPL</i>	<i>\$50 per child or \$100 maximum for two or more children¹⁶</i>	Office visits Outpatient hospital visits Generic prescriptions Brand prescriptions when no generics available Brand prescriptions when generics available Over-the-counter medications Non-emergency ER visit	\$5/visit \$5/visit \$1/script \$1/script \$10/script \$1/script \$25/visit

¹⁶ The NC Health Choice annual fee is collected by the counties, not by the BH I/DD Tailored Plan.

- (f) Cost Sharing Noticing Requirements
 - (1) The BH I/DD Tailored Plan shall provide written notice to members using the Department developed standardized template of any Department-initiated changes to the Medicaid or NC Health Choice benefits package or cost sharing requirements. Notification to members shall be provided at least thirty (30) Calendar Days in advance of the effective date of such change.
 - (2) The Department shall provide written notice to members of the aggregate family limit on cost sharing. The Department shall provide written notice to the BH I/DD Tailored Plan and members when a member incurs out-of-pocket expenses up to the aggregate household limit and individual household members are no longer subject to cost sharing for the remainder of the quarter.
- (g) Electronic Verification System Requirements.
 - (1) The BH I/DD Tailored Plan and its Providers must utilize an Electronic Visit Verification (EVV) system to verify personal care services, including Medicaid State Plan and all waiver services that provide assistance with ADLs that are provided in the member's home and are not provided as a per diem service, prior to releasing payment.
 - (2) The BH I/DD Tailored Plan must utilize an EVV system to collect the following data from Providers as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:
 - i. Type of service performed;
 - ii. Individual receiving the service;
 - iii. Date of the service;
 - iv. Time that the service begins;
 - v. Location of service delivery;
 - vi. Individual providing the service; and
 - vii. Time that service ends
 - (3) If the BH I/DD Tailored Plan utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.
 - (4) The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for State Plan Personal Care Services, Innovations waiver services, and TBI waiver services is in effect by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for Home Health Care Services is in effect by January 1, 2023.
 - (5) At time of BH I/DD Tailored Plan implementation, the BH I/DD Tailored Plan shall deliver the EVV data elements to the Encounter Processing System (EPS) for personal Care Services or services that provide support with activities of daily living in a member's home that are not daily rate services.
 - (6) The BH I/DD Tailored Plan shall permit providers to continue using their existing EVV system provided that the system is compliant with state and federal regulations.
- (h) Moral and Religious Objection
 - (1) The BH I/DD Tailored Plan is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R. § 438.102(b) have been met. This provision does not apply to a BH I/DD Plan that is also a governmental entity.
 - (2) If the BH I/DD Tailored Plan elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the BH I/DD Tailored Plan shall furnish information about the services it does not cover to the Department, and to any other Department partner as directed by the Department,

whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).

- ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members
 - (i) The BH I/DD Tailored Plan shall cover services, products, or procedures for a Medicaid member under the age of twenty-one (21) if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination. This includes any evaluation by a physician or other licensed practitioner.
 - (ii) The BH I/DD Tailored Plan shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under NC Medicaid Direct and as defined in the Department's EPSDT policies.
 - (iii) The BH I/DD Tailored Plan shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.
 - (iv) The BH I/DD Tailored Plan shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for Medicaid members under twenty-one (21) years of age.
 - (v) When adjudicating service authorizations for members under twenty-one (21) years of age, the BH I/DD Tailored Plan shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the member.
 - (vi) Upon conclusion of an individualized review of medically necessary services, the BH I/DD Tailored Plan shall cover medically necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The BH I/DD Tailored Plan shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this Contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the BH I/DD Tailored Plan responsible for delivery of the referred service, product, or treatment.
 - (vii) The BH I/DD Tailored Plan may provide medically necessary services in the most economic mode possible, if:
 - (a) The treatment made available is similarly efficacious to the service requested by the member's physician, therapist, or other licensed practitioner;
 - (b) The determination process does not delay the delivery of the needed service; or
 - (c) The determination does not limit the member's right to a free choice of providers within the BH I/DD Tailored Plan's Network.
 - (viii) Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, UM policies, service definitions, or billing codes do not apply to Medicaid members who are less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians. Note that visits to dentists shall not be billed to the BH I/DD Tailored Plan but shall be billed to NC Medicaid Direct.
 - (ix) The BH I/DD Tailored Plan shall:

- (a) Require all in-network primary care providers to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule.
- (b) Require all in-network primary care providers to refer infant Medicaid members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to NC Medicaid Direct.
- (c) Require that participating primary care providers include all of the following components in each medical screening.
 - (1) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents."
 - i. Screening for developmental delay at each visit through the fifth (5th) year; and
 - ii. Screening for Autistic Spectrum Disorders per AAP guidelines.
 - (2) Comprehensive, unclothed physical examination.
 - (3) All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
 - (4) Laboratory testing (including blood lead screening appropriate for age and risk factors).
 - (5) Health education and anticipatory guidance for both the child and caregiver.
- (x) The BH I/DD Tailored Plan shall ensure and verify that network BH providers coordinate with primary care providers and specialists conducting EPSDT screenings.
- (xi) The BH I/DD Tailored Plan shall not require prior authorization for preventive care (early and periodic screens/wellness visits) for Medicaid members less than twenty-one (21) years of age. The BH I/DD Tailored Plan may require prior authorization for other diagnostic and treatment products and services provided under EPSDT.
- (xii) The BH I/DD Tailored Plan shall comply with the Department's standards for the timely provision of EPSDT services. For purposes of this Contract, the "timely provision of the EPSDT services" shall mean that a member shall have a scheduled appointment for an EPSDT service no more than six (6) calendar weeks from the date of the request for an appointment.
- (xiii) The BH I/DD Tailored Plan shall provide referral assistance for non-medical treatment not covered by the plan but found to be needed because of conditions disclosed during screenings and diagnosis. The referral assistance must include giving the family or member the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.
- (xiv) The BH I/DD Tailored Plan shall effectively inform families or primary caregivers of eligible children under twenty-one (21) years of age of the EPSDT benefit, including availability and importance of:
 - (a) Regular preventive care, and
 - (b) Scope of services, products and treatments available when medically necessary to correct or ameliorate a health condition or problem.
- (xv) The BH I/DD Tailored Plan shall inform all EPSDT eligible individuals (or their families) about the EPSDT program within sixty (60) Calendar Days of eligibility determination, annually thereafter for individuals who have not accessed the benefit, and as defined in *Section V.B.1.iii. Member Engagement*.
- (xvi) The BH I/DD Tailored Plan shall perform outreach to members who are due or overdue for an EPSDT screening service monthly.

- (xvii) The BH I/DD Tailored Plan shall effectively inform members and/or their parents or primary caregivers who are blind or deaf or who cannot read or understand the English language about the EPSDT benefit in accordance with the *Section V.B.1.iii. Member Engagement*.
- (xviii) The BH I/DD Tailored Plan shall not make an adverse benefit determination on a service authorization request for a child until the request is reviewed per EPSDT criteria.
- (xix) While an EPSDT request is under review, the BH I/DD Tailored Plan may suggest alternative services that may be better suited to meet the child's needs, engage in clinical or educational discussions with participants or providers, or engage in informal attempts to resolve participant concerns as long as the BH I/DD Tailored Plan makes clear that the member has the right to request authorization of the services he or she wants to request.
 - (a) The BH I/DD Tailored Plan shall not request that providers or members withdraw or modify a request for EPSDT services to accept a fewer number of hours, or less intensive type of service, or to modify a SNAP (Support Needs Assessment Profile) or other clinical assessment.
 - (b) Material misinformation to or intimidation of providers or members who has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH Appeals is prohibited.
 - (c) Nothing in this Section should be construed to prevent clinical or treatment discussions.
- (xx) The BH I/DD Tailored Plan shall offer assistance with scheduling appointments for EPSDT services, upon a member's request.
- (xxi) The BH I/DD Tailored Plan shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services) for referrals. The BH I/DD Tailored Plan shall also make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.
- (xxii) The BH I/DD Tailored Plan shall develop and maintain an EPSDT Policy. The BH I/DD Tailored Plan shall submit the EPSDT Policy to the Department for review one hundred fifty (150) days after Contract Award and annually thereafter.
- (xxiii) Educational and Training Materials
 - (a) The BH I/DD Tailored Plan shall develop written and verbal educational materials on EPSDT, including educational materials for members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
 - (1) The BH I/DD Tailored Plan shall submit the materials to the Department for review and approval as defined in *Section V.B.1.iii. Member Engagement*.
 - (2) The BH I/DD Tailored Plan may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.
 - (3) As long as the education materials clearly state that they apply to the BH I/DD Tailored Plan, the education materials may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (b) As part of the Provider Training Plan defined in *Section V.B.4.iii. Provider Relations and Engagement*, the BH I/DD Tailored Plan shall provide training to all Network providers where EPSDT is relevant to the providers' area of practice on an annual basis. Training must include information related to:
 - (1) EPSDT benefits;
 - (2) EPSDT medical necessity review per federal criteria: standards and processes;
 - (3) AAP/Bright Futures Periodicity Schedule;
 - (4) Immunizations;

- (5) Required components of an EPSDT screening service;
- (6) Providing or arranging for all required lab screenings;
- (7) Medical transportation services available to members;
- (8) Outreach activities related to EPSDT provided by the BH I/DD Tailored Plan;
- (9) Necessary documentation required for reimbursement of EPSDT services; and
- (10) Into the Mouths of Babes/Physician Fluoride Varnish Program.

iii. Pharmacy Benefits

- (i) Prescription drugs play a significant and increasing role in maintaining health and treating illnesses, giving members the opportunity to become healthier and improve their quality of life. Through current pharmacy program management strategies, the BH I/DD Tailored Plan shall implement a pharmacy benefit which ensures members and providers access to therapeutically needed medications that will provide the best overall value to members, providers and the Department.
 - (a) The BH I/DD Tailored Plan shall administer both point of sale (POS) and Physician's Drug Program (PDP) as a part of the pharmacy benefit. The BH I/DD Tailored Plan shall cover prescription drugs in the same program as the Medicaid FSS pharmacy benefit. The BH I/DD Tailored Plan may, at its discretion, cover the drug under the other program (i.e. POS drugs may be covered by the PDP), unless otherwise prohibited by the Department in the Medication Coverage Restriction List.
- (ii) The BH I/DD Tailored Plan shall:
 - (a) Cover all covered outpatient drugs for which the manufacturer has a CMS rebate agreement and for which the Department provides coverage. 42 C.F.R. § 438.3(s)(1);
 - (b) Adhere to the Department's defined preferred drug list (PDL); and
 - (c) Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2).
- (iii) Drug Formulary and PDL
 - (a) The BH I/DD Tailored Plan shall not be allowed to maintain a closed formulary as defined in N.C. Gen. Stat. § 58-3-221(c)(1).
 - (b) In accordance with N.C. Gen. Stat. § 108D-65(6)b., the BH I/DD Tailored Plan shall use the same drug formulary established by the Department.
 - (c) The drug formulary shall, at minimum, include:
 - (1) All drugs included the North Carolina Medicaid and NC Health Choice PDL as posted on the Department's website. The BH I/DD Tailored Plan shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid and NC Health Choice PDL.
 - (2) All other covered drugs in drug classes not listed on the Department's PDL except for outpatient drugs excluded by state or federal policy, as defined in 42 C.F.R. § 438.3(s)(1).
 - (d) The BH I/DD Tailored Plan may substitute a brand drug with a generic drug when the drug is considered bioequivalent and clinically efficacious unless the brand drug is preferred on the Department's PDL.
 - (e) Beginning in Contract Year 2, the BH I/DD Tailored Plan may submit additional information or requests for the inclusion of additional drug classes in the Department's PDL for the Department's review and approval.
 - (1) The BH I/DD Tailored Plan will adhere to the Department defined uniform review and approval process for requests for the inclusion of additional drug classes in the Department PDL.
 - (2) The BH I/DD Tailored Plan shall use the same drug formulary established by the Department, until provided written approval by the Department.

- (f) In accordance with 42 C.F.R. § 438.10(h)(4)(i), the BH I/DD Tailored Plan shall make available to members and providers in a machine-readable electronic file and paper format, the following information about the drug formulary:
 - (1) List of all covered drugs (including over the counter, brand name, and generic prescription drugs); and
 - (2) Each covered drug’s tier (i.e. PDL preferred, PDL non-preferred, and non-PDL).
- (g) Drug formulary updates:
 - (1) The BH I/DD Tailored Plan will be provided by the Department’s PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid and NC Health Choice PDL. The BH I/DD Tailored Plan shall update their pharmacy claim system within one (1) Calendar Day of file receipt of the PDL file from Department’s PDL vendor.
 - (2) The BH I/DD Tailored Plan shall implement routine PDL changes within thirty (30) Calendar Days of notification of changes to the PDL by the Department (i.e. annual or quarterly updates based on the Department’s routine PDL review).
 - (3) The BH I/DD Tailored Plan shall, at the direction of the Department, perform off-cycle PDL file updates within one (1) Calendar Day of file receipt of the PDL file from Department’s PDL vendor.
- (iv) Pharmacy Utilization Management:
 - (a) As defined herein, the BH I/DD Tailored Plan shall develop a UM program, inclusive of pharmacy benefits.
 - (b) For pharmacy services, the BH I/DD Tailored Plan shall follow the existing NC Medicaid Direct and NC Health Choice Fee-for-Service clinical coverage policies and prior authorization (PA) criteria and clinical criteria into the UM program as described in:
 - (1) Clinical Coverage Policies: *Section V.B.2. Table 8: Required Pharmacy Clinical Coverage Policies* below. The BH I/DD Tailored Plan shall not implement any clinical or prior authorization criteria beyond those included in the policies.
 - (2) Prior Authorization Criteria: Drugs and/or drug classes requiring prior approval are available at the following link, accurate as of August 9, 2022: <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html>.
 - (3) Clinical Criteria: Drugs and/or drug classes subject to clinical criteria are available at the following link, accurate as of August 9, 2022: <https://www.nctracks.nc.gov/content/public/providers/pharmacy/pa-drugs-criteria-new-format.html>

Section V.B. Table 8: Required Pharmacy Clinical Coverage Policies
<i>9: Outpatient Pharmacy</i>
<i>9A: Over-the-counter products</i>
<i>9B: Hemophilia Specialty Pharmacy Program</i>
<i>9D: Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17</i>
<i>1B: Physician Drug Program</i>

- (c) Consistent with N.C. Gen. Stat. § 108A-68.1, the BH I/DD Tailored Plan shall not require PA for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.
- (d) The UM program shall include PA processes, as defined within Section 1927(d)(5) of the Social Security Act and 42 C.F.R. § 438.3(s)(6), including but not limited to:
 - (1) The BH I/DD Tailored Plan shall process pharmacy PA requests within twenty-four (24) hours from when the request is received.
 - (2) The BH I/DD Tailored Plan shall notify the prescriber of the decision by electronic means within twenty-four (24) hours from when the request was received, unless it is necessary for the PA request to be pended to obtain additional information (in which case, the BH I/DD Tailored Plan shall notify the prescriber of the need for additional information within twenty-four (24) hours from when the request was received, and the BH I/DD Tailored Plan shall have twenty-four (24) additional hours from the receipt of additional information to notify the prescriber of the decision).
 - (3) The BH I/DD Tailored Plan shall allow the satisfying of any PA requirement that mandates prior use of an alternative drug or drugs if the prescribing physician certifies that the member has previously used an alternative drug not requiring PA and/or the alternative drug has been determined detrimental to the member's health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the member's health or ineffective in treating the condition again. The BH I/DD Tailored Plan shall not void or refuse to renew a provider contract because the provider has provided a certification for a medically necessary drug.
 - (4) The BH I/DD Tailored Plan shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement in an emergency situation, the BH I/DD Tailored Plan must cover a seventy-two (72)-hour emergency supply of the prescription.
 - (5) The BH I/DD Tailored Plan shall not require a pharmacy to dispense a seventy-two (72)-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the member's health or safety, and he or she has made good faith efforts to contact the prescriber.
 - (6) The BH I/DD Tailored Plan shall allow the pharmacy to bill consecutive seventy-two (72) hour supplies if the prescriber is unavailable and a decision in response to the prior authorization request has not been made during the initial 72-hour period.
 - (7) The BH I/DD Tailored Plan shall reimburse the pharmacy for dispensing the temporary supply of medication and the pharmacy shall only receive one dispensing fee per month for each medication dispensed.
 - (8) The BH I/DD Tailored Plan shall develop and maintain an Emergency Preparedness Protocol, consistent with Required Pharmacy Clinical Coverage Policy 9: Outpatient Pharmacy, to prevent a significant disruption in medication access during a state of emergency or disaster.
 - (9) The BH I/DD Tailored Plan shall align prior authorization requirements as defined in the Opioid Misuse Prevention and Treatment Program.
 - (10) The BH I/DD Tailored Plan shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program, NC Health Choice program, a Standard Plan or another BH I/DD Tailored Plan through the expiration date of the active service authorization.
- (e) The BH I/DD Tailored Plan shall implement PA policies and procedures and pharmacy point of service edits process consistent with the A+KIDS program as part of its UM program to prevent

overprescribing and inappropriate prescribing of antipsychotics in members under the age of eighteen (18).

- (f) As new drugs are approved to the market, the BH I/DD Tailored Plan may require PA for those drugs based on the drug's FDA approved indication(s) and use(s) until the Department determines the need for and establishes clinical coverage and PA criteria.
- (g) Beginning in Contract Year 2, the BH I/DD Tailored Plan, after consultation with its or its vendor/subcontractor's Pharmacy and Therapeutics Committee consistent with N.C. Gen. Stat. § 58-3-221(a)(1), may submit alternative pharmacy clinical coverage and PA criteria to the Department for review and approval. The BH I/DD Tailored Plan shall:
 - (1) Adhere to the Department-defined uniform review and approval process to request alternative clinical coverage and PA criteria.
 - (2) Seek the Department's approval of alternative prior authorization criteria prior to implementing the alternative criteria.
- (h) Pharmacy Prior Authorization Process
 - (1) The BH I/DD Tailored Plan shall develop and maintain web-based PA processes, which provides an electronic review system accessible to providers and the Department's staff.
 - (2) The BH I/DD Tailored Plan shall utilize a common PA request form(s), developed by the Department, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.
 - (3) The BH I/DD Tailored Plan's pharmacy claim processing system shall have the ability to integrate member pharmacy claims and diagnosis history to automate the adjudication of pharmacy claims requiring PA based on criteria requiring the existence of diagnosis or prior pharmacy claims history.
- (v) Pharmacy Services Website
 - (a) The BH I/DD Tailored Plan shall maintain its own pharmacy services web page available to providers and members with information regarding the drug formulary and UM Program Policy.
 - (b) The BH I/DD Tailored Plan shall post to their pharmacy services web page, at a minimum:
 - (1) The drug formulary;
 - (2) UM Policy, including pharmacy clinical coverage and PA criteria; and
 - (3) PA request form(s).
 - (4) Information about how to access medication during a disaster or emergency
 - (c) All additions or changes to the drug formulary, UM Program Policy and PA request form shall be posted thirty (30) Calendar Days prior to the effective date of the requirement or revision.
 - (d) If the BH I/DD Tailored Plan utilizes a Pharmacy Benefits Manager (PBM), the BH I/DD Tailored Plan's pharmacy services web page may direct providers and members to their PBM's pharmacy services web page which shall adhere to all the same requirements outlined in this Section.
- (vi) Pharmacy Benefit Managers
 - (a) The BH I/DD Tailored Plan may contract with a pharmacy benefits manager (PBM) to administer the pharmacy benefit as detailed in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
 - (b) If the BH I/DD Tailored Plan utilizes a PBM, the BH I/DD Tailored Plan shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor PBM performance, and ensure the confidentiality of member information and the Department information that is not public.
 - (c) The BH I/DD Tailored Plan shall report all financial arrangements between the BH I/DD Tailored Plan/subcontractors and all drug-related companies to the Department on an annual basis.

Drug-related companies include manufacturers, labelers, compounders, and benefit managers in a manner to be specified by the Department.

- (d) If the PBM is owned wholly or in part by a retail participating pharmacy, chain drug store or pharmaceutical manufacturer, the BH I/DD Tailored Plan shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of member and the Department proprietary information.
 - (e) The PBM shall provide a liaison with whom the Department will communicate with directly. The PBM liaison shall be available for direct communication with pharmacy providers to resolve issues, and to work with the Department to resolve rebate issues resulting from the BH I/DD Tailored Plan's encounter and drug utilization files.
- (vii) Pharmacy Programs:
- (a) The BH I/DD Tailored Plan shall develop and maintain the following pharmacy programs.
 - (1) Drug Utilization Review
 - i. As required by 42 C.F.R. § 438.3(s)(4), the BH I/DD Tailored Plan shall operate a drug utilization review (DUR) program that includes prospective DUR, retrospective DUR, and an educational program for prescribers and pharmacists. The DUR must comply with 42 C.F.R. part 456, subpart K and Section 1927(g) of the Social Security Act.
 - ii. The prospective DUR program shall:
 - a) Operate at pharmacy point of sale.
 - b) Address, but not be limited to the following:
 - 1) Screening for potential drug therapy problems due to therapeutic duplication;
 - 2) Drug-disease contraindications;
 - 3) Drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs);
 - 4) Incorrect drug dosage or duration of drug treatment, drug-allergy interactions;
 - 5) Clinical abuse or misuse; and
 - 6) Include other parameters as appropriate.
 - iii. The retrospective DUR program shall, at a minimum:
 - a) Address the following:
 - 1) Therapeutic appropriateness;
 - 2) Over- and under-utilization;
 - 3) Use of anti-psychotics in children and youth;
 - 4) Psychotropic polypharmacy in children and youth;
 - 5) Appropriate use of generic products;
 - 6) Therapeutic duplication, drug-disease contraindication;
 - 7) Drug-drug interaction;
 - 8) Incorrect drug dosage;
 - 9) Incorrect duration of drug treatment; and
 - 10) Clinical abuse or misuse.
 - b) Conduct at least a quarterly review of paid drug pharmacy and medical claims utilization data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and members; and
 - c) Address other programs and initiatives as directed by the Department.

- iv. The educational program within the DUR for prescribers and pharmacists that includes, at a minimum, the following:
 - a) Written, verbal, or electronic reminders containing patient-specific or drug utilization review-specific information (or both) and suggested changes in prescribing or dispensing practices;
 - b) Face-to-face discussions, with follow up discussions when necessary, between health care professionals who are experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices;
 - c) Intensified review or monitoring of selected prescribers or pharmacists; and
 - d) Other educational activities as appropriate. 42 C.F.R. 456 subpart K.
 - v. The BH I/DD Tailored Plan shall implement DUR programs to address opioid misuse. The Department reserves the right to require the BH I/DD Tailored Plan to develop DUR programs for other targeted populations, drug classes and/or disease states.
 - vi. The BH I/DD Tailored Plan shall provide a detailed description of its DUR program activities to the Department on an annual basis. 42 C.F.R. § 438.3(s)(5).
 - vii. The BH I/DD Tailored Plan shall report DUR program data to the Department in a format consistent with the Department’s reporting format for the CMS annual report no later than ninety (90) Calendar Days prior to the CMS due date.
- (2) Opioid Misuse Prevention and Treatment Program is defined in *Section V.B.3.ix. Prevention and Population Health Programs*.

(viii) Pharmacy Reimbursement

(a) Dispensing Fees

- (1) In accordance with N.C. Gen. Stat. § 108D-65(5)b., the BH I/DD Tailored Plan shall reimburse pharmacies a dispensing fee at a rate established by the Department.
- (2) The pharmacy dispensing fee shall be defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).
 - i. The BH I/DD Tailored Plan may choose to reimburse based on flat dispensing fee of \$10.24 as defined in the Department’s 2015 cost of dispensing (COD) study or the Department’s current composite rate utilized in fee-for-service.
- (3) The Department shall perform a cost of dispensing study every five (5) years to inform the NC Medicaid Direct and NC Health Choice Fee-for-Service dispensing rate and notify the BH I/DD Tailored Plan of any changes to the pharmacy dispensing fee.
- (4) The calculation used to determine the quarterly generic dispensing rate (GDR) for tiered reimbursement shall be the same used by the Department.
- (5) A claim level GDR report shall be provided to each pharmacy provider prior to each quarterly dispensing rate adjustment for tiered reimbursement.
- (6) For 340B and Non-340B Hemophilia drugs, the dispensing fee is paid based on the submitted quantity and multiplier at \$0.04 for 340B and at \$0.025 for Non-340B.
- (7) The BH I/DD Tailored Plan shall not reimburse pharmacy professional dispensing fees to drug reimbursement under the all-inclusive rate “AIR” or bundle payment.

(b) Ingredient Costs

- (1) The BH I/DD Tailored Plan shall reimburse pharmacies’ ingredient costs at the same rate at the NC Medicaid Direct and NC Health Choice Fee-for-Service rate.
- (2) The NC Medicaid Direct and NC Health Choice Fee-for-Service rates includes the National Average Drug Acquisition Cost (NADAC). If there is no NADAC: Wholesale Acquisition Cost (WAC), or State Maximum Allowable Cost (SMAC) list, and other financial arrangements established by the Department.

- (3) Based on lesser of logic methodology, such that the pharmacy is reimbursed the usual and customary cost or GAD if it is less than the NADAC, WAC or SMAC.
- (4) 340B hemophilia purchased drugs are reimbursed based on the Hemophilia reimbursement methodology which reimburses 340B ingredient drugs at the lesser of Ceiling Prices (CP), Usual and Customary Charges (U&C)+Professional Dispensing Fess or the Gross Amount Due (GA).
- (5) Non-340 hemophilia drugs are reimbursed based on the Hemophilia reimbursement methodology which reimburses Non-340B ingredient drugs at the lesser of Actual Acquisition Costs (AC), Usual and Customary Charges (U&C) or the Gross Amount Due (GAD).
- (6) The BH I/DD Tailored Plan shall reimburse the Indian Health Services or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/TU) as defined in section 4 of Indian Health Care Improvement Act (25 U.S.C 1603 and authorized by Public Law 93-638 Agreement) for drugs with calculated allowable amount of less than \$1,000 at the OMB encounter reimbursement methodology, which will pay a maximum of two (2) OMB encounter payments. Any additional drugs (3 and up) calculated at OMB encounter rate will pay zero. For drugs with calculated allowable amount equal or greater than \$1,000 the I/T/U will continue to reimburse at current Fee-for-Services rates. The following is a list of exclusion to the I/T/U OMB encounter (AIR) POS Pharmacy reimbursement methodology:
 - i. Drugs and vaccines free of charge,
 - ii. Emergency supply dispensation,
 - iii. Eyeglasses,
 - iv. Prosthetic devices and hearing aids,
 - v. Diabetic testing supplies and continuous glucose monitors,
 - vi. Drug counseling or medication therapy management,
 - vii. 340B drugs,
 - viii. Medicare Part-B drugs,
 - ix. Medication assisted treatment (MAT) drugs,
 - x. Professional dispensing fees,
 - xi. Collection of rebates,
 - xii. Drug delivery or mailing, and
 - xiii. Drugs dispensed to beneficiaries assigned to Health Choice and Family Planning Waiver benefit plans.
- (c) The BH I/DD Tailored Plan shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.
- (d) Subject to Department review and approval, in Contract Year 2, the BH I/DD Tailored Plan may develop its own pharmacy contracting for ingredient reimbursement if the BH I/DD Tailored Plan can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the BH I/DD Tailored Plan must also submit a pharmacy network access monitoring plan.
- (e) The BH I/DD Tailored Plan shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the BH I/DD Tailored Plan.
- (f) Reimbursement Inquiries. The BH I/DD Tailored Plan shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.
- (ix) Drug Rebates
 - (a) The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid and NC Health Choice Program. The Department shall not delegate authority

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

- (b) The BH I/DD Tailored Plan shall submit outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims encounter data to the Department or its Encounter Data Processing vendor on a weekly basis, no later than seven (7) Calendar Days following the date on which the BH I/DD Tailored Plan or its Subcontractor adjudicated the claims for drug rebate invoicing as defined in *Section V.B.6.ii. Encounters*.
- (c) The BH I/DD Tailored Plan shall submit all pharmacy and medical drug encounter data for rebate invoicing in a format determined by the Department or its Drug Rebate vendor. At a minimum, the data should be at claims level and include the total number of units by strength by NDC of each covered outpatient pharmacy drug, outpatient hospital drug and physician administered drug paid for by the BH I/DD Tailored Plan or its Subcontractor. 42 C.F.R. § 438.3(s)(2).
- (d) For Medicaid Benefits, the BH I/DD Tailored Plan shall submit drug encounters using a HCPCS/CPT code for Medical Drug Encounters with the following:
 - (1) An NDC that is appropriate for the HCPCS/CPT code based on the drug description, strength and date of service.
 - (2) HCPCS/CPT units and NDC units reported that represent a medically appropriate dosing and package size.
 - (3) Date of service that is not past the termination date of the drug.
 - (4) An NDC that is from a rebate-eligible manufacturer on the date of service of the claim.
- (e) 340B covered entities:
 - (1) The BH I/DD Tailored Plan pharmacy provider contracts shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit national Council for Prescription Drug Programs (NCPDP) code "8" in Basis of Cost Determinations filed 423-DN and 20 in the submission clarification code field at the point of sale to identify claims submitted for drugs purchased through the 340B program.
 - (2) The BH I/DD Tailored Plan pharmacy provider contracts shall require 340B covered entities to identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3).
 - (3) The BH I/DD Tailored Plan pharmacy provider contracts shall require that 340B covered entities' written agreements with contracted pharmacies specify that contract pharmacies comply with the point of sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3).
 - (4) The BH I/DD Tailored Plan pharmacy provider contracts shall require contract pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).
 - (5) The BH I/DD Tailored Plan shall report to the Department the commencement, conclusion and final results of all HRSA audits.
 - (6) The BH I/DD Tailored Plan shall review 340B covered entities' HRSA audits and coordinate with the Department to ensure the prevention of duplicate discounts.

- (f) The BH I/DD Tailored Plan shall disclose to the Department all financial terms and arrangements for remuneration of any kind that apply between the BH I/DD Tailored Plan and other entities identified in the BH I/DD Tailored Plan Operating Plan and any drug manufacturer, labeler or PBM including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.
 - (1) The Department shall maintain the confidentiality of information disclosed by the BH I/DD Tailored Plan pursuant to this Section, to the extent that the information is confidential under North Carolina or federal law.
 - (2) The Department may audit financial terms and arrangements for remuneration of any kind that apply between the BH I/DD Tailored Plan and any drug manufacturer or labeler.
 - (g) The BH I/DD Tailored Plan shall support the Department with drug rebate dispute resolution processes within the timeframe requested by the Department.
 - (1) The BH I/DD Tailored Plan or its Subcontractor shall assign a single point of contact to research any encounters that are denied on submission to the Department or identified as a dispute by the drug manufacturers and within thirty (30) Calendar Days shall resolve.
 - (2) The BH I/DD Tailored Plan or its Subcontractor shall provide an explanation of such disputes to the Department at the encounter claim level in a spreadsheet.
 - (3) If the encounter claim information is found to be in error, the encounter shall be voided within five (5) Business Days of the determination.
- iv. Non-Emergency Medical Transportation
- (i) The BH I/DD Tailored Plan shall provide non-emergency medical transportation (NEMT) services to ensure that members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid-enrolled providers.
 - (ii) The BH I/DD Tailored Plan shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct and consistent with the Department's NC Non-Emergency Medical Transportation Managed Care Policy.
 - (iii) The BH I/DD Tailored Plan shall provide NEMT services for all enrolled Medicaid members:
 - (a) By the least expensive mode available and appropriate for the member;
 - (b) To the nearest appropriate medical providers; and
 - (c) For a Medicaid covered service, including services carved out of Medicaid Managed Care provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider).
 - (d) When providing NEMT services, the BH I/DD Tailored Plan shall use the most appropriate form of transportation to meet the needs of the Member.
 - (iv) NEMT services shall include:
 - (a) NEMT transportation vendors including public transportation, taxis, van, wheel-chair vans, mini-bus, mountain area transports, or other transportation systems and non-emergency ambulance transportation.
 - (b) Other transportation services including volunteers, family members and friends, attendant expenses, ancillary costs and attendant pay, and non-emergency air travel.
 - (c) Travel related expenses including food, parking, fees/tolls, transportation vouchers (i.e. taxis, ride sharing services, public transit), and mileage.
 - (v) The BH I/DD Tailored Plan shall guarantee the following rights to members:
 - (a) To be informed of the availability of Medicaid NEMT;
 - (b) To be informed that there is no cost to the member;
 - (c) To be informed of who may accompany a member without cost;
 - (d) To be informed that a member under the age of eighteen (18) does not have to ride alone;
 - (e) To have the BH I/DD Tailored Plan's NEMT Policy, as defined below, explained including:

- (1) How to request or cancel a trip;
 - (2) Limitations on transportation;
 - (3) Advanced notice requirements; and
 - (4) Expected member conduct and procedures for no-shows.
- (f) To be transported to medical appointments if unable to arrange or pay for transportation and by means appropriate to circumstances;
- (g) To arrive at provider in time for the scheduled appointment; and
- (h) To request an Appeal, as defined in the Contract, if the request for transportation assistance is denied.
- (vi) The BH I/DD Tailored Plan shall not require members to make transportation requests more than two (2) Business Days in advance.
- (vii) The BH I/DD Tailored Plan shall ensure that an attendant 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.
- (viii) The individuals included in *Section V.B.2. Table 9: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the BH I/DD Tailored Plan.

Section V.B.2. Table 9: Individuals Not Eligible to Receive NEMT Services	
Population	Additional Detail
NC Health Choice Members	Not a covered benefit (unless offered by the BH I/DD Tailored Plan as a value-added benefit)
Members in a nursing home	The facility is responsible for providing transportation to their patients.
Members in a long-term care facility	The facility is responsible for providing transportation to their patients.
Members during an inpatient hospital stays	Not a covered benefit
Members in the Innovations waiver obtaining Day Supports, Respite, Community Living and Support, or Supported Employment services	Transportation is included in the Medicaid provider's payment; members can use NEMT for transportation to other services
Members in the TBI waiver obtaining Supported Employment, Day Supports, Cognitive Rehabilitation or Community Networking	Transportation is included in the Medicaid provider's payment; members can use NEMT for transportation to other services

- (ix) The BH I/DD Tailored Plan shall develop a network of NEMT providers sufficient to fulfill the requirements as outlined in this Section.
- (x) The BH I/DD Tailored Plan shall provide copies of its contract(s) with subcontractor(s) providing NEMT services upon Contract Award or within fourteen (14) Calendar Days of signing any new agreement or modification with the BH I/DD Tailored Plan's NEMT subcontractor(s).

- (xi) The BH I/DD Tailored Plan shall develop, submit and maintain a NEMT Policy. The BH I/DD Tailored Plan shall submit the Policy one hundred fifty (150) days after Contract Award and annually thereafter, for use with Members.
 - (a) The Policy shall include, at a minimum, the following:
 - (1) Transportation options available to members;
 - (2) Methods and process by which to request transportation;
 - (3) Driver and vehicle requirements;
 - (4) Process for transportation assessment;
 - (5) Member rights and responsibilities; and
 - (6) Hours of operation.
 - (xii) The NEMT 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 hour before the appointment; nor have to 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 defined in this Section.
3. Care Management
- i. Overview
 - (i) The Department believes that care management is a crucial driver to help achieve key goals of BH I/DD Tailored Plans, including integrated, whole-person care and fostering coordination and collaboration among care team members across disciplines and settings.
 - (ii) The Department has developed Tailored Care Management, described in *Section V.B.3.ii. Tailored Care Management*, as the predominant care management model for the BH I/DD Tailored Plan population.
 - (iii) The BH I/DD Tailored Plan shall be responsible for implementing the Tailored Care Management model as described in *Section V.B.3.ii. Tailored Care Management* and engaging its members in Tailored Care Management.
 - (iv) Beyond Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for delivering care coordination and managing care transitions for all members, regardless of whether they participate in Tailored Care Management, as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*.
 - (v) The BH I/DD Tailored must also provide additional care management and care coordination functions as detailed in *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver*, *Section V.B.3.v. Other Care Management Programs*, *Section V.B.3.vii. System of Care*, and *Section V.B.3.viii. In-reach and Transition from Institutional Settings*.
 - (vi) The BH I/DD Tailored Plan must also meet the requirements set forth in *Section V.B.3.vi. Care Management Policy*, *Section V.B.3.ix. Prevention and Population Health Program*, *Section V.B.3.x. Health Opportunities*, and *Section V.B.3.xi. Relocation of Members Following Emergency Residential Facility Closures*.
 - ii. Tailored Care Management
 - (i) Model Overview and Objectives
 - (a) Tailored Care Management is built on the principle that provider- and community-based care management is crucial to the success of fully integrated managed care. The BH I/DD Tailored Plan must ensure that care managers delivering Tailored Care Management coordinate across

a member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.

- (b) The Department is committed to the principle that placing care management as close as possible to the beneficiary and the site of care will drive better health outcomes.
- (c) The BH I/DD Tailored Plan shall ensure that Tailored Care Management is available to all BH I/DD Tailored Plan members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services as defined in *Section V.B.3.ii.(xix)(g) Duplication of Care Management*.
- (d) Tailored Care Management is also designed to align with the North Carolina System of Care framework. The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with BH needs.
- (e) Federal Health Home Structure
 - (1) Upon CMS approval of a SPA to add Tailored Care Management as a Health Home State Plan benefit, the BH I/DD Tailored Plan shall act as the designated Health Home for its members. In its role as a Health Home, the BH I/DD Tailored Plan shall ensure that members have access to Care Management that meet the requirements of this Section and federal Health Home requirements.
 - (2) The BH I/DD Tailored Plan shall cooperate with the Department in the administration of North Carolina's Section 2703 Health Home SPA, including implementation, providing reporting and data, and other requirements.
- (ii) Delivery of Tailored Care Management
 - (a) The BH I/DD Tailored Plan must offer the following three approaches for delivering Tailored Care Management:
 - (1) AMH+: To be eligible to become an AMH+, the practice must intend to become a PCP in the BH I/DD Tailored Plan network. Only AMH Tier 3 practices certified as an AMH+ practice may provide Tailored Care Management as defined in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*.
 - (2) Care Management Agency (CMA): To be eligible to become a CMA, an organization must, at the time of certification, have as its primary purpose the delivery of NC Medicaid, NC Health Choice, or State-funded Services, other than Care Management, to the BH I/DD Tailored Plan eligible population in North Carolina. Provider organizations must be certified as a CMA to provide Tailored Care Management as defined in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*.
 - (3) BH I/DD Tailored Plan-based care managers: The BH I/DD Tailored Plan may provide Tailored Care Management.
 - (b) Provider-based Tailored Care Management
 - (1) The Department considers Tailored Care Management delivered by an AMH+ practice or a CMA to be provider-based.
 - (2) The BH I/DD Tailored Plan must contract with all organizations in its Region that receive AMH+ or CMA certification to provide Tailored Care Management, with limited exceptions as described in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs* and *Section V.B.3.ii.(xix) Oversight*.
 - (3) The BH I/DD Tailored Plan shall meet annual requirements established by the Department for the percentage of Members actively engaged in Provider-based Tailored Care Management approaches, meaning Members who are receiving at least one (1) of the following six (6) core Health Home services in that month:

- i. Comprehensive care management: a team-based, person centered approach to effectively manage Members’ medical, social and behavioral conditions;
 - ii. Care coordination: the act of organizing Member care activities and sharing information among all the participants involved with a Health Home Member’s care to achieve safer and more effective care. Through organized care coordination, Members’ needs and preferences are known ahead of time and communicated at the right time to the right people to provide safe, appropriate, and effective care;
 - iii. Health promotion: education and engagement of a Member in making decisions that promote achievement of good health, pro-active management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems;
 - iv. Comprehensive transitional care/follow-up: the process of assisting a Health Home member to transition to a different care setting or through a life stage that results in or requires a modification of services (e.g. school-related transitions);
 - v. Individual and family supports: the coordinating of information and services to support Health Home members (or their caretakers/guardian) to maintain and promote the quality of life, with particular focus on community living options; or
 - vi. Referral to community and social support services: providing information and assistance for the purpose of referring Health Home members to resources that address their unmet-health resource needs identified in the care plan/ISP.
 - vii. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf>.
 - viii. The percentage shall be calculated as:
 - a) Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department
 - b) Denominator: Total number of members actively engaged in Tailored Care Management.
- (4) Each year, the Department will divide the amount of Tailored Care Management that was delivered to each BH I/DD Tailored Plan’s members by AMH+s and CMAs (and Clinically Integrated Networks (CINs) or Other Partners on their behalf) by the amount of all Tailored Care Management delivered to members of that BH I/DD Tailored Plan. The annual required percentages for Provider-based Care Management delivered to BH I/DD Tailored Plan members are as follows:
- i. Contract Year 1: 30 percent (30%);
 - ii. Contract Year 2: 45 percent (45%);
 - iii. Contract Year 3: 60 percent (60%); and
 - iv. Contract Year 4: 80 percent (80%).
- (5) The Department will assess compliance with annual required percentages for each Contract Year during the first quarter of subsequent Contract Year, beginning in Contract Year 2.
- (6) The Department may adjust the annual required percentages at its discretion.
- (7) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall provide a plan for supporting development of Provider-based Care Management and oversight of Provider-based Care Management

- (iii) Eligibility for Tailored Care Management
 - (a) All members, including those enrolled in North Carolina’s 1915(c) Innovations and TBI waivers, are eligible for Tailored Care Management, with the following exceptions for members participating in services that are duplicative of Tailored Care Management:
 - (1) Members obtaining Assertive Community Treatment (ACT);
 - (2) Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
 - (3) Members participating in Care Management for At-Risk Children; and
 - (4) Members participating in the High-Fidelity Wraparound program as described in *Section V.B.3.v.(v) High-Fidelity Wraparound*.
 - (b) The Department reserves the right to require BH I/DD Tailored Plans to allow beneficiaries enrolled in NC Medicaid Direct to enroll in Tailored Care Management if they meet the Health Home eligibility criteria that will be specified in the forthcoming Health Home SPA.
- (iv) Enrollment in Tailored Care Management
 - (a) The BH I/DD Tailored Plan shall auto-enroll all members eligible for Tailored Care Management into Tailored Care Management at BH I/DD Tailored Plan launch.
 - (b) The BH I/DD Tailored shall allow members to opt out of Tailored Care Management at any time.
 - (1) The BH I/DD Tailored Plan shall permit members who do not want to participate in Tailored Care Management to opt-out via a Tailored Care Management Opt-out Form, which the BH I/DD Tailored Plan shall submit to the Department for approval as part of its Care Management Policy. The form must include a place to provide the reason for opting out.
 - i. The BH I/DD Tailored Plan shall permit the Tailored Care Management Opt-out Form to be mailed in, completed online, filled out in person with the care manager, or filled out over the telephone with either the BH I/DD Tailored Plan or organization assigned to provide Tailored Care Management.
 - (2) The BH I/DD Tailored Plan shall permit a member who has opted out to opt back into Tailored Care Management at any time by contacting the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall provide care coordination and manage care transitions for members who opt-out of Tailored Care Management as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*.
 - i. In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver.
 - (4) The BH I/DD Tailored Plan shall submit a sample care management enrollment packet as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (v) Tailored Care Management Assignment
 - (a) The BH I/DD Tailored Plan shall ensure that all members, including those enrolled in the Innovations or TBI waiver, have a choice of care management approach (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*). To facilitate timely engagement in Tailored Care Management, the BH I/DD Tailored Plan shall make initial Tailored Care Management assignments as described in this Section. The assignment process for Tailored Care Management shall be distinct from the Primary Care Provider (PCP) assignment process described in *Section V.B.1.vii.(ii) PCP Choice and Assignment*.
 - (b) The BH I/DD Tailored Plan must submit to the Department its methodology for assigning eligible members to Tailored Care Management based at an AMH+ practice, a CMA or the BH I/DD Tailored Plan.

- (c) The BH I/DD Tailored Plan must assign members to a mix of the three Tailored Care Management approaches (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*) according to the factors described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
- (d) The BH I/DD Tailored Plan shall assign members to the most clinically appropriate care management approach as based on the factors described in herein . The BH I/DD Tailored Plan must assign each AMH+ and CMA providing Tailored Care Management a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the model.
- (e) The BH I/DD Tailored Plan must ensure that Tailored Care Management assignment aligns with the annual requirements for Provider-based Care Management as described in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*.
- (f) The BH I/DD Tailored Plan shall consider the following factors when assigning each member to care management at an AMH+ practice or a CMA, or at the BH I/DD Tailored Plan level:
 - (1) For Innovations and TBI waiver enrollees:
 - i. If the member enrolled in the Innovations or TBI waiver has an existing relationship with an LME/MCO care coordinator who meets the Tailored Care Management qualifications and training requirements as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements* and is employed by the member’s BH I/DD Tailored Plan or in the BH I/DD Tailored Plan’s network, the BH I/DD Tailored Plan must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.
 - ii. The BH I/DD Tailored Plan shall assign members enrolled in the Innovations or TBI waiver to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) waiver enrollees. 42 C.F.R. § 431.301(c)(1)(vi). The BH I/DD Tailored Plan shall ensure that members do not obtain both 1915(c) waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.
 - (2) For all members:
 - i. Assignment to a Tailored Care Management approach and organization providing Tailored Care Management must occur after the PCP assignment process (outlined in *Section V.B.1.vii.(ii) PCP Choice and Assignment*).
 - ii. The BH I/DD Tailored Plan shall follow the requirements in the Tailored Care Management Auto Assignment Requirements Document, as they develop their Tailored Care Management auto assignment algorithm.
 - iii. The BH I/DD Tailored Plan must take into account the member’s existing provider assignment to an AMH+ practice or existing treatment relationship with a CMA within the BH I/DD Tailored Plan’s network and give preference to that provider when making a Tailored Care Management assignment unless there is a specific cause not to do so, including in instances of conflict of interest for Innovations and TBI waiver enrollees.
 - iv. The BH I/DD Tailored Plan must take into account the member’s medical complexity as well as BH and I/DD complexity when making a Tailored Care Management assignment.
 - a) In instances where Children with Medical Complexity are receiving primary care through an AMH+ practice, the BH I/DD Tailored Plan shall give that AMH+ practice preference when assigning the member to a care management approach.

- v. The BH I/DD Tailored Plan must take into account the member's geographic location when making a Care Management assignment.
- vi. The BH I/DD Tailored Plan shall ensure capacity at an AMH+ practice or CMA before assigning a Member to the AMH+ practice or CMA. The BH I/DD Tailored Plan must permit AMH+ practices and CMAs to set limits on their panel sizes (i.e., decline assignments based on capacity).
 - a) The BH I/DD Tailored Plan shall monitor care management assignment to ensure that AMH+ practices and CMAs do not select members of their panel based on acuity tier.
- (g) The BH I/DD Tailored Plan shall permit members to change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause.
- (h) The Department shall consider the following as appropriate cause for changes in care management approach, assigned organization providing Tailored Care Management, and care manager:
 - (1) The AMH+, CMA, BH I/DD Tailored Plan or care manager has, as determined by the Member or the BH I/DD Tailored Plan, failed to furnish accessible and appropriate services to which the member is entitled.
 - (2) The AMH+, CMA, BH I/DD Tailored Plan or care manager is not able to reasonably accommodate the member's needs.
 - (3) There is a change in the accessibility of the AMH+, CMA, BH I/DD Tailored Plan or care manager, including but not limited to the following:
 - i. The organization or care manager moves to a location that is not convenient for the member.
 - ii. There is a Significant Change in the hours the AMH+ practice or CMA is open and the member cannot reasonably meet during the new hours.
 - iii. There is a Significant Change in the hours the care manager is available and the member cannot reasonably meet during the new hours.
 - (4) The member determines that a change would be in the best interest of the member.
 - (5) The member's assigned AMH+ practice or CMA leaves the BH I/DD Tailored Plan's Network or is no longer certified by the Department.
 - (6) The member's assigned AMH+ practice or CMA becomes excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).
 - (7) The care manager is no longer employed by the AMH+, CMA, or BH I/DD Tailored Plan.
- (i) The BH I/DD Tailored Plan shall educate members on the three different care management approaches and provide unbiased counseling on selecting a care management Provider as part of the choice period prior to launch.
- (j) The BH I/DD Tailored Plan shall send members information on Tailored Care Management, with information on their Tailored Care Management assignment and options for changing their assignment as part of the Member Welcome Packet.
- (k) After the initial launch of the BH I/DD Tailored Plan, on an ongoing basis the BH I/DD Tailored Plan shall complete Tailored Care Management assignments and send Tailored Care Management assignment and information to new members as part of the Member Welcome Packet.
- (l) The Tailored Care Management information in the Welcome packet must include:
 - (1) Information on The Tailored Care Management program, including services available for those who have opted out of Tailored Care Management

- (2) The nature of the care manager relationship
 - (3) Information on the member's Tailored Care Management assignment and options for changing their Tailored Care Management assignment
 - (4) Process and options for changing their Tailored Care Management assignment
 - (5) The Tailored Care Management opt-out form
 - (6) Circumstances under which member information will be disclosed to third parties
 - (7) The availability of the Grievance and Appeals process as described in *Section V.B.1.vi. Member Grievances and Appeals*.
- (m) The BH I/DD Tailored Plan must share with each AMH+ practice and CMA, at least monthly, a roster of their assigned members and members' current contact and demographic information in a manner specified by the Department.
 - (n) The BH I/DD Tailored Plan must share each member's Tailored Care Management organization assignment with the member's PCP within fourteen (14) days of assignment or changes in the member's Tailored Care Management organization in a manner specified by the Department. Upon changes in the member's assigned PCP, the BH I/DD Tailored Plan must share the member's Tailored Care Management organization assignment with the member's new PCP within fourteen (14) days of assignment to the new PCP.
 - (o) The BH I/DD Tailored Plan must share with each AMH+ and CMA all data elements specified in *Section V.B.3ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*
 - (p) The BH I/DD Tailored Plan must assign and must ensure that AMH+ practices and CMAs assign the member to a care manager with appropriate qualifications and experience according to the member's needs within thirty (30) days of BH I/DD Tailored Plan enrollment.
 - (q) The BH I/DD Tailored Plan shall submit its policies and procedures for Tailored Care Management assignment as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (vi) Outreach and Engagement
 - (a) The BH I/DD Tailored Plan shall require that care managers initiate contact with assigned members who have recently been enrolled in Tailored Care Management to start the care management comprehensive assessment within thirty (30) Calendar Days of BH I/DD Tailored Plan enrollment (see *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*). The care manager shall educate the member about the benefits of care management and work to engage the member in a care management comprehensive assessment and care planning.
 - (1) Contact for the purpose of starting the care management comprehensive assessment may be telephonic, through two-way real time video and audio conferencing, or in-person.
 - (b) The BH I/DD Tailored Plan shall develop and ensure that AMH+ practices and CMAs also develop, policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences, including sign language, closed captioning and/or video capture.
 - (c) The BH I/DD Tailored Plan shall submit its policies and procedures for outreach and engagement as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
 - (vii) Care Management Comprehensive Assessment¹⁷
 - (a) The care management comprehensive assessment shall serve as the federally required initial care needs screening. 42 CFR 438.208(b)(3).

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

- (b) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management is responsible for conducting the care management comprehensive assessment.
- (c) The BH I/DD Tailored Plan shall ensure that the care management comprehensive assessment is conducted in a location that meets the member's needs.
- (d) The BH I/DD Tailored Plan shall ensure that care managers make a best effort attempt to complete the care management comprehensive assessment in person, realizing that in limited instances it will be necessary to complete the care management comprehensive assessment via technology conferencing tools (e.g., audio and/or video tools).
- (e) The BH I/DD Tailored Plan shall verify that care management comprehensive assessments are completed in a timely manner as part of routine monitoring.
- (f) During Contract Year 1, the assigned organization providing Tailored Care Management shall make its best effort to complete the care management comprehensive assessment within the following timeframes:
 - (1) Members identified as high acuity: Best efforts to complete it within forty-five (45) days of BH I/DD Tailored Plan enrollment and no longer than sixty (60) days of BH I/DD Tailored Plan enrollment. 42 CFR § 438.208(b)(3).
 - (2) Members identified as medium/low acuity: Within ninety (90) days of BH I/DD Tailored Plan enrollment. 42 CFR § 438.208(b)(3).
 - (3) For purposes of provisions related to Tailored Care Management, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, to contact the member if the first attempt is unsuccessful.
- (g) During Contract Years after Contract Year 1, the BH I/DD Tailored Plan shall ensure that care managers make best efforts to complete the care management comprehensive assessment for new members within sixty (60) days of BH I/DD Tailored Plan enrollment. 42 C.F.R. § 438.208(b)(3).
- (h) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management make available the results of the care management comprehensive assessment to the member's PCP, BH, I/DD, TBI and LTSS providers, and the BH I/DD Tailored Plan within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, provided that the member consents to making results available, if required by law. The BH I/DD Tailored Plan shall not withhold medically necessary services for members while awaiting completion of the care management comprehensive assessment.
- (i) The BH I/DD Tailored Plan must attempt a care management comprehensive assessment at least annually for enrolled members who:
 - (1) Have neither opted out nor engaged in Tailored Care Management, and
 - (2) Are not receiving services duplicative of Tailored Care Management.
- (j) The BH I/DD Tailored Plan shall ensure that a reassessment for members already engaged in Tailored Care Management is done:
 - (1) At least annually;
 - (2) When the member's circumstances, needs or health status changes significantly;
 - (3) After Significant Changes in scores on Department-approved level-of-care determination and screening tools (e.g., Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS), ASAM, Child and Adolescents Needs and Strengths (CANS), SIS®, and Rancho Los Amigos Levels of Cognitive Functioning Scale);
 - (4) At the member's request;
 - (5) After triggering events, including:
 - i. Inpatient hospitalization for any reason ;

- ii. Two (2) emergency department (ED) visits since the last care management comprehensive assessment (including reassessment);
 - iii. An involuntary treatment episode;
 - iv. Use of BH crisis services;
 - v. Arrest or other involvement with law enforcement/the criminal justice system, including Division of Juvenile Justice;
 - vi. Becoming pregnant and/or giving birth;
 - vii. A change in member circumstances that results in an increased need for care, a decreased need for care, transition into or out of an institution, or loss of a family/friend/caretaker, or any other circumstance the plan deems to be a change in circumstance;
 - viii. Loss of housing; and
 - ix. Foster care involvement.
- (k) When a member requests a reassessment; experiences a Significant Change in circumstances, needs or health status; experiences a Significant Change in level of care score; or experiences a triggering event, the BH I/DD Tailored Plan shall ensure that the member receives a reassessment within thirty (30) days of when the BH I/DD Tailored Plan detects the change or event. Reassessments triggered by pregnancy or childbirth must address pregnancy-specific SUD and mental health screening covering the physical and BH needs of the infant and mother.
- (l) In circumstances in which a care management comprehensive assessment may have been recently performed, reassessment may consist of an addendum or update to a previous care management comprehensive assessment.
- (m) The BH I/DD Tailored Plan shall develop methodologies and tools for conducting the care management comprehensive assessment, as appropriate for differing member demographics and needs.
- (n) The care management comprehensive assessment shall address, at a minimum, the following:
- (1) Immediate care needs;
 - (2) Current services and providers across all health needs;
 - (3) Functional needs, accessibility needs, strengths and goals;
 - (4) Other state or local services currently used;
 - (5) Physical health conditions, including dental conditions;
 - (6) Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
 - (7) Physical, intellectual or developmental disabilities;
 - (8) Detailed medication history—a list of all medicines, including over-the-counter medication and prescribed medication, dispensed, or administered – and known allergies;
 - (9) Advanced directives, including advance instructions for mental health treatment;
 - (10) Available informal, caregiver or social supports;
 - (11) Standardized Unmet Health-Related Resource Needs questions to be provided by the Department covering four (4) priority domains:
 - i. Housing;
 - ii. Food;
 - iii. Transportation; and
 - iv. Interpersonal Violence/Toxic Stress;
 - (12) Any other ongoing conditions that require a course of treatment or regular care monitoring;
 - (13) For adults only, exposure to adverse childhood experiences (ACEs) or other trauma;

- (14) Risks to the health, well-being, and safety of the member and others (including sexual activity, potential abuse/exploitation, and exposure to second-hand smoke and aerosols);
 - (15) Cultural considerations (ethnicity, religion, language, reading level, health literacy, etc.);
 - (16) Employment/community involvement;
 - (17) Education (including individualized education plan and lifelong learning activities) ;
 - (18) Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
 - (19) Risk factors that indicate an imminent need for LTSS;
 - (20) Caregiver’s strengths and needs;
 - (21) Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.);
 - (22) Self-management and planning skills; and
 - (23) Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare.
- (o) For members with an I/DD or TBI diagnosis, the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* plus the following:
 - (1) Financial resources and money management; and
 - (2) Alternative guardianship arrangements, as appropriate.
 - (p) For members ages zero (0) up to age three (3), the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* and incorporate questions related to Early Intervention (EI) services for children, including:
 - (1) Whether the child is receiving EI services;
 - (2) Member’s current EI services;
 - (3) Frequency of EI services provided;
 - (4) Which local Children’s Developmental Service Agency (CDSA) or subcontracted agency is providing the services; and
 - (5) Contact information for the CDSA service coordinator.
 - (q) For BH I/DD Tailored Plan members ages three (3) up to twenty-one (21) with a mental health disorder and/or SUD who are receiving BH or substance abuse services, including members with a dual I/DD and mental health or SUD diagnosis, the care management comprehensive assessment shall incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community.
 - (r) The BH I/DD Tailored Plan’s assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.
 - (s) For specific requirements related to care management comprehensive assessments for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.
 - (t) The BH I/DD Tailored Plan will be required to send a monthly report listing all members who received the Standardized Unmet Health-Related Resource Needs screening in the form and manner specified by the Department. See *Section VII. First Revised and Restated Attachment J: Reporting Requirements* for more detail.
 - (u) The BH I/DD Tailored Plan shall submit its policies and procedures for Care Management comprehensive assessments as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (viii)Development of Care Plan/Individual Support Plan (ISP)

- (a) Using the results of the care management comprehensive assessment, the assigned organization providing Tailored Care Management shall develop a Care Plan for members with BH needs and an ISP for members with I/DD and TBI needs. 42 C.F.R. § 441.725.
- (b) The BH I/DD Tailored Plan shall ensure that all Care Plans and ISPs are developed and presented in a manner understandable to the member, including consideration for the member's reading level and alternate formats.
- (c) The BH I/DD Tailored Plan shall ensure that meetings related to the member's Care Plan/ISP are held at a location, date and time convenient to the member and the member's chosen participants.
- (d) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP is individualized and person-centered and is developed using a collaborative approach including member and family participation where appropriate.
- (e) The BH I/DD Tailored Plan shall make best efforts to complete an initial Care Plan or ISP within thirty (30) days of the completion of the care management comprehensive assessment.
 - (1) For purposes of completing an Initial Care Plan, "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, to contact the member if the first attempt is unsuccessful.
- (f) The BH I/DD Tailored Plan shall ensure that development of the Care Plan or ISP does not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a Care Plan/ISP to be developed, with the exception of Innovations waiver, TBI waiver, or any forthcoming 1915(i) services, for which prior authorization must be documented in the Care Plan/ISP. For members in the Innovations waiver, TBI waiver or any forthcoming 1915(i) services, the care manager will complete the minimum elements for the ISP service authorization request, when a member has a service need and the Care Plan is still in development.
- (g) The BH I/DD Tailored Plan shall ensure that the Care Plan or ISP is regularly updated incorporating input from the member and members of the care team, as part of ongoing care management, and that the Care Plan will be comprehensively updated:
 - (1) At minimum every twelve (12) months;
 - (2) When a member's circumstances or needs change significantly;
 - (3) At the member's request; and
 - (4) Within thirty (30) Calendar Days of (re)assessment.
- (h) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP incorporates results of the care management comprehensive assessment (including Unmet Health-Related Resource Needs questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
 - (1) LOCUS and CALOCUS;
 - (2) CANS;
 - (3) ASAM criteria;
 - (4) For Innovations waiver enrollees: SIS®; and
 - (5) For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale
- (i) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP contains, at a minimum:
 - (1) Names and contact information of key providers, care team members, family members and others chosen by the member to be involved in planning and service delivery;
 - (2) Measurable member goals;

- (3) Clinical needs including, but not limited to, any physical health, BH, I/DD-related, TBI-related, or dental needs;
 - (4) Interventions including addressing medication management, including adherence;
 - (5) Intended outcomes of interventions and goals;
 - (6) Social, educational and other services needed by the member;
 - (7) Strategies to increase social interaction, employment and community integration;
 - (8) Emergency/natural disaster/crisis plan;
 - (9) Strategies to mitigate risks to the health, well-being and safety of the members and of others;
 - (10) Information about Advance Directives, including advance instructions for mental health treatment, as appropriate;
 - (11) A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition; and
 - (12) Strategies to improve self-management and planning skills.
- (j) For members with SED, I/DD, or TBI, the care plan or ISP should also include caregiver supports, including connection to respite services, as necessary.
 - (k) For members ages three (3) up to age twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance use services, the BH I/DD Tailored Plan shall ensure:
 - (1) A Child and Family Team member is involved in developing the Care Plan/ISP and facilitating the planning process.
 - (2) The assigned organization providing Tailored Care Management uses the strengths assessment described in *Section V.B.3.ii.(vii)(q)* to build strategies included in the Care Plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the Child and Family Team (CFT). These strategies shall be included in the Care Plan or ISP.
 - (3) The Care Plan or ISP is regularly updated to respond to changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.
 - (l) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management monitors for completion of Care Plan/ISPs and review them for quality control.
 - (m) The BH I/DD Tailored Plan must conduct regular audits of care management comprehensive assessments, Care Plans, and ISPs to ensure they meet quality expectations.
 - (n) The BH I/DD Tailored Plan shall ensure that each Care Plan/ISP is documented and stored and made available to the member and the following representatives within fourteen (14) days of completion of the Care Plan or ISP:
 - (1) Care team members, including the member's PCP, other physical health, BH, I/DD, TBI and LTSS providers;
 - (2) Other providers delivering care to the member;
 - (3) The member's legal representative (as appropriate);
 - (4) The member's caregiver (as appropriate, with consent);
 - (5) Social service providers (as appropriate, with consent); and
 - (6) Other individuals identified and authorized by the member.
 - (o) For specific requirements related to ISPs for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.

- (p) The BH I/DD Tailored Plan shall submit its policies and procedures for Care Plan/ISP development with members as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*). As long as the Care Management and Care Coordination Policy clearly states that it applies to the BH I/DD Tailored Plan, the Care Management and Care Coordination Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (ix) Care Team Formation
- (a) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management establishes a multidisciplinary care team for each member based on the member's needs.
- (b) The BH I/DD Tailored Plan shall ensure that the multidisciplinary care team consists of the following members as applicable depending on member needs:
- (1) The member
 - (2) Caretaker(s)/legal guardians
 - (3) The member's care manager
 - (4) Supervising care manager
 - (5) PCP
 - (6) BH provider(s)
 - (7) I/DD and/or TBI providers
 - (8) Other specialists
 - (9) Nutritionists
 - (10) Pharmacists and pharmacy techs
 - (11) The member's obstetrician/gynecologist
 - (12) Peer support specialist
 - (13) In-reach and/or transition staff
 - (14) Other providers, as determined by the care manager and member
- (c) For members ages three (3) up age to twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance abuse services, the BH I/DD Tailored Plan shall ensure that the CFT is incorporated into the care team.
- (1) The CFT shall be built around the youth and family to meet their unique needs, and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the Care Plan.
 - (2) The CFT shall be convened at least once every thirty (30) days.
- (d) The BH I/DD Tailored Plan shall require timely communication across the care team.
- (x) Ongoing Care Management
- (a) The BH I/DD Tailored Plan shall establish policies and procedures to deliver care to, and coordinate services for, members in accordance with 42 C.F.R. § 438.208 and N.C. Gen. Stat. § 122c-115.4, regardless of risk or need.
- (b) The BH I/DD Tailored Plan shall ensure that each member who is actively engaged in Tailored Care Management receives care management according to their Care Plan or ISP.
- (c) The BH I/DD Tailored Plan shall ensure that care management includes:
- (1) Coordinating and providing referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by either BH I/DD Tailored Plans or NC Medicaid Direct:
 - i. Physical health;
 - ii. BH;
 - iii. I/DD;
 - iv. LTSS;

- v. TBI;
 - vi. Pharmacy;
 - vii. Vision; and
 - viii. Dental.
- (2) Coordinating and providing referral, information and assistance in obtaining and maintaining State-funded Services managed by the BH I/DD Tailored Plan.
 - (3) Coordinating social services provided by community and social providers to address a member's Unmet Health-Related Resource Needs.
 - (4) Coordinating Medicare services for members dually eligible for Medicare and Medicaid.
 - (5) Coordinating with other care management supports for members dually eligible for Medicare and Medicaid.
 - (6) Ensuring that members have scheduled annual physical exams, or well-child visits based on the appropriate age-related frequency.
 - (7) Conducting a care management comprehensive assessment at least every twelve (12) months *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*.
 - (8) Conducting continuous monitoring of progress toward goals identified in the Care Plan or ISP through in-person and collateral contacts with the member and the member's supports, including family, informal, and formal caregivers and routine care team reviews.
 - (9) Conducting medication management, including regular medication reconciliation (conducted by appropriate care team member; a community pharmacist at the CIN level may assume this role, in coordination with the AMH+ or CMA) and support of medication adherence.
 - (10) Supporting the member's adherence to prescribed treatment regimens and wellness activities.
 - (11) Communicating and consulting with other providers and the Member and the member's supports, including family, informal, and formal caregivers, as appropriate.
 - (12) Following up on referrals.
 - (13) Conducting transitional care management as described in *Section V.B.3.ii.(xi) Transitional Care Management*.
 - (14) Facilitating timely communication across the care team, including case conferencing.
- (d) For children and youth receiving BH services, ongoing care management shall also include:
- (1) Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports.
 - (2) Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self-determination and enhance self-sufficiency.
 - (3) Verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs.
 - (4) Development and implementation of proactive and reactive crisis plans in conjunction with the Care Plan/ISP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT shall be provided a copy of the plan.
 - (5) Use family and youth-friendly tools to document and demonstrate for the youth and family their progress over the course of treatment
- (e) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management provides or arranges for coverage for services, consultation or referral, and

treatment for emergency medical conditions, including, but not limited to, BH crisis, twenty-four (24) hours per day, seven (7) days per week.

- (f) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management has the ability twenty-four (24) hours per day, seven (7) days per week to (1) share information such as Care Plans/ISPs and Advance Directives, and (2) coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- (g) The BH I/DD Tailored Plan shall ensure that Tailored Care Management incorporates individual and family supports including:
 - (1) Training the member in self-management;
 - (2) Providing education and guidance on self-advocacy to the member, family members and support members;
 - (3) Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system;
 - (4) Providing information and connections to needed services and supports including but not limited to self-help services, peer support services and respite services;
 - (5) Providing information to the member, family members and support members about the member's rights, protections and responsibilities, including the right to change providers, the Grievance and complaint resolution process, and fair hearing processes;
 - (6) Health promotion, including promoting wellness and prevention programs (see *Section V.B.3.ix. Prevention and Population Health Programs*);
 - (7) Providing information on establishing Advance Directives, including advance instructions for mental health treatment, as appropriate, and guardianship options/alternatives, as appropriate;
 - (8) Connecting members and family members to resources that support maintaining employment, community integration and success in school, as appropriate;
 - (9) For high-risk pregnant women, inquiring about broader family needs, offering guidance on family planning; and
 - (10) and beginning discussions about the potential for an Infant Plan of Safe Care.
- (h) The BH I/DD Tailored Plan must establish policies and procedures for coordinating with services provided by community and social support providers and submit them as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*). 42 C.F.R. § 438.208(b)(2)(iv).
- (i) The BH I/DD Tailored Plan shall ensure that Tailored Care Management addresses Unmet Health-Related Resource Needs, including at a minimum:
 - (1) Provision of referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including:
 - i. Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers);
 - ii. Food and income supports;
 - iii. Housing;
 - iv. Transportation;
 - v. Employment services;
 - vi. Education;
 - vii. Child welfare services;
 - viii. Domestic violence services;
 - ix. Legal services;
 - x. Services for justice-involved populations; and

- xi. Other services that help individuals achieve their highest level of function and independence.
- (2) Use NCCARE360, to identify community-based resources, and connect members to such resources and track closed-loop referrals. The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management use NCCARE360, including for the following functionalities:
 - i. Act as their community-based organization and social service agency resource repository to identify local community-based resources;
 - ii. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
 - iii. Track closed-loop referrals.
- (3) Provision of comprehensive assistance--available either in-person or electronically, at the member's preference and depending on what is the most efficient, effective, and feasible approach--securing key health-related services, including assistance at initial application and renewal with filling out and submitting applications, and gathering and submitting required documentation, at a minimum to:
 - i. Food and Nutrition Services
 - ii. Temporary Assistance for Needy Families
 - iii. Child Care Subsidy
 - iv. Low Income Energy Assistance Program
 - v. ABLEnow Accounts (for individuals with disabilities)
 - vi. Women, Infants and Children (WIC) Program
 - vii. Other programs managed by the BH I/DD Tailored Plan that address Unmet Health-Related Resource Needs
- (4) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit its policies for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.
- (j) The BH I/DD Tailored Plan shall ensure that a member has a post-partum visit with a physician within fifty-six (56) days of delivery to assess for signs of postpartum depression. Postpartum care is further described in the *Obstetrics Clinical Coverage Policy 1E-5*.
- (k) The Department will establish a standardized methodology to assign each member to a Tailored Care Management acuity tier (e.g., high, medium, low) and will release additional detail on the methodology prior to BH I/DD Tailored Plan Contract Year 1.
 - (1) The BH I/DD Tailored Plan shall use the acuity tiers to guide the intensity of Tailored Care Management for each member according to minimum contact requirements as described in *Section V.B.3.ii.(x) Ongoing Care Management*.
 - (2) The BH I/DD Tailored Plan shall use the acuity tiers to determine payment for Tailored Care Management as described in *Section V.B.4.iv. Provider Payments*.
- (l) The BH I/DD Tailored Plan must ensure that the assigned organization providing Tailored Care Management meet the minimum contact requirements for members according to their acuity tier as outlined below, unless the member expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP and reviewed with the supervising care manager, or if the member is enrolled in the Innovations waiver (as described in *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver*). Contacts may be delivered by the care manager or staff supervised by the care manager, including but not limited to peer support specialists. The Department intends to release additional guidance on meeting contact requirements. In-person contact

requirements must be met as described below. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing, If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The Department intends to release additional guidance on circumstances in which a member's acuity tier may change.

- (1) Care manager contacts for members with BH needs
 - i. High Acuity: At least four (4) care manager-to-member contacts per month, including at least one (1) in-person contact with the member
 - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
 - iii. Low Acuity: At least two (2) care manager-to-member contacts per month and at least two (2) in-person contacts member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person)
- (2) Care manager contacts for members with an I/DD or TBI
 - i. High Acuity: At least three (3) care manager-to-member contacts per month, including at least two (2) in-person contacts
 - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
 - iii. Low Acuity: At least one (1) telephonic or two-way real time video and audio conferencing, contact per month and at least two (2) in-person care manager-to-member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).
- (3) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate.
- (4) For members with I/DD or TBI who have a guardian, telephonic or two-way real time video and audio conferencing contact may be with a guardian in lieu of the member, where appropriate or necessary. In-person contacts must involve the member.
- (m) The BH I/DD Tailored Plan shall ensure that in-person contacts occur at a location, date and time convenient to the member and their chosen participants.
- (n) For specific requirements for ongoing care management related to Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver.*
- (xi) Transitional Care Management
 - (a) Regardless of the organization providing Tailored Care Management, the BH I/DD Tailored Plan shall oversee care transitions for all members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i) and in addition to the requirements in this Section.
 - (b) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.

- (c) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management carry out the following transitional care management functions.
- (1) Ensure that a care manager is assigned to manage the transition.
 - (2) Have a care manager assume coordination responsibility for transition planning.
 - (3) Have a care manager or care team member visit the member during their stay in an institution (e.g., acute, subacute and long-term stay facilities) and be present on the day of discharge.
 - (4) Conduct outreach to the member's providers.
 - (5) Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff.
 - (6) Facilitate clinical handoffs.
 - (7) Refer and assist members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.
 - (8) Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.
 - (9) Develop a ninety (90) day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff and the member's care team, that outlines how the member will maintain or access needed services and supports, transition to the new care setting, and integrate into their community.
 - i. The ninety (90) day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP
 - ii. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) day post-discharge transition plan.
 - iii. The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
 - iv. Development of a ninety (90) day post-discharge transition plan is *not* required for all ED visits, but may be developed according to the care manager's discretion.
 - v. The assigned organization providing Tailored Care Management shall communicate with and provide education to the member and the member's caregivers and providers to promote understanding of the ninety (90) day post-discharge transition plan.
 - (10) Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.
 - (11) Ensure that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.
 - (12) Arrange to visit the member in the new care setting after discharge/transition.
 - (13) Conduct a care management comprehensive assessment within thirty (30) days of the discharge/transition or update the current assessment.
 - (14) Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) days of the discharge/transition based on the results of the care management comprehensive assessment.
- (d) The BH I/DD Tailored Plan must ensure that for individuals with I/DD or TBI, the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following "life transitions":

- (1) Instances where a member is transitioning out of school-related services;
 - (2) Instances where a member experiences life changes such as employment, retirement or other life events;
 - (3) Instances where a member has experienced the loss of a primary caregiver or a change of primary caregiver; and
 - (4) Instances where a member is transitioning out of foster care.
- (e) The BH I/DD Tailored Plan shall submit its policies and procedures for transitional care management, including the approach to working with members with LTSS needs, as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*),
- (xii) Diversion from Institutional Settings
- (a) The BH I/DD Tailored Plan shall ensure that members are identified who are at risk of requiring care in an institutional setting or ACH are provided diversion interventions as described below. The BH I/DD Tailored Plan shall ensure that diversion activities, including identification of eligible members, are the responsibility of the assigned organization providing Tailored Care Management (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*). In the event that a member who is not actively engaged in Tailored Care Management is eligible for diversion, the BH I/DD Tailored Plan shall conduct outreach to engage the member in Tailored Care Management and conduct diversion activities.
 - (1) The BH I/DD Tailored Plan must ensure that the assigned organization providing Tailored Care Management consults with BH I/DD Tailored Plan-based medical staff or medical staff based at the organization providing Tailored Care Management to assess the medical needs of the member receiving diversion services.
 - (b) Eligibility for Diversion
 - (1) Members eligible for diversion activities include those meeting the following criteria:
 - i. Have transitioned from an institutional or correctional setting, or an ACH for adult members, within the previous six (6) months; or
 - ii. Are seeking entry into an institutional setting or ACH; or
 - iii. Meet one of the following additional criteria for members with I/DD or TBI:
 - a) Member has an aging caregiver who may be unable to provide the recipient their required interventions; or
 - b) Member's caregiver is in fragile health, which may include but is not limited to member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); or
 - c) Member with two parents or guardians if one of those parents/guardians dies; or
 - d) Any other indications that a member's caregiver may be unable to provide the member their required interventions; or
 - e) Member is a child or youth with complex BH needs.
 - (c) Diversion Activities
 - (1) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*) performs the following diversion activities in a timely manner:
 - i. Screen and assess the member for eligibility for community-based services.
 - ii. Educate the member on the choice to remain in the community and the services that would be available to support that decision.
 - iii. Facilitate referral and linkages to community-based and other support services for assistance.

- iv. Determine if the member is eligible for supportive housing, if needed.
 - v. For those who choose to remain in the community:
 - a) Develop a Community Integration Plan (CIP) that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.
 - b) Integrate the member's CIP as an addendum in the member's Care Plan or ISP.
 - c) For members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.
 - (2) The BH I/DD Tailored Plan shall ensure all diversion activities are documented and stored and made available to the Department for review upon request.
- (xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver
- (a) Tailored Care Management shall incorporate all Innovations or TBI Waiver care coordination activities, as required in the applicable 1915(c) waivers.
 - (b) The BH I/DD Tailored Plan shall auto-enroll new members who obtain an Innovations or TBI waiver slot after BH I/DD Tailored Plan launch into Tailored Care Management if they are not already enrolled in Tailored Care Management. The BH I/DD Tailored Plan shall send new waiver enrollees information about Tailored Care Management and the option to opt out with the materials informing them of their waiver slot.
 - (c) The BH I/DD Tailored Plan must auto-enroll all current Innovations/TBI waiver enrollees in Tailored Care Management.
 - (1) Innovations/TBI waiver enrollees may opt out of Tailored Care Management.
 - (2) Innovations/TBI waiver enrollees who have opted out of Tailored Care Management shall still receive care coordination as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members* and Innovations and TBI waiver care coordination as described in *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver*.
 - (d) For members who were enrolled in the Innovations or TBI waiver prior to BH I/DD Tailored Plan launch and engage in Tailored Care Management:
 - (1) If the member's ISP annual update is in the first six (6) months of Year 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment prior to completing the ISP.
 - (2) If the member's annual update is in the second half of Year 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment according to the timeframes described in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*. The BH I/DD Tailored Plan shall ensure that the organization providing Tailored Care Management completes the care management comprehensive assessment prior to the annual update, and in subsequent years, aligns the timing of the reassessment with the ISP annual update.
 - (3) The ISP developed prior to BH I/DD Tailored Plan launch will continue to serve as the ISP under Tailored Care Management in Year 1 of BH I/DD Tailored Plan operation, until updated.
 - (4) The BH I/DD Tailored Plan must ensure that the ISP is aligned with Tailored Care Management requirements at the member's next annual update (during the month before the individual's birth month), after a triggering event or at the member's request.

- (5) Prior to the annual update, the member's care management comprehensive assessment results may be used to amend the ISP if appropriate, but a full update is not required.
 - (e) If the member is enrolled in the Innovations or TBI waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall adhere to, whichever is higher in frequency and modality (e.g. number of in-person contacts):
 - (1) The contact requirements found in the 1915(c) waiver, or
 - (2) The contacts noted in *Section V.B.3.ii.(x) Ongoing Care Management*.
 - (f) For Innovations waiver enrollees, the BH I/DD Tailored Plan shall ensure that results of the SIS® are shared with the member's care manager in an electronic format to aid completion of the care management comprehensive assessment.
- (xiv) Staffing and Training Requirements
- (a) The BH I/DD Tailored Plan shall ensure that each care manager across AMH+ practices, CMAs and the BH I/DD Tailored Plan is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers.
 - (1) Supervisors cannot have a caseload but will provide coverage for vacation and sick leave. They will be responsible for ensuring that all Care Plans/ISPs are complete, reviewing them for quality control, and providing guidance to care managers on how to meet members' needs.
 - (b) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management has access to clinical consultants to provide subject matter expert advice to the care team. The clinical consultants will not be part of the care team for any given member.
 - (1) The AMH+ practice or CMA may employ or contract with consultants or do so through a CIN or Other Partner.
 - (2) The consultants should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.
 - (3) The following consultants must be available:
 - i. An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served):
 - ii. A neuropsychologist or psychologist: and
 - iii. A primary care physician appropriate for the population being served, to the extent the member's PCP is not available for consultation.
 - (c) Care Management Staff Qualifications
 - (1) The BH I/DD Tailored Plan shall ensure that all care management staff providing Tailored Care Management to members have the following minimum qualifications:
 - i. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
 - a) If serving members with BH needs, the care manager must have two (2) years of experience working directly with individuals with BH conditions.
 - b) If serving members with an I/DD or TBI, the care manager must have two (2) years of experience working directly with individuals with I/DD or TBI.
 - c) If serving members with LTSS needs, the care manager shall meet 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.

- d) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine the appropriate care manager assignment.
- (2) The BH I/DD Tailored Plan shall ensure that all supervising care managers overseeing care managers performing Tailored Care Management have the following minimum qualifications:
- i. For members with BH conditions:
 - a) 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 an RN, and
 - b) Three (3) years of experience providing care management, case management, or care coordination to the population being served
 - ii. For members with an I/DD or TBI, have one (1) of the following minimum qualifications:
 - a) 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
 - b) A Master’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 three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI
 - iii. If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall ensure that the supervising care manager is qualified to oversee the member’s care manager.
 - iv. The Department will grant a one-time staff exception (‘grandfathering’) for specified BH I/DD Tailored Plan staff that:
 - a) Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan contract award (July 26, 2021)
 - b) This exception is based on the staff member possessing the required number of years of experience, but not the required degree, degree type or licensure type.
- (d) The BH I/DD Tailored Plan shall ensure all care managers and supervising care managers serving its members, whether based at the BH I/DD Tailored Plan, AMH+ or CMA, are trained on all the topics described in this Section.
- (e) The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes the following domains at a minimum in addition to any training requirements specified in N.C. General Statute § 122c-115.4:
- (1) BH I/DD Tailored Plan eligibility and services
 - i. BH I/DD Tailored Plan eligibility criteria, services available through BH I/DD Tailored Plans, and differences between Standard Plan and BH I/DD Tailored Plan benefit packages
 - ii. Principles of integrated and coordinated physical and BH care and I/DD and TBI services
 - iii. BH crisis response
 - iv. Knowledge of Innovations and TBI waiver eligibility criteria
 - (2) Whole-person health and unmet resource needs
 - i. Understanding and addressing ACEs, trauma, and trauma-informed care

- ii. Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the member navigate available social supports and resources at the member’s local level
 - iii. Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect BH I/DD Tailored Plan members
- (3) Community integration
- i. Independent living skills
 - ii. Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities
 - iii. Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community
 - iv. Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration
- (4) Components of Health Home care management
- i. Health Home overview, including but not limited to Health Homes’ purpose, target population, and services, in addition to members and their families’ role in care planning
 - ii. Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas and facilitating meetings
- (5) Health promotion
- i. Common physical comorbidities of BH I/DD Tailored Plan populations
 - ii. Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease)
 - iii. Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children,
 - iv. Standard of care tobacco treatment, including both counseling and FDA approved tobacco treatment medications
 - v. Self-management and self-help recovery resources (including substance use recovery)
 - vi. Brief tobacco use intervention and referral to treatment roles and responsibilities for medication management
 - vii. Use of IT in care management comprehensive assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360
- (6) Other care management skills
- i. Transitional care management best practices
 - ii. Supporting health behavior change, including motivational interviewing
 - iii. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs
 - iv. Preparing members for and assisting them during emergencies and natural disasters
 - v. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings.

- vi. General understanding of virtual (e.g., Telehealth) applications in order to assist members in using the tools
 - vii. Understanding needs of the justice-involved population
 - viii. Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible members, such as PACE
- (7) Additional trainings for care managers and supervisors serving members with I/DD or TBI
- i. Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers
 - ii. Understanding HCBS, related planning, and 1915(c) services and requirements
 - iii. Accessing and using assistive technologies to support individuals with I/DD and TBI
 - iv. Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services
 - v. Educating members with I/DD and TBI about consenting to physical contact and sex
- (8) Additional trainings for care managers and supervisors serving children
- i. Child- and family-centered teams
 - ii. Understanding of the "System of Care" approach (see *Section V.B.3.vii. System of Care*), including knowledge of child welfare, school, and juvenile justice systems
 - iii. Methods for effectively coordinating with school-related programming and transition-planning activities
- (9) Additional training for care managers and supervisors serving the children with complex needs
- i. Specialized training in addressing co-occurring mental health disorders and I/DDs
- (10) Additional trainings for care managers and supervisors serving pregnant and postpartum women with SUD or with SUD history
- i. Best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal.
- (11) Additional trainings for care managers and supervisors serving members with LTSS needs
- i. Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission.
- (12) Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children;
- (13) Services available from the Quitline benefit, as well as the evidence-based tobacco use treatment brief intervention known as the 5As. 5As training covers screening, brief interventions, and referral to treatment for tobacco use disorder, and covers the standard of care for tobacco treatment (a combination of counseling and FDA approved tobacco treatment medications); and
- (14) The State "System of Care" training curriculum (for care managers with assigned Members age three (3) up to age eighteen (18) with BH needs).
- (f) As a best practice, the BH I/DD Tailored Plan may collaborate with other BH I/DD Tailored Plans and any Tailored Care Management organization it sees appropriate on Tailored Care Management curriculum development.

- (g) The BH I/DD Tailored Plan shall allow care managers and supervisors, regardless of the organization in which they provide care management, to waive components of the required training if the care manager or supervisor can verify that they have previously completed and demonstrated competency in a specific training domain.
 - (1) The BH I/DD Tailored Plan must document and get approval for their approach to waiving components of the required training in their Care Management Policy. (*Section V.B.3.vi. Care Management Policy*).
- (h) The BH I/DD Tailored Plan must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.
- (i) The BH I/DD Tailored Plan shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.
- (j) The BH I/DD Tailored Plan shall identify core modules that care managers must complete before being deployed to serve members; care managers must complete the remaining training modules within thirty (30) days of being deployed to serve members.
- (k) Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.
- (l) The BH I/DD Tailored Plan shall provide training to its Network providers about Tailored Care Management.
- (m) The BH I/DD Tailored Plan shall not require care managers and supervisors working in multiple BH I/DD Tailored Plan regions to complete and pass each required domain of the Tailored Care Management training curriculum more than once. Care managers and supervisors should complete and pass the training in the region where they serve the most members.
 - (1) The BH I/DD Tailored Plan may require care managers and supervisors to complete additional training, beyond the required domains, specific to their region or the populations they serve.
- (n) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit to the Department its Tailored Care Management training plan for approval:
 - (1) Policies and procedures for training and qualification of care managers and other multidisciplinary team members;
 - (2) Training modalities (e.g., in-person versus online);
 - (3) Approach to tracking and verifying that care managers have completed trainings;
 - (4) Process for addressing noncompliance with trainings;
 - (5) Timing/frequency of trainings;
 - (6) Summary of curriculum;
 - (7) Approach for assessing competencies;
 - (8) Approach for annual refreshers and ongoing continuing education; and
 - (9) Approach for waiving specific training domains for care managers and supervisors.
- (xv) Data System Requirements, Data Sharing, and Risk Stratification
 - (a) Tailored Care Management Data System Requirements
 - (1) The BH I/DD Tailored Plan shall have a sophisticated IT infrastructure and data analytic capabilities to support the care management requirements of this Contract, including the capabilities to:
 - i. Consume and use physical health, BH, I/DD and TBI claims, pharmacy and encounter data, clinical data, ADT data, risk stratification information and/or Unmet Health-Related Resource Needs data; and
 - ii. Share and transmit data with AMH+ practices and CMAs.

- (2) The BH I/DD Tailored Plan shall have a single care management data system across Medicaid and State-funded Services.
 - (3) The BH I/DD Tailored Plan shall ensure all organizations providing Tailored Care Management have care management data systems that have the ability to:
 - i. Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers.
 - ii. Electronically document and store the care management comprehensive assessment and re-assessment.
 - iii. Electronically document and store Care Plans and ISPs.
 - iv. Consume claims and encounter data.
 - v. Provide role-based access to members of the multidisciplinary care team.
 - vi. Electronically and share the care management comprehensive assessment, Care Plan or ISP and reports/summaries of care to each member of the multidisciplinary care team to support case conferences. These documents can be made available using a member/provider portal.
 - vii. Track care management encounters electronically, including date and time of each attempted encounter, method of attempt (in-person, telephonic), personnel involved, and whether the attempt was successful
 - viii. Track referrals.
 - ix. Allow care managers to:
 - a) Identify risk factors for individual members;
 - b) Develop actionable Care Plans and ISPs;
 - c) Monitor and quickly respond to changes in a member's health status;
 - d) Track a beneficiary's referrals and provide alerts where care gaps occur;
 - e) Monitor a beneficiary's medication adherence;
 - f) Transmit and share reports and summary of care records with care team members; and
 - g) Support data analytics and performance.
 - x. Helping schedule and prepare members (via, e.g., reminders and transportation) for appointments
 - xi. The BH I/DD Tailored Plan shall submit a description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (b) Data Sharing in Support of Tailored Care Management
- (1) The BH I/DD Tailored Plan shall provide data to AMH+ practices and CMAs to support Tailored Care Management. The BH I/DD Tailored Plan shall follow DHHS requirements for data sharing outlined in the AMH+ and CMA Program Technical & Data Requirements document. This document will be posted in the PCDU.
 - (2) Reserved.
 - (3) In cases where the Department establishes additional a standard file formats for data-sharing reports, the BH I/DD Tailored Plan shall utilize the file format, timing, and frequency specified by the Department.
 - (4) To support care management activities, the BH I/DD Tailored Plan shall provide the following information to all AMH+ practices, CMAs, and CINs or Other Partners in a format that may be specified by the Department for the members assigned to them for Tailored Care Management:
 - i. Beneficiary Assignment Information as indicated above

- a) Acuity tiering and risk stratification using the DHHS specific format and frequency
 - ii. Reserved.
 - iii. Quality measure performance information at the practice level
 - a) The BH I/DD Tailored Plan shall provide quality scoring results on both an annual and an interim basis as specified by the Department, and in a format to be defined by the Department. These will include:
 - 1) Practice-specific numerators and denominators for each measure.
 - 2) An exhibit comparing the practice's performance on each measure to its contracted benchmarks, and to the performance of other practices contracting with the BH I/DD Tailored Plan.
 - 3) Practice-specific gap reports identifying members who are in the measure denominator but do not meet numerator criteria.
 - 4) Sufficient information on lags in encounter data, member (re) assignment, and other elements contributing to data quality that the practice can interpret the completeness and timeliness of the data included in the performance report.
 - iv. Historical & Current Claims and Encounter Data
 - a) Data flows from the BH I/DD Tailored Plan to AMH+ practices, CMAs, and CINs or Other Partners shall include only members assigned to the receiving practices or groups of practices.
- (5) The BH I/DD Tailored Plan shall also provide other available data or information that may be used to support Tailored Care Management (e.g., previously established care plans, historical member clinical information, ADT data) to all AMH+ practices and CMAs in a format agreed to by the BH I/DD Tailored Plan and AMH+ or CMA.
- (6) The BH I/DD Tailored Plan shall consume, integrate, and use available Medicare data to advance the whole-person care management activities and functions for members who are Dually-Eligible for Medicare and Medicaid as described in this Contract to the extent possible and applicable.
- (7) The BH I/DD Tailored Plan shall participate in a Department-led advisory committee addressing data sharing and infrastructure to support Tailored Care Management.
- (8) The BH I/DD Tailored Plan shall adopt standardized data-sharing formats and protocols as they are developed by the Advisory Committee.
- (9) The BH I/DD Tailored Plan shall develop a strategy to share data with members, in a format that is secure, takes into account varying levels of health literacy and promotes member engagement in care.
- (10) The BH I/DD Tailored Plan shall setup an onboarding process for AMH+ and CMA practices. The BH I/DD Tailored Plans shall provide technical assistance to the AMH+ and CMA practices on the technical requirements needed to develop all the data interfaces specified in the AMH+ & CMA data sharing requirements. The BH I/DD Tailored Plan will work with the AMH+ and CMA practices to guide the AMH+ and CMA practices through the development phase, share any test files and perform integration testing prior to start sharing and receiving production data with the AMH+ and CMA practices.
- (c) Risk Stratification
 - (1) As part of its approach to population health management, the BH I/DD Tailored Plan may choose to establish a risk stratification methodology in addition to the Department's acuity tiering methodology. Any such methodology may be used to support Tailored Care Management assignment and segmentation of the population to target interventions to

the right members at the right time (for example, to prioritize completion of care management comprehensive assessments across the population).

(2) If the BH I/DD Tailored Plan adopts its own risk stratification methodology in addition to acuity tiering, the Department recommends the methodology consider the following information:

- i. Acuity tier
- ii. Claims history
- iii. Claims analysis
- iv. Pharmacy data
- v. Risk factor assessment including assessment of tobacco use
- vi. Immunizations
- vii. Lab results
- viii. Admission, Discharge, Transfer (ADT) feed information
- ix. Provider referrals
- x. Member or caretaker self-referral
- xi. Referrals from social services
- xii. Member's zip code
- xiii. Member's race and ethnicity
- xiv. Administrative data to identify risk for:
 - a) Overutilization of physical and BH services
 - b) Adverse events
 - c) High costs of care
- xv. Results/scores of level-of-care determination and screening tools e.g., LOCUS, CALOCUS, ASAM, CANS, Rancho *Los Amigos* Levels of Cognitive Functioning Scale, and SIS[®] (to the extent available) and other tools, as recommended by the Department
- xvi. Results of the care management comprehensive assessment (to the extent available)
- xvii. Unmet Health-Related Resource Needs

(3) If the BH I/DD Tailored Plan adopts its own risk stratification methodology in addition to acuity tiering, as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit its risk stratification methodology.

(d) ADT Feeds for Organizations Providing Tailored Care Management

(1) As part of transitional care management, the BH I/DD Tailored Plan shall ensure that there is a systematic, clinically appropriate process with designated staffing for care managers responding to certain high-risk ADT alerts, including:

- i. Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up;
- ii. Same-day or next-day outreach for designated high-risk subsets of the population; and
- iii. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge).

(xvi) Tailored Care Management Payments

(a) The BH I/DD Tailored Plan shall make payments for Tailored Care Management according to the requirements in *Section V.B.4.iv. Provider Payments*.

(xvii) Technical Assistance to AMH+ Practices and CMAs

- (a) The BH I/DD Tailored Plan shall provide ongoing technical assistance to practices going through the certification process and already certified AMH+ practices and CMAs to enable them to become high-performing providers of Tailored Care Management.
 - (1) Areas of technical assistance shall include, but are not limited to, health IT and data analytics capabilities to support the Department's vision for Tailored Care Management; population health; quality measurement and performance; and integration of physical health, behavioral health, and I/DD services for care management purposes.
 - (2) The BH I/DD Tailored Plan shall submit a description of its approach for providing technical assistance as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (xviii) Certification of AMH+ Practices and CMAs
 - (a) The Department will implement a direct process to certify provider organizations to deliver provider-based Care Management under this model as AMH+ practices or CMAs, further described in *Section VII. First Revised and Restated Attachment M.3. AMH+ Practice and CMA Certification Policy* and <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd-tailored-plan>.
 - (b) Reserved.
 - (c) As stated above in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*, the BH I/DD Tailored Plan shall offer a contract for Tailored Care Management to all certified AMH+ practices and CMAs operating in its Region. For Contract Year 1, the Department will be responsible for providing BH I/DD Tailored Plans with the list of certified providers in each Region. The only permitted exceptions to this contracting requirement are the following:
 - (1) The AMH+ practice or CMA notifies the Department that it elects to withdraw from certification. The Department will provide guidance to providers for how to give such notification.
 - (2) During Readiness Review, if the BH I/DD Tailored Plan determines that the AMH+ practice or CMA (or CIN or Other Partner on behalf of such organizations) is not ready to meet the requirements of the Tailored Care Management model. In this situation, the BH I/DD Tailored Plan shall provide reasons to the Department why it proposes to decline to contract with that AMH+ practice, CMA or CIN or Other Partner, inclusive of technical assistance provided and why the AMH+ practice, CMA or CIN or Other Partner is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation, if it deems the BH I/DD Tailored Plan's reasons for not contracting to be unsatisfactory.
 - (3) After BH I/DD Tailored Plan launch, if the BH I/DD Tailored Plan finds the AMH+ practice or CMA to be out of compliance with the requirements of the Tailored Care Management model, then the BH I/DD Tailored Plan follows its documented process, as described in *Section V.B.3.ii.(xix) Oversight* to terminate the contract with the AMH+ practice or CMA.
 - (d) AMH practices other than those certified as AMH+ practices are not required to meet the Tailored Care Management requirements within this Section; however, in their capacity as assigned PCPs for BH I/DD Tailored Plan members, they shall meet the requirements for AMH practices contained in *Section VII. First Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members*.
 - (e) The BH I/DD Tailored Plan shall submit its policies and procedures for certification and recertification of AMH+ practices and CMAs as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

(xix) Oversight

- (a) The BH I/DD Tailored Plan shall ensure that all requirements included in this Section are met, regardless of whether Tailored Care Management is provided by the BH I/DD Tailored Plan, an AMH+ practice, or a CMA.
- (b) The Department shall permit but not require, AMH+ practices and CMAs to work with CINs or Other Partners to meet the requirements to provide Tailored Care Management.
 - (1) Subsidiaries of LME/MCOs, BH I/DD Tailored Plans, or other health plans generally may not be considered CINs or Other Partners for the purposes of Tailored Care Management, with one exception as follows:
 - i. The Department recognizes that AMH+ practices and CMAs may decide to enter into arrangements with BH I/DD Tailored Plans for use of their IT products or care management data systems, to meet the care management data system requirements. In this scenario, the BH I/DD Tailored Plan would be considered an “Other Partner” (not a CIN) for HIT support only.
 - (2) To the extent that a CIN or Other Partner contracts with the BH I/DD Tailored Plan on behalf of an AMH+ practice or CMA, the BH I/DD Tailored Plan must conduct oversight of the CIN or Other Partner.
 - (3) To the extent an AMH+ or CMA contracts with a CIN or Other Partner, the requirements and capabilities applicable to AMH+ and CMA apply to the CIN or Other Partner.
- (c) The BH I/DD Tailored Plan must create separate departments for UM and Care Management, overseen by separate leadership.
- (d) The BH I/DD Tailored Plan must ensure that no care managers (whether employed by the BH I/DD Tailored Plan, an AMH+ practice, or a CMA) are related by blood or marriage or financially responsible for any of the members to whom they are assigned or have any legal power to make financial or health-related decisions for any of their assigned members.
- (e) As part of its UM process, the BH I/DD Tailored Plan must review the utilization patterns of all members receiving Tailored Care Management (whether from the BH I/DD Tailored Plan, an AMH+ practice or a CMA).
 - (1) This UM review must assess whether any patterns exist that suggest that care managers have steered members toward or away from particular providers (e.g., toward the organization that employs the care manager or away from a competitor).
 - (2) As part of its standard UM responsibilities, the BH I/DD Tailored Plan must assess whether members are receiving the appropriate level of care corresponding to their clinical information as described in *Section V.B.2.i.(v)(b) UM Program Policy*.
- (f) For Innovations and TBI waiver members engaged in Tailored Care Management, the BH I/DD Tailored Plan must ensure compliance with federal requirements for conflict-free case management for members enrolled in a 1915(c) waiver as described further in *Section V.B.3ii.(v) Tailored Care Management Assignment*. 42 C.F.R. § 431.301(c)(1)(vi)
 - (1) The BH I/DD Tailored Plan shall submit its policies and procedures for ensuring conflict-free care management as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (g) Duplication of Care Management
 - (1) The BH I/DD Tailored Plan shall ensure that a member does not receive duplicative care management services and Providers do not receive payment for duplicative services.
 - (2) The Department has determined that case management provided through ACT and ICF-IIDs and care management provided through the High-Fidelity Wraparound program are duplicative of Tailored Care Management.

- (3) When a member is receiving a service besides one listed in *Section V.B.3.ii.(iii)(a)* that has potential for duplication with Tailored Care Management, the BH I/DD Tailored Plan and the provider of the duplicative service must explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
 - (4) If a Member enrolls in a duplicative services, the BH I/DD Tailored Plan must deny claims submitted by Providers for Tailored Care Management.
 - (5) The BH I/DD Tailored Plan shall submit its policies and procedures for ensuring members do not receive duplicative care management from multiple sources as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (h) The BH I/DD Tailored Plan shall hold each AMH+ and CMA accountable to all elements of the Tailored Care Management model contained in this Contract and associated guidance, by ensuring that all details are reflected in its contract with each AMH+ and CMA. Contract templates governing contracts between BH I/DD Tailored Plans and AMH+ practices and CMAs (or CINs or Other Partners on their behalf), including all sections and attachments of such contracts, shall be approved by the Department.
- (1) The BH I/DD Tailored Plan may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based on Department review and approval.
- (i) The BH I/DD Tailored Plan shall monitor AMH+ practices and CMAs' performance against requirements contained in this contract as reflected in their contracts with AMH+ practices and CMAs. Any contract terms additional to the requirement in this contract that the BH I/DD Tailored Plan seeks to offer to AMH+ practices and CMAs must be approved by the Department as part of contract review.
- (j) If the BH I/DD Tailored Plan contracts directly with a CIN or Other Partner that is acting on behalf of an AMH+ practice or CMA, the BH I/DD Tailored Plan shall monitor the CIN or Other Partner directly.
- (k) The BH I/DD Tailored Plan shall not require an AMH+ practice, CMA, or CIN or Other Partner to undergo a pre-delegation audit for the purposes of NCQA accreditation, although a delegation arrangement may be entered by mutual agreement. While the Department encourages BH I/DD Tailored Plans to align oversight of Tailored Care Management with oversight of NCQA-delegated functions, the BH I/DD Tailored Plan must ensure that in conducting oversight of AMH+ practices, CMAs and CINs or Other Partners that are delegates for NCQA plan-level functions, it is monitoring not only in terms of NCQA requirements but also Tailored Care Management-specific requirements contained in this RFA and the Tailored Care Management Provider Manual <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd-tailored-plan> .
- (l) To promote AMH+ practices and CMAs' ability to make informed decisions about CIN or Other Partner affiliations, the BH I/DD Tailored Plan must:
- (1) Send direct notification to each AMH+ practice or CMA practice describing the CIN or Other Partner oversight process, within ninety (90) days of contracting with the AMH+ practice or CMA.
 - (2) Send direct notification to each AMH+ practice or CMA practice affiliated with a CIN or Other Partner the results of CIN or Other Partner level audits, including CAPs or similar processes as described below, within sixty (60) days of the audit.
- (m) The BH I/DD Tailored Plan shall not terminate its contract with an AMH+, CMA or CIN or Other Partner under this provision until at least ninety (90) Calendar Days after BH I/DD Tailored Plan launch. Notwithstanding the foregoing, the BH I/DD Tailored Plan may immediately terminate

the contract with an AMH+, CMA, or CIN or Other Partner if it determines, in its sole discretion, of fraud, waste, or abuse involving the subcontractor or such subcontractor's continued provision of services under this Agreement creates an imminent harm to members.

- (n) In the event of underperformance by an AMH+ practice, CMA or CIN or Other Partner relative to the requirements for Tailored Care Management contained in this Section:
 - (1) The BH I/DD Tailored Plan shall send a notice of underperformance to the AMH+ practice/CMA within fourteen (14) Calendar Days of identifying the underperformance, with a copy to the Department.
 - (2) The BH I/DD Tailored Plan shall provide the AMH+ practice, CMA or CIN or Other Partner with the opportunity to remediate any identified issues through a Corrective Action Plan (CAP), and a copy of the CAP shall be sent to the Department.
 - (3) The BH I/DD Tailored Plan shall ensure that a minimum of thirty (30) Calendar Days is provided for remediation of the identified underperformance addressed by the CAP, although the parties may establish longer remediation periods by mutual agreement.
- (o) In the event of continued underperformance by an AMH+ practice, a CMA or a CIN or Other Partner that is not corrected after the time limit set forth on the CAP, and the BH I/DD Tailored Plan terminates its contract with the AMH+ practice, CMA, CIN, or other entity, then the BH I/DD Tailored Plan shall notify the Department within seven (7) Calendar Days that it will no longer be contracting with the AMH+ practice, CMA or CIN or Other Partner for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.
- (p) In the event of underperformance by an AMH+ practice, a CMA or a CIN or Other Partner for Tailored Care Management, the BH I/DD Tailored Plan shall ensure that there are no gaps in care management functions for members assigned to the AMH+ practice or CMA.
- (q) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall have a documented process for how it will oversee AMH+ practices, CMAs and CINs or Other Partners that meet all the requirements above. This process must:
 - (1) Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner.
 - (2) Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance.
 - (3) Describe how, if the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with AMH+ practice, CMA, or CIN or Other Partner, the BH I/DD Tailored Plan would reassign members who were obtaining care management from that organization, taking member preferences into account and using the process described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (4) Describe how, if the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to:
 - i. Provide Tailored Care Management without contracting with a CIN or Other Partner, which would require the AMH+ practice or CMA to enter a direct contract with the BH I/DD Tailored Plan for Tailored Care Management, or
 - ii. Contract with another CIN or Other Partner that in turn will contract with the BH I/DD Tailored Plan.

iii. Care Coordination and Care Transitions for all Members

- (i) The BH I/DD Tailored Plan shall be responsible for care coordination and care transitions for all members in accordance with 42 C.F.R. § 438.208, regardless of whether a member opts out of Tailored Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management.
- (ii) The BH I/DD Tailored Plan shall establish policies and procedures to deliver care to, and coordinate services for, all members in accordance with 42 C.F.R. § 438.208 and N.C. General Statute § 122c-115.4.
- (iii) The BH I/DD Tailored Plan must establish policies and procedures applying to all members to coordinate with services provided by community and social support providers. 42 C.F.R. § 438.208(b)(2)(iv).
- (iv) The BH I/DD Tailored Plan shall employ a sufficient number of dedicated housing specialist(s) with knowledge, expertise and experience to act as advisors on affordable and supportive housing programs for care managers and all members, consistent with the Department’s expectation that BH I/DD Tailored Plans will play an integral role in the State’s supportive housing approach utilizing a Housing First model; community integration initiatives for individuals with mental illness, I/DD and/or substance use disorders; and requirements as outlined in *Section V.A.4. Stakeholder Engagement and Community Partnerships*.
- (v) The BH I/DD Tailored Plan shall provide access to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers.
- (vi) The BH I/DD Tailored Plan shall fulfill responsibilities related to the Pilot Program responsibilities, if operating in a Pilot Region, as outlined in *Section V.B.3.x. Healthy Opportunities*.
- (vii) The BH I/DD Tailored Plan shall perform the following care coordination functions for members who are not participating in Tailored Care Management:
 - (a) For members with identified Unmet Health-Related Resource Needs who are not participating in Tailored Care Management, the BH I/DD Tailored Plan must, subject to member consent:
 - (1) Coordinate services provided by community and social support providers to address members’ Unmet Health-Related Resource Needs.
 - (2) Link members to local community resources and social supports.
 - (3) Monitor and modify approaches (*Section V.B.3.ii.(ii)(a)*), as needed.
 - (b) If a member has opted out of Tailored Care Management or is excluded from Tailored Care Management because of receipt of a duplicative service as described in *Section V.B.3.ii.(iii) Eligibility for Tailored Care Management*, the BH I/DD Tailored Plan must attempt to conduct an initial care needs screening as required by 42 CFR 438.208(b)(3).
 - (c) The BH I/DD Tailored Plan shall conduct a care needs screening on all members which meets federal requirements found in 42 C.F.R. 438.209(b)(3) based on the following requirements:
 - (1) The BH I/DD Tailored Plan shall undertake best efforts to conduct the care needs screening within ninety (90) Calendar Days of the effective date of a member’s BH I/DD Tailored Plan enrollment. 42 CFR 438.208(b)(3).
 - i. For purposes of care needs screening, “Best effort” is defined as including at least three documented strategic follow-up attempts to contact the member if the first attempt is unsuccessful (e.g., going to the member’s home or working with a known provider to meet the member at an appointment).
 - (2) The BH I/DD Tailored Plan shall establish an evidence-based or evidence-supported tool to conduct the care needs screening. At a minimum, the tool shall identify:
 - i. Chronic health conditions, including chronic pain, defined as pain that typically lasts greater than three (>3) months or past the time of normal tissue healing;
 - ii. Acute health conditions;

- iii. BH needs (inclusive of substance use disorders, mental health needs, and tobacco use disorders);
 - iv. I/DD and/or TBI related needs;
 - v. Risk of requiring LTSS;
 - vi. Detailed medication history—a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies; and
 - vii. Other factors or conditions (e.g., pregnancy) about which the BH I/DD Tailored Plan would need to be aware to arrange available interventions for the member.
- (3) The BH I/DD Tailored Plan shall include the Department’s standardized Heathy Opportunities screening questions to be provided by the Department for use in all care needs screenings, covering four (4) priority domains:
- i. Housing;
 - ii. Food;
 - iii. Transportation; and
 - iv. Interpersonal Violence/Toxic Stress.
- (4) The BH I/DD Tailored Plan must attempt a care needs screening at least annually for enrolled members who have opted out of Tailored Care Management.
- (5) The BH I/DD Tailored Plan shall share results of the Care Needs Screening monthly with Tailored care management entities (AMH+/CMA) using the DHHS approved template.
- (d) The BH I/DD Tailored Plan shall make member referrals to appropriate 1915(c) waiver programs using all information available to it, including member self-referrals.
- (e) The BH I/DD Tailored Plan shall connect members to programs and resources that can assist in securing employment, supported employment (such as through the Individual Placement and Support-Supported Employment (IPS-SE) program), apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.
- (viii) Care Transitions
- (a) The BH I/DD Tailored Plan shall oversee care transitions for all members, including those who opt out of or never engage in Tailored Care Management, who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes. 42 C.F.R. § 438.208(b)(2)(i).
 - (b) The BH I/DD Tailored Plan shall refer and assist all members in accessing needed social services and supports identified as part of the care transitions, including access to housing.
 - (c) The BH I/DD Tailored Plan must ensure that its contracts with institutions in the BH I/DD Tailored Plan provider network (hospitals, residential settings, rehabilitation settings, State Operated Health Care Facilities, ICF-IIDs, other facility-based treatment settings and LTSS providers) establish policies and procedures for care transitions that require the institution to:
 - (1) Permit transition staff (as described further in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*), including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process.
 - (2) Notify the BH I/DD Tailored Plan of member admissions/pending discharges and contact the assigned organization providing Tailored Care Management (if applicable) to integrate the organization into the discharge/transition planning process.
 - (3) Share relevant information (including the member’s current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team members and the member’s care team if applicable.

- (4) Establish relationships with AMH+ practices and CMAs to facilitate care transitions.
 - (d) The BH I/DD Tailored Plan shall develop a methodology for identifying members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:
 - (1) Frequency, duration, and acuity of inpatient, skilled nursing facility (SNF), and LTSS admissions or ED visits
 - (2) Discharges from inpatient, crisis, other facility-based, and residential treatment settings
 - (3) NICU discharges
 - (4) Identification of patients by severity of condition, medications, risk score, Unmet Health-Related Resource Needs and other factors the BH I/DD Tailored Plan may prioritize
 - (e) For members transitioning out of an ACH, a state psychiatric facility, a state developmental center, ICF-IID, PRTF, or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, the BH I/DD Tailored Plan shall also meet the requirements described in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*
 - (ix) The BH I/DD Tailored Plan shall submit its policies and procedures for care coordination and care transitions for all members as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
- (i) In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver.
 - (a) The BH I/DD Tailored Plan shall ensure that Innovations and TBI waiver care coordination services are performed by a care manager meeting the following qualifications:
 - (1) Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area;
 - (2) Two (2) years of experience working directly with individuals with I/DD or TBI; and
 - (3) Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience.
 - (b) The Department will not make a Tailored Care Management payment to the BH I/DD Tailored Plan for members who opt out of Tailored Care Management.
 - (ii) For all members enrolled in the Innovations or TBI waiver, regardless of whether they engage in Tailored Care Management, the BH I/DD Tailored Plan shall ensure that waiver care coordination includes:
 - (a) Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:
 - (1) The BH I/DD Tailored Plan shall ensure that the member's care manager convenes a person-centered planning meeting and completes the ISP. This is done after the member is administered the SIS® and the level of care determination for initial plans of care.
 - (2) If applicable, the BH I/DD Tailored Plan shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall review ISP for waiver compliance, medical necessity, and the member's health and safety needs.
 - (4) The BH I/DD Tailored Plan shall approve or deny the ISP within standard service authorization periods except for in the case of initial plans which must be received within sixty (60) days of level of care determination. In the case where services are needed more immediately, an interim plan of care may be completed so that services may be approved with the full ISP being completed afterwards and within the 60 days of level of care determination.

- (5) The BH I/DD Tailored Plan shall ensure that waiver services begin within forty-five (45) days of ISP approval.
- (b) Monitoring and contact requirements found in the 1915(c) waiver.
- (c) Explaining the individual budgeting tool, the service authorization process and the mechanisms available to the member/legally responsible person (LRP) to modify their budget.
- (d) Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the ISP, including providing a list of available providers and arranging provider interviews.
- (e) Monitoring ISP goals at a minimum frequency based on the target date assigned to each goal.
- (f) Maintaining close contact with the member/LRP (if applicable), providers and other members of the ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
- (g) Informing the member/LRP of the option to participate in individual-directed/family-directed supports.
- (h) Assisting in the appointment of the representative for self-direction, as needed.
- (i) Assessing the employer of record, managing employer and representative, if applicable, to determine the areas of support needed to self-direct services.
- (j) Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the member.
- (k) Completing annual reassessment of the member's level of care.
- (l) Ensuring that the member/LRP completes the Freedom of Choice statement annually.
- (m) Completing the NC Innovations Risk/Support Needs Assessment /TBI Risk/Support Needs Assessment, or other approved assessment, prior to the development of the ISP and updating at least annually or as significant changes occur with the member.
- (n) Providing timely notification to BH I/DD Tailored Plan utilization management of updates to the level of care determination and timely processing of updates to the ISP.
- (o) Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support Plan.
- (p) Monitoring of service delivery to verify that:
 - (1) At least one (1) service is utilized monthly, per Innovations or TBI waiver requirements, with the exception of children under the age of twenty-one (21) with a diagnosis of autism spectrum disorder (ASD) who are actively engaged in a research-based intervention for the treatment of ASD.
 - (2) Services are furnished in accordance with the ISP.
 - (3) Member is offered a choice of waiver service providers.
 - (4) Member has access to services and services meet the member's needs.
 - (5) Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-waiver service needs (medical care) are addressed and documented as appropriate.
 - (6) Services utilized do not exceed authorization.
 - (7) Member is satisfied with the services being rendered.
- (iii) The BH I/DD Tailored Plan shall monitor service utilization to remain within service authorizations.
- (iv) The BH I/DD Tailored Plan shall notify the member's provider and AMH+ practice or CMA, if applicable, of authorization decisions.
- v. Other Care Management Programs
 - (i) Overview

- (a) While Tailored Care Management will be the predominant care management model for the BH I/DD Tailored Plan population, the BH I/DD Tailored Plan must offer additional care management sections targeted towards special populations, as detailed in this Section.
- (ii) Local Health Departments
 - (a) The BH I/DD Tailored Plan shall be required to contract with local health departments (LHDs) during a transitional period that will align with the transitional period established for Standard Plans. Accordingly, in Contract Year 1, the BH I/DD Tailored Plan shall be required to offer a right of first refusal with each LHD in its Region to provide Care Management for High Risk Pregnancy (CMHRP).
 - (b) The BH I/DD Tailored Plan shall work with LHDs for the provision of CMHRP to high-risk pregnant women who are BH I/DD Tailored Plan members as follows:
 - (1) In Contract Year 1, the BH I/DD Tailored Plan shall offer the right of first refusal to each LHD in its Region to provide CMHRP to any members eligible for CMHRP.
 - (2) The BH I/DD Tailored Plan shall identify high-risk pregnancies for referral to CMHRP through one or more of the following mechanisms:
 - i. Standardized risk screening tool conducted by providers
 - ii. Risk stratification by the BH I/DD Tailored Plan
 - iii. Direct referral by providers, members or families.
 - (3) Reserved.
 - (4) In Contract Year 1, the BH I/DD Tailored Plan shall make best efforts to engage members participating in CMHRP into Tailored Care Management and shall assign them to care management according to *Section V.B.3.v. Tailored Care Management Assignment*. Care managers providing Tailored Care Management will address other needs that are not included in the LHD model. A member can receive CMHRP and Tailored Care Management simultaneously.
 - (5) For women enrolled in CMHRP as well as Tailored Care Management simultaneously, the BH I/DD Tailored Plan shall be responsible for ensuring that the assigned organization providing Tailored Care Management coordinates with LHD care managers to ensure all the members' needs are met, pertinent information is shared, and services are not duplicated between the two programs.
 - (6) For all contracts developed with LHDs for CMHRP, the BH I/DD Tailored Plan shall use standard contract language provided by the Department, to ensure that CMHRP services include (but are not limited to):
 - i. Outreach;
 - ii. Motivational interviewing;
 - iii. Development of person-centered Care Plans;
 - iv. Identification of community resources available to meet the specific needs of the population; and
 - v. Referrals to childbirth education, oral health, BH or other needed services reimbursed by Medicaid.
 - (7) The BH I/DD Tailored Plan shall be allowed to incorporate additional standards and contract terms that are mutually agreed upon by the LHD and the BH I/DD Tailored Plan.
 - (8) The BH I/DD Tailored Plan shall incorporate all Department-defined care management practice standards for CMHRP into each of its contracts with LHDs, as noted in *Section VII. Attachment M.4. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members*.
 - (9) At the conclusion of Contract Year 1, the BH I/DD Tailored Plan shall have the option to continue to contract with LHDs for CMHRP; or to include CMHRP services within Tailored

Care Management for members experiencing high risk pregnancy (whether provided by the organization responsible for Tailored Care Management or by another organization under contract with the BH I/DD Tailored Plan).

- (c) In the event of underperformance by an LHD, the BH I/DD Tailored Plan shall follow standard procedures specified by the Department. In the event of continued underperformance by an LHD that is not corrected, the BH I/DD Tailored Plan shall be permitted to terminate the contract with that LHD and the LHD shall have the right to appeal the termination. The BH I/DD Tailored Plan shall notify the Department of underperformance by or contract termination of an LHD. The Department reserves the right to specify the timing and format of this notification.
 - (d) The BH I/DD Tailored Plan must participate in Department-led meetings involving the CMHRP and CMARC programs, including requiring attendance by appropriate clinical and operational leadership at meetings.
 - (e) The BH I/DD Tailored Plan must incorporate new guidance, policy, operational manuals and other program-specific requirements regarding CMARC and CMHRP into BH I/DD Tailored Plan operations and LHD contracts, as applicable, and within Department-specified timelines.
- (iii) Pregnancy Management Program
- (a) Pregnancy Management Program (PMP) in Coordination with Care Management for High-Risk Pregnant Women
 - (1) The BH I/DD Tailored Plan shall be required to participate in Department-led meetings involving the PMP program, including requiring attendance by appropriate clinical and operational leadership at meetings.
 - (2) The BH I/DD Tailored Plan shall be required to incorporate new guidance, policy, operational manuals and other program-specific requirements into BH I/DD Tailored Plan operations and PMP contracts, as applicable, and within Department-specified timelines.
 - (3) The BH I/DD Tailored Plan shall adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by the Department.
 - (4) The BH I/DD Tailored Plan shall be responsible for receiving standardized screening tool results from PMP providers and for arranging enrollment into CMHRP based on referrals by PMP providers.
 - (5) During Contract Year 1, when a high-risk pregnancy is referred to the BH I/DD Tailored Plan by a PMP provider, member, family or another entity, the BH I/DD Tailored Plan shall be responsible for arranging enrollment of the member into CMHRP and shall inform the member's PMP provider that the member has entered the program.
- (iv) HIV Case Management Providers
- (a) The BH I/DD Tailored Plan may contract with existing HIV case management providers, at their discretion.
- (v) High-Fidelity Wraparound
- (a) Overview of High-Fidelity Wraparound
 - (1) The Department recognizes that High-Fidelity Wraparound, an evidence-based intervention targeted toward youth ages three (3) to twenty (20) years old with serious emotional disturbance, has produced cost savings as compared with psychiatric residential treatment facility services and Level III/IV group home services.
 - (2) The Department is committed to expanding access to High-Fidelity Wraparound with the launch of BH I/DD Tailored Plans.
 - (3) If the BH I/DD Tailored Plan offers High-Fidelity Wraparound as an In Lieu of Service, the BH I/DD Tailored shall ensure the following:
 - i. That provider organizations have the opportunity to choose to seek certification to offer High-Fidelity Wraparound to children with serious emotional disturbance who

meet eligibility criteria that will be documented in the Department's forthcoming High-Fidelity Wraparound Policy. Only providers that meet requirements as described in this Section (*Section V.B.3.v.(v)*) may offer High-Fidelity Wraparound.

- ii. That High-Fidelity Wraparound providers meet all data sharing requirements described in *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*.
 - iii. That the High-Fidelity Wraparound program is subject to requirements for facilitating timely communication across the care team as described in *Section V.B.3.ii.(x) Ongoing Care Management*
 - iv. That it has sufficient providers in its Network to meet the needs of members who are eligible for the services, as defined below in *Section V.B.3.v.(v)(b) Eligibility and Assignment to High-Fidelity Wraparound*.
- (b) Eligibility and Assignment to High-Fidelity Wraparound
- (1) Youth ages three (3) through twenty (20) are eligible for High-Fidelity Wraparound if they meet the criteria documented in the Department's High-Fidelity Wraparound Policy.
 - (2) On an ongoing basis, if the BH I/DD Tailored Plan offers High-Fidelity Wraparound as an In Lieu of Service:
 - i. The BH I/DD shall identify members who may meet the High-Fidelity Wraparound eligibility criteria and would benefit from the program. The BH I/DD Tailored Plan shall also accept referrals from Network providers for members who may be eligible for and benefit from High-Fidelity Wraparound.
 - ii. If the BH I/DD Tailored Plan identifies that a member may meet the High-Fidelity Wraparound eligibility criteria, the BH I/DD Tailored Plan shall contact the member and their caretaker/legal guardian (if applicable) to determine interest in High-Fidelity Wraparound.
 - iii. If the member and their caretaker/legal guardian indicate interest in High-Fidelity Wraparound, the BH I/DD Tailored Plan shall determine whether the member meets the High-Fidelity Wraparound eligibility criteria, as specified in the Department's forthcoming High-Fidelity Wraparound Policy.
 - iv. If the BH I/DD Tailored Plan determines that the member meets the High-Fidelity Wraparound eligibility criteria, the BH I/DD Tailored Plan shall refer the member to a provider that offers High-Fidelity Wraparound for Care Management.
 - v. If the member meets the High-Fidelity Wraparound eligibility criteria and elects to participate in the intervention, the member will be transitioned from Tailored Care Management to High-Fidelity Wraparound. The assigned organization providing Tailored Care Management shall facilitate a Warm Handoff to the High-Fidelity Wraparound Team.
 - a) The BH I/DD Tailored Plan shall disenroll the member from Tailored Care Management at the time of the Warm Handoff.
- (c) High-Fidelity Wraparound Services and Fidelity Monitoring
- (1) If the BH I/DD Tailored Plan offers High-Fidelity Wraparound as an In Lieu of Service:
 - i. The BH I/DD Tailored Plan shall ensure that all providers offering High-Fidelity Wraparound meet fidelity requirements, as assessed by the Department's contracted vendor performing fidelity monitoring.
 - ii. The BH I/DD Tailored Plan must ensure that providers offering High-Fidelity Wraparound meet all requirements documented in the Department's High-Fidelity Wraparound Policy, including requirements for staffing, qualifications and training.
- (d) Transitions from High-Fidelity Wraparound

- (1) If the BH I/DD Tailored Plan offers High-Fidelity Wraparound as an In Lieu of Service:
 - i. When a member has completed the High-Fidelity Wraparound intervention, the BH I/DD Tailored Plan must assign the member to an AMH+, a CMA or the BH I/DD Tailored Plan for Tailored Care Management as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*, unless the member opts out of Tailored Care Management. The BH I/DD Tailored Plan must give preference to the provider that delivered High-Fidelity Wraparound if that provider is certified as a CMA and has the capacity to serve that member.
 - ii. The BH I/DD Tailored Plan shall require a Warm Handoff between the High-Fidelity Wraparound team and the assigned organization providing Tailored Care Management.
- (vi) Members Obtaining ACT or Residing in an ICF-IID
 - (a) The BH I/DD Tailored Plan must implement the following protocols for members obtaining ACT or services in an ICF-IID:
 - (1) Ensure that the member receives transitional care management, as described in *Section V.B.3.ii.(xi) Transitional Care Management*, in the first and last months of obtaining ACT.
 - (2) Ensure that the member receives transitional care management, as described in *Section V.B.3.ii.(xi) Transitional Care Management* in the first and last months of obtaining services in an ICF-IID.
 - (3) Deny claims submitted by providers for Tailored Care Management. Suspend enrollment in Tailored Care Management effective the month following initial receipt of ACT or ICF-IID services and report the suspension to the Department. The Department will cease making Tailored Care Management payments to the BH I/DD Tailored Plan for the member, except in the first and last months that the member receives ACT or ICF-IID services.
 - (4) Ensure that when a member begins obtaining ACT or services through an ICF-IID, the member's care manager for Tailored Care Management shares the member's Care Plan/ISP with the ACT or ICF-IID case manager, as lawful.
 - (vii) Coordination with Children's Developmental Service Agencies
 - (a) The BH I/DD Tailored Plan shall coordinate with every Early Intervention (EI) Program Children's Developmental Service Agency (CDSA) in the Region in which it operates.
 - (b) The BH I/DD Tailored Plan shall establish reciprocal information-sharing agreements with CDSAs that reflect parental consent requirements and are compliant with HIPAA and the Family Educational Rights and Privacy Act (FERPA).
 - (c) For children who are actively engaged in Tailored Care Management:
 - (1) The care manager providing Tailored Care Management shall coordinate with the CDSA service coordinator, to the maximum extent possible, to facilitate information sharing and coordination between the BH I/DD Tailored Plan and the CDSAs.
 - (2) For any child ages zero (0) to three (3) identified as receiving EI services through the needs assessment, the organization providing Tailored Care Management shall:
 - i. Incorporate the child's Individualized Family Service Plan (IFSP) into the Care Plan or ISP.
 - ii. Update the child's BH I/DD Tailored Plan Care Plan or ISP to reflect any changes to the IFSP on an ongoing basis.
 - iii. Request that the CDSA service coordinator take part in the child's Tailored Care Management case conferences, upon consent of the parent/legally responsible person.

- iv. Partner with the CDSA service coordinator to identify Unmet Health-Related Resource Needs and connect the family to appropriate social and community-based services, as needed.
- (3) For any child age zero (0) up to age three (3) who is not receiving EI services, but whose developmental assessment demonstrates evidence of developmental delay, the organization providing Tailored Care Management shall provide referral information to the parents for an EI evaluation, facilitate a Warm Handoff to the appropriate CDSA, and follow up on the results of the referral and whether an EI evaluation was conducted.
- (d) The BH I/DD Tailored Plan shall ensure that appropriate staff, such as member services staff and care managers, are generally knowledgeable about EI services and provide referrals to the appropriate local CDSA to assist and consult with enrollees concerning EI services.
- (e) In its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall detail the plan to ensure referral and coordination for all children who receive service coordination through a CDSA during Contract Year 1, or a time otherwise defined by the Department, and annually thereafter.
- (viii) Care Management through the Indian Health Service or EBCI
 - (a) At the request of the Department, the BH I/DD Tailored Plan shall enter into a contract with EBCI to perform care management or other functions for tribal members and IHS-eligibles as prescribed by the Department, in consultation with EBCI.
- vi. Care Management Policy
 - (i) The BH I/DD Tailored Plan shall submit its Care Management Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award. The BH I/DD Tailored Plan must submit an updated version of the Care Management Policy sixty (60) days prior to BH I/DD Tailored Plan launch and at the beginning of each Contract Year.
 - (ii) The Care Management Policy shall include the BH I/DD Tailored Plan's:
 - (a) Plan for supporting development of provider-based Care Management and oversight of Provider-based Care Management (including, but not limited to CAP procedures);
 - (b) Sample Tailored Care Management information for the Member Welcome packet and opt-out form
 - (c) Policies and procedures for Tailored Care Management assignment, including methodology for assigning eligible members, as defined in *Section V.B.3.ii.(iii) Eligibility for Tailored Care Management*, to Tailored Care Management based at an AMH+ practice, a CMA or the BH I/DD Tailored Plan.
 - (d) Policies and procedures for outreach and engagement
 - (e) Process for how members are notified of the name of their assigned care manager and how to contact them.
 - (1) Process for how the care manager is made aware of Grievances and Appeals filed by members or by providers (when providers file an Appeal based on a denial of service).
 - (2) Strategies to outreach to and engage members who are hard to contact/locate (because of, for example, incorrect address information, a missing or incorrect phone number, or homelessness).
 - (3) Strategies that shall be used to document attempted contacts; "robocalls" and automated telephone calls that deliver recorded messages can be part of the outreach strategy, but will not solely be an acceptable form of contacting members.
 - (4) Strategies to re-engage members who did not engage previously in Tailored Care Management.
 - (f) Policies and procedures for care management comprehensive assessments, including but not limited to:

- (1) Strategies to comply with federal care needs screening requirements (42 CFR § 438.208(b)(3));
 - (2) Assessment tools/questions used;
 - (3) Variation in care management comprehensive assessment based on population (including LTSS);
 - (4) Expected volume of care management comprehensive assessments monthly and annually ;
 - (5) Method of conducting the care management comprehensive assessment based on member needs or other factors; and
 - (6) Audits of care management comprehensive assessments to ensure they meet quality expectations.
- (g) Policies and procedures for Care Plan/ISP development with members, including:
- (1) Approach for involving multidisciplinary care team;
 - (2) Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the member and the member’s family, advocates, caregivers, and/or legal guardians are actively involved;
 - (3) Process for and frequency of Care Plan/ISP updates;
 - (4) Approach for ISP development for members enrolled in the Innovations or TBI waivers; and
 - (5) Audits of care plan/ISP to ensure they meet quality expectations.
- (h) Policies and procedures for transitional care management, including the approach to working with members with LTSS needs.
- (i) Policies, procedures for completing the required Care Needs Screening (CNS) according to requirements and a copy of the CNs to be used.
- (j) Policies and procedures for linkages with community resources for all members as needed, including for those identified as having Unmet Health-Related Resource Needs.
- (k) Policies and procedures for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.
- (l) Approach to providing technical assistance to AMH+ practices and CMAs
- (m) Training plan, including:
- (1) Policies and procedures for training and qualification of care managers and other multidisciplinary team members;
 - (2) Training modalities (e.g., in person versus online);
 - (3) Approach to tracking and verifying that care managers have completed trainings;
 - (4) Process for addressing noncompliance with trainings;
 - (5) Timing/frequency of trainings;
 - (6) Summary of curriculum and training modalities (e.g., in person versus online);
 - (7) Approach for assessing competencies;
 - (8) Approach for annual refreshers and ongoing continuing education; and
 - (9) Approach for permitting care managers and supervisors to waive specific training domains if they have previously obtained comparable training.
- (n) Policies and procedures for population health management, including any risk scoring and stratification approach in addition to acuity tiering.
- (o) Description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies.
- (p) Proposed methodology and schedule for sharing data with AMH+ practices and CMAs.
- (q) Proposed methodology for calculating costs and outcomes of the care management program.

- (r) Risk stratification methodology, if the BH I/DD Tailored Plan adopts its own methodology in addition to acuity tiering.
- (s) Policies and procedures for certification and recertification of AMH+ practices and CMAs.
- (t) Policies and procedures for conflict-free care management.
- (u) Policies and procedures for ensuring members do not receive duplicative care management from multiple sources.
- (v) Process for overseeing AMH+ practices, CMAs, and CINs or Other Partners, as described in *Section V.B.3.ii.(xix) Oversight*. This process must:
 - (1) Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner.
 - (2) Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance.
 - (3) Describe how, if the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with AMH+ practice, CMA or CIN or Other Partner, the BH I/DD Tailored Plan would reassign members who were obtaining care management through that organization, taking member preferences into account and using the process described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (4) Describe how, if the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to contract directly with the BH I/DD Tailored Plan or the option to contract with another CIN or Other Partner that in turn will contract with the BH I/DD Tailored Plan.
 - (5) Policies and procedures for care coordination and care transitions for all members, including:
 - i. Ensuring the member has an ongoing source of care;
 - ii. Coordination across settings of care; and
 - iii. Coordination during member transitions (including transitions from a Standard Plan to a BH I/DD Tailored Plan, from NC Medicaid Direct/LME/MCO into a BH I/DD Tailored Plan, among PHPs, among payers, and between community and social support providers).
- (w) Specialized care management strategies that address the medical and psychosocial needs of infants who are substance affected; address the needs of the infant's mother/caregiver, including parental/caregiver education on the potential psychosocial development of an infant who is substance affected; and establish coordination with the mother's care manager to ensure that care management services for the infant and the mother are aligned.
- (x) Care management strategies to manage the needs of pregnant and postpartum women with SUD diagnoses/history or mental health diagnoses/history, including strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes, and addiction and recovery treatment approaches.
- (y) Policies and procedures for referral and coordination for all children who receive service coordination through a CDSA.
- (z) Protocols for ensuring that individuals moving between the following services and the Tailored Care Management model experience smooth transitions:
 - (1) ACT;
 - (2) ICF-IIDs; and
 - (3) High-Fidelity Wraparound program.

- (aa) Plan is addressing health disparities and incorporating health equity into its internal and external policies and procedures.
 - (iii) The BH I/DD Tailored Plan shall modify the Care Management Policy based on EQRO review, Department review, or care management improvement activities as part of the QAPI.
- vii. System of Care
- (i) System of Care Background
 - (a) The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina’s System of Care is to provide evidence-based, trauma-informed/resiliency developed BH services to all children, youth and their families.
 - (b) The BH I/DD Tailored Plan shall use a System of Care approach, including use of specific strategies and protocols described in the BH I/DD Tailored Plan System of Care Policy (*Section V.B.3.vii.(iii) System of Care Policy*) for all members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving mental health or substance use services, including special populations such as youth with a dual I/DD and mental health disorder at risk of out-of-home placement or unable to return from out-of-home placement; youth with dual physical and mental health or SUD diagnoses with or without the risk of out-of-home placement; youth and young adults transitioning from child service systems into adult service systems; and youth involved in the child welfare and/or the juvenile justice system.
 - (c) The System of Care’s core elements are:
 - (1) Family-driven, youth-guided services;
 - (2) Interagency collaboration;
 - (3) Service coordination through a single facilitator;
 - (4) Individualized, strength-based, trauma-informed/resilience development approach;
 - (5) Culturally and Linguistically Competent care;
 - (6) Evidence-based or informed services provided in a home or community setting; and
 - (7) Family and youth involvement in regional and state policy development, implementation, and evaluation.
 - (ii) System of Care Staffing Requirements
 - (a) The BH I/DD Tailored Plan shall employ or contract with the following dedicated System of Care staff:
 - (1) At least one (1) System of Care Coordinator per three (3) counties for the Region in which it operates; and
 - (2) At least one (1) Family Partner per three (3) counties for the Region in which it operates.
 - (b) BH I/DD Tailored Plan System of Care Coordinators and Family Partners shall be responsible for comprehensive System of Care planning, implementation, coordination, and training related to required core functions within the Region in which it operates. System of Care Coordinators and Family Partners shall develop, facilitate, and evaluate the following required System of Care functions and responsibilities throughout the Region in which the BH I/DD Tailored Plan operates:
 - (1) Serve as staff to each city or county local community collaborative in the Region in which the BH I/DD Tailored Plan operates and shall recruit and maintain membership that includes family members and youth who are receiving or have received public BH services, child-serving agencies and a variety of community partners.
 - (2) Work with Community Collaboratives to:
 - i. Influence the development of a broad and appropriate service array to meet the range of BH needs of children being serviced under the System of Care framework.

- ii. Develop the capacity of the community collaborative to gather and use data for System of Care decision making.
 - iii. Support BH workforce development through systems partners jointly developing training plans and sharing resources to implement those plans.
 - iv. Develop and implement a strategic communication plan that promotes access to and utilization of BH services, deepens local leadership’s understanding of the System of Care framework, and builds public support for local Systems of Care.
- (3) Foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, work with care managers to ensure that youth and families are leading their person-centered planning processes, and provide and support leadership opportunities for youth and families.
 - (4) Work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of System of Care principles and processes, and provide or facilitate regular consultation, technical assistance and training to provider agencies in System of Care implementation fidelity.
 - (5) Work with community agencies in identifying and responding to community needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and substance abuse disorder treatment and recovery services.
 - (6) Regularly identify and respond to consultation, technical assistance and training needs of the Community Collaboratives, provider agencies, families and BH I/DD Tailored Plan staff, and either directly provide such System of Care consultation, technical assistance, and training or facilitate the provision of such activities.
 - (7) Take an active role in promoting BH I/DD Tailored Plan and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.
 - (8) Complete and submit BH I/DD Tailored Plan System of Care reports to the Department. These reports shall be submitted to the Department in accordance with the Department’s requirements.
 - (9) Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits to support a high level of statewide coordination, networking, monitoring, and evaluation for and with System of Care Coordinators and staff.
- (c) The BH I/DD Tailored Plan shall ensure System of Care Coordinators and Family Partners are trained on all the topics described in this Section.
 - (d) The BH I/DD Tailored Plan shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:
 - (1) Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system;
 - (2) Partnering with families and youth in Care Plan development, implementation, and evaluation process.
 - (3) Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive, and implementation is shared across sectors;
 - (4) Developing, supporting and expanding relationships among systems;

- (5) Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and
 - (6) Child and family team care management and High-Fidelity Wraparound.
- (iii) System of Care Policy
- (a) The BH I/DD Tailored Plan shall submit a System of Care Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award and annually thereafter.
 - (b) As long as the System of Care Policy clearly states that it applies to the BH I/DD Tailored Plan, the System of Care Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (c) The scope of this policy includes BH I/DD Tailored Plan members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving BH or substance abuse services.
 - (d) The System of Care Policy shall include a brief description of the BH I/DD Tailored Plan's history and experience coordinating with members' care under the System of Care framework, including examples of specific successes and challenges to date in meeting the needs of children with BH needs.
 - (e) The System of Care Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing the System of Care as required in the *Section V.B.3.vii.(iii) System of Care Policy* and:
 - (1) Integrating into the System of Care framework and applying the System of Care core elements into its approach for covering services for child and youth members with BH needs and their families.
 - (2) Ensuring that the BH I/DD Tailored Plan is an active partner within a member's System of Care.
 - (3) Supporting coordinated multi-system care delivery through:
 - i. Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
 - ii. Conducting outreach to families to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;
 - iii. Instituting effective and timely cross-system communication, including for children in crisis; and
 - iv. Collaborating with system partners to ensure that children receive needed services in the least restrictive setting.
 - (4) Describing how the BH I/DD Tailored Plan will work with local and State public agency partners to:
 - i. Reduce the number and length of out-of-home placements for children receiving public BH services;
 - ii. Ensure timely access to an appropriate service array of evidenced based home- and community-based care for children receiving Medicaid and state-funded public BH services;
 - iii. Reduce the number of children receiving public BH services prescribed multiple psychotropic medications; and,
 - iv. Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography.
 - (5) Describing how the BH I/DD Tailored Plan will develop capacity to strengthen existing and build new relationships with local and State public agency partners youth and/or family

members with lived experience with a child in the BH system and local child and family support education and/or advocacy groups, including but not limited to:

- i. Local school systems;
- ii. County government;
- iii. Juvenile justice system;
- iv. Child welfare system;
- v. Public health system;
- vi. Private and local community-based providers;
- vii. Child and Family Advisory Committees;
- viii. Community Collaboratives; and
- ix. The DMH/DD/SAS System of Care Coordinator.

viii. In-Reach and Transition from Institutional Settings

(i) In-Reach and Transition Overview

(a) The BH I/DD Tailored Plan shall assume primary responsibility for the in-reach and transition activities described in this Section.

(1) In-reach activities shall be conducted with the goal of identifying and engaging members receiving care in a setting described in *Section V.B.3.viii(ii) Eligibility for In-Reach and Transition Services* and *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State* who may be able to have their needs safely met in a community setting.

(2) Transition activities shall be conducted with the goal of facilitating the relocation of a member receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services* and *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State* to a community setting, while ensuring the appropriate level of services and supports that member requires.

(b) The BH I/DD Tailored Plan shall ensure all in-reach and transition activities are documented and stored and made available to the Department for review upon request.

(c) The BH I/DD Tailored Plan shall provide the in-reach and transition reports in the form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.

(ii) Eligibility for In-Reach and Transition Services

(a) The BH I/DD Tailored Plan shall consider all members residing in the following settings as eligible for in-reach and transition services:

- (1) State psychiatric hospitals,
- (2) ACHs (members with SMI only),
- (3) State developmental centers,
- (4) PRTFs, and
- (5) Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2.

(b) The BH I/DD Tailored Plan shall also provide in-reach and transition services to members residing in ICF-IIDs not operated by the state as described in *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State*.

(iii) The BH I/DD Tailored Plan shall ensure the individuals as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements* perform the following in-reach activities for members receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services*, beginning within seven (7) days of admission and occurring on a regular basis until the member is referred for transition services described in *Section V.B.3.viii.(iv)*:

- (a) Identify candidates for in-reach services. The BH I/DD Tailored Plan, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
 - (1) Claims and enrollment data;
 - (2) Facility referrals;
 - (3) Stakeholder and family/guardian referrals; and
 - (4) Automatic in-reach trigger points the BH I/DD Tailored Plan shall establish.
- (b) Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the member and the member's family members and/or guardians are accurately and fully informed about community-based options available.
- (c) Facilitate and accompany the member and their family members and/or guardians on visits to community-based services.
- (d) Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing.
- (e) To the maximum extent possible, explore and address the concerns of the member and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns.
 - (1) For members who decline the opportunity to transition, the BH I/DD Tailored Plan shall:
 - i. Continue to engage the member and/or their family members or guardians about the opportunity to transition to a more integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
 - ii. Clearly document that the member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the member of available community services, including supportive housing.
- (f) Provide the member and/or the member's family members or guardians opportunities to meet with other individuals with SMI, SED, I/DD or TBI (as relevant to the member) who are living, working and receiving services in integrated settings.
- (g) Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI, SED, I/DD or TBI to live in their home/community.
- (h) For all members who have previously opted out of Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for providing information on the opportunity and process for opting back in.
- (i) For members residing in an ACH or state developmental center, and members age 18 and over residing in a state psychiatric hospital and who have been identified for transition, refer the member to a BH I/DD Tailored Plan transition coordinator, the member's care manager in the Tailored Care Management model, or DSOHF Admission Through Discharge Manager for transition services (see *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*) and ensure a timely, Warm Handoff to the transition staff or care manager in the Tailored Care Management model that the BH I/DD Tailored Plan assigns to the member.
- (j) For members age 18 and above admitted to a state psychiatric hospital, BH I/DD Tailored Plan-based peer support specialists shall coordinate with the member's care manager in the Tailored Care Management model on in-reach activities, if applicable.
- (k) Additional required activities for members who may be eligible for supportive housing:
 - (1) Ensure the member and their family members and/or guardians are accurately and fully informed about all available supportive housing options.

- (2) Facilitate and accompany the member and their family members and/or guardians on visits to supportive housing settings.
- (iv) The BH I/DD Tailored Plan shall ensure the individual as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements* performs the following transition activities for members receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services*:
- (a) Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care upon referral from the BH I/DD Tailored Plan in-reach staff as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*.
 - (b) Collaborate with the following individuals, specialists, and provider types as applicable depending on the member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
 - (1) The member and/or the member's family or guardian
 - (2) Facility providers
 - (3) Facility discharge planners
 - (4) The member's care manager
 - (5) The member's community-based PCP once selected
 - (6) Peer support specialist or other individuals determined to have appropriate shared lived experience
 - (7) Educational specialists
 - (8) Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.
 - (c) Engage the member's community PCP and other providers as appropriate so that they are actively engaged in the transition planning process prior to member's discharge.
 - (d) Assist the member, prior to discharge, either by phone or in person, to select a qualified community PCP and clinical specialists as needed, including by assisting the member and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
 - (e) Collaborate with the member and/or the member's family members or guardians, Peer Support Specialists when available, facility providers, and other relevant community service providers to make arrangements for individualized supports and services needed to be in place upon discharge.
 - (f) Collaborate with the member and/or the member's family members or guardians, the facility provider, and selected community provider(s) prior to the member's discharge to identify and prioritize the most critical services necessary to address the member's specific needs, including complex BH, primary care and medical needs.
 - (g) Schedule post-discharge appointments for critical services to occur in a timely manner based upon the member's identified needs and no later than seven (7) Calendar Days following discharge.
 - (h) When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
 - (i) Assist the member and/or the member's family members or guardians in initiating selected community service options including but not limited to BH services.
 - (j) Work with receiving providers and/or agencies if applicable, to identify if any specific training is needed by the receiving providers and/or agencies to ensure a seamless transition.
 - (k) Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), resource

identification and referrals to qualified providers and care manager, and training of family or guardians and natural supports prior to the member's discharge.

- (1) Assess settings that the member is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.
- (l) Explore and secure appropriate and available funding options and work through any potential funding needs with community providers such as managing spend downs, if needed, prior to discharge.
- (m) When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the member's individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.
 - (1) If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the member's discharge.
 - (2) Make best efforts to ensure that the information contained in the discharge service order, the ninety (90)-day transition plan and the discharge summary are made available to the community providers who will be serving the member after discharge.
 - (3) Ensure the discharge service order, the transition plan and the discharge summary are made available to the organization providing Tailored Care Management if the member is eligible for Tailored Care Management.
- (n) For members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with the Department to ensure Medicaid eligibility is active upon or soon after discharge.
- (o) For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
- (p) For members residing in state developmental centers: If needed, request an extension of Memorandum of Agreement in writing to the DSOHF Developmental Center Director prior to the discharge date outlining the reasons for the extension and anticipated length of extension needed.
- (q) DSOHF Admission Through Discharge Managers shall coordinate with BH I/DD Tailored Plan In-Reach Specialists, Transition Coordinators, System of Care Coordinator, and other relevant community service providers as determined needed by the DSOHF Admission Through Discharge Managers in cases involving members with complex needs or severe symptoms.
- (r) On the day of discharge:
 - (1) Obtain a copy of the discharge plan and review the discharge plan with the member and/or the member's family members or guardians and facility staff.
 - (2) Assist the member in obtaining needed medications and ensure an appropriate care team member or facility staff conducts medication reconciliation/management and supports medication adherence.
- (s) Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct member population served, and the discharge

and transition responsibilities included in the Department contract including those set forth in this Section.

- (t) Following discharge, ensure the transition coordinator performs the following activities:
 - (1) Ensure member is receiving needed transition-related services.
 - (2) Coordinate and facilitate thirty (30)-day post-discharge meetings with the member and the member's family members or guardians, the member's care manager and/or Child and Family Team (if applicable), and community provider(s) including NC START (if applicable) to promptly address any areas of concern identified following transition of the member from the facility to the community.
 - (3) Convene follow-up post-discharge meetings no less than every thirty (30) days until any issues or areas of concern are addressed.
- (u) Additional required activities for members who may be eligible for supportive housing:
 - (1) Collaborate with the BH I/DD Tailored Plan's housing specialist to make arrangements for individualized supports and services needed to be in place upon discharge.
 - (2) Assist the member and/or the member's family members or guardians in initiating housing-related services and supports including but not limited to: locating and securing housing; ensuring the home environment is safe and move-in ready; and other ongoing tenancy supports that enable the member to maintain housing.
 - (3) Ensure the transition is completed within ninety (90) Calendar Days of receiving a housing slot.
- (v) Additional required activities for members residing in a PRTF or Residential Treatment Levels II/Program Type, III, and IV, and members under age 18 residing in a state psychiatric hospital:
 - (1) Convene the member's Child and Family Team and work with team, including the member's care manager, if applicable, to add new team members as needed to ensure an effective and timely transition.
 - (2) Engage the member's Child and Family Team through the entire transition planning process.
 - (3) Ensure PRTF Family Peer Partner is included in transition planning for members in a PRTF, when applicable.
 - (4) As required as part of Tailored Care Management (see *Section V.B.3.ii.(x) Ongoing Care Management*):
 - i. Provide the member and their family or guardian linkages to relevant state agencies and systems that support the development and well-being of children, including local school systems and child welfare systems.
 - ii. Provide the member and the member's family or guardian with linkages to community-based services and supports that address Unmet Health Related Resource Needs, including:
 - a) Disability benefits;
 - b) Food and income supports;
 - c) Transportation;
 - d) Education; and
 - e) Services for justice-involved populations.
 - (5) Collaborate with the member and their family or guardian and all relevant service providers to ensure needed individualized supports and services—including any school-related services, recreational and pro-social activities, supervision plans, and family supports—are in place upon discharge.
 - (6) Work with the member and their family or guardian to assess and prepare the member's home so that it provides the member with a safe and appropriate community setting.

- i. Assess settings that the member is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.
 - (7) Identify and address any barriers to active engagement of a member's family or guardian in transition planning.
 - (8) Educate and train the member and the member's family or guardians on resource availability, and how to independently access resources to maintain self-sufficiency in caring for the member in the community.
 - (9) If the member has no permanent family or guardian, work with supervising care manager to request that a Department of Social Services (DSS) guardian locate a permanent placement for the member and escalate to DSS supervising staff if permanent placement is not being pursued.
- (w) For members not already engaged in Tailored Care Management, the BH I/DD Tailored Plan shall assign members transitioning out of a facility to Tailored Care Management as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment* upon referral from the transition coordinator and/or DSOHF Admission Through Discharge Manager prior to discharge unless the member is transitioning to another ICF-IID or is authorized for ACT or High-Fidelity Wraparound.
 - (1) The BH I/DD Tailored Plan shall ensure a Warm Handoff from a member's transition coordinator or DSOHF Admission Through Discharge Manager to the member's assigned care manager, ACT team, High-Fidelity Wraparound provider, or other entity providing care management.
 - (2) The Warm Handoff to the care manager providing Tailored Care Management shall take place upon discharge.
 - (3) The transition coordinator and DSOHF Admission Through Discharge Manager shall ensure the care manager providing Tailored Care Management meets with the member and/or the member's family members or guardians prior to discharge.
 - (4) The transition coordinator shall remain a part of the member's care team following the Warm Handoff until ninety (90) days post-discharge. During this time the transition coordinator shall remain available to the care manager providing Tailored Care Management for consultation.
 - (5) For specific requirements related to members transitioning into Innovations/TBI waivers, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.
- (x) The BH I/DD Tailored Plan shall assign a member of the BH I/DD Tailored Plan clinical leadership (i.e., clinical Director-level or above) to attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm.
- (v) Staffing Requirements
 - (a) In-Reach Staffing Requirements
 - (1) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the following parties are responsible for in-reach activities:
 - i. For members admitted to a PRTF or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by the member's care manager as part of the Tailored Care Management model.

- ii. For members under age 18 admitted to a state psychiatric hospital, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by the member’s care manager as part of the Tailored Care Management model.
 - iii. For members admitted to an ACH and members age 18 and above admitted to a state psychiatric hospital, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based peer support specialist.
 - iv. For members admitted to a state developmental center, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based in-reach specialist.
- (b) Transition Staffing Requirements
- (1) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the transition coordinator is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii.(iv)* for the following populations:
 - i. Members transitioning from a state psychiatric hospital to supportive housing, including members under age twenty-one (21),
 - ii. Members transitioning from an ACH into supportive housing, and
 - iii. Members transitioning from a state developmental center.
 - (2) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the DSOHF Admission Through Discharge Manager is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii.(iv)* for members age twenty-one (21) and above transitioning from a state psychiatric hospital who are not transitioning to supportive housing.
 - (3) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that a member’s care manager is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii. (iv)* for the following populations:
 - i. Members transitioning from an ACH who are not transitioning into supportive housing,
 - ii. Members transitioning from a PRTF,
 - iii. Members transitioning from Residential Treatment Levels II/Program Type, III, and IV as defined in the Department’s Clinical Coverage Policy 8-D-2, and
 - iv. Members under age twenty-one (21) transitioning from a state psychiatric hospital who are not transitioning to supportive housing.

Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements			
	Setting	Individual Responsible for Conducting In-Reach Activities	Individual Responsible for Conducting Transition Activities
1.	DSOHF Psychiatric Hospital	<p><i>Members Under Age 18:</i> Member’s Care Manager in Tailored Care Management model</p> <p><i>Members Age 18 and Above:</i> BH I/DD Tailored Plan-Based Peer Support Specialist</p>	<p><i>All Members Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based Transition Coordinator</p> <p><i>Members Under Age 21 Not Transitioning to Supportive</i></p>

Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements			
	Setting	Individual Responsible for Conducting In-Reach Activities	Individual Responsible for Conducting Transition Activities
			<p><i>Housing:</i> Member's Care Manager in Tailored Care Management model</p> <p><i>Members Age 21 and Above Not Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based DSOHF Admission Through Discharge Manager</p>
2.	ACH	BH I/DD Tailored Plan-Based Peer Support Specialist	<p><i>Members Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based Transition Coordinator</p> <p><i>Members <u>Not</u> Transitioning to Supportive Housing:</i> Member's Care Manager in Tailored Care Management model</p>
3.	DSOHF Developmental Center	BH I/DD Tailored Plan-Based In-Reach Specialist	BH I/DD Tailored Plan-based Transition Coordinator
5.	PRTF	Member's Care Manager in Tailored Care Management model	Member's Care Manager in Tailored Care Management model
6.	Residential Treatment Levels II/Program Type, III, and IV	Member's Care Manager in Tailored Care Management model	Member's Care Manager in Tailored Care Management model

(c) Transition Supervisor Requirements

- (1) The BH I/DD Tailored Plan shall ensure that all BH I/DD Tailored Plan-based in-reach and transition staff working with members who are in or transitioning out of an institutional setting or ACH are supervised by a transition supervisor.
- (2) The BH I/DD Tailored Plan shall ensure transition supervisors have no caseload but will provide coverage for other in-reach and transition staff's vacation and sick leave.
- (3) The BH I/DD Tailored Plan shall ensure transition supervisors are responsible for providing guidance to Peer Support Specialists, In-Reach Specialists, Transition Coordinators, DSOHF Admission Through Discharge Managers, and care managers under the Tailored Care Management model working with individuals transitioning out of an institutional setting or an ACH.

- (4) The BH I/DD Tailored Plan shall ensure transition supervisors attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm.
- (d) Additional Staffing Requirements for DSOHF Facilities
 - (1) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager to each DSOHF psychiatric hospital associated with the BH I/DD Tailored Plan's region.
 - (2) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager who will be responsible for serving its members across all DSOHF developmental centers.
 - (3) The BH I/DD Tailored Plan shall ensure that the total number of DSOHF Admission Through Discharge Managers is sufficient for fulfilling transition responsibilities for its members at DSOHF facilities.
- (e) For members for whom in-reach and transition activities are coordinated and/or performed by the member's care manager as part of the Tailored Care Management model as described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, but who have previously opted out of Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for coordinating and/or performing in-reach and transition activities.
- (f) The BH I/DD Tailored Plan shall ensure all individuals responsible for conducting in-reach and transition activities report potential rights violations of Members residing in ACHs in accordance with General Statute 131D.
- (vi) In-Reach and Transition Staff Qualifications
 - (a) The BH I/DD Tailored Plan shall ensure that Peer Support Specialists serving members residing in an ACH or state psychiatric hospital have the following minimum qualifications:
 - (1) NC Certified Peer Support Specialist Program Certification, and
 - (2) Specific background and expertise working with people with SMI and their families or guardians, and
 - (3) Must be knowledgeable about community services and supports, including supportive housing.
 - (b) The BH I/DD Tailored Plan shall ensure that In-Reach Specialists serving members residing in a state developmental center have the following minimum qualifications:
 - (1) Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area.
 - (2) Must be knowledgeable about community services and supports, including supportive housing.
 - (3) Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.
 - (c) The BH I/DD Tailored Plan shall ensure that DSOHF Admission Through Discharge Manager serving residents of DSOHF psychiatric hospitals have the following minimum qualifications:
 - (1) Master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), or bachelor's-level registered nurse (RN) plus one (1) year of experience working directly with individuals with SMI.
 - (d) The BH I/DD Tailored Plan shall ensure that DSOHF Admission Through Discharge Manager serving residents of DSOHF developmental centers have the following minimum qualifications:
 - (1) Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or

- (2) Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or
 - (3) Bachelor's-level registered nurse (RN) plus three (3) year of relevant experience working directly with individuals with I/DD.
- (e) The BH I/DD Tailored Plan shall ensure that Transition Coordinators have the following minimum qualifications:
- (1) If serving members with SMI needs:
 - i. Master's degree in a human services field or licensure as a registered nurse (RN), plus one (1) year of relevant experience working directly with individuals with SMI or SED; or
 - ii. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with SMI or SED.
 - (2) If serving members with I/DD or TBI:
 - i. Master's degree in a human services field or licensure as a registered nurse (RN), plus one (1) year of relevant experience working directly with individuals with I/DD or TBI; or
 - ii. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD or TBI.
- (f) The BH I/DD Tailored Plan shall ensure that Transition Supervisors overseeing BH I/DD Tailored Plan in-reach and transition staff meet the minimum qualifications of a supervising care manager as described in *Section V.B.3.ii.(xiv)(c) Care Manager Qualifications*. Transition Supervisors shall also meet the following minimum qualifications:
- (1) Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
- (g) The BH I/DD Tailored Plan may submit to the Department for approval alternate minimum qualifications for in-reach and transition staffing as part of the BH I/DD Tailored Plan In-Reach and Transition Policy as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.
- (1) The BH I/DD Tailored Plan shall provide in the application justification for the alternate minimum qualifications and shall describe how the BH I/DD Tailored Plan will ensure individuals conducting in-reach and transition activities provide required in-reach and transition services in a clinically appropriate manner as described in this Section (*Section V.B.3.viii. In-Reach and Transition from Institutional Settings*).
- (vii) In-Reach and Transition Staff Training
- (a) The BH I/DD Tailored Plan shall conduct training for individuals conducting in-reach and transition activities as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements*.
 - (b) In addition to the training domains described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements*, the BH I/DD Tailored Plan shall develop a separate training module for in-reach and transition staff that addresses the following domains:
 - (1) Full knowledge of the array of available community services and supports that ensure the health and well-being and safe community living for members receiving in-reach and transition services.
 - (2) Engagement methods including assertive engagement, and active listening skills.
 - (3) Motivating and working with a member's family or guardian and facility staff, including cultural and linguistic needs of a member and their family or guardian.
 - (4) Developing an interdisciplinary transition plan.

- (5) Components of the Permanent Supportive Housing model during pre-tenancy, tenancy, and post-tenancy phases, including the process for assessing living arrangements for health and safety issues.
- (viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State
- (a) The Department seeks to expand community inclusion opportunities for members residing in ICF-IIDs not operated by the state, and has established the requirements described in this Section in order to create opportunities for members in ICF-IIDs not operated by the state to receive services in more integrated settings.
 - (b) The BH I/DD Tailored Plan shall ensure that members residing in ICF-IIDs not operated by the state receive in-reach and transition services as described in this Section.
 - (1) The BH I/DD Tailored Plan is not subject to in-reach and transition requirements described in *Sections V.B.3.viii.(iii)-(vii)* for members residing in ICF-IIDs not operated by the state.
 - (c) The BH I/DD Tailored Plan shall be responsible for providing members residing in ICF-IIDs not operated by the state in-reach services on a regular basis until the member is referred for transition services. In-reach activities for members residing in ICF-IIDs not operated by the state must include, at a minimum:
 - (1) Provide age- and developmentally-appropriate education for the member and the member's family members and/or guardians about the opportunity to receive care in a more integrated setting and available services in such settings.
 - (2) Provide the member and/or the member's family members or guardians opportunities to meet with other individuals with I/DD who are living, working and receiving services in a more integrated setting.
 - (3) Identify, document and attempt to address barriers to relocation to a more integrated setting.
 - i. For members who decline the opportunity to transition, the BH I/DD Tailored Plan shall clearly document that the member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the member of available community services.
 - (4) Engage and collaborate with stakeholder groups that represent members residing in non-state operated ICF-IIDs and/or their family members or guardians, provider groups, and state and local government agencies on the in-reach process, including identifying more integrated settings for members to transition to and supports and services available in those settings.
 - (d) The minimum frequency for ongoing in-reach engagement for members residing in ICF-IIDs not operated by the state will be determined by the Department.
 - (e) The BH I/DD Tailored Plan shall be responsible for providing transition services for members residing in ICF-IIDs not operated by the state. Transition activities for members residing in ICF-IIDs not operated by the state must include, at a minimum:
 - (1) Collaborate with the member and/or the member's family members or guardians, facility and community-based providers and specialists, and the member's support network as applicable and depending on the member's needs to ensure effective and timely discharge and transition to a more integrated setting.
 - (2) Provide referrals and linkages to individualized community-based supports and services, including but not limited to:
 - i. Medical care, including primary care, clinical specialists, and specialized therapies;
 - ii. Tailored Care Management;
 - iii. Behavioral health services;
 - iv. Crisis prevention services;

- v. I/DD services;
 - vi. Employment services;
 - vii. Innovations Waiver waitlist;
 - viii. For children/young adults: relevant state and local agencies and systems that support the development and well-being of children.
- (3) Continuity planning for young adult members transitioning into adult services.
 - (4) For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
 - (5) Identify, document and attempt to address barriers to relocation in a more integrated setting.
 - (6) Following discharge, ensure the member is receiving needed transition-related services and promptly address any areas of concern identified following transition of the member to a more integrated setting.
- (f) The BH I/DD Tailored Plan shall develop policies and procedures for providing in-reach and transition services to members residing in ICF-IIDs not operated by the state, including the proposed staffing model for these activities, and submit them to the Department as part of the BH I/DD Tailored Plan In-Reach and Transition Policy as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*
 - (ix) The BH I/DD Tailored Plan shall permit their in-reach and transition staff to transport members and their family or guardians when needed to fulfill the required in-reach and transition activities described in this Section.
 - (x) The Department reserves the right to establish caseload requirements for BH I/DD Tailored Plan-based in-reach and transition staff serving members in and transitioning out of an ACH or institutional setting, including ICF-IIDs not operated by the state, and will release any additional requirements in forthcoming guidance.
 - (xi) The BH I/DD Tailored Plan shall be subject to any additional in-reach and transition requirements issued by the Department, including those developed as part of North Carolina's Olmstead Plan.
 - (xii) The BH I/DD Tailored Plan shall ensure that a member does not receive in-reach and transition services that are duplicative of other care management services the member is receiving.
 - (a) When a member is receiving both in-reach and transition services and Tailored Care Management, the BH I/DD Tailored Plan must ensure that the in-reach and transition staff and organization providing Tailored Care Management explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
 - (b) When a member is receiving both in-reach and transition services and another care management service besides Tailored Care Management, the BH I/DD Tailored Plan must ensure that the in-reach and transition staff and provider of the duplicative service explicitly agree on the delineation of responsibility and document that agreement in the Care Plan or ISP to avoid duplication of services.
 - (xiii) In-Reach and Transition Policy
 - (a) The BH I/DD Tailored Plan shall submit an In-Reach and Transition Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award and annually thereafter.
 - (b) The scope of this policy includes all BH I/DD Tailored Plan members eligible for in-reach and transition services as described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services* and members residing in ICF-IIDs not operated by the state.

- (c) The In-Reach and Transition Policy shall include the BH I/DD Tailored Plan’s policies and processes for implementing in-reach and transition requirements described in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*, including:
 - (1) Policies and procedures for outreach and engagement of members eligible to receive in-reach and/or transition services.
 - (2) Training plan for individuals responsible for conducting in-reach and transition activities.
 - (3) Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support member transitions to more integrated settings.
 - (4) Additional required policies and processes for members residing in ICF-IIDs not operated by the state:
 - i. Staffing model for conducting in-reach and transition activities for members residing in ICF-IIDs not operated by the state. The model shall address supervision and oversight, minimum qualifications, training requirements, and caseload requirements for all in-reach and transition staff.
 - ii. Approach for identifying, engaging, and collaborating with stakeholders on providing in-reach and transition services to members residing in ICF-IIDs not operated by the state.
 - iii. Approach to expanding opportunities for community inclusion for members residing in ICF-IIDs not operated by the state.
 - (d) The In-Reach and Transition Policy shall include a checklist that individuals responsible for conducting transition activities will use to assess the safety and appropriateness of settings that BH I/DD Tailored Plan members will transition to when leaving an institutional setting or ACH. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards and are consistent across BH I/DD Tailored Plans.
- ix. Prevention and Population Health Programs
- (i) Roles and Responsibilities
 - (a) The BH I/DD Tailored Plan must take a population-based approach to improving the overall health of Medicaid members and work collaboratively with community partners on targeted public health initiatives (e.g., opioid crisis, infant mortality, mental health awareness, nicotine use prevention/cessation).
 - (b) The BH I/DD Tailored Plan shall establish prevention and population health programs aligned with the Department’s larger public health goals and Quality Strategy. ¹⁸ The Department will provide population-level measures to the BH I/DD Tailored Plan, such as measures related to infant and maternal mortality, that are intended to inform the BH I/DD Tailored Plan about regional trends and assist the BH I/DD Tailored Plan in performance improvement efforts.
 - (c) The BH I/DD Tailored Plan shall implement initiatives to increase access to medication-assisted treatment, including initiatives to increase the number of providers offering this treatment.
 - (d) The BH I/DD Tailored Plan shall ensure that AMH+ practices and CMAs, as well as care managers employed or contracted with the BH I/DD Tailored Plan, promote wellness and prevention by educating members about and referring them to BH I/DD Tailored Plan prevention and population health management programs and/or other programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse

¹⁸ North Carolina Medicaid Division of Health Benefits Quality Management and Improvement: <https://medicaid.ncdhhs.gov/quality-management-and-improvement>

prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the member's needs and preferences.

- (e) The Department's selected population health priorities as defined in the Quality Strategy (to be updated on a regular basis by the Department) include:
 - (1) Diabetes;
 - (2) Asthma;
 - (3) Obesity;
 - (4) Hypertension;
 - (5) Tobacco cessation;
 - (6) Infant mortality;
 - (7) Low birth weight;
 - (8) Early childhood health and development; and
 - (9) Additional prevention and population health management programs to encourage improved health and wellness among members, such as interventions that will improve functional status and quality of life among members with BH issues, I/DD or TBI.
- (f) The BH I/DD Tailored Plan shall identify individuals for prevention and population health programs through several mechanisms, including but not limited to:
 - (1) Care management comprehensive assessment;
 - (2) Claims analysis and risk scoring;
 - (3) Member self-referral;
 - (4) Provider referral;
 - (5) Caregiver referral; and
 - (6) Legal representative referral.
- (g) The BH I/DD Tailored Plan shall ensure that prevention and population health programs are available to all members.
- (h) The BH I/DD Tailored Plan will be expected to engage as an active partner in Healthy NC 2020 and 2030 planning, including thorough review and discussion of BH I/DD Tailored Plan-level data and quality performance consistent with *Section V.B.5.i. Quality Management and Quality Improvement*. The BH I/DD Tailored Plan should incorporate information from LHD Community Health Assessments in the development of their population health programs.
- (i) In addition to the Opioid Misuse Prevention and Treatment Program description and Tobacco Cessation Plan (described below), the BH I/DD Tailored Plan shall develop a comprehensive Prevention and Population Health Management Plan that defines the BH I/DD Tailored Plan's methods to promote better health outcomes, including the Department's selected health priorities, and integration with the Department's other public health and human services programs. The Prevention and Population Health Management Plan shall be submitted to the Department for review and approval annually or upon request by the Department.
- (ii) Tobacco Cessation Services
 - (a) The BH I/DD Tailored Plan shall contract with the Department's Quitline vendor at a minimum benefit level defined by the Department that promotes evidence-based standards of care for tobacco cessation. The BH I/DD Tailored Plan contract with the Quitline shall include coverage of the Quitline BH protocol.
 - (b) The BH I/DD Tailored Plan shall ensure that members are given complete information about the coverage of tobacco cessation items and services.
 - (c) The BH I/DD Tailored Plan shall partner with the Department to, at a minimum:
 - (1) Promote the full Tobacco Cessation Benefit to members;
 - (2) Partner with the Department and the Department's Quitline vendor on outreach; and

- (3) Submit marketing and educational materials for review and approval consistent with the requirements pursuant to the Contract.
- (d) The BH I/DD Tailored Plan shall develop a comprehensive Tobacco Cessation Plan and a tobacco cessation program aimed at reducing tobacco use, including associated marketing strategies.
 - (1) The program should at a minimum include the following strategies to reduce tobacco use across members
 - i. Promote tobacco free campuses at contracted facilities;
 - ii. Ensure tobacco screening and treatment, including nicotine replacement and other appropriate medications, are provided to all relevant members in both inpatient, other facility-based, and outpatient/community settings;
 - iii. Ensure tobacco use/exposure needs (including e-cigarettes) are assessed and addressed in all relevant Care Needs Screenings, Comprehensive Assessments and Care Plans/ISPs;
 - iv. Increase use of 99406 and 99407 CPT codes in all appropriate settings;
 - v. Use incentives for members and providers as allowed by the Contract;
 - vi. Use the specialized Behavioral Health Program for tobacco users with one or more BH conditions;
 - vii. Provider training;
 - viii. A yearly report on efforts and outcomes; and
 - ix. Promote and educate on the Department's Quitline benefit.
 - (e) The BH I/DD Tailored Plan shall submit the Tobacco Cessation Plan to the Department for review and approval annually or upon request by the Department.
- (iii) Opioid Misuse Prevention and Treatment Program
 - (a) The BH I/DD Tailored Plan shall implement:
 - (1) A comprehensive Opioid Misuse Prevention and Treatment Program
 - (2) A member lock-in program
 - (3) A cumulative maximum morphine milligram equivalent dosage limit not subject to utilization management prior approval, as established by the Department in opioid clinical coverage criteria
 - (4) Diagnosis codes, which may be established by the Department, exempt from the prior authorization requirements in opioid clinical coverage criteria and incorporated into the UM Program
 - (b) Opioid Misuse Prevention and Treatment Program
 - (1) The program shall:
 - i. Align with the North Carolina Opioid Action Plan, including recommendations from NC Payers Council.
 - ii. Promote appropriate utilization of healthcare resources by monitoring potential abuse or inappropriate utilization of targeted medications.
 - iii. Contain interventions that support and promote safer prescribing of opioids, management of acute and chronic pain with opioid-sparing pharmacologic non-narcotic pharmacologic, and non-pharmacologic modalities; early detection of opioid misuse and intervention; Screening, Brief Intervention and Referral to Treatment; and increased access to naloxone and substance use disorder treatment, including medication-assisted therapy (in alignment with *Section V.B.2. Benefits*).
 - iv. Promote access to naloxone through formulary structures and benefit design, in alignment with *Section V.B.2. Benefits and V.B.2.iii.(iii) Drug Formulary and PDL*

- v. Increase access substance/opioid use disorder treatment and BH treatment through Telehealth when clinically appropriate, in alignment with *Section V.B.2.i.(vi) Telehealth, Virtual Patient Communications and Remote Patient Monitoring*.
 - vi. Support programs focused on the treatment and transport to alternative sites of care for people with substance/opioid use disorder (e.g., community paramedicine)
 - vii. Plan to meet network adequacy for medication-assisted treatment for opioid use disorders as determined by the Department, including the standards laid out in the *First Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards* for office based opioid treatment (OBOT), SA Comprehensive Outpatient (adult), SA Intensive Outpatient Program (adults and children), and Opioid treatment (adult).
 - viii. Provide non-emergency medical transportation for members to substance use disorder treatment, in alignment with *Section V.B.2.iv. Non-Emergency Medical Transportation*.
 - ix. Specifically acknowledge how the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.
- (2) The program shall incorporate requirements in the Strengthen Opioid Misuse Prevention (STOP) Act¹⁹ including quantity limits, mandatory electronic prescribing, utilization of the Controlled Substances Reporting System and reporting.
 - (3) The program shall use analytics to identify outlier opioid analgesic prescribers for education, coaching, and/or fraud investigation, as approved by the Department.
 - (4) Include secure storage initiatives such as prescription drug lockboxes and chemical medication disposal kits. Encourage and improve access to information about permanent medication drop box sites, take back days and other places to safely dispose of medications.
 - (5) The program shall describe goals and metrics as specified by the Department to report progress toward goals on at least a biannual basis. Required metrics to be finalized by the Department.
 - (6) The BH I/DD Tailored Plan shall develop an Opioid Misuse Prevention and Treatment Program Policy and submit it to the Department ninety (90) days after the Contract Award. The Opioid Misuse and Prevention Program is subject to Department review and approval, and the department may require changes. The Policy shall be made available on a public website and in the BH I/DD Tailored Plan's Provider Manual.
 - (7) Member lock-in program
 - i. The BH I/DD Tailored Plan's lock-in program criteria shall comply with the Department lock-in program criteria as defined in NC Gen. Stat. § 108A-68.2.
 - ii. The BH I/DD Tailored Plan shall not require members to be enrolled in the lock-in period for more than two (2) years without reassessing for continued eligibility in the program.
 - iii. The BH I/DD Tailored Plan shall report lock-in program outcomes, including but not limited to reduced ED visits and reduced opioid misuse, in a format to be developed by the Department.

¹⁹ The STOP Act, Session Law 2017-74, <https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf>, was enacted by the NC General Assembly on June 29, 2017.

- iv. The BH I/DD Tailored Plan shall accept and enroll all individuals enrolled in NC Medicaid Direct or another BH I/DD Tailored Plan lock-in program in the BH I/DD Tailored Plan's lock-in program for the remaining duration of the lock-in period.
- (iv) Additional Prevention and Population Health Programs
- (a) The BH I/DD Tailored Plan shall actively participate in and support the Department's public health initiatives and coordinate with all existing public health and human services programs, including reporting, education and care management activities. That includes coordination with the following:
 - (1) Women, Infants and Children (WIC) Program
 - i. The BH I/DD Tailored Plan shall identify members potentially eligible for the WIC program based on the following criteria, make referrals to the WIC program, and provide comprehensive application assistance to help members access the WIC program (as described in *Section V.B.3.ii. Tailored Care Management*) as needed:
 - a) Pregnant women;
 - b) Women up to six (6) months postpartum;
 - c) Breastfeeding women up to one (1) year postpartum;
 - d) Infants; and
 - e) Children under age five (5)
 - ii. The BH I/DD Tailored Plan shall establish relationships with the WIC entities.
 - iii. The BH I/DD Tailored Plan shall collaborate with the office of the state WIC director to establish a plan to coordinate these activities and share data as needed to accomplish joint program goals.
 - (2) Newborn Screening Programs
 - i. Consistent with NC Gen. Stat. §§ 130A-125 and 130A-130.2, the BH I/DD Tailored Plan shall comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and shall ensure that all lab testing for samples drawn for newborn screening under this statute be sent to the NC State Lab for processing.
 - ii. The BH I/DD Tailored Plan shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Section VII. First Revised and Restated Attachment M.8. Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members*.
 - iii. The BH I/DD Tailored Plan shall establish a joint plan with the Department to implement reporting, education and care management activities regarding children who screen positive for hereditary and congenital disorders, including sickle cell anemia, during Contract Year 1 or a time period otherwise defined by the Department.
 - (3) Newborn Hearing Screening Program
 - i. Consistent with NC Gen. Stat. § 130A-125 and 10A NCAC 43F, the BH I/DD Tailored Plan shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the Early Hearing Detection and Intervention (EHDI) Program at <https://wcs.ncpublichealth.com>.
 - ii. The BH I/DD Tailored Plan shall establish a joint plan with the Department to implement the requirements of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or a time period otherwise defined by the Department.
 - (4) Vaccines for Children (VFC) Program and NC Immunization Registry

- i. Pursuant to Section 317(j) of the Public Health Service Act, 42 U.S.C. § 247b(j), the BH I/DD Tailored Plan shall provide education to providers on the VFC program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.
 - ii. The BH I/DD Tailored Plan shall educate providers on the use of the NC Immunization Registry.
 - (b) The BH I/DD Tailored Plan shall engage in public awareness campaigns, including federally and state-supported campaigns designed to reduce the stigma associated with BH, I/DD and TBI needs, promote prevention, wellness, healthy behavior and wellness campaigns.
 - (c) The BH I/DD Tailored Plan shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) by members and to improve the emotional health and well-being of their members
 - (d) The BH I/DD Tailored Plan will submit a plan annually for Departmental approval, as an appendix to its QAPI, which details how the BH I/DD Tailored Plan will ensure Hepatitis C and HIV screenings occur for members in accordance with Centers for Disease Control and Prevention (CDC) guidelines. See *Section V.B.5.i. Quality Management and Quality Improvement*.
- (v) Informing and Educating Members and Providers
 - (a) Members
 - (1) The BH I/DD Tailored Plan shall inform all members through the Member Handbook and through other mechanisms of the availability and accessibility of Prevention and Population Health Programs, including the use of program services.
 - (2) The BH I/DD Tailored Plan shall provide members with information regarding their participation eligibility, how to self-refer, and how to opt into or opt out of a program.
 - (3) The BH I/DD Tailored Plan shall have the option to notify the member's PCP and CMA (if applicable) of the member's participation in a Prevention and Population Health Program.
 - (b) Providers
 - (1) As part of the Provider Training Plan, the BH I/DD Tailored Plan is responsible for educating providers regarding the operation and objectives of all Prevention and Population Health programs. The BH I/DD Tailored Plan shall give providers instructions on how to access specific services and benefits.
 - (2) For those members receiving Prevention and Population Health Program support, the BH I/DD Tailored Plan will notify their PCP and CMA (if applicable) by letter, email, fax or secure web portal of their patient's involvement, unless the member notified the BH I/DD Tailored Plan not to inform their PCP and CMA (if applicable) as described above.
- x. Healthy Opportunities
 - (i) Working collaboratively with its BH I/DD Tailored Plans, the Department envisions establishing North Carolina as a national leader in optimizing the health and well-being for all by effectively stewarding resources that bridge our communities and our health care system to address all factors that impact health.
 - (ii) The Department has identified four (4) priority domains to address members' Unmet Health-Related Resource Needs: housing, food, transportation and interpersonal violence/toxic stress.
 - (iii) The BH I/DD Tailored Plan shall address these priority Healthy Opportunities domains and any other identified Unmet Health-Related Resource Needs to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:
 - (a) Tailored Care Management: The BH I/DD Tailored Plan shall establish care management competencies, workforce and procedures that enable the care team to comprehensively

address members' identified Unmet Health-Related Resource Needs, including assessing and addressing such needs; referral, and navigation, and follow-up support to connect with community-based resources and social support services; comprehensive application assistance for the programs listed in *Section V.B.3.ii.(ix) Care Team Formation* for which the member is eligible; select health-related programs, including food assistance; and assistance connecting to resources related to housing, medical-legal partnerships, and employment opportunities and to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers. For full Tailored Care Management requirements, see *Section V.B.3.ii. Tailored Care Management*.

- (b) **Quality:** The BH I/DD Tailored Plan shall report on rates of completed screenings for Unmet Health-Related Resource Needs; conduct at least one (1) non-clinical performance improvement project annually; and incorporate a description of its contributions to health-related resources in its QAPI Plan. For full quality requirements, see *Section V.B.5.i. Quality Management and Quality Improvement*.
 - (c) **VBP:** As part of its Value-Based Payment (VBP) Strategy, the BH I/DD Tailored Plan shall submit a written plan to the Department that indicates how it will incorporate addressing Unmet Health-Related Resource Needs into its overall VBP strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full VBP requirements, see *Section V.B.5.ii. Value-Based Payments (VBP)*.
 - (d) **Stakeholder Engagement:** The BH I/DD Tailored Plan shall partner with community organizations, counties, the Department and other stakeholders to understand, support and connect members with resources available in the communities it serves, including those that address members' Unmet Health-Related Resource Needs. The BH I/DD Tailored Plan shall also play an integral role in the State's supportive housing approach, including by collaborating with other public and private agencies and Department housing staff. See *Section V.A.4. Stakeholder Engagement and Community Partnerships* for full requirements.
 - (e) **In Lieu of Services:** The BH I/DD Tailored Plan is encouraged to use In Lieu of Services to offer services that improve health through connecting members with or providing resources, social services and other supports upon receipt of the Department approval. For full In Lieu of Services requirements, see *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package*.
 - (f) **Value-Added Services:** The BH I/DD Tailored Plan is encouraged to use Value-Added Services to offer services that improve health through connecting members with or providing resources, social services and other supports upon receipt of the Department approval. For full Value-Added Services requirements, see *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package*.
 - (g) **Contributions to Health-Related Resources:** The BH I/DD Tailored Plan is encouraged to make contributions to health-related resources that help to address members' and their communities' Unmet Health-Related Resource Needs. See *Section V.B.7.ii. Medical Loss Ratio* and below in this Section for full requirements.
 - (h) **Healthy Opportunities Pilot Program:** BH I/DD Tailored Plans operating in a Pilot program Region shall implement the program for its Pilot-eligible enrollees, as described below in this Section.
- (iv) The BH I/DD Tailored Plan shall use North Carolina-developed tools to address the four (4) priority domains for Healthy Opportunities including:
- (a) **Standardized Unmet Health-Related Resource Needs Questions:** As part of Tailored Care Management, the BH I/DD Tailored Plan shall undertake best efforts to conduct a care management comprehensive assessment of every member eligible for Tailored Care

Management, and a care needs screening for those members who actively opt out of care management or who are excluded from Tailored Care Management based on participation in a duplicative service, as defined in as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*. The comprehensive assessment and care needs screening shall include a set of Department-defined standardized questions to identify Unmet Health-Related Resource Needs in the priority Healthy Opportunities domains.

(b) NCCARE360:

- (1) The BH I/DD Tailored Plan shall use NCCARE360 beginning at Tailored Plan launch as described in *Section V.B.3.ii.(x) Ongoing Care Management*, to:
 - i. Act as its community-based organization and social service agency resource repository to identify local community-based resources.
 - ii. Identify community-based resources available on NCCARE360 and connect members to such resources; and
 - iii. Track the outcome of referrals to ensure that Members are connected to needed resources.
- (2) The Department will ensure that the BH I/DD Tailored Plan gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support to use NCCARE360 for its Medicaid Members at no cost to the BH I/DD Tailored Plan. All BH I/DD Tailored Plan requirements outlined in this Subsection are available through the NCCARE360 Base Package and Base Support.
 - i. NCCARE360 Base Package includes:
 - a) Unlimited NCCARE360 licenses for BH I/DD Tailored Plan users to assist Medicaid Members;
 - b) Unite Us standard reporting package; and
 - c) Unite Us pre-launch workflow consultation and planning
 - ii. NCCARE360 Base Support includes:
 - a) One-time in-person training;
 - b) Self-guided e-learning training;
 - c) Recurring Unite Us training webinars;
 - d) License maintenance and updates; and
 - e) Technical support ticketing.
- (3) The BH I/DD Tailored Plan may, at its discretion, add additional NCCARE360 product offerings or services other than the Base Package and Base Support, such as interoperability or integration capabilities, payment interfaces or software, or solutions engineering. The BH I/DD Tailored Plan shall pay for any additional offerings or services above the Base Package and Base Support functionality described in *Section V.C.8.e.ii.b*. Sharing or sublicensing access to the base package as describe above, is not considered an add on as described in this subsection.
- (4) The BH I/DD Tailored Plan shall work directly with Unite USA, Inc. to:
 - i. Execute necessary agreements with Unite USA, Inc. to access the NCCARE360 licenses and training purchased by the Department.
 - ii. Ensure that care management staff who will use NCCARE360 receive NCCARE360 training.
- (5) Other care management entities under contract with Tailored Plans :
 - i. Care management entities (including AMH+s/CMAs) are encouraged, but not required, to use NCCARE360 for the functions outlined in *Section V.C.8.e.ii.a*, unless the entity is participating in the Healthy Opportunities Pilots, in which case it is required to use NCCARE360.

- ii. The Department intends to work with Unite USA, Inc. to facilitate NCCARE360 licensing and training for delegated care management entities.
 - iii. The Department will ensure that any care management entity that chooses to use NCCARE360 for the functions outlined in *Section V.C.8.e.ii.a* for Medicaid Members gains and maintains access to the Unite USA, Inc. (doing business as Unite Us) NCCARE360 Base Package and Base Support, as outlined in *Section V.C.8.e.ii.b*, to use NCCARE360 for Medicaid Members at no cost to the care management entity. All BH I/DD Tailored Plan requirements outlined in *Section V.C.8.e.ii.a* are available through the NCCARE360 Base Package and Base Support.
- (c) The BH I/DD Tailored Plan shall participate in regular meetings with the Department regarding their use of NCCARE360 during the implementation, onboarding, and training process to discuss progress, challenges, and best practices. The Department may release additional guidance on NCCARE360-related topics such as consent, privacy/security/confidentiality, reporting, and licensure.
- (d) North Carolina “Hot Spot” Map: The NC “Hot Spot” Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. The BH I/DD Tailored Plan may use this tool to strategically guide contributions to health-related resources in the communities it serves. (The “Hot Spot” map is available at: <http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b>)
- (v) Contributions to Health-Related Resources:
 - (a) The Department encourages the BH I/DD Tailored Plan to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the communities it serves.
 - (b) The BH I/DD Tailored Plan that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V.B.7.ii. Medical Loss Ratio*, subject to Department review and approval.
 - (c) The BH I/DD Tailored Plan is encouraged to identify opportunities to contribute to health-related resources in the QAPI plan. See *Section V.B.5.i. Quality Management and Quality Improvement*.
- (vi) Healthy Opportunities Pilots to Address Unmet Health-Related Resource Needs, also known as Healthy Opportunities Pilots
 - (a) Background
 - (1) CMS has authorized an Enhanced Case Management and Other Services Pilot, the “Healthy Opportunities Pilot program,” for a five (5)-year period, from November 1, 2019, through October 31, 2024, as a part of North Carolina’s Section 1115 Medicaid Demonstration waiver.
 - (2) Through the Healthy Opportunities Pilot program, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) Healthy Opportunities priority domains (housing, food, transportation, and interpersonal violence/toxic stress) can be delivered effectively to Medicaid members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the Pilot program is to learn which evidence-based interventions and processes are most effective to improve health, lower health care costs for specific populations, and to inform health care delivery statewide.
 - (3) Through a competitive procurement process, the Department will procure up to three (3) Lead Pilot Entities and define Healthy Opportunities Pilot Regions in the State to provide

a subset of Medicaid beneficiaries with services, interventions and benefits targeted to measurably improve health and lower costs.

- (4) A local Pilot Region :
 - i. Must cover no less than three (3) contiguous North Carolina counties;
 - ii. Shall cover the entirety of any county included in the Local Pilot Region;
 - iii. May cross Standard Plan and BH I/DD Tailored Plan_BH I/DD Tailored Plan_Region boundaries;
 - iv. Will promote cross-county collaboration since Medicaid Members seek services across county lines; and
 - v. May include a subset of counties from within the_BH I/DD Tailored Plan regions.
 - (5) The Lead Pilot Entity's primary role is to develop, contract with and manage a network of Human Service Organizations (HSOs) to deliver the evidence-based Pilot interventions across each of the four (4) Healthy Opportunities priority domains for Medicaid members within the Pilot Regions.
- (b) BH I/DD Tailored Plan Pilot Program Responsibilities. Any BH I/DD Tailored Plan operating in a local Pilot Region shall implement the Pilot program for its Pilot-eligible members, contingent on the availability of state and federal funding, in accordance with the roles and responsibilities enumerated below and in any additional requirements and guidance issued by the Department:
- (1) Receive payments from the Department up to a specific capped allotment to fund Pilot services, based on the anticipated cost and volume of specified services authorized for the BH I/DD Tailored Plan's eligible members, and recognizing the overall cap on federal funds under the 1115 waiver. This allotment will be in addition to and not included in the Medicaid Managed Care capitation payments.
 - (2) Manage total Pilot funding against allocations for eligible populations and Pilot services.
 - i. The Department may provide further requirements and/or guidance to ensure that Pilot services are targeted to the Pilot-eligible Medicaid members for whom Pilot services may most efficiently improve outcomes and/or reduce costs and that Pilot participants receive the least costly, most necessary and appropriate Pilot services.
 - (3) Make payments to other Pilot-participating entities for executing Pilot responsibilities and for delivering Pilot services from the Pilot allocations, consistent with guidance to be developed by the Department.
 - (4) Determine eligibility for and authorize Pilot program enrollment and specific Pilot services for members, based on guidelines to be developed by the Department.
 - i. Pilot program eligibility criteria include, at a minimum, physical and BH qualifying conditions and social risk factors as defined in the 1115 waiver. Each Pilot service may also have specific eligibility criteria determined by the Department.
 - (5) Ensure that Pilot services do not displace nor duplicate other services, resources or programs for which the member is eligible, including Medicaid State Plan services, Medicaid waiver services, State-funded Services provided by the BH I/DD Tailored Plan, or other resources or programs available to the member, including those provided by the BH I/DD Tailored Plan.
 - i. The Department shall provide guidance to BH I/DD Tailored Plans regarding which services, resources and programs have been identified by the Department as duplicative with Pilot program services. The BH I/DD Tailored Plan may add to the Department's list of potentially duplicative or displaceable services, resources and programs as part of the Pilot authorization approach, based on its knowledge and experience. The BH I/DD Tailored Plan shall provide this list to the Department upon request.

- ii. The BH I/DD Tailored Plan shall define and implement policies and procedures for authorizing Pilot services as part of its UM program, consistent with *Section V.B.2.i.(v) Utilization Management*, that provide for:
 - a) Validation that no identified other service, resource or program, including those managed by the BH I/DD Tailored Plan, would meet the member's Pilot service needs is available to the member at the time of Pilot service authorization, consistent with Department guidance.
 - b) Validation that the member's Pilot service needs cannot be fully addressed through an identified, available federal, State or local program (e.g., the Supplemental Nutrition Assistance Program), consistent with Department guidance, at the time of Pilot service authorization.
 - c) If a federal, State or local program is available that could address the member's Pilot service needs in full or in part, the authorization process must ensure that Tailored Care Management requirements, as outlined in *Section V.B.3.ii. Tailored Care Management*, that require connecting the member with those services, including in some cases through comprehensive application assistance, have been fulfilled.
 - d) The BH I/DD Tailored Plan's Pilot service authorization process must include verification of connection to and/or the provision of comprehensive application assistance to relevant available programs, where applicable.
 - e) The BH I/DD Tailored Plan may not authorize Pilot services once the member is receiving services from another federal, state or local program, if that program fully meets the member's Pilot service need.
 - f) Training for staff conducting Pilot service authorization specific to preventing duplication and displacement of BH I/DD Tailored Plan-managed and other available services, resources and programs with Pilot services.
 - g) Regular, at least monthly, audits of Pilot service authorization procedures and outcomes to prevent duplication or displacement of BH I/DD Tailored Plan-managed and other available services, resources and programs with Pilot services.
 - iii. The BH I/DD Tailored Plan shall:
 - a) Make Pilot service authorization policies and procedures available to the Department upon request.
 - b) Retain documentation of member-level Pilot service authorization determinations, including validation that no identified duplicative or displaceable service, resource or program, including those managed by the BH I/DD Tailored Plan, that could meet the member's Pilot service need was available to the member at the time of Pilot service authorization for the time period specified in *Section III.C.39: Records Retention*.
 - c) Make member-level Pilot service authorization documentation available to the Department upon request, including for monitoring and audits, in accordance with *Section III.D.40. Response To State Inquires And Request For Information*.
- (6) Contract with any Lead Pilot Entity operating within the BH I/DD Tailored Plan Region for the use of the Lead Pilot Entity's HSO network for delivery of Pilot services to eligible members residing in the local Pilot Region using a Department developed model contract.
- (7) Submit data and reports to support the Department's efforts to oversee and evaluate the Pilot program, as described in *Section V.B.3.x.(vi) Healthy Opportunities Pilots to Address*

Unmet Health-Related Resource Needs: Reporting Requirements and Section VII. First Revised and Restated Attachment J. Reporting Requirements.

- (8) Participate in learning collaboratives with the Department and other Pilot-participating entities to share best practices and improve Pilot program policies and practices.
 - (9) Support the Department's efforts to evaluate the effectiveness of the Pilot program by reporting on a range of metrics in a form and frequency to be determined by the Department, and as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements* including but not limited to reports on:
 - i. Pilot enrollment;
 - ii. Pilot service utilization;
 - iii. Pilot expenditures;
 - iv. Pilot-participating member health outcomes; and
 - v. Pilot-participating member cost and utilization metric.
 - (10) Expenditures on and utilization of services and other resources managed by the BH I/DD Tailored Plan that may be duplicated or displaced by Pilot services, as identified in guidance to be developed by the Department, by members residing in local Pilot Region counties.
- (c) Care Manager Pilot Program Responsibilities. The BH I/DD Tailored Plan shall utilize care managers to execute key Pilot program functions. Care managers with Pilot program responsibilities may be employed by or under contract with the BH I/DD Tailored Plan, or an AMH+, CMA, Local Health Department (for some members excluded from Tailored Care Management) or High-Fidelity Wraparound (for some members excluded from Tailored Care Management). The BH I/DD Tailored Plan shall ensure that care managers assigned to members residing in Pilot program Regions:
- (1) Evaluate members using a forthcoming Department-developed Pilot Program Eligibility and Assessment form to assess whether they meet baseline Pilot eligibility criteria.
 - (2) Integrate a member's need for, authorization of, referral to and status of Pilot services into the member's Care Plan or ISP.
 - (3) Secure determination of Pilot program enrollment and authorization of Pilot services from the BH I/DD Tailored Plan.
 - (4) Obtain authorized members' Pilot program participation consent, including related to enrollment, Pilot services and information sharing, based on guidance to be developed by the Department.
 - (5) Communicates approved Pilot enrollment determination and service authorization to members.
 - (6) Refer members approved for Pilot program enrollment and specific Pilot services to HSOs in the Lead Pilot Entity's network for approved Pilot services and track Pilot services delivered to Pilot participants by conducting "closed-loop referrals," using the NCCARE360 platform.
 - (7) Conduct a reassessment of:
 - i. Eligibility for specific Pilot services no less frequently than every three (3) months, or earlier if a member experiences a change in eligibility for an identified service, resource or program that can meet the member's Pilot service need, including those managed directly by BH I/DD Tailored Plans; and,
 - ii. Eligibility for the Pilot program and services no less frequently than every six (6) months.

- (8) Support the Department’s Pilot program oversight and evaluation efforts by providing information and data on Pilot participants and Pilot program operations in accordance with guidance to be developed by the Department.
 - (9) Meet any other Pilot-related requirements outlined by the Department.
 - (d) For members excluded from Tailored Care Management and residing in Pilot program Regions, the BH I/DD Tailored Plan shall:
 - (1) Conduct the above Pilot-related care manager responsibilities directly for those members obtaining ACT services;
 - (2) Require that the above Pilot-related care manager responsibilities are conducted by the LHD for members receiving CMARC and excluded from Tailored Care Management; and
 - (3) Require that the above Pilot-related care manager responsibilities are conducted by the High-fidelity Wraparound team for members receiving High-fidelity Wraparound services.
 - (4) Exclude individuals receiving ICF-IID services from Pilot program eligibility, following Pilot eligibility and enrollment procedures to be defined in Department guidance.
- xi. Relocation of Members Following Emergency Residential Care Facility Closures
 - (i) The Department understands that the safe and prompt relocation of members residing in licensed residential care facilities that suddenly close requires coordination across multiple Divisions, local services agencies and BH I/DD Tailored Plans.
 - (ii) The BH I/DD Tailored Plan shall assist the transition of care and relocation of members in licensed residential care facilities subject to Emergency Closure in accordance with the Department’s Operational Guide for a Coordinated Response to a Sudden Closure of an Adult Residential Care Facility, or as otherwise defined by the Department.²⁰
 - (iii) Emergency Closures of Adult Care Homes:
 - (a) The Department has developed an intra-Departmental Emergency Closures “Adult Care Home (ACH) Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions—DHSR, DAAS and DMH/DD/SAS—BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program these are housed within the Area Authorities on Aging).
 - (b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closures “Adult Care Response Hub” upon notification of an Emergency Closures of a licensed group home where members reside.
 - (c) The BH I/DD Tailored Plan shall be responsible for relocating members following Emergency Closures of adult care homes and coordinating with the local DSS on the following activities:
 - (1) Conduct a site visit of the ACH that is closing;
 - (2) Identify members who are residents;
 - (3) Meet with members and/or guardians;
 - (4) Implement a relocation plan for members;
 - (5) Link members to services as appropriate;
 - (6) Review member medication needs and manage personal items;
 - (7) Participate in daily morning situation calls;
 - (8) Submit discharge information to local DSS contact person;
 - (9) Follow up with relocated members; and
 - (10) Participate in debrief conference call after the closure.

²⁰ The Department’s Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Care Facility is available here: https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf

(iv) Emergency Closures of Group Homes

- (a) The Department has developed an intra-Departmental Emergency Closures “Group Home Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents. The “Group Home Response Hub” is comprised of the following Divisional partners: DHSR, DMH/DD/SAS, DHB and DAAS.
- (b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closure “Group Home Response Hub” upon notification of an Emergency Closure of a licensed group home where members reside.
- (c) The BH I/DD Tailored Plan shall be responsible for relocating members following Emergency Closures of group homes including taking the following steps to appropriately and quickly transition care. Additionally, as needed, the Department will support the BH I/DD Tailored Plan in facilitating such care transitions and coordinating with the local DSS on the following activities:
 - (1) Conduct a site visit of group home that is closing;
 - (2) Identify members who are residents;
 - (3) Meet with members and/or guardians;
 - (4) Implement relocation plan for members;
 - (5) Link members to services as appropriate;
 - (6) Review member medication needs and manage personal items;
 - (7) Participate in daily morning situation calls;
 - (8) Submit discharge information to the Department;
 - (9) Follow up with relocated members; and
 - (10) Participate in debrief conference call after the closure.

4. Providers

i. Provider Network

- (i) Providers are the backbone of North Carolina’s Medicaid and NC Health Choice Program and the Department has a rich tradition of partnering with the provider community to support the Department’s overall vision of creating a healthier North Carolina. The Department seeks BH I/DD Tailored Plans that share and support that tradition.
- (ii) The Department seeks a BH I/DD Tailored Plan with a robust Network to meet the medical, BH, I/DD, TBI, LTSS, and pharmacy needs of all members within its Region, including those with limited English proficiency, physical disability, or BH I/DD needs. The BH I/DD Tailored Plan shall demonstrate that its Network meets Department’s availability, access, quality goals, and requirements and is willing to act to continuously improve its delivery of health care services to members.
- (iii) Availability of Services (42 C.F.R. § 438.206)
 - (a) The BH I/DD Tailored Plan shall establish and maintain a Network that is sufficient to ensure that all services covered under the Contract are available and accessible to all members in a timely manner, including those members with limited English proficiency or physical or mental disabilities. The BH I/DD Tailored Plan shall enter into a written contract with each Network provider, the terms of which are further specified herein.
 - (b) The BH I/DD Tailored Plan shall meet all federal and state provisions for availability, including:
 - (1) Providing for a second opinion from a Network provider or arrange for the member to obtain an opinion from an out-of-network provider at no cost to the member if requested by the member, provided that the out-of-network provider is not excluded from participation in federal or the State’s health care programs and subject to the UM program requirements if applicable. The BH I/DD Tailored Plan shall clearly state its procedure for obtaining a second opinion in its Member Handbook.

- (2) Adequately and timely covering services out-of-network for a member if the BH I/DD Tailored Plan's network is unable to provide the covered service within its current Network, taking into account the urgency of the need for services. BH I/DD Tailored Plan shall cover the member's out-of-network services for the duration of the Network's inability to provide them in network.
 - (3) Ensuring that no incentive is given to providers, monetary or otherwise, for withholding medically necessary services.
 - (4) Coordinating payment for services to out-of-network providers and ensuring the cost to the member is not greater than it would be if the services were furnished by a Network provider.
 - (5) Ensuring there are sufficient family planning providers to ensure timely access to covered services.
 - (6) Providing female members with direct access to a women's health specialist within the Network for covered care necessary to provide women's routine and preventive health care services; this shall be in addition to the member's designated provider of primary care if that provider is not a women's health specialist.
- (c) Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)
- (1) The BH I/DD Tailored Plan shall make good faith efforts to contract with Indian Health Care Providers (IHCPs) and demonstrate that a sufficient number of IHCPs are participating in its network to ensure timely access to contracted services for the members of federally recognized tribes and other individuals eligible to receive services at IHS facilities.
 - (2) The BH I/DD Tailored Plan shall allow any members eligible to receive services from an IHCP to choose the IHCP, without contract, as the member's PCP if the IHCP has the capacity to provide PCP services. The BH I/DD Tailored Plan shall consider any referral from such IHCP acting as the member's PCP to a Network provider as satisfying any coordination of care or referral requirement of the Contract, as described in *Section V.A.4.i. Engagement with Tribes for Medicaid Only*.
 - (3) The BH I/DD Tailored Plan shall provide members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
 - (4) The BH I/DD Tailored Plan shall permit members to obtain services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.
 - (5) If the BH I/DD Tailored Plan cannot provide timely access to necessary services in state and/or in-network for Tribal members, the BH I/DD Tailored Plan must provide access to out-of-state and/or out-of-network IHCPs.
 - (6) The BH I/DD Tailored Plan must refer Tribal members to IHCPs and other sources of Culturally and Linguistically Competent care as determined by the Department. The BH I/DD Tailored Plan enrolling Tribal populations shall provide training for Culturally and Linguistically Competent care to all of its Network providers.
 - (7) The BH I/DD Tailored Plan shall permit out-of-network IHCPs to make referrals to Network providers for any of its members without prior authorization or a referral from a Network provider.
 - (8) The BH I/DD Tailored Plan shall permit IHCPs to refer its member to any provider within the IHCP Purchased and Referred Care network, even if the provider is not a Network provider, without having to obtain prior authorization or a referral from a Network provider

- (9) The BH I/DD Tailored Plan shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contracted health services.
- (d) Outpatient Commitment
- (1) The BH I/DD Tailored Plan shall ensure the availability of qualified providers of services provided under Outpatient Commitment to members who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment.
 - (2) Consistent with the requirements in N.C. Gen. Stat. § 122C-263, the BH I/DD Tailored Plan shall be able to accept a copy of the Outpatient Commitment order for members who are served by Network outpatient treatment physicians and centers.
 - (3) 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.
 - (4) Once the BH I/DD Tailored Plan is notified of a member's Outpatient Commitment order, the BH I/DD Tailored Plan shall provide care management services for its members who are under an Outpatient Commitment order in accordance with *Section V.C.3. Care Management and Prevention*.
- (e) Pharmacy Services
- (1) The BH I/DD Tailored Plan shall ensure its pharmacy Network meets the time or distance standards defined in *Section VII. First Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*, as amended by the Department from time to time.
 - (2) The BH I/DD Tailored Plan shall maintain a Pharmacy Provider Network Audit Program. The BH I/DD Tailored Plan shall submit the program to Department for approval ninety (90) days after Contract Award and annually thereafter.
 - (3) The BH I/DD Tailored Plan shall not require members to accept mail order pharmacy services unless mail order is the only dispensing channel for a drug. The BH I/DD Tailored Plan may allow members to choose to receive prescribed drugs through mail order pharmacy services.
 - (4) The BH I/DD Tailored Plan shall submit its Mail Order Program Policy, including a sample of all member mail order-related correspondence, to the Department for approval ninety (90) days after Contract Award and annually thereafter. The BH I/DD Tailored Plan shall specifically identify any pharmacy service where mail order is the only dispensing channel for a drug.
 - i. The request for approval must be submitted in accordance with the Implementation Plan.
 - ii. The BH I/DD Tailored Plan must submit any Significant Changes to its mail order program to Department for approval at least ninety (90) Calendar Days before implementation target date of the change.
 - (5) The BH I/DD Tailored Plan may contract with a limited specialty pharmacy network if the BH I/DD Tailored Plan demonstrates that:
 - i. A specialty drug is only available through a limited network of pharmacies; and
 - ii. The specialty pharmacy has clinical and care coordination programs that improve medication adherence and drug therapy outcomes.
 - (6) BH I/DD Tailored Plan may contract with 340B covered entities. Drugs purchased through the 340B program shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus dispensing fee as defined in *Section V.B.2.iii. Pharmacy Benefits*.

- (f) Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services
 - (1) The BH I/DD Tailored Plan may use Telehealth, Virtual Patient Communications and Remote Patient Monitoring as tools for facilitating access to needed services in a clinically appropriate manner that are not available from providers in the Network and in accordance with the NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communication and Remote Patient Monitoring.
 - (2) The BH I/DD Tailored Plan shall be permitted to include Telehealth in its Request for Exception to the Department's BH I/DD Tailored Plan Network adequacy standards, as clinically appropriate.
 - (3) The BH I/DD Tailored Plan shall not require a member to receive services from Telehealth, Virtual Patient Communications and Remote Patient Monitoring and must allow the member to access an in-person service from an out-of-network provider, if the member requests.
 - (4) Access to Telehealth providers does not count toward meeting Network adequacy standards, unless approved as part of an exception to Network requirements.
- (g) Innovations and Traumatic Brain Injury Waiver Services
 - (1) The BH I/DD Tailored Plan shall ensure that Innovations providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and requirements set forth by the Department.
 - (2) The BH I/DD Tailored Plan shall ensure that TBI waiver providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and requirements set forth by the Department.
 - (3) Provider agencies shall comply with the applicable provider specifications for services set forth in the TBI and the Innovations waivers.
 - (4) For Beneficiaries enrolled in the Tribal Option for primary care case management who also receive services through the Innovations waiver, Innovations waiver services shall be provided by the BH I/DD Tailored Plan operating in Region 1. The BH I/DD Tailored Plan shall coordinate with the Tribal Option to ensure the receipt and coordination of appropriate services
 - (5) National accreditation is required of most providers of Innovations and TBI waiver services per the NC Innovations and TBI waivers. Upon contracting with the BH I/DD Tailored Plan, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the waiver(s). The provider organization must be established as a legally constituted entity capable of meeting all of the requirements of the BH I/DD Tailored Plan.
- (h) SUD Residential Treatment Services
 - (1) BH I/DD Tailored Plans shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VII. First Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*.
 - (2) The Department will establish network adequacy standards for SUD residential treatment services prior to BH I/DD Tailored Plan launch.
- (iv) Furnishing of Services (42 C.F.R. § 438.206(c))
 - (a) The BH I/DD Tailored Plan shall meet the network time or travel distance, and appointment wait time standards established by the Department as described in *Section VII. First Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*, unless otherwise approved by the Department in accordance with the requirements herein.

- (1) The BH I/DD Tailored Plan shall monitor Network providers regularly to determine compliance with the timely access requirements.
 - (2) The BH I/DD Tailored Plan shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
 - (3) The Department is studying the application of provider-patient ratios and may implement ratios by Region. The Department shall provide the BH I/DD Tailored Plan one hundred twenty (120) Calendar Days prior notice of the ratio requirements.
 - (4) The Department may adopt new or amend the network time or travel distance, appointment wait time, or other adequacy standards from time-to-time through an amendment to the Contract or through Notice to the BH I/DD Tailored Plan as defined in *Section III D.32. Notices*. BH I/DD Tailored Plan shall comply with the new or amended standards as directed by the Department, but the BH I/DD Tailored Plan shall have no less than ninety (90) Calendar Days to comply with any new or amended network adequacy standards adopted by the Department
- (b) The BH I/DD Tailored Plan shall meet and require its Network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services.
 - (c) The BH I/DD Tailored Plan shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service, if the provider serves only Medicaid or NC Health Choice.
 - (1) The Department may require after hours and weekend hours to address the needs of the member.
 - (d) The BH I/DD Tailored Plan shall ensure that covered services are available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
 - (e) The BH I/DD Tailored Plan shall ensure that Network providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all members with physical disabilities or BH I/DD needs.
 - (f) The BH I/DD Tailored Plan shall promote the delivery of services by Network providers in a Culturally and Linguistically Competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation or gender identity.
 - (1) The BH I/DD Tailored Plan shall assist providers with meeting these requirements, including educating providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.
 - (2) The BH I/DD Tailored Plan shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.
 - (3) The BH I/DD Tailored Plan shall ensure that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment that does not affirm their orientation
 - (g) The BH I/DD Tailored Plan is encouraged to contract with providers outside of the BH I/DD Tailored Plan's Region to ensure services to meet member's accessibility needs.
 - (1) An individual member's accessibility and BH I/DD Tailored Plan's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.
- (v) Essential Providers

- (a) The BH I/DD Tailored Plan shall include all Essential Providers located in the BH I/DD Tailored Plan's Region in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.
 - (1) Essential Providers include federally qualified health centers, rural health centers, free clinics, local health departments, and any other providers as designated by the Department. N.C. Gen. Stat. § 108D-22(b),
 - (2) Except for a Veterans Home, a BH I/DD Tailored Plan must submit a request for an alternative arrangement relating to any Essential Provider with whom the BH I/DD Tailored Plan has failed to contract.
 - (3) The BH I/DD Tailored Plan shall contract with newly identified Essential Providers within 90 calendar days of notification of the addition of a new Essential Provider. If at the end of the 90 days a contract with the Essential Provider has not been established, the BH I/DD Tailored Plan shall submit a request for an alternative arrangement relating to the Essential Provider.
- (b) At such time the BH I/DD Tailored Plan is notified by the Department that a member is determined eligible for and transferred for treatment to a Department of Military and Veterans Affairs (DMVA)-operated Veterans Home, the BH I/DD Tailored Plan shall include the Veterans Home operated by the DMVA in its Network as an Essential Provider and shall reimburse the veterans home at the rates established by the Department until such time as the member is disenrolled as provided in the Contract.
- (vi) Exceptions to Network Requirements
 - (a) Network adequacy measures ensure the BH I/DD Tailored Plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, and all health care services included under the terms of the Contract. Recognizing that there are circumstances which cannot be remedied by the BH I/DD Tailored Plan alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to network requirements in a time-limited manner.
 - (b) The BH I/DD Tailored Plan may request approval for an alternative arrangement in contracting with an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision. An alternative arrangement request must:
 - (1) Be made for each Essential Provider that the BH I/DD Tailored Plan is proposing to not contract with;
 - (2) Describe efforts to negotiate in good faith;
 - (3) Include justification for the alternative arrangement with a description of how the alternative arrangement will meet member needs; and
 - (4) Include the BH I/DD Tailored Plan's approach to address member needs and remedy the need for the alternative arrangement including a suggested time line for implementation.
 - (c) In accordance with 42 C.F.R. § 438.68(d)(1), the BH I/DD Tailored Plan may request Department approval for an exception to meeting the Department's BH I/DD Tailored Plan network adequacy standards in a specific county for a specific provider type and Member age (adult or pediatric, as applicable). Requests must:
 - (1) Be made in writing;
 - (2) Describe efforts to negotiate in good faith;
 - (3) Include justification for the exception and a description of how member needs for the specific county and provider type will be met; and

- (4) Include the BH I/DD Tailored Plan's plan to address member needs and remedy the network deficiency, including an estimated time line to close the network gap.
- (d) The Department's approval of an exception request to the BH I/DD Tailored Plan network adequacy standards or an Essential Provider alternative arrangement will be limited to specific time frame. Forty-five (45) Calendar Days before an exception/alternative arrangement is set to expire, the BH I/DD Tailored Plan shall submit a new request for the exception or alternative arrangement or inform the Department the exception and alternative arrangement is no longer needed.
- (e) The Department is not required to approve a request for an alternative arrangement with an Essential Provider or exception to meeting the Department's BH I/DD Tailored Plan network adequacy standards and may deem a BH I/DD Tailored Plan to be out of compliance.
- (vii) Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)
- (a) The BH I/DD Tailored Plan shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's BH I/DD Tailored Plan Network adequacy standards (as found *Section VII. First Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*), state and federal law, and the terms of this Contract.
- (1) The BH I/DD Tailored Plan's Network Access Plan must:
- i. Demonstrate compliance, or submit plans for compliance before launch of BH I/DD Tailored Plans, with all the following components:
 - a) Offers an appropriate range of preventive, primary care, specialty, BH I/DD, TBI, LTSS, and pharmacy services that is adequate for the anticipated number of members for the Region.
 - b) Maintains a Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the Region, including Tribal members.
 - ii. Include procedures to address the following:
 - a) Referrals;
 - b) Disclosures and notices to members of BH I/DD Tailored Plan services and features;
 - iii. Coordination and continuity of care; and
 - iv. Transition of Care that complies with Department requirements set forth in *Section V.B.1.iv. Transition of Care*.
 - v. Demonstrate the BH I/DD Tailored Plan's efforts to:
 - a) Address the needs of all members, including those with limited English proficiency or illiteracy;
 - b) Address the needs of Historically Marginalized Populations;
 - c) Ensure that Network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities;
 - d) Assist the Department, as directed, to assess the capacity of select providers to ensure that members residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:
 - 1) Nursing homes licensed under 10A NCAC 13D
 - 2) Community ICF-IIDs licensed under 10A NCAC 27G .2100

- 3) Behavioral health residential treatment facilities licensed under 10A NCAC 27G .1300, .1700, .3100, 3200, .3400, .4100, .4300, .5600
 - 4) Adult care homes licensed under 10A NCAC 13F and 13G
 - e) Support and sustain providers, including hospitals, in rural and other traditionally underserved areas, as well as providers representative of Historically Marginalized Populations; and
 - f) Reach agreements with local education agencies that are responsible for providing the education within child and adolescent day treatment programs. This may include, but is not limited to, the list of school districts with which the BH I/DD Tailored Plan has an agreement for day treatment and how these agreements provide adequate coverage.
 - g) Assist the Department, as directed, to assess the capacity of nursing home providers to ensure that members residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies where in-person visitation is restricted.
- vi. Include the BH I/DD Tailored Plan's:
- a) Efforts to establish a Network that meets the Department's BH I/DD Tailored Plan Network adequacy standards.
 - b) Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all members on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a calendar quarter.
 - c) Factors used to build the Network, including a description of the Network and how the BH I/DD Tailored Plan uses the Medicaid Enrolled Provider data supplied by the Department, or the Department's vendor, in its network development and provider contracting process.
 - d) Process and methodology to understand the distribution of member health care needs against available providers and provider capacity to serve those needs.
 - e) Plan to provide timely access to the tribal population to contracted services from a sufficient number of IHCPs.
 - f) Plan to provide access to contracted services for Non-emergency Medical Transportation in accordance with *Section V.B.2.iv. Non-Emergency Medical Transportation*.
 - g) Plan to provide in-network access, compliant with the Department's BH I/DD Tailored Plan network adequacy standards, to children to the full range of age-appropriate health care providers, subspecialists and facilities, including:
 - 1) Method for ensuring children's physical health, BH, and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in pediatrics or in child health and development and approach to assure children's access to child psychologists, child and adolescent psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomate status as a child/adolescent psychiatrist), pediatric occupational, physical and speech therapists, pediatric neurologists, and pediatric surgeons.
 - h) Reserved.

- i) Report annually to Department on the number of members under age eighteen (18) who are prescribed an antipsychotic medication and the proportion who have been assessed at least once in the preceding twelve (12) months in the outpatient setting by a child/adolescent psychiatrist (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).
- j) Approach to assure members residing in CASPs that are outside of the BH I/DD Tailored Plan's Region have access to physical health providers (e.g., primary care, specialty care, etc.), including through collaboration with the BH I/DD Tailored Plan that covers the Region where the CASP is located.
- k) Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
- l) Geographical location of providers in the Network in relation to where members reside.
- m) The BH I/DD Tailored Plan shall describe how it will address Cultural and Linguistic Competency for specific populations, such as people with TBIs, people with disabilities, people who are blind or visually impaired, people who are deaf or hard of hearing, members who are in the Armed Services, veterans and their families, pregnant women with SUD, people who identify themselves as LGBTQ, people who are in jails or prisons, youth in the juvenile justice system, justice-involved populations more broadly, Historically Marginalized Populations, and other vulnerable populations.
- n) Strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:
 - 1) Electroconvulsive therapy (ECT) for indicated conditions, including how the BH I/DD Tailored Plan shall ensure appropriate Regional availability of both inpatient and outpatient ECT, develop clinical practice guidelines related to appropriate utilization of ECT and educate and train network providers on appropriate utilization of ECT consistent with these clinical guidelines;
 - 2) Clozapine for the treatment of chronic psychotic disorders, including how the BH I/DD Tailored Plan shall:
 - 3) Analyze and monitor clozapine utilization, including how the target population for clozapine use would be defined, baseline current utilization for the BH I/DD Tailored Plan current estimated target population, and goal targets for future utilization with timelines to achieve the targets;
 - 4) Develop clinical practice guideline(s) related to appropriate utilization of clozapine and educate and train network providers on clozapine utilization consistent with these clinical guidelines; and
 - 5) Pursue other efforts to enhance access and develop provider capacity for clozapine prescribing (e.g. leverage Telehealth, organize learning collaboratives, support infrastructure for required medical/lab monitoring).
- o) First episode psychosis programs (FEP), including how the BH I/DD Tailored Plan shall: analyze and monitor utilization of FEPs, develop clinical practice guideline(s) related to appropriate utilization of FEP and education and training of providers, and pursue efforts to enhance access and develop FEP capacity with

- a focus on members between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect individuals to existing programs, conduct active surveillance of those at-risk).
- vii. Detail how the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.
- (2) The Network Access Plan must be provided as follows:
 - i. Thirty (30) days after Contract Award;
 - ii. As specified by the Department;
 - iii. Annually; and
 - iv. Within thirty (30) days of a Significant Change, including merger or county disengagement.
 - (3) Format of Network Access Plan
 - i. The BH I/DD Tailored Plan's Network Access Plan shall use the current format a provided by the Department.
 - ii. The Department will provide the template no later than seven (7) Calendar Days after Contract award.
 - iii. Future revisions to the template will be issued no less than thirty (30) Calendar Days' notice.
 - (4) The demonstration that the BH I/DD Tailored Plan has the capacity to serve the expected enrollment shall be on a county basis for every county in the BH I/DD Tailored Plan's Region.
 - (5) The Department shall supply to the BH I/DD Tailored Plan member eligibility information, including county of residence and zip codes for each Medicaid and NC Health Choice beneficiary that is in the BH I/DD Tailored Plan-eligible population as of the date of the Department's report. The information will be provided to the BH I/DD Tailored Plan, at a date to be defined by the Department for purposes of demonstrating compliance with the time or distance standards found in *Section VII. First Revised and Restated Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid* during the Readiness Review, and as other times as needed as part of the network adequacy oversight.
 - (6) The Network Access Plan shall be subject to Department review and approval. The BH I/DD Tailored Plan shall amend the Network Access Plan as directed by the Department.
- (b) The BH I/DD Tailored Plan and its Network providers shall comply and cooperate with EQRO network adequacy validations and activities including:
 - (1) Annual validation of BH I/DD Tailored Plan's network adequacy and compliance with state and federal network requirements.; and
 - (2) Telephone surveys of Network providers to verify accuracy of reported data or other aspects of program requirements or performance.
 - (c) The BH I/DD Tailored Plan shall provide the Department with Network data files quarterly and anytime there is Significant Change that impacts network adequacy and the ability to provide services. The Department shall prescribe the standardized file format and content. The standardized detailed file layout must include, but is not limited to, the following data elements:
 - (1) Provider names (first, middle, last);
 - (2) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - (3) Street address(as) of service location(s);
 - (4) County(ies) of service location(s);
 - (5) Telephone number(s) at each location;

- (6) Provider specialty;
 - (7) Provider NPI or API;
 - (8) NPI type (individual or organization/facility providers);
 - (9) Taxonomy(ies);
 - (10) Whether provider is accepting new members and the conditions if applicable;
 - (11) Identification as an IHCP;
 - (12) Identification as an Essential Provider;
 - (13) Identification as an Advanced Medical Home/Primary Care Provider;
 - (14) Identification of limitations on age of members seen by provider;
 - (15) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
 - (16) Whether provider has completed Cultural and Linguistic Competency training; and
 - (17) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.
- (d) Ongoing Monitoring and Significant Changes in the Provider Network
- (1) At least once a calendar quarter, the BH I/DD Tailored Plan shall monitor its Provider Network for a Significant Change that would affect the adequacy capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *Section VII. First Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards*.
 - (2) The BH I/DD Tailored Plan shall report the results of the monitoring for significant change performed during a calendar quarter in the quarterly submission for that calendar quarter of the Network Data Details Extract Report described in *First Revised and Restated Attachment J: First Revised and Restated Reporting Requirements*.
 - (3) If the BH I/DD Tailored Plan determines a significant change has occurred that negatively affects adequate capacity or services and compliance with the time/distance and/or appointment wait time standards, the BH I/DD Tailored Plan shall prepare and concurrently submit the following information to the Department when the BH I/DD Tailored Plan submits the quarterly Network Data Details Extract Report that documents the significant change:
 - i. An updated Network Access Plan, including an updated attestation of compliance with the time/ distance and/or appointment wait time standards established by the Department; and
 - ii. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.
- ii. Provider Network Management
- (i) The BH I/DD Tailored Plan shall manage its Network to meet availability, accessibility, and quality goals and requirements.
 - (a) In developing its network for physical health and pharmacy services, the BH I/DD Tailored Plan shall negotiate with any willing provider in good faith regardless of provider or BH I/DD Tailored Plan affiliation.
 - (b) In developing its network for BH, I/DD, and TBI services, the Department expects the BH I/DD Tailored Plan to ensure network adequacy and the BH I/DD Tailored Plan has the authority to maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23. Pending legislative change, the BH I/DD Tailored Plan shall include all essential providers for BH, I/DD, and TBI services located in the BH I/DD Tailored Plan's Region in its Network regardless of closed network requirements.

- (c) The BH I/DD Tailored Plan shall have a provider monitoring program to ensure providers are meeting member needs and program requirements.
- (ii) To help recognize the Department’s aim of engaging and supporting providers, the Department is establishing a centralized credentialing process including a standardized provider enrollment application and qualification verification process. The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the PDM/CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency. The period before the PDM/CVO has achieved full implementation will be considered the “Provider Credentialing Transition Period”. The Medicaid Enrolled provider information gathered by the Department will be shared with the BH I/DD Tailored Plan who will use that information for network contracting.
- (iii) Provider Contracting
 - (a) The BH I/DD Tailored Plan contracts with providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses listed in *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid.*
 - (b) The BH I/DD Tailored Plan shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) Calendar Days after the Contract Award.
 - (1) The BH I/DD Tailored Plan may utilize proposed contract templates submitted to the Department for review prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
 - (2) Upon approval by the Department, the BH I/DD Tailored Plan shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The BH I/DD Tailored Plan shall discontinue use of previously submitted contract templates once an amended version is approved.
 - (3) The BH I/DD Tailored Plan shall submit newly developed contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers.
 - i. During contract negotiations with a provider, the BH I/DD Tailored Plan may, without the Department’s prior approval, make amendments to a previously approved provider contract template.
 - a) Any change to a standard provision required by *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid,* is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.u., 1.v., 1.w., or 1.x., which must be prior approved by the Department.
 - b) Any change to a standard provision required in Section 2 of *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid,* must be prior approved by the Department.
 - c) Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.
 - d) The BH I/DD Tailored Plan shall submit an unapproved contract template to the Department for approval at least sixty (60) Calendar Days before use with

- providers, including amended previously approved templates with significant changes.
- ii. The BH I/DD Tailored Plan may only make changes to the provisions required in Section 3. of *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*, when directed to do so by the Department.
- (c) The BH I/DD Tailored Plan shall not include any provider (including ordering, prescribing, or referring only providers) in its Medicaid Managed Care Network that is not enrolled in North Carolina Medicaid.
 - (1) The BH I/DD Tailored Plan shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done monthly thereafter.
 - (d) The BH I/DD Tailored Plan shall not employ or contract with any person or entity appearing on one of the Exclusion Lists.
 - (e) In accordance with N.C. Gen. Stat. § 108D-22, except as otherwise allowed under the Contract, the BH I/DD Tailored Plan shall not exclude eligible providers from its physical health network except under the following circumstances:
 - (1) When a provider appears on one of the Exclusions Lists; or
 - (2) When a Provider refuses to accept network rates (which shall not be less than any applicable rate floors).
 - (f) Require that contracted facilities, with the exception of the residential provider facilities noted below, implement a tobacco-free policy covering any portion of the property on which the participating provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting participating providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve. However, contracted facilities that are owned or controlled by the provider and which provide ICF-ID services or residential services that are subject to the HCBS final rule are exempt from this requirement. In these settings:
 - (1) Indoor use of tobacco products shall be prohibited in all provider owned/operated contracted settings.
 - (2) For outdoor areas of campus, providers shall:
 - i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
 - ii. Prohibit staff/employees from using tobacco products anywhere on campus.
 - (g) The BH I/DD Tailored Plan shall not deny a pharmacy the opportunity to participate in its network as required by N.C. Gen. Stat. § 58-51-37(c)(2).
 - (h) The BH I/DD Tailored Plan shall offer to contract with a provider in writing.
 - (1) All offers shall include the standard provisions for provider contracts found in *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*, including the prescribed provisions located therein.
 - (2) If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the BH I/DD Tailored Plan may consider the request for inclusion in the Medicaid Managed Care network rejected by the provider. If

discussions are ongoing, or the contract is under legal review, the BH I/DD Tailored Plan shall not consider the request rejected.

- (3) The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan.
- (i) The BH I/DD Tailored Plan shall not require individual practitioners, as a condition of contracting with BH I/DD Tailored Plan, to agree to participate or accept other products offered by the BH I/DD Tailored Plan nor shall the BH I/DD Tailored Plan automatically enroll the provider in any other product offered by BH I/DD Tailored Plan. This requirement shall not apply to facility providers. This requirement shall not preclude the BH I/DD Tailored Plan from requiring individual practitioners, as a condition of contracting with the BH I/DD Tailored Plan, to provide State-funded Services.
- (j) The BH I/DD Tailored Plan shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the BH I/DD Tailored Plan's final decision. The notice shall include the reason for the BH I/DD Tailored Plan's decision, the Provider's right to Appeal that decision, and how to request an Appeal. 42 C.F.R. § 438.12(a)(1).
- (k) The BH I/DD Tailored Plan shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Direct rates:
 - (1) The BH I/DD Tailored Plan shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department.
 - (2) The BH I/DD Tailored Plan shall implement applicable rate changes within agreed upon timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest and penalty payments to the applicable provider.
- (l) The BH I/DD Tailored Plan shall, with regard to payment to any provider or Subcontractor that is "related to" the BH I/DD Tailored Plan, comply with the requirements in *Section V.A.1.iv. BH I/DD Third Party (Subcontractor) Contractual Relationships* and *Section V.B.7.ii. Medical Loss Ratio*.
- (m) The BH I/DD Tailored Plan shall include a provision in the provider contract regarding a provider's right to file a Grievance or Appeal (as described in *Section V.B.4.v. Provider Grievances and Appeals*) in its contract with providers. The BH I/DD Tailored Plan shall include a notice in all provider contracts that the internal Appeal process with the BH I/DD Tailored Plan must be exhausted before seeking other legal or administrative remedies under state or federal law.
- (n) The BH I/DD Tailored Plan shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding:
 - (1) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (2) Any information the member needs to decide among all relevant treatment options.
 - (3) The risks, benefits, and consequences of treatment or non-treatment.
 - (4) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 C.F.R. § 438.102(a)(1)(i)-(iv).

- (o) The BH I/DD Tailored Plan shall include a provision in the provider contract that requires all in-network PCPs to perform EPSDT screenings for members less than twenty-one (21) years of age in accordance with *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members.*
- (p) The BH I/DD Tailored Plan shall include a provision in the provider contract that requires providers notify the BH I/DD Tailored Plan when a member in a high acuity clinical setting is being discharged.
- (q) The BH I/DD Tailored Plan may utilize evergreen contracts, i.e. a contract that automatically renews, with Medicaid Managed Care providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed.
- (r) The BH I/DD Tailored Plan shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.
- (s) In contracting with providers, the BH I/DD Tailored Plan shall comply with all applicable Chapter 58 statutes in accordance with *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid.*
- (t) The BH I/DD Tailored Plan shall include in provider contracts that participating providers shall not submit claim or encounter data for services covered by Medicaid Managed Care and BH I/DD Tailored Plans directly to the Department.
- (u) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall contract with each LHD in its Region to provide Care Management for At-Risk Children and Care Management for High Risk Pregnant Women, to the extent that each LHD chooses to provide these services.
- (v) DSOHF Facilities
 - (1) The BH I/DD Tailored Plan shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the DSOHF facilities:
 - i. Julian F Keith ADATC,
 - ii. R.J. Blackley ADATC,
 - iii. Lakeside
 - iv. Woodsite Treatment Center (State funded)
 - v. Cherry Hospital,
 - vi. Broughton Hospital,
 - vii. Central Regional Hospital,
 - viii. Caswell Developmental Center,
 - ix. J. Iverson Riddle Developmental Center,
 - x. Murdoch Developmental Center, and
 - xi. Whitaker Psychiatric Residential Treatment Facility.
 - (2) The BH I/DD Tailored Plan shall consider these DSOHF facilities to have successfully completed the State's Centralized Credentialing and Re-credentialing Process (CCRP) and are enrolled as a provider in the NC Medicaid program.
 - (3) The BH I/DD Tailored Plan shall use a Department-developed contract template to contract with these DSOHF facilities, to be delivered by the Department after award.
- (w) The BH I/DD Tailored Plan shall contract with all Cross-Area Service Programs (CASPs) located throughout the state that will be listed in a forthcoming Department guidance. The BH I/DD Tailored Plan shall use a standard contract for all providers who are CASPs.
- (x) The Department may at its discretion require the BH I/DD Tailored Plan to use a Department-developed contract template of other state-owned providers.

- (y) For any provider subject to a rate floor as outlined in *Section V.B.4.iv. Provider Payments*, a BH I/DD Tailored Plan may include a provision in the provider’s contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a “lesser than” provision. A BH I/DD Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider’s refusal to agree to a “lesser than” provision.
- (iv) Provider Preventable Conditions
 - (a) The BH I/DD Tailored Plan shall comply with 42 C.F.R. § 438.3(g), which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. The BH I/DD Tailored Plan shall provide a report on all identified provider preventable conditions in a form or frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
 - (b) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires the provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the BH I/DD Tailored Plan.
- (v) Critical Incident Reporting
 - (a) The BH I/DD Tailored Plan shall establish a process for timely identification, response, reporting, and follow-up to member incidents.
 - (b) The BH I/DD Tailored Plan shall require Network providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System.
 - (c) The BH I/DD Tailored Plan shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of members.
 - (d) The BH I/DD Tailored Plan shall report information on incidents and deaths in accordance with Department procedures.
 - (e) The BH I/DD Tailored Plan shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Second Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*.
 - (f) The BH I/DD Tailored Plan shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
 - (g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for members obtaining services in DSOHF facilities as detailed in *Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities Providers*
- (vi) Indian Health Care Providers
 - (a) The BH I/DD Tailored Plan shall use the Medicaid Managed Care Addendum for IHCPs when contracting with IHCPs as described in *Section VII. Second Revised and Restated Attachment H. Addendum for Indian Health Care Providers* and adhere to the Tribal Payment Policy (*Section VII.M.11. Tribal Payment Policy*).
 - (b) The BH I/DD Tailored Plan shall not include any additional special terms and conditions to the IHCP Addendum or Tribal Payment Policy (*Section VII. First Revised and Restated Attachment M.11. Tribal Payment Policy*) when contracting directly with IHCPs without mutual consent of

both BH I/DD Tailored Plan and the IHCP. For any mutually agreed upon additional special terms and conditions, the BH I/DD Tailored Plan shall:

- (1) Within thirty (30) Calendar Days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.
 - (2) Recognize that the IHCP Addendum provisions supersedes any conflicting terms of the contract between BH I/DD Tailored Plan and IHCP.
- (c) As long as the Additional Special Terms with IHCP policies and procedures, clearly states that it apply to the BH I/DD Tailored Plan, the Additional Special Terms with IHCP policies and procedures may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (d) The BH I/DD Tailored Plan must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148. IHCPs are not subject to licensure and credentialing of the Department.
- (e) The BH I/DD TPs shall honor all NC Medicaid EPSDT approved services under NC Medicaid Direct or In-Lieu of services including but not limited to the Tribal Integrated Classroom, Family Safety, Tribal Therapeutic Foster Care, Tribal Peer Support.
- (vii) Program Integrity
- (a) The BH I/DD Tailored Plan shall develop policies and procedures to perform monitoring and auditing of provider payments. The BH I/DD Tailored Plan shall provide those policies and procedures to the Department upon request for review or as otherwise required by this Contract.
 - (b) The BH I/DD Tailored Plan shall require Network providers and Subcontractors to have compliance program that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
 - (c) The BH I/DD Tailored Plan shall require Network providers and out-of-network providers to have policies and procedures that recognize and agree that Medicaid as “the payer of last resort,” except in the instances that a member is also accessing State-funded services where State-funded services are “the payer of last resort.”
 - (d) The BH I/DD Tailored Plan shall prohibit providers and referral providers from billing members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. § 438.106.
 - (e) The BH I/DD Tailored Plan shall not impose a monetary advantage or penalty that would affect a member’s choice of pharmacy in accordance with N.C. Gen. Stat. § 58-51-37(c)(4) or any other provider.
- (viii) Credentialing and Re-credentialing Process
- (a) The BH I/DD Tailored Plan shall follow the Department’s uniform credentialing and recredentialing policy.
 - (1) The BH I/DD Tailored Plan shall follow documented processes and procedures for credentialing and re-credentialing Network Providers. 42 CFR § 438.214.
 - (b) The BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department’s written prior approval. The BH I/DD Tailored Plan is not prohibited from collecting other information from providers necessary for the BH I/DD Tailored Plan’s contracting process.
 - (c) The BH I/DD Tailored Plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.B.4. Providers*.

- (d) The BH I/DD Tailored Plan is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.
- (e) Re-credentialing:
 - (1) During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment Process, the BH I/DD Tailored Plan shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on a daily Provider Enrollment File. The BH I/DD Tailored Plan's process shall occur no less frequently than every five (5) years consistent with the Department's policy and procedure.
 - (2) After the Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on a daily Provider Enrollment File. The BH I/DD Tailored Plan's process shall occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
- (f) Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all BH I/DD Tailored Plan Network providers as Medicaid enrolled providers. 42 C.F.R. § 438.602(b)(1).
 - (1) The BH I/DD Tailored Plan may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, for up to one hundred twenty (120) days but must terminate a Network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected members. 42 C.F.R. § 438.602(b)(2).
- (g) The BH I/DD Tailored Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.
- (h) Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section III.C.5. Availability of Funds*, DHHS shall indemnify, defend, and hold harmless the BH I/DD Tailored Plan, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the BH I/DD Tailored Plan by the Department, Contract Verification Organization, or other Vendor providing such information to the BH I/DD Tailored Plan and relied upon by the BH I/DD Tailored Plan in credentialing a provider for participation in the BH I/DD Tailored Plan's Network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The BH I/DD Tailored Plan shall have the option to participate at its own expense in the defense of such claims or actions filed and the BH I/DD Tailored Plan shall be responsible for its own litigation expenses if it exercises this option. In no event shall the BH I/DD Tailored Plan be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The BH I/DD Tailored Plan shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the BH I/DD Tailored Plan's use of and reliance on such credentialing information.
- (ix) Network Provider System Requirements
 - (a) The BH I/DD Tailored Plan shall accurately and timely load into the BH I/DD Tailored Plan's claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.

- (b) Unless otherwise written in the contract, the BH I/DD Tailored Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a member and billed to the BH I/DD Tailored Plan by the provider:
 - (1) New Medicaid Enrolled provider within ten (10) Business Days after completing contracting;
 - (2) New Medicaid Enrolled hospital or facility provider within fifteen (15) Business Days after completing contracting;
 - (3) New Medicaid Enrolled provider attached to an existing contract within five (5) Business Days after completing contracting;
 - (4) Changes for a re-enrolled Medicaid provider, hospital, or facility attached to an existing contract within five (5) Business Days after completing receipt of notification of the change through the Medicaid Enrolled Provider data from the Department;
 - (5) Change to existing contract terms within thirty (30) Calendar Days of the effective date after the change; and
 - (6) Changes to a provider's service location or demographic data or other information related to a member's access to services must be updated no later than thirty (30) Calendar Days after the BH I/DD Tailored Plan receives updated provider information.
- (c) Payment should be made to the provider for previously rendered services on the next payment cycle following the requirement outlined above.
- (d) In no case shall a provider be used as a PCP or loaded into the Provider Directory during a timeframe in which the provider cannot receive payment in accordance with the BH I/DD Tailored Plan current payment cycle.
- (x) Network Provider Credentialing and Re-credentialing
 - (a) The BH I/DD Tailored Plan shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2). BH I/DD Tailored Plan shall apply these criteria consistently to all providers.
 - (b) Reserved.
 - (c) Reserved.
 - (d) Reserved.
 - (e) Network Contracting Decisions
 - (1) The BH I/DD Tailored Plan shall establish and maintain a process to make network contracting decisions in accordance with the Department's Credentialing and Re-credentialing Policy.
 - (2) The BH I/DD Tailored Plan shall provide written notice of network contracting decisions to providers within five (5) Business Days of determination of the Provider's status as an active Medicaid Enrolled Provider.
 - (f) Provider Disenrollment and Termination
 - (1) Payment Suspensions
 - i. The BH I/DD Tailored Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise fail to meet Department requirements.
 - ii. The BH I/DD Tailored Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within the Department's allotted timeframes, the Department will terminate the provider from Medicaid.

- iii. The BH I/DD Tailored Plan shall not be liable for interest or penalties for late claim payment related to payment suspension.
 - iv. The BH I/DD Tailored Plan shall address payment suspension in its Provider Manual.
- (2) Termination as a Medicaid Provider by the Department:
- i. The BH I/DD Tailored Plan shall remove any provider from claims payment system, and terminate the provider's contract consistent within one (1) Business Day of receipt of a notice from the Department that the provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.
 - ii. If the BH I/DD Tailored Plan suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the BH I/DD Tailored Plan shall release applicable claims and deny payment for dates of service after the date of termination from Medicaid.
 - iii. There are no appeal rights against the BH I/DD Tailored Plan for a provider terminated or sanctioned, including suspension of provider payment, by the Department.
- (3) BH I/DD Tailored Plan Provider Termination
- i. The BH I/DD Tailored Plan may terminate a provider from its Network with or without cause. Any decision to terminate must comply with the requirements of the Contract.
 - ii. The BH I/DD Tailored Plan shall comply with the Program Integrity Provider Termination Requirements outlined in *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
 - iii. The BH I/DD Tailored Plan must provide written notice to the Network provider of the decision to terminate to the provider. The notice, at a minimum, must include:
 - a) The reason for the BH I/DD Tailored Plan's decision;
 - b) The effective date of termination;
 - c) The provider's right to Appeal the decision; and
 - d) How to request an Appeal.
 - iv. The BH I/DD Tailored Plan shall provide a report on the number of providers terminated by provider type in a form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements for Medicaid*. If a waiver provider has been terminated due to HCBS issues, the BH I/DD Tailored Plan shall notify Department waiver administrators.
- (g) Member Notice of Provider Disenrollment/Termination
- (1) The BH I/DD Tailored Plan shall notify each member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the Network. BH I/DD Tailored Plan shall:
- i. Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the BH I/DD Tailored Plan. 42 C.F.R. 438.10(f)(1).
 - ii. Include in the notice information about selecting or being auto-assigned a new PCP.
 - iii. Describe the BH I/DD Tailored Plan's efforts to support transition of care for the member to the new provider.
 - iv. If the terminated provider was a specialist, assist impacted members with transition of care.
- (h) Provider Directory
- (1) The BH I/DD Tailored Plan shall develop a consumer-facing provider Network Directory of all Network providers including the required information for all such providers, except

providers of types which the Department has permitted the BH I/DD Tailored Plan to suppress based upon industry practices or provider characteristics.

- i. Notwithstanding *Section V.B.4.ii.x.g.1.*, the BH I/DD Tailored Plan may use best practices to exclude a Network Provider from the consumer-facing directories if the BH I/DD Tailored Plan includes in a Provider Directory Policy, or other policy as appropriate, an explanation of the process and rules used by the BH I/DD Tailored Plan when deciding whether to include a provider in a consumer-facing directory.
 - ii. The BH I/DD Tailored Plan shall provide the Provider Directory Policy, or other policy as appropriate, to the Department for review at the request of the Department.
 - iii. As used in this section, best practices specifically include, but are not limited to:
 - a) A provider opts out of being in the directory, such as when the provider is not open to the general public (e.g., a student health center open only to students of the educational organization).
 - b) A provider cannot traditionally be contacted directly for making appointments, such as facility-based providers like anesthesiologists or radiologists.
 - c) Provider is otherwise outside the scope of what would normally be included in a provider directory, such as a Value-added service.
- (2) The Network Directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by Department.
- (3) The BH I/DD Tailored Plan shall ensure that the Network Directory:
- i. Be in a format that is machine-readable and readily accessible;
 - ii. Is placed in a location on the BH I/DD Tailored Plan’s website that is prominent and readily accessible by members;
 - iii. Includes accurate and updated provider information consistent with Contract requirements;
 - iv. Is provided in an electronic form which can be electronically retained and printed; and
 - v. Is available in paper form without charge upon member request and if requested, is provided within five (5) Business Days.
- (4) In accordance with 42 C.F.R. § 438.10(h)(3):
- i. The BH I/DD Tailored Plan shall update the paper directory at least monthly and clearly identify the date of the update. The paper directory can be updated once per quarter if a mobile directory is enabled.
 - ii. The BH I/DD Tailored Plan shall update the electronic version of the Network Directory no later than ten (10) Business Days after the BH I/DD Tailored Plan receives updated provider information in the PEF file from the Department and clearly identify the date of the update.
- (5) The BH I/DD Tailored Plan shall provide the Department with a copy of both the electronic and paper versions of the Network Directory as follows:
- i. At the request of the Department during the Readiness Review;
 - ii. Annually; and
 - iii. Any time there has been a Significant Change in BH I/DD Tailored Plan operations that impacts the content of the directory.
- (6) The member facing provider directory must comply with 42 C.F.R. § 438.10(h)(1). and shall include the following information, at a minimum:
- i. Provider name;
 - ii. Provider demographics (first, middle, and last name, gender);

- iii. Provider DBA Name;
 - iv. Provider Service Location Name;
 - v. Provider type (PCP, etc.);
 - vi. Provider type effective date;
 - vii. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - viii. Street address(as) of service location(s);
 - ix. County(ies) of service location(s);
 - x. Telephone number(s) at each location;
 - xi. After hours telephone number(s) at each location;
 - xii. Provider specialty () by location;
 - xiii. Whether provider is accepting new beneficiaries;
 - xiv. Whether provider serves Medicaid and NC Health Choice beneficiaries;
 - xv. Whether BH provider is serving children and adolescents;
 - xvi. Provider’s linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider’s office;
 - xvii. Whether provider has completed Cultural and Linguistic Competency training,
 - xviii. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;
 - xix. A telephone number at the BH I/DD Tailored Plan where a member can call to confirm the information in the directory;
 - xx. Essential provider indicator;
- (i) In no case shall a provider be loaded into the provider directory which cannot receive payment on the BH I/DD Tailored Plan’s current payment cycle.
 - (j) The BH I/DD Tailored Plan shall provide the provider directory to NCTracks for inclusion in the Consolidated Provider Directory made available the Enrollment Broker as described in *Section V.B.8. Technical Specifications*.
 - (k) As long as the BH I/DD Tailored Plan Provider Directory clearly identifies which providers are available under which health plan, a unified Provider Directory may apply to other BH I/DD Tailored Plan Operations without imitation the PIHP.
- iii. Provider Relations and Engagement
 - (i) Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to members. The BH I/DD Tailored Plan shall engage and support providers through a call center and provider web portal as well as provide training and education on the Medicaid program and their rights within the program.
 - (ii) Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
 - (a) The BH I/DD Tailored Plan shall operate a Provider Relations function, that includes a Provider Support Service Line consistent with the applicable standards found in *Section V.A.2. Program Operations*. The Provider Support Service Line should comply with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* if BH I/DD Tailored Plan utilizes a Subcontractor to provide or operate the service line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*). The Provider Support Service Line may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (b) Be staffed with personnel specifically trained on the requirements, policies and procedures of the BH I/DD Tailored Plan operating in North Carolina and are able to respond to all areas within the Provider Manual, including resolving claims payment inquires, in “one-touch.”
 - (c) The BH I/DD Tailored Plan shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web

portal shall include access to the Provider Manual. The provider web portal may apply to other LME/ MCO operations, including, without limitation, the PIHP.

- (d) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) Business Days of executing a contract with the provider for participation within its Medicaid Managed Care network. The Provider Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.
 - (e) The BH I/DD Tailored Plan shall develop and maintain a Provider Support Plan as described in *Section V.B.5.i. Quality Management and Quality Improvement* and make it available to Department upon request.
- (iii) Provider Education and Training
- (a) The BH I/DD Tailored Plan shall provide periodic and reasonable education, specific to the Medicaid Managed Care requirements, policies, including the Department's Managed Care Provider Billing Guide, and procedures, training and technical assistance on all BH I/DD Tailored Plan-specific administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.
 - (b) The BH I/DD Tailored Plan shall communicate with Network providers, or include in its training and technical assistance, information as requested by Department.
 - (c) The BH I/DD Tailored Plan shall provide training to Network providers within thirty (30) days of provider joining the Network. Additional training will be provided as determined by the BH I/DD Tailored Plan and as requested by Department.
 - (d) The BH I/DD Tailored Plan shall make training materials available on the provider Web portal as determined appropriate by the BH I/DD Tailored Plan and upon request by network providers or Department.
 - (e) The BH I/DD Tailored Plan shall develop a Provider Training Plan that outlines training topics and dates. The BH I/DD Tailored Plan Provider Training Plan shall reference and acknowledge the broader role the BH I/DD Tailored Plan has in supporting Department initiatives. As long as the Provider Training Plan, clearly states that it apply to the BH I/DD Tailored Plan, the Provider Training Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP Training must include:
 - (1) Annual EPSDT, where EPSDT is relevant to the provider's area of practice;
 - (2) BH I/DD Tailored Plan prevention and population health management programs;
 - (3) Into the Mouth of Babies (IMB) program training (required before being permitted to receive reimbursement for IMB program);
 - (4) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings;
 - (5) Any other training topics required under this Contract; and
 - (6) How the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.
 - (f) The BH I/DD Tailored Plan shall submit the Provider Training Plan to the Department as follows:
 - (1) Upon award of the Contract;
 - (2) When material changes are made to the Training Plan; and
 - (3) Annually.
- (iv) Provider Manual

- (a) The BH I/DD Tailored Plan shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the BH I/DD Tailored Plan and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:
- (1) Clinical practice standards and UM Program;
 - (2) Covered services, additional benefits and carved-out services;
 - (3) Eligibility for State-funded services, including federal funding restrictions and requirements;
 - (4) Care management (including in-reach, transition management and diversion) delivered through the BH I/DD Tailored Plans’
 - (5) Provider responsibilities;
 - (6) Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
 - (7) Telehealth;
 - (8) Network adequacy and access standards;
 - (9) Billing, claim editing, SNIP editing and clearinghouse requirements;
 - (10) Cultural and Linguistic Competency and accessibility requirements;
 - (11) Authorization, utilization review, and care management requirements;
 - (12) Care coordination and discharge planning requirements;
 - (13) Department-required documentation requirements;
 - (14) Provider Appeals and Grievance process;
 - (15) Complaint or Grievance investigation and resolution procedures;
 - (16) Notification of the availability of the Department’s provider Ombudsman service where a provider may submit a complaint about a BH I/DD Tailored Plan. The manual shall include instructions on how to submit the complaint;
 - (17) Performance improvement procedures including member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
 - (18) Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
 - (19) Interest and penalty provisions for late or under-payment by the BH I/DD Tailored Plan;
 - (20) Member rights and responsibilities;
 - (21) Member cost sharing requirements;
 - (22) Provider Program Integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other federal and state requirements; and
 - (23) Disaster and emergency relief planning and response in the event of a disaster or emergency situation that results in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, and/or for an epidemic or pandemic disease .
- (b) The BH I/DD Tailored Plan shall also include in the Provider Manual providers’ obligations to:
- (1) Monitor and audit provider’s own activities to ensure compliance and prevent and detect fraud, waste and abuse;
 - (2) Monitor and report on provider preventable conditions;
 - (3) Retain Member records for the mandated period;
 - (4) Ensure that all documentation regarding services provided is timely, accurate, and complete;
 - (5) Ensure BH I/DD Tailored Plan is the payer of last resort; and

- (6) To report and promptly return overpayments within sixty (60) days of identifying the overpayment.
- (c) The BH I/DD Tailored Plan shall include standardized language in the Provider Manual as requested by the Department.
- (d) The BH I/DD Tailored Plan shall submit the Provider Manual to Department for approval thirty (30) days after Contract Award. The BH I/DD Tailored Plan shall not use or distribute the Provider Manual prior to approval by Department.
- (e) The BH I/DD Tailored Plan shall review and update the Provider Manual annually, with submission due on July 1st, or upon request by the Department to reflect changes to applicable federal and state laws, rules and regulations, Department or BH I/DD Tailored Plan policies, procedures, bulletins, guidelines or manuals, or BH I/DD Tailored Plan business processes as necessary. Within the Provider Manual, the BH I/DD Tailored Plan shall track and maintain a list of revisions made to the manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.
- (f) The BH I/DD Tailored Plan may update the provider manual once per quarter in the event of substantive updates or revisions that impact providers or BH I/DD Tailored Plan business. . Submissions of the provider manual to the Department by the BH I/DD Tailored Plan during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section..
- (g) When seeking review and approval of the provider manual, the BH I/DD Tailored Plan shall submit the provider manual to Department for approval within fifteen (15) Calendar Days of making substantive updates. The BH I/DD Tailored Plan shall not post, print or enforce the updates until the BH I/DD Tailored Plan has received approval from the Department.
- (h) The BH I/DD Tailored Plan shall have fifteen (15) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process.
- (i) The BH I/DD Tailored Plan shall make the provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
- (j) The BH I/DD Tailored Plan shall make the redline provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal only.
- (v) Provider Survey
 - (a) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its provider relations staff via standardized provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - (1) Provider surveys shall be made available after each web, call center or in-person interaction;
 - (2) Conduct surveys and internal audits intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness; and,
 - (3) Provide reports, including the results of provider surveys and BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, to the Department on a regular basis as determined by the Department, and ad hoc as requested.

vi. Provider Recruitment

- (a) The Department views BH I/DD Tailored Plan recruitment activities as a method to help

publicize Medicaid Managed Care and educate potential Providers about health plan contracting options, while ensuring the protection of Providers from coercive or misleading practices.

- (b) The BH I/DD Tailored Plan shall comply with all recruitment requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the BH I/DD Tailored Plan to ensure that Providers receive accurate oral and written information.
- (c) The BH I/DD Tailored Plan shall not market nor distribute any recruitment materials without obtaining written approval from the Department.
- (d) The BH I/DD Tailored Plan shall ensure that recruitment materials are accurate and does not mislead, confuse, or defraud Providers or the Department.
- (e) The BH I/DD Tailored Plan shall establish and maintain, a system of control over the content, form, and method of dissemination of all recruitment materials. All recruitment materials, regardless by whom written, produced, created, designed, or presented shall be the responsibility of the BH I/DD Tailored Plan.
- (f) If the BH I/DD Tailored Plan chooses to recruit, the BH I/DD Tailored Plan shall distribute recruitment materials to the entire region served by the BH I/DD Tailored Plan.
- (g) The BH I/DD Tailored Plan shall ensure that all recruitment materials comply with the language, accessibility, and cultural competency requirements and the Provider materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- (h) The BH I/DD Tailored Plan shall ensure that all recruitment materials and recruitment strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy.
- (i) The BH I/DD Tailored Plan shall assign a unique recruitment code to all recruitment materials distributed to Providers.
- (j) Department Approval of Recruitment Materials
 - (1) The BH I/DD Tailored Plan shall submit recruitment materials to the Department for review at least ninety (90) Calendar Days before the proposed use of the material.
 - (2) If the BH I/DD Tailored Plan makes a significant change to recruitment materials that have been previously approved by the Department, the BH I/DD Tailored Plan must resubmit the materials, in accordance with this section, for Department review and approval.

v. Provider Payments

- (i) Provider payment requirements are established to comply with State law, encourage continued provider participation in the Medicaid program to ensure member access, and support safety-net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of BH I/DD Tailored Plan steerage to other providers. Nothing in this section is meant to preclude the BH I/DD Tailored Plan from using different reimbursement amounts for different specialties for practitioners in the same specialty. 42 C.F.R. § 438.12(b)(2)
- (ii) The BH I/DD Tailored Plan shall support the Department in complying with all federal laws, state laws, State Plans, waivers, PI or audit requirements, investigations, findings or corrective action plans related to provider payments.
- (iii) The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.
- (iv) Physician and Physician Extender Payments
 - (a) The BH I/DD Tailored Plan shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or

- bundle, as set by the Department, unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
- (b) The BH I/DD Tailored Plan shall reimburse all in-network physicians and physician extenders providing obstetric services no less than one hundred percent (100%) of the Medicaid Fee for Service rate for obstetrics services, which includes an enhanced rate for all vaginal deliveries (equal to the Medicaid Fee for Service rate for caesarian deliveries) unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
 - (1) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.
 - (c) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as outlined below in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.
 - (d) The BH I/DD Tailored Plan shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with N.C. Gen. Stat. § 58-50-26.
- (v) Hospital Payments (Excluding BH Claims)
- (a) The BH I/DD Tailored Plan shall reimburse all in-network hospitals no less than the applicable Medicaid Fee for Service rate specified below for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)) and utilize the applicable Medicaid Fee for Service payment methodology, unless the BH I/DD Tailored Plan and hospital have mutually agreed to an alternative reimbursement amount or methodology.
 - (b) The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee for Service rate using the Medicaid Fee for Service case weights and outlier methodology.
 - (c) The applicable rate floor and methodology for outpatient hospital services, including emergency department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.
 - (d) The hospital rate floors shall apply for the following defined time periods, after which the BH I/DD Tailored Plan will have flexibility to negotiate reimbursement arrangements with the hospitals:
 - (1) The first four (4) contract years for critical access hospitals and hospitals in economically depressed counties defined as Tier 1 or Tier 2 counties as designated by the North Carolina Department of Commerce in November 2020 (https://files.nc.gov/nccommerce/documents/files/2019-Tiers-memo_asPublished.pdf).
 - (2) The first two (2) contract years for non-critical access hospitals.
 - (e) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*
 - (f) The Department shall reimburse hospitals directly for any graduate medical education payments pursuant to the requirements defined in the State Plan (as allowed under 42 C.F.R. § 438.60).
 - (g) The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments pursuant to the requirements defined in the State Plan.
- (vi) Hospital Payments for BH Claims
- (a) The BH I/DD Tailored Plan shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims to be defined by the Department.

- (vii) Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments
 - (a) The BH I/DD Tailored Plan shall reimburse FQHCs and RHCs for covered services at no less than the following rates:
 - (1) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
 - (2) All core services shall be based on each FQHC's or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.
 - (b) The BH I/DD Tailored Plan shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by the Department on a schedule to be defined by the Department.
- (viii) Indian Health Care Provider (IHCP) Payments
 - (a) 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:
 - (1) Those IHCPs that are not enrolled as an FQHC, regardless of whether they participate in the BH I/DD Tailored Plan's Network;
 - (2) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - (3) The Medicaid Fee for Service rate for services that do not have an applicable encounter rate.
 - (4) Those IHCPs 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.
 - (b) 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.
 - (c) The BH I/DD Tailored Plan shall reimburse IHCPs for Pharmacy Claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan.
- (ix) Local Health Department (LHD) Payments
 - (a) The BH I/DD Tailored Plan shall reimburse in-network LHDs no lower than base rates specified in the North Carolina Medicaid LHD Fee Schedule. The BH I/DD Tailored Plan shall reimburse the LHDs in accordance with this schedule for EPSDT well child exams, low-risk family planning and obstetrical services or sexually transmitted disease (STD) exams provided by enhanced role nurses.
 - (b) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in NC Medicaid Direct (Fee for Service) prior to the start of the BH I/DD Tailored Plan contract (\$4.56 PMPM for all enrolled children ages zero (0) to five (5)).
 - (c) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in Medicaid Fee-for-Service prior to the start of the BH I/DD Tailored Plan contract (\$4.96 PMPM for all enrolled women, ages fourteen (14) to forty-four (44)).
 - (d) Reserved.
 - (e) In addition to base reimbursements, the BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network LHDs as defined by the Department and as

outlined below in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.

- (f) The BH I/DD Tailored Plan shall reimburse in-network LHDs providing lab services, as defined by the Department's Laboratory Fee Schedule, at no less than 100% of the Medicare Fee Schedule (as allowed under 42 C.F.R. § 438.6(c)), unless the BH I/DD Tailored Plan and LHD have mutually agreed to an alternative reimbursement arrangement.
- (x) Public Ambulance Provider Payments
 - (a) The BH I/DD Tailored Plan shall reimburse in-network public ambulance providers no less than 100% of base rates specified in the North Carolina Medicaid Managed Care Public Ambulance Provider Cost-Based Fee Schedule for Medicaid and NC Health Choice members (as allowed under 42 C.F.R. § 438.6(c)(iii)(B)), unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
 - (b) The BH I/DD Tailored Plan shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full for NC Health Choice.
- (xi) State Owned and Operated Facilities Payments
 - (a) The BH I/DD Tailored Plan shall reimburse facilities that are state-owned and operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) according to the rates and their respective effective dates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).
 - (b) At such time that the BH I/DD Tailored Plan is required to cover services provided by Veterans Homes operated by the DMVA, the BH I/DD Tailored Plan shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).
- (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))
 - (a) The BH I/DD Tailored Plan shall make additional directed payments as determined by the Department to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center.
 - (b) Additional directed payments will be prescribed by the Department and approved by CMS. Types of payments may include but may not be limited to payment based on utilization of certain services multiplied by a Department-defined specific dollar amount or a percentage of the base payment.
 - (c) The BH I/DD Tailored Plan shall include the Department defined additional directed payments in its contracts with applicable providers.
 - (d) The BH I/DD Tailored Plan shall determine a due date for providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.
 - (e) The BH I/DD Tailored Plan shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) Business Days of receiving the payment from the State.
 - (1) The BH I/DD Tailored Plan is not in violation of this Section nor subject to interest payments and penalties if its failure to comply with this Section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the BH I/DD Tailored Plan's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, a BH I/DD Tailored Plan is not in violation of this section or subject to interest or penalty payments to the Provider under this section if the BH I/DD Tailored Plan has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

- (f) The BH I/DD Tailored Plan shall submit the data to substantiate additional directed payments to the Department and each applicable provider quarterly in a format to be defined by the Department.
 - (g) The Department shall reconcile the data to the BH I/DD Tailored Plan's encounter submissions. The BH I/DD Tailored Plan shall provide the information and date necessary in a timely manner to support the reconciliation process upon request from the Department.
 - (h) The BH I/DD Tailored Plan shall adhere to the directed payment service unit encounter requirements as described in *Section V.B.6.ii. Encounters*.
 - (i) Interest and Penalties
 - (1) The BH I/DD Tailored Plan shall pay interest on late directed payments to the Provider at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the directed payment should have been paid as specified in the Contract.
 - (2) In addition to the interest on late directed payments required by this Section, the BH I/DD Tailored Plan shall pay the provider a penalty equal to one percent (1%) of the directed payment for each calendar day following the date that the directed payment should have been paid as specified in the Contract.
- (xiii) Nursing Facility Payments
- (a) For Contract Year 1, the BH I/DD Tailored Plan shall reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee for Service rate in effect the first day of each quarter (e.g., January 1, April 1, July 1 and October 1), unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
- (xiv) Hospice Payments
- (a) The BH I/DD Tailored Plan shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:
 - (1) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY)).
 - (2) For hospice services provided to members residing in nursing facilities, the BH I/DD Tailored Plan shall reimburse the hospice provider:
 - i. Hospice rate, and
 - ii. Ninety-five percent (95%) of the Medicaid Fee-for-Service nursing home room and board rate in effect at the time of service.
- (xv) Pharmacy Payments
- (a) The BH I/DD Tailored Plan shall adhere to the pharmacy claims payments requirements as described in *Section V.B.2.iii. Pharmacy Benefits*.
- (xvi) Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management
- (a) For Tailored Care Management, the BH I/DD Tailored Plan shall pay AMH+ practices and CMAs Tailored Care Management payment for each month in which the AMH+ practice or CMA performed Tailored Care Management for each Medicaid member. For Medicaid Members, the Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. These fixed rates shall apply for both Medicaid and NC Health Choice members. For NC Health Choice Members, the fixed rates were incorporated in capitation rates and the Department expects that the BH I/DD Tailored Plan will pay the same rate as for Medicaid Members. This Tailored Care Management payment shall not be placed at risk. The BH I/DD Tailored Plan shall pay AMH+ practices or CMAs the Tailored Care Management payment for any month in which the Medicaid or NC Health Choice member is assigned to the AMH+/CMA the AMH+/CMA delivers at least one (1) care management contact. The BH I/DD Tailored Plan

shall not withhold payment or adjust the payment rate during a month in which an AMH+/CMA delivers at least one (1) care management contact, even if the AMH+/CMA has not delivered the minimum number of contacts during the month based on the member's acuity tier, as described in Section V.B.3.ii.(x)(l).

- (1) The BH I/DD Tailored Plan may but are not required to make performance incentive payments to AMH+ or CMA. The Department encourages the BH I/DD Tailored Plan to base performance incentive payment on the metrics included as the AMH+ and CMA metrics in the Department's Technical Specifications Manual, once released.

(xvii) Payments of Medical Home Fees to Advanced Medical Homes

- (a) In addition to the payment for services provided, the BH I/DD Tailored Plan shall pay all AMH practices a Medical Home Fee. "AMH practices" means all practices participating in the AMH program for the purposes of contracting with Standard Plans and BH I/DD Tailored Plans, including, but not limited to, AMH practices also certified as AMH+ practices for the purposes of Tailored Care Management.
- (b) The BH I/DD Tailored Plan shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 1 –3 practices may be prorated for partial months and shall be no less than the following amounts for Contract Years 1 and 2:
 - i. \$1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee for Service program) (Tier 1 shall continue to exist only for the first year of BH I/DD Tailored Plan, or until the end of contract year two (2) of Standard Plans, whichever is sooner);
 - ii. \$5.00 PMPM for all BH I/DD Tailored Plan members in Tier 2 and 3 practices (consistent with Age, Blind, and Disabled (ABD) beneficiaries under Carolina ACCESS II in the Medicaid Fee for Service program, and increasing the level of PMPM to \$5.00 for every BH I/DD Tailored Plan member, regardless of ABD status).

(xviii) Payment Limitations

- (a) Upon request by the Department, the BH I/DD Tailored Plan shall submit information on payments to related providers and Subcontractors and provide a demonstration of how payment levels for related providers and Subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are Value-Based Payment arrangements in place.

(xix) Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)

- (a) With the exception of out-of-network emergency services, post-stabilization services and services provided during transitions in coverage, the BH I/DD Tailored Plan shall be prohibited from reimbursing an out-of-network provider more than ninety percent (90%) of the Medicaid Fee for Service rate if the BH I/DD Tailored Plan has made a good faith effort to contract with the provider but the provider has refused that contract.
- (b) The BH I/DD Tailored Plan shall develop Good Faith Provider Contracting Policy that includes a description of how the BH I/DD Tailored Plan will conclude that a "good faith" contracting effort has been made. The BH I/DD Tailored Plan shall submit the policy to the Department for review ninety (90) days after Contract Award.
 - (1) The BH I/DD Tailored Plan shall consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused the plan's "good faith" contracting effort.
- (c) The BH I/DD Tailored Plan shall reimburse an out-of-network provider who is providing services to a member in accordance with the Transition of Care requirements of the Contract at one

- hundred percent (100%) of the Medicaid Fee for Service rate or the predominant rate [as established by specific LME/MCO] for applicable behavioral health I/DD or TBI service.
- (d) Unless an agreement has been negotiated, the BH I/DD Tailored Plan shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate for:
- (1) Physical health and pharmacy services when the BH I/DD Tailored Plan has not made a “good faith” effort as defined in the contract with the provider in accordance with the BH I/DD Tailored Plan’s Good Faith Provider Contracting Policy; and
 - (2) BH, I/DD, and TBI services when the BH I/DD Tailored Plan has not made a “good faith” effort to contract with the provider in accordance with the BH I/DD Tailored Plan’s Good Faith Provider Contracting Policy or the BH I/DD Tailored Plan has exercised its authority to maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23.
- (e) The BH I/DD Tailored Plan shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee for Service rates specified in SPAs 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:
- (1) Are more reasonably available than can be provided by an in-state Network provider; or
 - (2) The care and services are provided in any one of the following situations:
 - i. In response to an Emergency Medical Condition;
 - ii. The health of the member would be endangered if the care and services were postponed until the member returns to North Carolina; or
 - iii. The health of the member would be endangered if travel were undertaken to return to North Carolina.
- (f) In accordance with 42 C.F.R. § 438.206(b)(5), the BH I/DD Tailored Plan shall coordinate payment with the out-of-network provider to ensure that the cost to the member is no greater than it would be if services were provided by a provider in the Network.
- (xx) Out-of-Network Emergency Services and Post-Stabilization Services Payments
- (a) In accordance with 42 C.F.R. § 438.114, the BH I/DD Tailored Plan shall be subject to the following requirements:
- (1) The BH I/DD Tailored Plan shall cover and pay for emergency services without regard to prior authorization or whether the provider that furnishes the service has a contract with the BH I/DD Tailored Plan.
 - (2) The BH I/DD Tailored Plan shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the member having been instructed by a representative of the BH I/DD Tailored Plan to seek emergency services.
 - (3) Likewise, the BH I/DD Tailored Plan shall not hold a member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - (4) The BH I/DD Tailored Plan shall provide coverage and payment of services until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on the BH I/DD Tailored Plan.
- (b) In accordance with SSA 1932(b)(2)(D), the BH I/DD Tailored Plan shall pay out-of-network providers who provide emergency services or post-stabilization services to a member no more than the applicable Medicaid Fee for Service rates.

- (c) The BH I/DD Tailored Plan shall reimburse out-of-state hospitals that are also out-of-network for emergency and post-stabilization care services according to the applicable Medicaid Fee for Service rates.
- (d) In accordance with 42 C.F.R. § 422.113(c), the BH I/DD Tailored Plan shall be subject to following requirements:
 - (1) The BH I/DD Tailored Plan shall be required to reimburse for out-of-network post-stabilization care services that are pre-approved by a BH I/DD Tailored Plan representative.
 - (2) The BH I/DD Tailored Plan shall be financially responsible for post-stabilization care services that are not pre-approved but are administered to maintain the member's stabilized condition within one (1) hour of a request to the BH I/DD Tailored Plan for pre-approval of further post-stabilization care services.
 - (3) Additionally, the BH I/DD Tailored Plan shall be required pay for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the member's stabilized condition in the following instances:
 - i. If the BH I/DD Tailored Plan cannot be contacted;
 - ii. If the BH I/DD Tailored Plan does not respond to request for pre-approval within one (1) hour;
 - iii. If the BH I/DD Tailored Plan representative and the treating physician cannot reach an agreement concerning the member's care and a BH I/DD Tailored Plan physician is not available for consultation.
 - iv. If the BH I/DD Tailored Plan representative and treating physician cannot reach an agreement concerning the member's care and a BH I/DD Tailored Plan physician is not available for consultation, the BH I/DD Tailored Plan shall give the treating physician the opportunity to consult with a BH I/DD Tailored Plan physician and the treating physician may continue with the care of the member until the BH I/DD Tailored Plan physician is reached or one of the other post-stabilization care services criteria is met.
 - (4) The BH I/DD Tailored Plan shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:
 - i. Once a Network physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. Once a Network physician assumes responsibility for the member's care through transfer;
 - iii. Once a BH I/DD Tailored Plan representative and the treating physician reach an agreement regarding the member's care; or
 - iv. Once the member is discharged.
 - (5) The BH I/DD Tailored Plan shall limit charges to members for post-stabilization care services to an amount no greater than what the BH I/DD Tailored Plan would charge the member if he or she obtained the services through the BH I/DD Tailored Plan in-network provider.
- (xxi) Payments under Locum Tenens Arrangements
 - (a) The BH I/DD Tailored Plan shall recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 45 C.F.R. § 455.410(b).
- (xxii) The BH I/DD Tailored Plan shall establish and maintain a Locum Tenens Policy to comply with the requirements of N.C. Gen. Stat. § 58-3-231(b) and (c) and shall submit the Locum Tenens Policy to the Department for review ninety (90) days after Contract Award. As long as the Locum Tenens

Policy, clearly states that it apply to the BH I/DD Tailored Plan, the Locum Tenens Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

(xxiii) The BH I/DD Tailored Plan shall develop and maintain a Reimbursement Policy consistent with N.C. Gen. Stat. § 58-3-227(a)(5). The BH I/DD Tailored Plan shall provide the Reimbursement Policy to the Department upon request, for review. As long as the Reimbursement Policy, clearly states that it apply to the BH I/DD Tailored Plan, the Reimbursement Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

(xxiv) North Carolina State Laboratory of Public Health

(a) For Contract Year 1, in instances where a LHD submits a communicable disease test, as defined by the Department, to the North Carolina State Laboratory of Public Health, the BH I/DD Tailored Plan shall reimburse the North Carolina State Laboratory of Public Health according to applicable Medicaid Fee for Service fee schedule, unless the BH I/DD Tailored Plan and North Carolina State Laboratory of Public Health have mutually agreed to an alternative reimbursement arrangement.

(xxiv) Physician Incentive Plans

(a) The BH I/DD Tailored Plan may develop physician incentive plans provided that any such physician incentive plans are in compliance with the requirements set forth in Section 1903(m)(2)(A)(x) of the SSA and 42 C.F.R §§ 438.3(i), 422.208, and 422.210. In 42C.F.R. § 422.208, references to 'MA organization', 'CMS', and 'Medicare beneficiaries' must be read as references to 'BH I/DD Tailored Plan', 'the Department', and 'Medicaid beneficiaries', respectively.

(b) If the BH I/DD Tailored Plan puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the BH I/DD Tailored Plan must ensure that the physician/physician group has adequate stop-loss protection.

(c) The BH I/DD Tailored Plan shall submit to the Department all physician incentive plans for review and approval prior to BH I/DD Tailored Plan implementation of such incentives.

(d) The BH I/DD Tailored Plan shall submit to the Department annual reports containing a detailed overview of any implemented (and previously approved) physician incentive plans, or, if no such arrangement is in place, attest to that fact. Annual physician incentive plan reports must provide assurance satisfactory to the Department that the requirements of 42 C.F.R. § 422.208 are met.

(e) The BH I/DD Tailored Plan shall provide the following information to any Medicaid Member who requests it:

- (1) Whether the BH I/DD Tailored Plan uses a physician incentive plan that affects the use of referral services;
- (2) The type of incentive arrangement; and
- (3) Whether stop-loss protection is provided.

(xxv) Payment for Durable Medical Equipment

(a) Consistent with Section 11 of Session Law 2020-88, for Contract Years 1 – 3, the BH I/DD Tailored Plan shall reimburse durable medical equipment and supplies and orthotics and prosthetics consistent with the Medicaid Fee-for-Service reimbursement based on the lesser of the supplier's usual and customary rates up to one hundred percent (100%) of the maximum allowable Medicaid fee-for-service rates for durable medical equipment and supplies and orthotics and prosthetics.

(xxvi) Payment for Crisis Providers

- (a) The BH I/DD Tailored Plan shall reimburse in-network providers for mobile crisis services and facility-based crisis services no less than the Department’s Enhanced Behavioral Health Fee Schedule unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
- (xxvii) Provider Hardship Payments
 - (a) The BH I/DD Tailored Plan shall have the capability to process Hardship Payment requests from a provider within seven (7) calendar days of receipt of a hardship request or three (3) calendar days of receipt of an urgent hardship request.
 - (b) The BH I/DD Tailored Plan shall develop a Provider Hardship Payment Policy and submit to the Department for review and approval prior to forty-five (45) days from the date of execution of this Contract. The Provider Hardship Payment Policy shall include:
 - (1) Method for providers to submit hardship payment requests,
 - (2) Description of timeline for payment for standard and urgent requests, including integration into check write schedule,
 - (3) Criteria for requests to be reviewed and approved by the BH I/DD, and
 - (4) Description of how providers and Department will be notified of status of the request and payment, if applicable.
 - (c) The BH I/DD Tailored Plan shall recoup Hardship Payments by offsetting the provider’s future claim payments or through a one-time repayment by the provider.
- vi. Provider Grievances and Appeals
 - (i) The BH I/DD Tailored Plan shall handle provider Appeals and Grievances promptly, consistently, fairly, and in compliance with State and federal law and Department requirements. The BH I/DD Tailored Plan shall have in place a provider Appeals and Grievance system, distinct from that offered to members, that includes a Grievance process for providers to bring issues to the BH I/DD Tailored Plan, an Appeals process for providers to challenge certain BH I/DD Tailored Plan decisions, and information regarding recourse available under contract or law . The BH I/DD Tailored Plan shall be transparent with providers regarding its Appeals and Grievance processes and procedures. The BH I/DD Tailored Plan shall ensure the Grievance and Appeals system comply with *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan has contracted with a Subcontractor for the Grievance and Appeals system.
 - (ii) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) days after Contract Award. The BH I/DD Tailored Plan shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.
 - (iii) The BH I/DD Tailored Plan shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience.
 - (iv) The BH I/DD Tailored Plan shall not discriminate against or retaliate against any provider based on any action taken by the provider under Provider Grievances and Appeals Section of the Contract (*Section V.B.4.v.*) or under Member Grievances and Appeals Section of the Contract (*Section V.B.1.vi.*) taken on behalf of a member.
 - (v) Grievances
 - (a) The BH I/DD Tailored Plan shall have a process in place to receive and resolve Grievances with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
 - (b) The BH I/DD Tailored Plan shall accept and resolve provider Grievances regarding the BH I/DD Tailored Plan referred from the Department.
 - (c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit Grievances through the BH I/DD Tailored Plan provider web portal.

- (d) The BH I/DD Tailored Plan shall provide a report on provider Grievances in a form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements* and upon request.
- (vi) Appeals
 - (a) The BH I/DD Tailored Plan shall offer providers Appeal rights as described in *Section VII. Second Revised and Restated Attachment I. Provider Appeals for Medicaid, NC Health Choice and State-funded Providers*.
 - (b) The BH I/DD Tailored Plan shall provide written notice of provider's right to Appeal with the notice of decision giving rise to the provider's right to Appeal.
 - (c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit Appeals through the BH I/DD Tailored Plan provider web portal.
 - (d) The BH I/DD Tailored Plan shall accept a written request for an Appeal from the provider within thirty (30) Calendar Days on which:
 - (1) Provider receives written notice from the BH I/DD Tailored Plan of the decision giving rise to the right to Appeal; or
 - (2) BH I/DD Tailored Plan should have taken a required action and failed to take such actions.
 - (e) The BH I/DD Tailored Plan shall acknowledge receipt of each Appeal request within five (5) Calendar Days of receipt of the request.
 - (f) The BH I/DD Tailored Plan shall extend the timeframe by thirty (30) Calendar Days for providers to request an Appeal for good-cause shown as determined by the BH I/DD Tailored Plan.
 - (1) BH I/DD Tailored Plan shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an Appeal request.
 - (2) BH I/DD Tailored Plan shall consider the voluminous nature of required evidence/supporting documentation, as good-cause reasons to extend the timeframe.
 - (g) The BH I/DD Tailored Plan shall provide information regarding provider Appeals to Department upon request.
 - (h) The BH I/DD Tailored Plan Grievances and Appeals Policy shall provide that a provider must exhaust the BH I/DD Tailored Plan internal Appeals process before seeking recourse under any other process permitted by contract or law.
- (vii) Resolution of Appeal
 - (a) The BH I/DD Tailored Plan shall establish a committee to review and make decisions on provider Appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.
 - (b) The BH I/DD Tailored Plan shall provide written notice of decision of the Appeal within thirty (30) Calendar Days of receiving a complete Appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the BH I/DD Tailored Plan. Notice shall include information regarding further Appeal rights, if any.
 - (c) The BH I/DD Tailored Plan shall allow providers to be represented by an attorney during the Appeals process.
- (viii) Appeals of Suspension or Withhold of Provider Payment
 - (a) The BH I/DD Tailored Plan shall limit the issue on Appeal in cases of suspension or withhold or provider payment to whether the BH I/DD Tailored Plan had good-cause to commence the withhold or suspension of provider payment. BH I/DD Tailored Plan shall not address whether the provider has or has not committed fraud or abuse.
 - (b) The BH I/DD Tailored Plan shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.

- (c) The BH I/DD Tailored Plan shall offer the provider an in person or telephone hearing when provider is Appealing whether BH I/DD Tailored Plan has good cause to withhold or suspend payment to the provider.
- (d) The BH I/DD Tailored Plan shall schedule the hearing and issue a written decision regarding whether BH I/DD Tailored Plan had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's Appeal. Upon a finding that BH I/DD Tailored Plan did not have good-cause to suspend or withhold payment, BH I/DD Tailored Plan shall reinstate any payments that were withheld or suspended within five (5) Business Days.
- (e) The BH I/DD Tailored Plan shall pay interest and penalties, as outlined in Section V.B.6.i.(iv)(d) for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.
- (ix) Notice to Department
 - (a) The BH I/DD Tailored Plan shall provide notice to the Department of any provider Appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by BH I/DD Tailored Plan, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.
 - (b) The BH I/DD Tailored Plan shall notify Department if a provider has sued BH I/DD Tailored Plan in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.

5. Quality and Value

i. Quality Management and Quality Improvement

- (i) The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. For BH I/DD Tailored Plans, which are tasked with caring for North Carolinians with complex BH, I/DD, and TBI needs, the Department intends to incorporate additional standards and opportunities related to the unique aspects of the BH I/DD Tailored Plan population, while maintaining standards relevant to the Standard Plans. The Department intends to promote the highest quality of care for physical health, BH, I/DD, TBI and LTSS needs and to promote integration among physical and BH service providers and providers of LTSS and I/DD care.
- (ii) The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. For the populations served by BH I/DD Tailored Plans, the Department will emphasize integration between care delivery for physical health needs and care delivery for BH needs, as well as care specific to the needs of individuals with I/DD and TBI.
- (iii) As North Carolina transitions to Medicaid Managed Care, the Department will work with the BH I/DD Tailored Plan to develop a data-driven, outcomes-based continuous QI process. The QI process builds upon the Department's experience in NC Medicaid Direct and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards BH I/DD Tailored Plans and, in turn, providers for advancing quality goals and health outcomes.
- (iv) The BH I/DD Tailored Plan shall have an IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations. The BH I/DD Tailored Plan shall engage with the Department and its designees to share quality data reported by the BH I/DD Tailored Plan and receive quality data calculated by the BH I/DD Tailored Plan or its designees.

- (v) The BH I/DD Tailored Plan shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan, and comply with the quality management and quality improvement assurances and other requirements contained in North Carolina's federal Medicaid waivers (e.g., Section 1115, Section 1915(c), and other active waivers relevant for the BH I/DD Tailored Plan).
- (a) Quality Assessment and Performance Improvement (QAPI) Plan (42 C.F.R. § 438.330)
- (1) The BH I/DD Tailored Plan shall submit an annual combined QAPI Plan for Medicaid, NC Health Choice, and State-funded services, delineating the BH I/DD Tailored Plan's plans for performance improvement programs and other quality improvement efforts as part of the QAPI Plan. As long as the QAPI clearly states that it applies to the BH I/DD Tailored Plan, the System of Care Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - (2) The BH I/DD Tailored Plan shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
 - (3) The QAPI Plan shall include the following elements:
 - i. Completion of PIPs specified by the Department;
 - ii. Collection and submission of all quality performance measurement data required by the Department;
 - iii. Mechanisms to detect both underutilization and overutilization of services;
 - a) Use of congregate care settings including county-by-county and Member demographic-based monitoring where available;
 - b) Use of EDs (inclusive of lengths of stay) for behavioral (including behavioral health) crises;
 - c) Out of home placements greater than 30 miles/30 minutes (urban) or 60 miles/60 minutes (rural) away from a Member's/family's home, including out of state placements;
 - d) Time to service initiation from request of service or determination of service need by a provider, and lengths of stay in inappropriate settings while awaiting access to appropriate services;
 - e) Use of community/home-based services for youth residing in foster care settings who have behavioral health diagnoses; and
 - f) 30/60/180 day readmissions to congregate care settings and ED settings following discharge from any congregate care setting;
 - iv. Mechanisms to assess the quality and appropriateness of care for members' special health care needs;
 - v. Mechanisms to assess the quality and appropriateness of care provided to members needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan;
 - vi. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS, members transitioning out of State hospitals and transitioning out of or diverted from adult care homes);
 - vii. Mechanisms to incorporate population health programs targeted to improve outcome measures;

- viii. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS services and programs;
 - ix. Mechanisms to assess and address health disparities, including findings from the Department disparity report; and
 - x. The BH I/DD Tailored Plan's contributions to Health-Related Resources that can support or align with broader improvement in particular health outcomes outlined in the Quality Strategy, for example through engagement with the Department around understanding state performance on the Behavioral Risk Factor Surveillance System survey.
 - xi. Mechanisms to assess and address health equity including access to culturally and linguistically appropriate services and a diverse provider pool.
- (4) The Quality Assessment and Improvement Program (QAPI) reporting shall also include Consumer and Family Advisory Committee (CFAC) activity, result summaries, and program assessments of the following:
- i. Mechanisms to collect and assess feedback from the BH I/DD Tailored Plan's CFAC;
 - ii. The BH I/DD Tailored Plan's actions/initiative taken based on CFAC feedback in alignment with improvement and appropriateness of care provided to Members;
 - iii. Mechanisms to review member satisfaction and feedback on the member experience with BH I/DD Tailored Plan responsiveness to member issues/comments/concerns;
 - iv. The BH I/DD Tailored Plan shall submit an updated CFAC roster of committee members when there are modifications made to the CFAC representatives. This roster shall include demographics of the committee members i.e., race/ethnicity, geographic location, disability designation (e.g., MH, SUD), etc.
- (vi) The BH I/DD Tailored Plan shall participate in monthly BH I/DD Tailored Plan Quality Director Meetings.
- (vii) The BH I/DD Tailored Plan shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.
- (viii) The BH I/DD Tailored Plan shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of each BH I/DD Tailored Plan's overall QAPI program design as directed by the Department.
- (ix) Quality Measures
- (a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in NC Medicaid Managed Care Technical Specifications document, posted annually on the Nc DHHS Quality Management and Improvement website, that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and, beginning in Contract Year 2, financial accountability for a select set of measures to be specified by the Department.
 - (b) The BH I/DD Tailored Plan shall calculate and report on those measures identified by the Department that require claims or encounter data or clinical data. Department identified measures are indicated in *Section VII. First Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics for Medicaid, Tables 1-4*. The Department will monitor other measures that are not designated in *Section VII. First Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics for Medicaid, Tables 1-4* and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance reports. The Department reserves the right to add and remove measures from

the NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website.

- (c) The BH I/DD Tailored Plan shall submit to the Department all data necessary for the Department to calculate the BH I/DD Tailored Plan's performance on measures listed in the NC Medicaid Managed Care Technical Specifications document, posted annually on the NC DHHS Quality Management and Improvement website.
 - (d) Detailed specifications around measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plans prior to launch and annually thereafter.
 - (e) The BH I/DD Tailored Plan shall incorporate Department identified measures into the BH I/DD Tailored Plan's QAPI and quality improvement activities. Department identified measures are indicated in *First Revised and Restated Attachment E. First Revised and Restated Required BH I/DD Tailored Plan Quality Metrics*. The Department reserves the right to change the quality measures identified for BH I/DD Tailored Plan's QAPI and quality improvement activities.
 - (f) Beginning in Contract Year 2, the Department may implement a quality withhold/incentive program based on quality measures used to administer a BH I/DD Tailored Plan. A subset of the Measures may be included in the Withhold/Incentive Program. The Department reserves the right to add and remove measures that may be subject to future withholds.
 - (g) The Department intends to monitor CMS's development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.
- (x) Measurement of Outcomes
- (a) The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas of quality of life, functional status and member satisfaction. This measurement may involve the use of surveys that may be administered by providers or third-party contractors, and may involve the development and piloting of novel survey instruments.
 - (b) The BH I/DD Tailored Plan shall support the administration of surveys as requested by the Department. This support may include conducting outreach to members and providers, incorporating in provider contracting requirements related to survey administration, and conducting analysis of internal data to support survey piloting, quality assurance, and performance improvement.
 - (c) The BH I/DD Tailored Plan shall ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department.
 - (d) The Department is also exploring administrative data from other State agencies to support measurement of outcomes outside of the health care system for Medicaid beneficiaries.
- (xi) Disparities Reporting and Tracking
- (a) The BH I/DD Tailored Plan shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
 - (1) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plan after Contract Award and annually thereafter.
 - (b) The BH I/DD Tailored Plan shall address disparities as determined by the Department during review of the BH I/DD Tailored Plan's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.
 - (1) The Department will define the strata to be applied to each measure after Contract Award and annually thereafter.

(xii) Public Health Reporting and Tracking

- (a) The BH I/DD Tailored Plan shall work with the Department to target areas of collaboration and develop programs as part of QI efforts that can:
 - (1) Remove barriers (e.g., benefit coverage, implementation challenges, member education);
 - (2) Align incentives by targeting withholds for measures that will affect public health priorities; and
 - (3) Require select quality initiatives to be embedded in QAPIs, including PIPs and contributions to health-related resources.
- (b) The BH I/DD Tailored Plan shall be an active partner in Healthy NC 2030 (<https://nciom.org/healthy-north-carolina-2030/>) goals planning by participating at a minimum as follows:
 - (1) Joining planning meetings;
 - (2) Designating a senior level clinical staff person to engage in public health issue discussions; and
 - (3) Aligning QI activities to support Healthy NC 2030 goals.

(xiii) Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)

- (a) The BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program, and may be required to develop additional performance improvement projects for specific focus areas and/or clinical measures as directed by the Department. The BH I/DD Tailored Plan's PIPs must be approved by the Department annually as part of the BH I/DD Tailored Plan's QAPI program. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in this document.
- (b) As long as the PIP clearly states that it applies to the BH I/DD Tailored Plan, the PIP may apply to other LME/ MCO operations, including, without limitation, the PIHP.
- (c) The BH I/DD Tailored Plan shall develop a PIP that is:
 - (1) Designed to achieve significant improvement in health outcomes as part of the annual BH I/DD Tailored Plan QAPI program review; and
 - (2) Includes measurement of performance using quality indicators as part of the annual BH I/DD Tailored Plan QAPI program review.
- (d) Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
- (e) The BH I/DD Tailored Plan shall conduct at least one (1) non-clinical performance improvement project on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
- (f) The BH I/DD Tailored Plan shall be required to develop and execute one (1) clinical performance improvement projects annually that must be related to one or more of the following areas:
 - (1) Maternal health;
 - (2) Tobacco cessation;
 - (3) Diabetes prevention;
 - (4) Birth outcomes;
 - (5) Early childhood health and development;
 - (6) Hypertension; and
 - (7) Behavioral-physical health integration
- (g) All BH I/DD Tailored Plans shall be required to develop or maintain and execute two (2) clinical performance improvement project annually that is related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional or ACH settings.

- (h) The BH I/DD Tailored Plan performs below seventy-five percent (75%) for overall CMS 416 rates for EPSDT screening, the BH I/DD Tailored Plan shall submit one (1) PIP on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical PIPs annually.
- (xiv) External Quality Review (42 C.F.R. § 438.3(s)(1))
 - (a) The BH I/DD Tailored Plan shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO. This may include a consolidated approach assessing both Medicaid and state-funded services.
 - (b) The BH I/DD Tailored Plan shall participate in the annual Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS), the Provider Survey, the Consumer Perception of Care survey, and the National Core Indicators (NCI) survey,
 - (c) The BH I/DD Tailored Plan shall comply with validation and research activities related to surveys, including survey instruments under development, that are required by the Department.
- (xv) Quality Improvement - Provider Supports
 - (a) The BH I/DD Tailored Plan shall provide support to providers tailored to advance State interventions and ensure providers' ability to achieve the goals outlined in the Quality Strategy.
 - (b) The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.
 - (c) The BH I/DD Tailored Plan shall develop and maintain a BH I/DD Tailored Plan Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the BH I/DD Tailored Plan Provider Support Plan.
 - (d) The Provider Support Plan shall be developed as a component part of the QAPI and provider support activities should relate to improvement in specific health outcomes.
 - (e) The BH I/DD Tailored Plan Provider Support Plan shall include:
 - (1) All planned technical support activities;
 - (2) Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy; and
 - (3) An overview of which metrics the BH I/DD Tailored Plan will use to evaluate its provider engagement progress over time.
 - (4) How the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.
 - (f) The BH I/DD Tailored Plan shall provide QI support to Network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
 - (1) The Opioid Misuse Prevention and Treatment Program;
 - (2) Healthy Opportunities interventions, including but not limited to interventions delivered through the Healthy Opportunities Pilots;
 - (3) The Tailored Care Management model;
 - (4) BH integration;
 - (5) VBP;
 - (6) Pregnancy management/Pregnancy Management Program;
 - (7) Tobacco Cessation Plan;
 - (8) Activities to support at-risk children;
 - (9) The CDC 6|18 initiative; and
 - (10) Support for other activities such as response to or recovery from COVID-19, or future resilience efforts, as indicated by the Department.

ii. Value-Based Payments (VBP)

- (i) To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, integration of physical and BH, appropriateness of care and other measures related to value included in the BH I/DD Tailored Plan Quality Strategy, the Department is requiring adoption of VBP arrangements between the BH I/DD Tailored Plan and providers. The Department will issue additional guidance and details on VBP requirements for BH I/DD Tailored Plans.
- (ii) The Department defines VBP arrangements as payment arrangements between the BH I/DD Tailored Plan and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>. The Department reserves the right to narrow the definition of VBP and the range of acceptable BH I/DD Tailored Plan VBP arrangements with providers in the future.
 - (a) Payments to AMH+ and CMA providers will be considered VBP only when these contracts include a performance incentive payment, as described in *Section V.B.4.iv. Provider Payments*.
 - (b) All VBP arrangements must be aligned with the BH I/DD Tailored Plan Quality Strategy and related measures.
 - (c) The BH I/DD Tailored Plan shall re-submit contract templates to the Department for review at least ninety (90) Calendar Days before use in the market when any new VBP arrangements (excluding AMH+s, which is covered in *Section V.B.4.iv. Provider Payments*) or changes to VBP arrangements are added.
- (iii) The Department will set minimum targets for VBP contracting starting in Contract Year 2, and implement withholds associated with these targets. Targets will be published at least six (6) months prior to Contract Year 1.
- (iv) The BH I/DD Tailored Plan shall have IT infrastructure and data analytic capabilities to support the Department's vision in moving toward VBP, including having systems that can support alternative payment arrangement models which require data-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.
- (v) The BH I/DD Tailored Plan shall complete a VBP Assessment based on the categories developed by HCP-LAN, as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*. The Department will provide specifications on the assessment methodology following Contract Award.
 - (a) The Department shall use the VBP Assessment to demonstrate the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the amount of total medical expenditures and covered lives under these VBP payment arrangements, and compare documented progress to the BH I/DD Tailored Plan's final VBP Strategy on an annual basis.
 - (b) The BH I/DD Tailored Plan shall report the initial results of its VBP Assessment focused on VBP contracts in place to date no later than September 30, 2023.
 - (c) The BH I/DD Tailored Plan shall update the VBP Assessment on an annual basis, within ninety (90) days of the end of each contract year.
- (vi) To ensure the BH I/DD Tailored Plan's response aligns with the Department's strategy and goals, the BH I/DD Tailored Plan shall develop a BH I/DD Tailored Plan VBP Strategy for Contract Years 1 -3, in alignment with the Department's short- and long-term goals to shift from a fee for service system to VBP.
 - (a) The BH I/DD Tailored Plan VBP Strategy must be submitted to the Department within six (6) months of notice by the Department it is due.

(b) As long as the VBP Strategy clearly states that it applies to the BH I/DD Tailored Plan, the VBP Strategy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

(c) The VBP Strategy shall contain the following elements:

(1) A narrative description addressing:

- i. The BH I/DD Tailored Plan's goals, strategies and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the BH I/DD Tailored Plan will involve BH and intellectual and developmental disability providers in its VBP arrangements.
- ii. A description of the VBP model(s) that will be pursued by the BH I/DD Tailored Plan and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers.
- iii. An explanation of how the BH I/DD Tailored Plan will ensure that physical, BH, and I/DD services are integrated under its VBP arrangements.
- iv. The BH I/DD Tailored Plan's plan for measurement of outcomes and ROI related to VBP by year.
- v. The BH I/DD Tailored Plan's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes. For full Healthy Opportunities requirements, see *Section V.B.3.x. Healthy Opportunities*.
- vi. A description of the BH I/DD Tailored Plan's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the BH I/DD Tailored Plan VBP programs. Specific functionalities to address include:
 - a) Risk adjustment;
 - b) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
 - c) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - d) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - e) Reporting capabilities; and
 - f) Payment functions.
- vii. The BH I/DD Tailored Plan's approach to address health disparities and incorporate health equity into their internal and external policies, and procedures.

(2) The BH I/DD Tailored Plan's projected annual targets for the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the percent of total medical expenditures and covered lives under these VBP payment arrangements, in a format to be determined by the Department.

(vii) Additionally, the BH I/DD Tailored Plan shall participate in any VBP stakeholder meeting process initiated by the Department. The BH I/DD Tailored Plan will be responsible for meeting any requirements outlined by a Departmental VBP stakeholder group for future contract years.

6. Claims and Encounter Management

i. Claims

(i) In order to incentivize successful Medicaid Managed Care and increase provider participation, the BH I/DD Tailored Plan shall pay all providers on a timely basis upon receipt of any Clean Claims for covered services rendered to members who are enrolled with the BH I/DD Tailored Plan in

accordance with State and Federal statutes. To maximize Federal match and ensure accurate reporting, the BH I/DD Tailored Plan shall comply with the Department's Managed Care Provider Billing Guide or as otherwise directed by the Department.

- (ii) Incorrect claim payment or inappropriate claim denial result in increased administrative costs to both the provider and the BH I/DD Tailored Plan and by extension, increase the program costs of Medicaid Managed Care. Therefore, the BH I/DD Tailored Plan shall develop, maintain and operate a claims payment, review and Program Integrity process which minimizes incorrect claim payments and inappropriate claim denials.
- (iii) Claims Processing and Reprocessing Standards
 - (a) The BH I/DD Tailored Plan shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when the Department decisions are made that would warrant reprocessing (i.e., member retrospective eligibility determinations or plan enrollment changes).
 - (b) In addition to processing claims for all Medicaid Managed Care covered services, the BH I/DD Tailored Plan shall have the operational and administrative capability to process ILOS, Value-Added Services, value-based services and qualifying EPSDT services which may be otherwise non-covered.
 - (c) The BH I/DD Tailored Plan shall process and reimburse providers in accordance with the Department's prompt payment standards, regardless of provider contracting status.
 - (1) Prior to paying a claim, the BH I/DD Tailored Plan shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of provider contracting status.
 - (2) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid and NC Health Choice programs, are subject to an out-of-state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.
 - (d) The BH I/DD Tailored Plan shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:
 - (1) The BH I/DD Tailored Plan shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.
 - (2) The BH I/DD Tailored Plan shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate member enrollment or program changes.
 - (3) The BH I/DD Tailored Plan shall capture and retain the IP address/location and the user login/user name for all claims submitted via the online provider portal(s).
 - (e) In instances where a provider submits an adjustment to a previously adjudicated claims, the BH I/DD Tailored Plan shall adjudicate the adjusted claim within the same timeframes as required for the initial Clean Claim.
 - (f) The BH I/DD Tailored Plan shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.
 - (g) The BH I/DD Tailored Plan shall ensure the claim processes align with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan has delegated claims processing to a Subcontractor.
- (iv) Prompt Payment Standards

- (a) The BH I/DD Tailored Plan shall promptly pay Clean Claims, regardless of provider contracting status. The BH I/DD Tailored Plan shall reimburse providers in a timely and accurate manner when a clean medical or pharmacy claim is received.
- (1) 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 medical Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Clean 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.
 - (2) Pharmacy Claims
 - i. The BH I/DD Tailored Plan shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a pharmacy Clean 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.
 - (3) 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).
- (b) The BH I/DD Tailored Plan shall reprocess medical and pharmacy claims, including resubmitted and corrected claims, in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
- (c) Pursuant to N.C. Gen. Stat. § 58-3-225(f), the BH I/DD Tailored Plan may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the member by the health care provider and, in the case of health care provider facility claims, within 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.
- (d) Interest and Penalties
- (1) The BH I/DD Tailored Plan shall pay interest on late payments to the provider, including, but not limited to, AMH+ practices and CMAs, 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.
 - (2) In addition to the interest on late payments required by this Section, the BH I/DD Tailored Plan shall pay the provider, including, but not limited to, AMH+ practices and CMAs, 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.
 - (3) 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).

- (4) The BH I/DD Tailored Plan shall implement fee schedule changes and reprocess all impacted claims with dates of services from the effective date of the DHB fee schedule change with correct rates within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's website. This standard is only applicable for NC DHB rate floor programs. Failure to implement fee schedule changes within the required timeframe shall result in interest and penalty payments to the Provider as defined in this Section beginning on the forty-sixth (46th) Calendar Day after the BH I/DD Tailored Plan received notification from the Department .
- (e) 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).
- (f) For purposes of actions which must be taken by a BH I/DD Tailored Plan as found in *Section V.B.6.i.(iv) Prompt Payment 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.
- (g) The BH I/DD Tailored Plan shall comply with the Department's Tribal Payment Policy, to be provided by the Department upon Contract Award.
- (v) Overpayment or Underpayment Recovery
 - (a) The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. 42 C.F.R. § 438.608(a)(2).
 - (b) In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with N.C. Gen. Stat. § 58-3-225(h).
 - (c) The BH I/DD Tailored Plan shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
- (vi) System Standards
 - (a) The BH I/DD Tailored Plan shall have a Claims Processing and Management Information System (MIS) capable of meeting Medicaid Managed Care requirements and maintaining compliance throughout the term of the Contract.
 - (b) The BH I/DD Tailored Plan shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a member.
- (vii) Mass Adjustment
 - (a) The BH I/DD Tailored Plan shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
 - (b) The BH I/DD Tailored Plan shall comply with the Department's policies and procedures on mass adjustment.
- ii. Encounters
 - (i) The Department collects and uses provider service encounter data for many purposes including, but not limited to, Federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud, waste, and abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.
 - (ii) The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with Medicaid Managed Care.

- (iii) Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, and penalties paid or recovered, incentive payments paid or recovered, “zero paid” claim lines, cost settlements, sub-capitated services, third-party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the BH I/DD Tailored Plan, its delegees or Subcontractors.
- (iv) Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPPA rejection and not a denied claim or claim line.
- (v) Submission Standards and Frequency
 - (a) The BH I/DD Tailored Plan shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Companion Guides – 837I, 837P, and NCPDP developed by the Department or its vendor(s) to be provided at Contract Award.
 - (b) The BH I/DD Tailored Plan shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
 - (c) The BH I/DD Tailored Plan shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP..
 - (d) Encounter data submissions must contain adjustments made by BH I/DD Tailored Plan due to payment errors and/or provider adjusted claims.
 - (e) The BH I/DD Tailored Plan shall submit a monthly certification from the BH I/DD Tailored Plan Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
 - (f) The BH I/DD Tailored Plan is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
 - (g) Specifications
 - (1) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department’s two publications, Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.
 - (2) Encounters are defined in two (2) groups:
 - i. BH, I/DD, TBI, ILOS, Value-Added services, value-based services, and ECM pilot services.
 - ii. Pharmacy, including outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.
 - (3) The BH I/DD Tailored Plan shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
 - i. The BH I/DD Tailored Plan shall have the capability to submit to the Department encounter data from:
 - a) Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
 - b) Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
 - (4) The BH I/DD Tailored Plan shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.

- (5) The BH I/DD Tailored Plan, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.
- (6) The BH I/DD Tailored Plan shall reference the same edit codes as the Department's system, which are defined in the Department Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP..
- (h) The BH I/DD Tailored Plan shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the BH I/DD Tailored Plan submitted an encounter data file.
- (i) Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
 - (1) Timeliness
 - i. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim payment date.
 - ii. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the claim payment date.
 - (2) Completeness
 - i. The BH I/DD Tailored Plan shall submit all claims processed as encounters, as defined in this Section.
 - ii. The BH I/DD Tailored Plan encounter data submissions shall meet or exceed a monthly data acceptance rate of ninety-eight percent (98%) as compared to the BH I/DD Tailored Plan's monthly certification.
 - iii. Encounter data completeness shall be measured as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
 - iv. If the BH I/DD Tailored Plan encounter submission rate is less than one hundred percent (100%), the BH I/DD Tailored Plan shall submit one hundred percent (100%) of omitted encounters from the initial encounter submission date.
 - (3) Accuracy
 - i. BH I/DD Tailored Plan encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
 - ii. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.
- (j) Initial Encounter Data at Medicaid Managed Care Launch
 - (1) The BH I/DD Tailored Plan shall include encounter data for medical claims which have a date of service on or after the Medicaid Managed Care launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.
 - (2) The BH I/DD Tailored Plan shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.
- (k) To support the Department achieving efficient encounter data processing, the BH I/DD Tailored Plan shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.

- (l) In the event the BH I/DD Tailored Plan enters into a sub-capitated or other VBP reimbursement arrangement with a provider, the BH I/DD Tailored Plan shall be responsible for submitting all encounters to the Department, containing all the required data fields.
- (m) The BH I/DD Tailored Plan shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.
- (n) The BH I/DD Tailored Plan shall submit to NC Tracks, within thirty (30) days of claim payment, an electronic Tailored Care Management Payment claim for the first Tailored Care Management contact service paid by the BH/DD Tailored Plan.
- (vi) Encounter Data Resubmission Standards
 - (a) Following the Department's validation and processing of encounter data submissions, the BH I/DD Tailored Plan shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.
 - (b) The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial date of service.
 - (1) The BH I/DD Tailored Plan shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
 - (2) The Department will work with a BH I/DD Tailored Plan for any retroactive encounter denial longer than three (3) years after the initial date of service.
 - (c) Timeliness
 - (1) The BH I/DD Tailored Plan will receive notification of encounter data errors requiring correction and resubmission within thirty (30) Calendar Days of the BH I/DD Tailored Plan's initial encounter data submission date.
 - i. BH I/DD Tailored Plan shall, where the BH I/DD Tailored Plan submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.
 - ii. BH I/DD Tailored Plan shall, where BH I/DD Tailored Plan submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.
 - (2) Within thirty (30) Calendar Days after a pharmacy encounter fails NCPDP edits, X12 (EDI) edits or EPS system edits, the BH I/DD Tailored Plan or its subcontractor shall correct and resubmit each pharmacy encounter for which errors can be remedied.
 - (d) Completeness and Accuracy. Unless otherwise directed by the Department, the BH I/DD Tailored Plan shall correct and successfully resubmit:
 - (1) Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) Calendar Days from the date the 277 was generated;
 - (2) Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) Calendar Days from the date the XML Response File was generated;
 - (3) Ninety-nine percent (99%) of encounter transactions represented on an XML Response File as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) Calendar Days from the date the 277 was generated.

- (e) The BH I/DD Tailored Plan or its subcontractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP pharmacy encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) Calendar Days of the respective action.

(vii) Data Validation and Processing

- (a) The BH I/DD Tailored Plan shall have the capability to access sufficient enrollment information to perform member and service provider matching on all claim and/or encounter transactions, if necessary.
- (b) The Department shall utilize data validation protocols on encounter data files to assess BH I/DD Tailored Plan encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).
- (c) The BH I/DD Tailored Plan shall perform testing with the Department prior to system changes when medical or pharmacy clinical policy changes that may impact operational transactions (i.e. encounter submissions) are identified by BH I/DD Tailored Plan or by Department. The BH I/DD Tailored Plan shall not implement any system changes until testing is approved by the Department.
- (d) The BH I/DD Tailored Plan shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.
- (e) The BH I/DD Tailored Plan shall, in instances where the BH I/DD Tailored Plan is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) days prior to the date the modified file will be submitted to the Department production environment.
- (f) The BH I/DD Tailored Plan shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.
- (g) At the discretion of the Department, the BH I/DD Tailored Plan may be prohibited from submitted a specific encounter type to the Department's Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the BH I/DD Tailored Plan. In addition, if the BH I/DD Tailored Plan's access to the Production Encounter Processing System is revoked, the BH I/DD Tailored Plan must actively test with the Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any penalties incurred by the BH I/DD Tailored Plan because of the loss of production access are the responsibility of the BH I/DD Tailored Plan.

(viii) Denied Claims Submitted as Encounters

- (a) The BH I/DD Tailored Plan shall submit denied claims as encounters to support denial trend analysis.
- (b) BH I/DD Tailored Plan submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
- (c) On denied claims submitted as encounters, the BH I/DD Tailored Plan shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
- (d) Denied claims submitted as encounters must also include the same data content, including provider, member and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.

- (e) The BH I/DD Tailored Plan shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction or the Department designated pharmacy encounter format.
- (ix) Communication and Oversight
 - (a) If the BH I/DD Tailored Plan experiences a technical issue preventing encounter data submission, the BH I/DD Tailored Plan shall notify the Department via the approved communication method within the predefined timeline.
 - (b) The BH I/DD Tailored Plan shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the BH I/DD Tailored Plan's system(s) or process(es) that prevents the BH I/DD Tailored Plan from submitting encounter data files as scheduled.
 - (c) The BH I/DD Tailored Plan shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
 - (d) The BH I/DD Tailored Plan shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.
- (x) Testing
 - (a) The BH I/DD Tailored Plan will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the BH I/DD Tailored Plan to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The BH I/DD Tailored Plan shall pass the testing phase for all encounter claim type submissions at a time specified by the Department
 - (b) The BH I/DD Tailored Plan shall submit the test encounters to the Department electronically according to the specifications included in the Department Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.
- (xi) In the event of Contract termination or non-renewal, the BH I/DD Tailored Plan shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) Calendar Days following the Contract termination effective date for adjudicated claims with the date of service (DOS) on or before the Contract termination or non-renewal effective date.
- (xii) In instances where the Contract has been terminated for greater than ninety (90) Calendar Days from the contract termination effective date, the BH I/DD Tailored Plan shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

7. Financial Requirements

i. Capitation Payments

- (i) Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of BH I/DD Tailored Plans. Capitation payments include monthly PMPM payments, maternity event payments and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Medicaid Tailored Plan Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFA. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Medicaid Tailored Plan Draft Rate Book.
- (ii) The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates. More information on rate setting can be found in the Medicaid Tailored Plan Draft Rate Book. Further details will be provided after Contract Award.

- (iii) The Department shall set BH I/DD Tailored Plan capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.
 - (iv) The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.
 - (v) The BH I/DD Tailored Plan shall supply, certify, and validate data to support rate setting, risk adjustment (applicable to Standard Plan PHPs) and the risk corridor program (as applicable), and qualified directed payments based on schedules to be provided by the Department after Contract Award.
 - (vi) The Department has established a separate maternity event payment. This payment will be made to the BH I/DD Tailored Plan after the BH I/DD Tailored Plan submits required documentation of a successful delivery event, defined as a qualifying birth, to the Department.
 - (a) BH I/DD Tailored Plan shall follow with the Department's Maternity Event Payment Billing Guide.
 - (b) The BH I/DD Tailored Plan shall void the claim within thirty (30) Calendar Days after notice from the Department that valid documentation is not found during the Maternity Event Reconciliation with Encounters as part of the Maternity Event Payment Billing Guidance
 - (vii) The Department has established a separate payment outside of the capitation rate for Tailored Care Management for members enrolled in Medicaid. This payment will be made to the BH I/DD Tailored Plan for any month in which the member is engaged in Tailored Care Management. For members enrolled in NC Health Choice, the cost of Tailored Care Management is incorporated in the capitation rate, and the Department will not make separate payments for Tailored Care Management for these members.
 - (viii) The Department will reimburse BH I/DD Tailored Plan for additional directed payments to providers as required under *Section V.B.4.iv. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The BH I/DD Tailored Plan is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The BH I/DD Tailored Plan shall provide the necessary data to support this process in a format and frequency to be defined by the Department.
 - (ix) The Department will make capitation payments in accordance in with the Payment and Reimbursement term in *Section III.C.36. Payment and Reimbursement*.
- ii. Medical Loss Ratio
- (i) The Medical Loss Ratio (MLR) standards are to ensure the BH I/DD Tailored Plan is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.
 - (ii) The BH I/DD Tailored Plan shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:
 - (a) The BH I/DD Tailored Plan shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
 - (1) The numerator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the BH I/DD Tailored Plan's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
 - (2) The denominator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall equal the BH I/DD Tailored Plan's adjusted premium revenue. The adjusted premium revenue shall be defined as the BH I/DD Tailored Plan's premium revenue minus

- the BH I/DD Tailored Plan's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
- (b) The BH I/DD Tailored Plan shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.
- (1) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:
- i. The BH I/DD Tailored Plan is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:
 - a) Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.
 - b) Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.
 - ii. The BH I/DD Tailored Plan is prohibited from including in the Department-defined MLR numerator any of the following expenditures:
 - a) Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.
 - b) Payments to related providers that violate the Payment Limitations as required in the Contract.
 - iii. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:
 - a) Payments from the Department to reimburse for required additional directed payments to providers shall be subtracted from the denominator along with any associated taxes and fees.
- (iii) The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
- (a) The BH I/DD Tailored Plan's classification of activities that improve health care quality, and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.
 - (b) The BH I/DD Tailored Plan shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:
 - (1) Interest or penalty payments to providers for failure to meet prompt payment standards;
 - (2) Fines and penalties assessed by the Department or other regulatory authorities;
 - (3) Rebates paid to the Department if the BH I/DD Tailored Plan exceeds the minimum MLR threshold for a prior year;
 - (4) Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the BH I/DD Tailored Plan exceeds the minimum MLR threshold for a prior year; and
 - (5) The BH I/DD Tailored Plan shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), PBM fees and spread pricing, marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations.

- (c) The BH I/DD Tailored Plan shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
- (d) The BH I/DD Tailored Plan shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting year.
- (e) Payments related to the Healthy Opportunities Pilot Program shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
- (f) All revenue, payments to providers and Tailored Plan expenditures related to Tailored Care Management shall be incorporated into the MLR except as otherwise excluded in Section V.B.7.b.iii.b.
- (g) The BH I/DD Tailored Plan shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.
- (iv) If the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold, the BH I/DD Tailored Plan shall do one of the following:
 - (a) Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
 - (b) Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.B.3.x. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
 - (c) Allocate a portion of the total obligation to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments, the remaining portion to a rebate to the Department, with amounts for each BH I/DD Tailored Plan, subject to approval by the Department.
- (v) The minimum MLR threshold for the BH I/DD Tailored Plan shall be eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49.
- (vi) The BH I/DD Tailored Plan must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).
- (vii) The BH I/DD Tailored Plan shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the BH I/DD Tailored Plan within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the BH I/DD Tailored Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).
- (viii) In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the BH I/DD Tailored Plan shall:
 - (a) Re-calculate the MLR for all MLR reporting years affected by the change, and
 - (b) Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m).
- iii. Financial Management
 - (i) The Department's financial management requirements were developed to monitor and promote program sustainability. The BH I/DD Tailored Plan shall be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve member health. The Department will pay the BH I/DD Tailored Plan a capitation payment that is set in an actuarially

sound manner. The BH I/DD Tailored Plan shall manage BH I/DD Tailored Plan expenditures within the capitation payments and have access to sufficient capital to cover any losses the BH I/DD Tailored Plan experiences.

- (ii) The BH I/DD Tailored Plan shall closely track and report their revenue and expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor BH I/DD Tailored Plan expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.
- (iii) Any financial arrangements between BH I/DD Tailored Plans and third parties should align with the parameters outlined in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
- (iv) Managing and Monitoring Cost Growth
 - (a) The BH I/DD Tailored Plan shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
 - (b) Pursuant to N.C. Gen. Stat. § 108D-65(6)a., risk-adjusted cost growth for the BH I/DD Tailored Plan's members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."
 - (c) The Department shall monitor annual cost growth of BH I/DD Tailored Plan expenditures by Region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
 - (d) The BH I/DD Tailored Plan shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth as outlined in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.
- (v) Pharmacy Savings
 - (a) N.C. Gen. Stat. § 108D-65(6)b., requires that BH I/DD Tailored Plan spending for prescribed drugs, net of rebates, ensures the Department realizes a net savings for the spending on prescription drugs. To ensure net savings, the Department shall monitor BH I/DD Tailored Plan compliance with the Department's Preferred Drug List and compliance with pharmacy claims encounter reporting.
 - (b) The BH I/DD Tailored Plan shall provide reports as requested, and in a format prescribed, by the Department to demonstrate net pharmacy savings as outlined in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
- (vi) Reinsurance
 - (a) The BH I/DD Tailored Plan shall have and maintain at all times an adequate plan for protection against insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C. Any reinsurance or alternative arrangement proposed by the BH I/DD Tailored Plan is subject to review and approval by the Department. The agreement must provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage.
 - (b) The BH I/DD Tailored Plan shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify the BH I/DD Tailored Plan of any required changes to the proposed reinsurance arrangement or alternative mechanism. The BH I/DD Tailored Plan shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.

- (c) The BH I/DD Tailored Plan shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. The Department may require additional protections and documentation at any time.
 - (d) The Department reserves the right to revisit reinsurance requirements annually and to modify or establish the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that a specific threshold is deemed warranted by the Department.
 - (e) The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a BH I/DD Tailored Plan or its reinsurer within forty-five (45) calendar days of the request by the BH I/DD Tailored Plan.
 - (f) The BH I/DD Tailored Plan shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the BH I/DD Tailored Plan or the reinsurance carrier, the BH I/DD Tailored Plan shall be fully responsible for all pending and unpaid claims.
 - (g) Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include Medicaid Managed Care Members as a covered class.
 - (h) The BH I/DD Tailored Plan shall notify the Department when the BH I/DD Tailored Plan incurs a claim against the reinsurance policy.
- (vii) Financial Viability
- (a) The BH I/DD Tailored Plan must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C.
 - (b) The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund BH I/DD Tailored Plan capital reserves at twelve and a half percent (12.5%)²¹ of total expected annual BH I/DD Tailored Plan Medicaid capitation.
 - (1) If a BH I/DD Tailored Plan fails to meet the Medicaid twelve and a half percent (12.5%) reserves requirement outlined in *Section V.B.7.iii.(vii) Financial Viability* by Day 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan must submit a viable plan outlining how the BH I/DD Tailored Plan will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section V.A.1. vi. Readiness Reviews*.
 - (2) For a Tailored Plan to be considered viable at the time of readiness review and subsequently have their solvency plan evaluated, a BH I/DD Tailored Plan must document capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation by Day 1 of BH I/DD Tailored Plan launch.
 - (c) The BH I/DD Tailored Plan shall maintain capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation as determined from the monthly, quarterly, and annual financial reporting schedules.
 - (1) If a BH I/DD Tailored Plan's capital reserves fall below 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves, and projections of the impact of the corrective actions on the capital reserve levels.

²¹ 12.5% of expected annual BH I/DD Tailored Plan capitation is used as a proxy for appropriate Risk Based Capital (RBC) solvency standards. 300% RBC is approximately equal to 1.5 months of claims, or approximately 12.5%.

- (2) If a BH I/DD Tailored Plan's capital reserves fall below 6.25 % of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the BH I/DD Tailored Plan must submit a report to the Department as described in *Section V.B.7.iii.(vii)(c)(1)* for Department review. The Department reserves the right to stipulate required corrective action for the BH I/DD Tailored Plan.
- (3) If a BH I/DD Tailored Plan capital reserves fall below 4.0 % of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the Department reserves the right to place the BH I/DD Tailored Plan under the control of the regulator or initiate actions outlined in *Section V.B.7.iii.(vii)(c)(2)*.
- (d) The Department will provide expected annual BH I/DD Tailored Plan Medicaid Capitation revenue for use in these calculations. Medicaid capitation revenue will include monthly PMPM capitation payments and maternity event payments, but exclude all other managed care payments defined in *Section 5.a of the Terms and Conditions* (i.e. Tailored Care Management payments, monthly single stream allocations, additional directed payments to certain providers, and any Healthy Opportunity Pilot program payments.)
- (e) For purposes of the capital requirements, capital reserves are defined as unobligated assets net of liabilities.
- (f) The BH I/DD Tailored Plan must, at least ninety days (90) before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-110, contingent upon legislative authority.
- (g) The BH I/DD Tailored Plan shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current Assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%).
 - (1) If a BH I/DD Tailored Plan's Current Ratio falls below 1.0 at any point in time, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.
- (h) The BH I/DD Tailored Plan shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the period measured in days.
 - (1) If a BH I/DD Tailored Plan's Defense Interval Ratio falls below 30 days at any point in time, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.
- (i) The BH I/DD Tailored Plan shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.
- (j) The Department may, at its discretion, implement a risk corridor program to provide additional protection to the BH I/DD Tailored Plan and the Department to address any uncertainty associated with pricing or enrollment. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.
- (viii) Financial Accounting and Audit
 - (a) The BH I/DD Tailored Plans accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and this Contract. The

Department will not recognize or pay services that cannot be properly substantiated by the BH I/DD Tailored Plan and verified by the Department. The BH I/DD Tailored Plan shall:

- (1) Maintain accounting records for this Contract separate and apart from other corporate accounting records;
 - (2) Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
 - (3) Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the BH I/DD Tailored Plan;
 - (4) Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts;
 - (5) Provide copies of the most recent annual audit within thirty (30) calendar days of certification, to verify the BH I/DD Tailored Plan's financial status, solvency, and viability; and
 - (6) Provide copies of the BH I/DD Tailored Plan's annual cost allocation plan for the Department's review at least sixty (60) calendar days prior to the start of the state fiscal year.
- (b) The annual financial audit and cost allocation plans shall be subject to annual independent verification and audit by the Department or a firm(s) of the Department's choosing, in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A-87. All such audits shall be arranged to occur at dates and times that are mutually agreeable, and the BH I/DD Tailored Plan shall be provided with reasonable notice of the Department's intent to perform, or cause to be performed, any such audits. The costs for such audits shall be the responsibility of the Department.
- (c) The BH I/DD Tailored Plan shall reimburse the Department, if reimbursement is sought, for reasonable costs incurred by the Department to perform examinations, investigations, audits, or other types of attestations the Department reasonably determines are necessary to ensure BH I/DD Tailored Plan compliance with this Contract. The use and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are at the Department's sole discretion.
- (d) If, as a result of an audit or review of payments made to the BH I/DD Tailored Plan, the Department discovers a payment error or overcharge, the Department will notify the BH I/DD Tailored Plan of such error or overcharge. The Department will be entitled to recover such funds as an offset to future payments to the BH I/DD Tailored Plan, or to collect such funds directly from the BH I/DD Tailored Plan.
- (1) The BH I/DD Tailored Plan must return funds owed to the Department within thirty (30) days after receiving notice of the error or overcharge, or interest will accrue on the amount due.
 - (2) The Department will calculate interest at twelve percent (12%) per annum, compounded daily. If an audit reveals that errors in reporting by the BH I/DD Tailored Plan have resulted in errors in payments to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will indemnify the Department for any losses resulting from such errors, including the cost of audit.

- iv. Tailored Care Management Capacity Building Performance Incentive Program
 - (i) To qualify for the Tailored Care Management Capacity Building Performance Incentive Program, the Contractor must develop and submit a Capacity Building Distribution Plan for Departmental approval. The Contractor shall use the Department-approved template, detailing how Contractor will invest in care management capacity and Tailored Care Management providers in its Tailored Plan Region to achieve specific milestones. In completing the Capacity Building Distribution Plan, the Contractor shall set quarterly targets associated with each milestone. The Capacity Building Distribution Plan template, including the list of milestones and additional guidance on the submission and approval process will be published on the PCDU. Submission and approval of the Capacity Building Distribution Plan is a milestone and the Contractor will receive the initial incentive payment following the approval of the Capacity Building Distribution Plan.
 - (ii) To receive incentive payments in addition to the initial payment described in subsection (i), Contractor shall submit on a quarterly basis the Capacity Building Quarterly Report, due thirty (30) calendar days after the end of each calendar quarter, April 29, 2022. Contractor shall use Department-defined template, showing the milestones and associated targets that have been met and a list of participating AMH+ practices and CMAs. Quarterly incentive payments are contingent on the Contractor meeting targets/milestones. Contractor will receive funding associated with targets/milestones that are proportionate to progress on those targets/milestones. If the Contractor does not make progress on a target or milestone, then, for that quarter, the Contractor will not be eligible to receive the funding associated with that target/milestone. For any quarter where the Contractor does not meet a target/milestone, Contractor will be eligible to receive funding in a future quarter when the targets/milestones are met. The Capacity Building Quarterly Report template and timeline for submission of all quarterly reports will be published on the PCDU.
 - (a) Contractor shall also submit Capacity Building Monthly Reports, due on the last day of each month, after BH I/DD Tailored Plan launch, so long as the Contractor Distribution Plan has been approved by the Department. Contractor shall use the Department -defined template, with progress updates on achieving milestones. The Capacity Building Monthly Report template-will be published on the PCDU.
 - (b) Contractor shall submit an updated Capacity Building Distribution Plan for DHHS approval along with the Capacity Building Quarterly Report, if Contractor's Capacity Building Distribution Plan has changed significantly from the approach approved by DHHS.
 - (iii) The Contractor shall:
 - (a) Participate in calls/meeting with the Department to discuss its Care Management Capacity Building program, upon request by the Department with reasonable advance notice.
 - (b) Provide additional documentation supporting the expenditures and distribution of funds to participating providers, within five (5) business days of the request by the Department.
 - (iv) The Department reserves the right to modify Capacity Building Distribution Plans to account for providers participating in multiple BH I/DD Tailored Plan's Tailored Care Management Capacity Building Performance Incentive Programs, in efforts to minimize duplicative investments.
 - (v) Capacity Building Milestones
 - (a) The Department has identified the following six capacity building milestones to enhance HIT infrastructure, build the care manager workforce, and promote operational readiness:

Milestone 1	Submission of a detailed distribution plan that specifies the BH I/DD Tailored Plan’s approach (including quarterly targets) and proposed budget for meeting the remaining capacity building milestones, for DHHS approval
Milestone 2	Submission of a Tailored Care Management training curriculum and conducting trainings for care managers employed by BH I/DD Tailored Plan awardee and contracted AMH+ practices and CMAs
Milestone 3	Purchase or upgrades of care management related HIT infrastructure and systems for AMH+ practices/CMAs
Milestone 4	Hiring new care managers and supervisors at AMH+ practices and CMAs
Milestone 5	Completing Tailored Care Management training for AMH+ practices and CMAs’ care managers and supervisors
Milestone 6	AMH+ practices/CMAs meeting other competencies linked to operationalizing Tailored Care Management (e.g., development of policies and procedures and education and outreach to members on the Tailored Care Management model)

(b) Sub-milestones and targets will also be developed as part of the Distribution Plan, including sub-milestones targeted at supporting Historically Underutilized Providers. Capacity building funding is not intended to support BH I/DD Tailored Plan, AMH+, and CMA needs in areas other than Tailored Care Management or that are not reflected in these milestones, sub-milestones, and targets.

8. Technical Specifications

i. Data Exchange Model

- (i) The following diagram and accompanying matrix provides a point in time, high-level view of the primary data exchanges associated with the BH I/DD Tailored Plan, the Department, AMH+s/CMAs, and Department Vendors. As the program evolves and technical designs are finalized the data exchanges depicted below will change. The BH I/DD Tailored Plan will be responsible for implementing the data exchanges as defined by the Department.
- (ii) The Department anticipates changes to its Information Technology Systems. The BH I/DD Tailored Plan will update its Information Technology Systems to conform with any updates to the Department’s Information Technology System changes including but not limited to data exchanges and interfaces, file formats, data exchange frequencies, data exchange protocols and transports, source and target systems, and file size (i.e. number of records per file). The Department will provide test environments to allow adequate testing time.

No.	First Revised and Restated Data Exchange Description – For Informational Purposes
1.	The BH I/DD Tailored Plan will send the Department or its Vendors the following data: <ul style="list-style-type: none"> a. Encounter Data – Medical and pharmacy encounter data b. AMH+/CMA Assignment Data c. PCP Assignment Data d. Lock-in Data – Member lock-in data (including pharmacy and prescriber) e. Provider Network Data f. Member Insurance Data

No.	First Revised and Restated Data Exchange Description – For Informational Purposes
	<ul style="list-style-type: none"> g. Member Enrollment – On request the BH I/DD Tailored Plan will send the Department its current, complete roster of members h. Data to support Transition of Care as specified in the Transitions of Care requirements
2.	<p>The Department will send the BH I/DD Tailored Plan the following data:</p> <ul style="list-style-type: none"> a. Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated member records b. Capitation Payment Information c. Member Reconciliation Date – The Department will send weekly 834 files to be used by the BH I/DD Tailored Plan for reconciliation purposes d. Member Acuity data for the provision of tailored care management
3.	<p>The Department will send the Enrollment Broker the following data:</p> <ul style="list-style-type: none"> a. NC Medicaid Direct Providers – The Department will send the Enrollment Broker its NC Medicaid Direct provider roster for inclusion in the Consolidated Provider Directory.
4a.	<p>The Department will send the Provider Enrollment File to the BH I/DD Tailored Plan on a daily basis. This will be a full file.</p>
4b.	<p>The Provider Enrollment File is made available to the BH I/DD Tailored plan daily. The data in the Provider Enrollment File is to be used by the BH I/DD Tailored Plan for contracting and provider reconciliation. This is a full file which includes demographic and enrollment information for all NC Medicaid enrolled providers.</p>
5.	<p>The BH I/DD Tailored Plan will send the Enrollment Broker the following data:</p> <ul style="list-style-type: none"> a. All Contracted Providers – The BH I/DD Tailored Plan will send to the Enrollment Broker its directory of contracted providers for inclusion in the Consolidated Provider Directory
6.	<p>The BH I/DD Tailored Plan will send data to the AMH+s/CMA's or CINs or Other Partners on their behalf as described in <i>Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification</i>.</p>
7.	<p>The BH I/DD Tailored Plan and the Provider will exchange the following data:</p> <ul style="list-style-type: none"> a. Claims Data – The Contracted Providers will send claims data for payment to the BH I/DD Tailored Plan b. Payment Data – The BH I/DD Tailored Plan will send payments to the provider

ii. Electronic Data Submission

(i) Electronic Data Interchange (EDI) and Other Integrations

- (a) Integrations between the BH I/DD Tailored Plan, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.
- (b) The BH I/DD Tailored Plan shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 142.308(d).
- (c) If the BH I/DD Tailored Plan stores, transmits, or maintains data or information in an encrypted format, the BH I/DD Tailored Plan will, at the Department's request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
- (d) The BH I/DD Tailored Plan will work with the Department or its designated Vendor to establish and manage all integration.

- (e) Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours of the BH I/DD Tailored Plan's discovery of such. If the failure impacts the BH I/DD Tailored Plan's ability to deliver member services, it must be reported immediately. The BH I/DD Tailored Plan will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at its discretion will track issues reported by the BH I/DD Tailored Plan and may require a more comprehensive corrective action plan if the Department identifies trends in the BH I/DD Tailored Plan's performance.
- (ii) Retransmissions
 - (a) If the BH I/DD Tailored Plan receives an unintelligible transmission from the Department or Department vendor, the BH I/DD Tailored Plan will immediately notify the Department via the Tech Ops team and the Department shall retransmit as soon as the errors are remediated.
 - (b) If the BH I/DD Tailored Plan is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the BH I/DD Tailored Plan shall retransmit as soon as the errors are remediated.
 - (c) For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparsable xml, etc.), or is incomplete.
- (iii) Test Data Transmission
 - (a) The BH I/DD Tailored Plan will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for member enrollment prior to open enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the BH I/DD Tailored Plan, or between the BH I/DD Tailored Plan and other Department vendors such as the Enrollment Broker or Provider Data Contractor. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.
- iii. Enrollment and Reconciliation
 - (i) Member Enrollment and Reconciliation
 - (a) Enrollment:
 - (1) The BH I/DD Tailored Plan shall accept an 834 eligibility file daily from the Department with new, modified, and terminated member records.
 - (2) The BH I/DD Tailored Plan shall add, modify, or terminate members daily based on 834 eligibility file.
 - (3) The BH I/DD Tailored Plan shall send a daily pharmacy lock-in file to the Department, or entity designated by the Department.
 - (b) Reconciliation:
 - (1) The Department will provide to the BH I/DD Tailored Plan a weekly 834 eligibility file, including all members who were added, modified, and terminated for the period.
 - (2) The BH I/DD Tailored Plan at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
 - (3) At the Department's request, the BH I/DD Tailored Plan shall provide a full roster of members currently enrolled in their BH I/DD Tailored Plan in the Department's preferred format within seventy-two (72) hours.

- (4) The BH I/DD Tailored Plan is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
 - (5) The Department shall determine if corrections are needed to the enrollment data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
 - (6) The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the BH I/DD Tailored Plan.
 - (7) The BH I/DD Tailored Plan shall add, modify, or terminate members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
 - (8) The BH I/DD Tailored Plan shall reconcile the monthly 820 payment file with the weekly 834 eligibility file.
 - (9) The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
 - (10) In addition to the reconciliation process defined above, the BH I/DD Tailored Plan shall be able to identify duplicate members and report those findings to the Department in a format defined by the Department.
- (ii) AMH+/CMA and PCP Assignment and Reconciliation
- (a) All AMH+/CMA and PCP assignments made by the member at application will be transmitted to the BH I/DD Tailored Plan by the Department via an 834 transaction.
 - (b) If not choice is made by the Member, the BH I/DD Tailored Plan shall assign a PCP and transmit to the Department on a daily basis.
 - (1) The file format and layout will be defined by the Department. IT is anticipated this will be a daily batch.
 - (c) The BH I/DD Tailored Plan shall reconcile AMH+/CMAs and PCP data with the Department at least monthly using the monthly 834 file described above.
 - (d) The BH I/DD Tailored Plan is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
 - (e) The Department shall determine if corrections are needed to the AMH+/CMAs and PCP data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
- (iii) Provider Enrollment and Credentialing
- (a) The Department or a designated vendor will provide to the BH I/DD Tailored Plan a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment and credentialing information.
 - (1) During the Provider Credentialing Transition Period, the information will be provided daily, in a format and transmission protocol to be defined by the Department.
 - (2) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the BH I/DD Tailored Plan a notice of change to the frequency and format not less than one hundred twenty (120) days prior to implementation.
 - (b) The BH I/DD Tailored Plan shall reconcile provider data with the Department, or designated vendor, at least daily.
 - (c) The BH I/DD Tailored Plan is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
 - (d) The Department, or designated vendor, shall determine if corrections are needed to the provider data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
 - (e) The The BH I/DD Tailored Plan shall integrate the daily provider enrollment file sent by the

- department and apply any provider updates to their database.
- (f) The Department or designated vendor will provide the BH I/DD Tailored Plan with a Response File after successfully receiving the Tailored Plan's full network directory file daily.
 - (g) The BH I/DD Tailored Plan shall accept the Response File from the department or designated vendor daily, work to correct any errors within twenty four (24) hours, and provide notice to the department of any discrepancy.
- iv. Provider Identification Numbers (NPIs, Atypical Providers)
 - (i) In accordance with requirements set forth in Sections 1932(d)(4) and 1173(b)(2) of the Social Security Act, the BH I/DD Tailored Plan must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the BH I/DD Tailored Plan.
 - (ii) The Department produces a daily provider enrollment file that includes all active and terminated Medicaid Providers. BH I/DD Tailored Plan is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.
 - v. Provider Directory
 - (i) NCTracks shall validate and integrate the provider directory information transmitted by the BH I/DD Tailored Plan and supply the Enrollment Broker and NC Fast with a Consolidated Provider Directory to support BH I/DD Tailored Plan choice counseling and selection..
 - (a) The BH I/DD Tailored Plan should use the National Provider Identifier (NPI) enrolled with the Department plus the assigned Service Location Code as the unique provider identifier. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by the Department's system should be used.
 - (b) The BH I/DD Tailored Plan shall ensure the Provider Directory aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if the BH I/DD Tailored Plan delegates this activity to a Subcontractor.
 - (c) The BH I/DD Tailored Plans shall verify that all providers included in the Provider Directory are actively enrolled in NC Medicaid/NCHC.
 - (ii) Consolidated Provider Directory Data Transmissions
 - (a) The Department has designated a vendor to create a Consolidated Provider Directory which will include all Medicaid Managed Care and NC Medicaid Direct providers.
 - (b) The BH I/DD Tailored Plan will, at a frequency defined by the Department, create a full provider directory file including data (as defined in the Contract) on all contracted and sub-contracted providers in their network. The BH I/DD Tailored Plan will deliver the file to the Department's designated vendor based on the Department's defined technical process.
 - (c) The final file format will be determined by the Department; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).
 - (d) The transport method will also be determined by the Department; however, it is also anticipated to be an industry standard method (SFTP, etc.).
 - (e) The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration required.
 - (f) The BH I/DD Tailored Plan shall be provided with policies and process flows developed by the Department that defines the overall process.
 - vi. Technology Documents
 - (i) The BH I/DD Tailored Plan shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.
 - (ii) Security Compliance Plan: The BH I/DD Tailored Plan shall provide a plan that details how the BH I/DD Tailored Plan will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the

Security Compliance Plan shall be updated annually and resubmitted to the Department for review. As long as the Security Compliance Plan, clearly states that it applies to the BH I/DD Tailored Plan, the Security Compliance Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP. The plan must include at a minimum:

- (a) Approach to customer and member data protection including internal programs and policies;
 - (b) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
 - (c) Approach to complying with HITECH and HIPAA;
 - (d) Process and procedures necessary to comply with 42 C.F.R. Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:
 - (1) Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 C.F.R. Part 2; and
 - (2) Where appropriate, secure Member consent prior disclosing member protected health information covered under 42 C.F.R. Part 2 requirements and;
 - (3) Establish functionality or procedures to remove or redact information protected by 42 C.F.R. Part 2 prior to disclosure of the information.
 - (e) Approach to risk analysis and assessment associate with NIST;
 - (f) Processes for monitoring for security vulnerabilities including the use of external organization such as US CERT;
 - (g) Processes and plans for vulnerability and breach management including response processes; and
 - (h) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).
 - (i) Process and procedures necessary to comply with 42 C.F.R. Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:
 - (1) Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 C.F.R. Part 2;
 - (2) Where appropriate, secure Member consent prior disclosing member protected health information covered under 42 C.F.R. Part 2 requirements and;
 - (3) Establish functionality or procedures to remove or redact information protected by 42 C.F.R. Part 2 prior to disclosure of the information.
- (iii) Encounter Implementation Approach. The BH I/DD Tailored Plan shall provide a plan that shows how the BH I/DD Tailored Plan will implement its encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
- (a) Approach to meeting performance, accuracy, and timeliness requirements;
 - (b) Operating model including staffing and technology to process and submit encounters;
 - (c) Reference data management process including how the State's reference data (if applicable) will be integrated into the encounter management process;
 - (d) Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
 - (e) Quality assurance and process improvement processes including how errors detected by the State's Encounter Processing System are addressed by the BH I/DD Tailored Plan, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Applicant's processes; and
 - (f) The plan should include distinctions for medical (i.e., integrated physical and BH services) and pharmacy encounter management.

- (iv) System Interface Design. The BH I/DD Tailored Plan shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
 - (a) Detailed design by interface showing the BH I/DD Tailored Plan approach to meeting the requirements defined by the State;
 - (b) Approach to managing EDI transactions including technology;
 - (c) Technical integration architecture including the Applicant's technical approach to integrating multiple internal systems with external partners;
 - (d) Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
 - (e) Software and platform testing processes for new interfaces including the data management approach.
- (v) System Test Plan. The BH I/DD Tailored Plan shall develop and maintain a System Test Plan inclusive of the BH I/DD Tailored Plan's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. As long as the System Test Plan, clearly states that it apply to the BH I/DD Tailored Plan, the System Test Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP. The Test Plan shall be submitted to the Department annually at the end of each Contract Year by July 31 and otherwise upon request by the Department and shall include:
 - (a) High level description of the scope of each testing phase;
 - (b) Applications or Systems that are part of the testing;
 - (c) Integrations that are part of the testing;
 - (d) Testing techniques or tools that will be used for testing;
 - (e) Test Environment; and
 - (f) Test Metrics and Reporting of Defects.
- vii. BH I/DD Tailored Plan Data Management and Health Information Systems
 - (i) The following Section contains high-level information on Health Information System and member data that will be established, maintained, analyzed, and reported by the BH I/DD Tailored Plan. Specific details on the data, analysis, and reporting will be provided upon Contract Award.
 - (a) The BH I/DD Tailored Plan shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the BH I/DD Tailored Plan's operations as well as satisfying the reporting requirements detailed in this RFA which may include but are not limited to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
 - (b) The BH I/DD Tailored Plan shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.
 - (c) The BH I/DD Tailored Plan shall collect and maintain data on member and provider characteristics and interactions as specified by the Department and on all services furnished to members through a claims processing system or other methods as specified by the state.
 - (d) All data, reports, and information submitted by the BH I/DD Tailored Plan on behalf of the providers (including providers within or outside of its networks) shall be validated by the BH I/DD Tailored Plan as accurate and complete prior to submission.

- (e) The BH I/DD Tailored Plan shall collect data from providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
- (f) The BH I/DD Tailored Plan shall make all collected data available to the Department and upon request to CMS.
- (ii) North Carolina's Health Information Exchange
 - (a) The BH I/DD Tailored Plan shall submit encounters and claims to North Carolina's Health Information Exchange, known as NC HealthConnex, as required by Article 29B of Chapter 90 of the NC General Statutes, the Statewide Health Information Exchange Act.
- viii. Pursuant to N.C. Gen. Stat. § 90-414.4(a1)(3), the BH I/DD Tailored Plan may authorize the Department to submit the required data NC HealthConnex on behalf of the BH I/DD Tailored Plan. Test Environments
 - (i) The BH I/DD Tailored Plan shall have at least two (2) dedicated testing environments – one (1) for Systems Integration Testing, and one (1) for End to End testing. The environments shall use the appropriate data sets (production or synthetic) as defined by the Department.
 - (ii) The BH I/DD Tailored Plan shall ensure test environments are compliant with all security requirements defined by North Carolina State and the Department's Privacy and Security Office to support testing with production data.
 - (iii) The BH I/DD Tailored Plan shall have test environments available and configured within one hundred twenty (120) Calendar Days of the Department's written notice.
 - (iv) The BH I/DD Tailored Plan shall have the ability to refresh test environments from production data as needed for testing, as well as the ability and capacity to ingest production sized files with limited to no down time.

C. State-funded Services

1. Recipients
 - a. Eligibility for State-funded BH, I/DD, and TBI Services
 - i. The Department believes that establishing eligibility guidelines for State-funded Services enables the Department and the BH I/DD Tailored Plans to:
 - a) Target State-funded Services to populations with low and modest incomes and/or who need specialized services that are not otherwise available to them;
 - b) Encourage uninsured State-funded Services potential recipients to apply for Medicaid to obtain comprehensive insurance coverage; and
 - c) Maximize the impact of limited state funds available for behavioral health and I/DD services by ensuring other available coverage and payments sources are pursued.
 - ii. Upon BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan may choose to use the following eligibility guidelines for State-funded BH, I/DD, and TBI services established by the Department:
 - a) BH Services:
 1. Income: ≤300% of the federal poverty level; and
 2. Insurance Status/Other Financial Resources:
 - i. Uninsured, or insured with third-party insurance (including Medicaid) that:
 - a) Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; or
 - b) Covers the State-funded SUD service, but associated cost-sharing is unaffordable.
 3. BH I/DD Tailored Plans shall encourage non-Medicaid covered potential

recipients to apply for Medicaid coverage.

- b) I/DD and TBI Services:
 - 1. Income: no specified limits
 - 2. Insurance Status/Other Financial Resources:
 - i. Uninsured, or insured with third-party coverage (including Medicaid) that:
 - a) Does not cover the State-funded service, and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; and
 - b) Applied for Medicaid coverage.
 - iii. NC Medicaid and NC Health Choice beneficiaries who are members of Standard Plans are ineligible to obtain State-funded Services.
 - iv. In recognition of the BH I/DD Tailored Plan's knowledge of its recipients' needs and other resources available throughout its catchment, the Department shall permit the BH I/DD Tailored Plan to propose its own eligibility criteria for State-funded Services.
 - v. The BH I/DD Tailored Plan shall include a proposal for eligibility for State-funded Services in the Applicant's Application for the Department's review and approval.
 - vi. The BH I/DD Tailored Plans will be required to solicit feedback from their Consumer and Family Advisory Committee (CFAC) on their proposed State-funded Services eligibility criteria.
 - vii. When approved by the Department, the Department shall amend the BH I/DD Tailored Plan's contract to reflect the eligibility criteria.
 - viii. The BH I/DD Tailored Plan shall not impose eligibility criteria on behavioral health crisis services funded with State dollars, including detoxification services listed in *Section V.C.2 Table 1: Required State-funded BH, I/DD, and TBI Services*.
 - ix. The Department reserves the right to require standard eligibility criteria for State-funded Services across the State in the future.
 - x. The Department may instruct the BH I/DD Tailored Plan waive any of its eligibility criteria in the case of supporting the State's coordinated response to a disaster or state of emergency.
 - xi. Recipient Eligibility Policy for State-funded Services
 - a) The BH I/DD Tailored Plan shall submit a Recipient Eligibility Policy for State-funded Services to the Department for review and approval one hundred fifty (150) Calendar Days after Contract Award. The BH I/DD Tailored Plan must submit an updated version of the Recipient Eligibility Policy for State-funded Services sixty (60) calendar days prior to BH I/DD Tailored Plan launch and at the beginning of each contract year.
 - b) The Recipient Eligibility Policy for State-funded Services shall include the BH I/DD Tailored Plan's:
 - 1. Final eligibility criteria;
 - 2. Processes and procedures for:
 - 3. Implementing final eligibility criteria including the role of providers in implementation;
 - 4. Monitoring the implementation of the final eligibility criteria;
 - 5. Supporting a potential recipient in applying for available other coverage; and
 - 6. Collecting and reporting eligibility criteria to the Department.
 - xii. Waiting List for State-funded Services
 - a) The BH I/DD Tailored Plan shall develop and maintain a waiting list for individuals waiting for any State-funded BH, I/DD or TBI service that is organized by the following disability groups:
 - 1. All disability
 - 2. Adult mental health
 - 3. Child/adolescent mental health
 - 4. Adult SUD

5. Child/adolescent SUD
 6. I/DD
 7. TBI
- b) By BH I/DD Tailored Plan launch, the Department plans to develop a system to maintain and aggregate a statewide waiting list for individuals waiting for any State-funded BH, I/DD or TBI service across all BH I/DD Tailored Plans.
 - c) Upon the launch of the statewide waiting list, the BH I/DD Tailored Plan shall report its waiting list to the Department in a format and frequency to be specified by the Department.
 - d) The BH I/DD Tailored Plan shall ensure that its contracted providers report their waiting lists, by both disability group (e.g., SUD, MH, I/DD or TBI) and by specific service type, to the BH I/DD Tailored Plan on a monthly basis.
 - e) The BH I/DD Tailored Plan shall provide interim services as defined by 42 CFR 96.121 and 42 CFR 96.126 for individuals who are pregnant and using substances and individuals who are injecting drugs who are on waiting lists for SUD services until services that meet the individual's level of need are available. These individuals are priority populations under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).
- b. Recipient Engagement
- i. Recipients, their families, and caregivers may need support from the BH I/DD Tailored Plan providers and the Department in order to benefit fully as recipients of State-funded Services. The BH I/DD Tailored Plan will be responsible, individually and in partnership with the Department and other entities specified in this Contract, for assisting recipients and their families with understanding State-funded Services, navigating the health care system, improving overall recipient health through various avenues including maintaining a Recipient Services Department, and conducting recipient and community engagement and outreach. The Department strongly encourages the BH I/DD Tailored Plan to develop innovative approaches, including the use of electronic mechanisms for recipient education, engagement, and outreach.
 - ii. The BH I/DD Tailored Plan shall be responsible for engaging Recipients of State-funded Services and their Authorized Representatives to help callers understand State-funded Services and recipients rights and responsibilities. Information shall be available and provided to recipients in-person, by telephone, by mail, and online/electronically.
 - iii. The BH I/DD Tailored Plan shall utilize various engagement strategies and communication mediums to engage, educate, and assist recipients. The engagement strategy shall include the operation of a Recipient Services Department which, at a minimum, shall:
 - a) Maintain a recipient call center and a recipient services website;
 - b) Engage with the Department's Recipient's Engagement and Customer Services offices, as well as local community and county organizations in the recipient's service area;
 - c) Provide written and in-person educational materials, activities, and programs;
 - d) Collaborate with other entities operating within the State-funded Services delivery system; and
 - e) Comply with requirements of *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan delegates any of the requirements to a Subcontractor.
 - iv. The BH I/DD Tailored Plan may operate its recipient engagement activities utilizing shared staffing and infrastructure with its Medicaid member engagement activities.
 - v. Recipient Services Department
 - a) The BH I/DD Tailored Plan shall have and implement recipient services policies and procedures that address all recipient services activities.
 - b) The BH I/DD Tailored Plan shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to recipients in

accordance with translation and interpreter services requirements in the Contract to achieve effective communication.

- c) The recipient services staff shall be responsible, at a minimum, for the following functions:
 - 1. Explaining operation of the BH I/DD Tailored Plan and what to do in an emergency, disaster or urgent medical situation;
 - 2. Educating and assisting recipients with determining eligibility and obtaining State-funded Services for which they are eligible;
 - 3. Explaining care management services offered by the BH I/DD Tailored Plan;
 - 4. Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
 - 5. Fielding and responding to recipients' questions and complaints;
 - 6. Clarifying for recipients information in the Recipient Handbook;
 - 7. Advising recipients of and assisting recipients with the Appeals, Complaints, and State Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Appeals Panel processes;
- d) The BH I/DD Tailored Plan shall operate and maintain the following two (2) recipient-facing service lines:
 - 1. Member and Recipient Service Line (see V.A.2.a. Service Lines for Medicaid and State-funded Services); and
 - 2. Behavioral Health Crisis Line (see V.A.2.a. Service Lines for Medicaid and State-funded Services).
- e) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Recipient Services Department via surveys of recipients of State-funded Services and internal audits of departments to ensure recipient satisfaction and compliance with applicable performance standard metrics as specified in the Contract and shall take corrective action as necessary.
 - 1. Recipient surveys shall be made available after each web, call center (with exception of BH Crisis Line).
 - 2. Surveys and internal audits are intended to measure the recipient's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
 - 3. Reports, including the results of provider surveys and the BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- vi. Recipient Services Website
 - a) The Department encourages the BH I/DD Tailored Plan to utilize processes, procedures and technology to improve the recipient experience and effectively reduce or ease administrative burdens on the recipient.
 - b) The BH I/DD Tailored Plan shall develop and maintain a State-funded Services website that, at a minimum, has the functionality to allow the recipient to search for in-network providers. The Recipient Services website may be a part of the BH I/DD Tailored Plan's Medicaid website.
 - c) The BH I/DD Tailored Plan shall also include on its website within two (2) "clicks" from the homepage, at a minimum:
 - 1. An up-to-date copy of the Recipient Handbook;
 - 2. Information on hours of operation;
 - 3. How to contact the recipient services staff;
 - 4. How to access BH I/DD Tailored Plan services;
 - 5. Appeals, complaints, and State MH/DD/SA Appeals Panel;

6. Health promotion and educational materials;
 7. Any specific prevention or care management programs offered by the BH I/DD Tailored Plan;
 8. Information relevant to any disasters or states of emergency affecting the BH I/DD Tailored Plan region; and Other information the BH I/DD Tailored Plan believes would support the recipient and their families.
- d) The BH I/DD Tailored Plan shall meet the same literacy standards identified for written materials in any materials made available electronically.
 - e) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
 - f) The BH I/DD Tailored Plan website shall be accessible via mobile devices.
 - g) The BH I/DD Tailored Plan website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's systems that impact the ability for the website to operate correctly.
 1. The BH I/DD Tailored Plan shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.
 2. The BH I/DD Tailored Plan shall notify the Department of unscheduled downtime within one (1) hour of the BH I/DD Tailored Plan becoming aware and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the BH I/DD Tailored Plan.
- vii. Communications with Recipients and Potential Recipients
- a) The BH I/DD Tailored Plan shall ensure all contacts with recipients and Authorized Representatives are Culturally and Linguistically Competent and provide effective communication, with deference to the method requested by the recipient, to the recipient, including sign language interpreters, and occur in a timely manner that protects the privacy and independence of an individual with a disability.
 - b) The BH I/DD Tailored Plan shall ensure that recipients and potential recipients are provided all information required in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
 - c) The BH I/DD Tailored Plan shall address the following in the development of recipient materials:
 1. The population size and geographic/regional needs and differences throughout the BH I/DD Tailored Plan's Region;
 2. Language proficiencies;
 3. Types of disabilities;
 4. Literacy levels;
 5. Cultural needs of the recipient population;
 6. Age and age-specific or other targeted learning skills or capabilities; and
 7. Ability to access and use technology.
 - d) The BH I/DD Tailored Plan shall be permitted to provide information required to be communicated to recipients and potential recipients in the following manner:
 1. Mailing a printed copy of the information to the recipient's mailing address is the default absent an explicit preference stated by the recipients or their Authorized Representative;
 2. Emailing the information, after receiving the recipient's or potential recipient's express consent to receive information via email and obtaining a valid, up to date email address. The BH I/DD Tailored Plan may email information unencrypted if the Member or potential

- Member explicitly requests that emails are not encrypted and signs a waiver acknowledging the risk of unencryption;
3. Posting the information on the BH I/DD Tailored Plan’s website and advising the recipient or potential recipient in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a recipient may request communication accommodations; and
 4. Providing the information by any other method that can reasonably be expected to result in the recipient receiving the information.
- e) The BH I/DD Tailored Plan shall not construe any requirement herein to limit or alleviate the BH I/DD Tailored Plan’s obligation to communicate directly with the recipient, a recipient’s Authorized Representative, parent or guardian, or potential recipient as required under the Contract or under federal or state law or regulation.
 - f) The BH I/DD Tailored Plan shall provide information in the recipient’s preferred format upon request at no cost (e.g., a recipient with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
 - g) The BH I/DD Tailored Plan shall comply with guidelines promulgated by the Department’s Office of Communications, including Creative Services.
- viii. Written and Verbal Recipient Materials
- a) The BH I/DD Tailored Plan shall provide all written materials to recipients and potential recipients consistent with the following:
 1. Use easily understood language and format.
 2. Use a sans serif font type and a font size no smaller than 12-point. The font type and size shall be appropriate to the audience.
 3. Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of recipients or potential recipients with disabilities or limited English proficiency.
 4. Include a tagline that is sufficiently conspicuous and visible (sans serif font type and font size no smaller than 12 points) for Recipients or potential Recipients to see and read the information on how to request auxiliary aids and services, including materials in alternative formats. The font type and size shall be appropriate to the audience.
 - i. Taglines are required on materials that are critical for potential recipients and recipients to understand and obtain services. These materials include, but are not limited to, enrollment forms and brochures, comparison charts, rate or cost sheets, prescription drug lists, recipient handbooks, appeal and grievance notices, and denial and termination notices
 5. Written in accordance with the most recent Associated Press Style guidance and Department provided template.
 6. Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
 7. Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the BH I/DD Tailored Plan’s Member and Recipient Service Line. The top fifteen (15) prevalent non-English languages in North Carolina include:
 - i. Spanish,
 - ii. Chinese (Mandarin Simplified),
 - iii. Vietnamese,
 - iv. Korean,

- v. French,
 - vi. Arabic,
 - vii. Hmong,
 - viii. Russian,
 - ix. Tagalog,
 - x. Gujarati,
 - xi. Mon-Khmer (Cambodia),
 - xii. German,
 - xiii. Hindi,
 - xiv. Laotian, and
 - xv. Japanese.
- b) The BH I/DD Tailored Plan shall ensure that all audio-reliant materials (e.g., videos, webinars, and recorded presentations) have accessible captioning at the time they are made available to recipients in their original format.
 - c) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
 - d) The BH I/DD Tailored Plan shall ensure that all written materials made available electronically are accessible on various platforms, such as website and mobile devices.
- ix. Mailing Materials to Recipients
- a) The BH I/DD Tailored Plan shall verify addresses against a United States Postal Service approved product or service on all recipients of State-funded Services through BH I/DD Tailored Plan prior to mailing materials, at no additional cost to the Department or the recipient.
 - 1. The BH I/DD Tailored Plan shall make all reasonable attempts to identify the correct mailing address and mail information to the recipient within applicable timeframes, as required under the Contract.
 - 2. The BH I/DD Tailored Plan shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
 - 3. The BH I/DD Tailored Plan shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
 - b) Reserved.
 - c) If the BH I/DD Tailored Plan identifies a new, updated address, the BH I/DD Tailored Plan shall resend only recipient specific information at no additional cost to the Department or the recipient.
 - d) All materials mailed to potential recipients, recipients, and, when applicable, Authorized Representatives, shall be sent via first class mail.
 - e) The BH I/DD Tailored Plan shall consider cost-effective methods for controlling postage costs when producing recipient materials for mailing.
 - f) The BH I/DD Tailored Plan shall develop a Member and Recipient Mailing Policy, subject to Department review and approval. The BH I/DD Tailored Plan shall submit to the Department ninety (90) Calendar Days after Contract Award.
- x. Translation and Interpretation Services
- a) The BH I/DD Tailored Plan shall make interpretation services available to all potential recipients and recipients for interactions between the BH I/DD Tailored Plan and potential recipients or recipients. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent.

- b) The BH I/DD Tailored Plan shall notify its recipients of the availability of interpretation services and inform them of how to access such services, including providing the following information:
 - 1. That verbal information is available for any language and written translation is available in prevalent languages free of charge to each recipient; and
 - 2. That auxiliary aids and services are available upon request and at no cost for recipients with disabilities.
 - c) The BH I/DD Tailored Plan shall offer qualified interpreter services for verbal contacts with recipients and Authorized Representatives whose primary language is not English.
 - d) The BH I/DD Tailored Plan shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
 - e) The BH I/DD Tailored Plan shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with recipient audiences.
 - f) The BH I/DD Tailored Plan shall make interpretation services available free of charge to each recipient.
 - g) The BH I/DD Tailored Plan shall staff recipient facing Member and Recipient and BH Crisis Service Lines with a sufficient number of fluent Spanish speakers to converse with recipients who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the recipient or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department. The Department shall provide at least thirty (30) days written notice before adding a required language to be interpreted under this Contract.
 - h) Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:
 - 1. Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
 - 2. Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
 - i) The BH I/DD Tailored Plan shall notify the Department in writing within five (5) Business Days each time the BH I/DD Tailored Plan or its Subcontractor charges a recipient, potential recipient, Authorized Representative or guardian for interpreter or translation services.
 - j) The BH I/DD Tailored Plan shall notify the Department of any change in the language preference for recipients in an electronic format and frequency as defined by the Department.
- xi. Recipient Welcome Packet
- a) The BH I/DD Tailored Plan shall send a Welcome Packet to the recipient within eight (8) Calendar Days (for Year 1) and six (6) Calendar Days (for Year 2 and after) after the BH I/DD Tailored Plan receives notice of recipient's first service use. On an annual basis, the BH I/DD Tailored Plan shall verify if the recipient continues to use State-funded Services:
 - 1. If the recipient continues to use State-funded Services, the BH I/DD Tailored Plan shall send a Welcome Packet; and
 - 2. If the recipient does not continue to use State-funded Services, the BH I/DD Tailored Plan shall not send a Welcome Packet and shall not have an obligation to verify if the recipient continues to use State-funded Services thereafter.
 - b) The BH I/DD Tailored Plan shall include the following in the recipient Welcome Packet:
 - 1. A welcome letter that provides the following information to the recipient:
 - 2. The toll-free service line numbers which a recipient may call for the Member and Recipient Service Line and BH Crisis Line;
 - 3. Information on how to inquire about accessing care management services; and

4. A current Recipient Handbook.
 - c) The BH I/DD Tailored Plan may opt to send the handbook separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
 - d) The BH I/DD Tailored Plan shall submit a sample copy of the contents of its Recipient Welcome Packet to the Department for review and approval within ninety (90) Calendar Days of Contract Award, and then annually thereafter.
- xii. The BH I/DD Tailored Plan may send the Welcome Packet electronically or via paper mail. Recipient Handbook
- a) The BH I/DD Tailored Plan shall ensure that each recipient receives a Recipient Handbook, which provides a summary of services, within eight (8) Calendar Days (for Year 1) and six (6) Calendar Days (for Year 2 and after) Calendar Days after the BH I/DD Tailored Plan receives notice that the recipient is receiving State-funded Services through the BH I/DD Tailored Plan.
 - b) The BH I/DD Tailored Plan shall use the Department's forthcoming guidance to develop the Recipient Handbook.
 - c) The BH I/DD Tailored Plan shall ensure that all Recipient Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
 - d) The BH I/DD Tailored Plan shall ensure that the Recipient Handbook includes sufficient information that enables the recipient to understand how to effectively use State-funded Services. This information shall include at a minimum:
 1. Covered services provided by the BH I/DD Tailored Plan.
 2. Waiting list policies for covered services.
 3. Procedures for obtaining services, including any requirements for service authorizations and/or referrals for specialty care.
 4. Information on how to access case management services and care management delivered through the BH I/DD Tailored Plan.
 5. Information on services offered for recipients residing in institutional settings or adult care homes for recipients with SMI related to housing and community integration.
 6. Recipient rights and responsibilities, including the elements specified under the Contract.
 7. Complaint, appeal, and State MH/DD/SA Appeals Panel procedures and timeframes developed or approved by the Department, including information on:
 8. The right to file complaints and appeals;
 9. The requirements and timeframes for filing a complaint or appeal or State MH/DD/SA Appeals Panel Hearing;
 10. The availability of assistance in the filing process;
 11. The right to request a State MH/DD/SA Appeals Panel after the BH I/DD Tailored Plan makes a decision on the recipient's appeal which is adverse to the recipient.
 12. How to exercise an Advance Directive.
 13. An overview of its continuation of services policy and define when, why, and how a recipient or a recipient's Authorized Representative may file for a continuation of services.
 14. How to access auxiliary aids and services, including additional information in alternative formats or languages.
 15. The toll-free help line numbers for the Member and Recipient Service Line and BH Crisis Line.
 16. Information on how to report suspected fraud, waste or abuse.
 17. Information about the BH I/DD Tailored Plan's prevention health programs.

- e) The BH I/DD Tailored Plan shall make the Recipient Handbook available for review by the Department, upon request.
 - f) The BH I/DD Tailored Plan shall provide the Department for review any changes to the Recipient Handbook forty-five (45) Calendar Days prior to the intended effective date of the change.
- xiii. Recipient Education and Outreach
- a) The BH I/DD Tailored Plan shall provide education and outreach to recipients and potential recipients, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department may be present. The BH I/DD Tailored Plan may provide education and outreach about other products, including without limitation the PIHP contract, at the same health awareness events, community events and health fairs.
 - b) The BH I/DD Tailored Plan shall provide information regarding its planned recipient education efforts to the Department for review and approval sixty (60) Calendar Days after Contract Award and annually thereafter.
 - c) In support of the Department's Health Equity goals, the BH I/DD Tailored Plan shall develop a Recipient Engagement and Marketing Plan for Historically Marginalized Populations for review by the Department. The plan shall include the BH I/DD Tailored Plan's goals and strategies for engaging with historically marginalized populations, specific initiatives to address disparities, and expected outcomes of the plan. The plan shall be submitted no later than on hundred twenty (120) Calendar Days after execution of this Amendment and annually thereafter to the Department.
- xiv. Health Education and Promotion Programs
- a) The BH I/DD Tailored Plan shall develop recipient health education and promotion programs that address prevention and wellness from illness and disease.
 - b) The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care.
 - c) The BH I/DD Tailored Plan shall make the health education and promotion programs available to recipients through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
 - d) The Department may select additional specific educational and health promotion topics for the BH I/DD Tailored Plan to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- xv. The BH I/DD Tailored Plan shall make best efforts to ensure diversity of conveners and Members on the committee which supports person-centered, racially and culturally diverse perspectives and involvement to reflect the range of individuals served by BH I/DD Tailored Plan.
- c. Marketing
- i. The Department views BH I/DD Tailored Plan marketing activities as a method to help publicize State-funded Services, while ensuring the protection of recipients from coercive or misleading practices.
 - ii. The BH I/DD Tailored Plan shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the BH I/DD Tailored Plan to ensure that recipients receive accurate verbal and written information.
 - iii. The BH I/DD Tailored Plan shall not market nor distribute any marketing materials without obtaining written approval from the Department. Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
 - iv. The BH I/DD Tailored Plan shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud recipients or the Department.

- v. The BH I/DD Tailored Plan shall establish and maintain a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented shall be the responsibility of the BH I/DD Tailored Plan.
- vi. If the BH I/DD Tailored Plan chooses to market, the BH I/DD Tailored Plan shall distribute marketing materials to the entire Region served by the BH I/DD Tailored Plan.
- vii. The BH I/DD Tailored Plan shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the recipient materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- viii. The BH I/DD Tailored Plan shall ensure that all marketing materials and marketing strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy. In addition, the BH I/DD Tailored Plan shall not discriminate against recipients or potential recipients who may:
 - a) Live or receive health care in rural or underserved areas; or
 - b) Experience income disparities.
- ix. The BH I/DD Tailored Plan shall assign a unique marketing code provided by the Department to all marketing materials distributed to recipients.
- x. Marketing Materials and Activities
 - a) Permissible Marketing Activities
 - 1. The BH I/DD Tailored Plan may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
 - 2. The BH I/DD Tailored Plan shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.
 - 3. The BH I/DD Tailored Plan may participate in community-based marketing events or activities (e.g., health fairs, community events).
 - 4. The BH I/DD Tailored Plan may sponsor outreach activities and events, including as a financial sponsor.
 - 5. The BH I/DD Tailored Plan may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.
 - 6. The BH I/DD Tailored Plan may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
 - b) Prohibited Statements, Claims, and Activities (Written or Oral)
 - 1. The BH I/DD Tailored Plan shall not claim that the BH I/DD Tailored Plan is endorsed by SAMHSA, the federal or State government, or similar entity.
 - 2. The BH I/DD Tailored Plan shall not use the Department or State logo or other proprietary material in marketing.
 - 3. The BH I/DD Tailored Plan shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
 - 4. The BH I/DD Tailored Plan shall not reference competing BH I/DD Tailored Plans or other contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department or other BH I/DD Tailored Plans in any of its marketing materials.
 - 5. The BH I/DD Tailored Plan shall not cross-market with a Standard Plan.

6. The BH I/DD Tailored Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities, including direct mailings and solicitation.
 7. The BH I/DD Tailored Plan shall not falsely describe available services, availability of network providers, or qualifications or skills of network providers.
 8. The BH I/DD Tailored Plan shall not market materials or activities that are discriminatory
 9. The BH I/DD Tailored Plan shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
 10. The BH I/DD Tailored Plan shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
 11. The BH I/DD Tailored Plan shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
- c) References to Studies and Statistics
1. The BH I/DD Tailored Plan shall not use irrelevant facts or inaccurate statistical information in any marketing materials and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
 2. If references to a study or statistics are included in any marketing material, the BH I/DD Tailored Plan shall provide reference information (e.g., publication, date, page number) and information about the BH I/DD Tailored Plan's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.
- xi. Department Approval of Marketing Materials
- a) The BH I/DD Tailored Plan shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.
 - b) If the BH I/DD Tailored Plan makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the BH I/DD Tailored Plan must resubmit the materials, in accordance with this section, for Department review and approval.
- xii. The BH I/DD Tailored Plan shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the BH I/DD Tailored Plan's marketing activities in accordance with *Section VI. Contract Performance for Medicaid and State-funded Services*.
- d. Recipient Rights and Responsibilities
- i. The Department expects the BH I/DD Tailored Plan to treat recipients with dignity and respect, to protect recipients' rights, to inform recipients of their responsibilities as recipients of State-funded Services, and ensure each recipient is not subject to any unlawful discrimination in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any Network provider of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall establish and maintain written policies and procedures that are designed to protect the rights of recipients and describe the responsibilities of each recipient. The BH I/DD Tailored Plan shall develop and submit to the Department for review a Recipient Rights and Responsibilities Policy ninety (90) Calendar Days after Contract Award. As long as the Recipient Rights and Responsibilities Policy clearly states that it applies to the BH I/DD Tailored Plan, the Recipient Rights and Responsibilities Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - iii. The BH I/DD Tailored Plan shall include a written description of the rights and responsibilities of recipients in the Recipient Welcome Packet and the Recipient Handbook.

- iv. The BH I/DD Tailored Plan shall provide a copy of its Recipient Rights and Responsibilities Policy to all BH I/DD Tailored Plan employees and Network providers.
- v. The BH I/DD Tailored Plan shall ensure its written policies and procedures, at a minimum, afford recipients the right to:
 - a) Receive information in a manner and format that may be easily understood and is readily accessible;
 - b) Be treated with respect and with due consideration for their dignity and privacy;
 - c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the recipient's condition and ability to understand;
 - d) Participate in decisions regarding their health care, including the right to refuse treatment;
 - e) Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - f) If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
 - g) Be furnished, consistent with the Scope of Services of this Contract.
- vi. The BH I/DD Tailored Plan shall not attempt to influence, limit, or otherwise interfere with the recipient's decision to exercise their rights as provided in this Contract.
- vii. The BH I/DD Tailored Plan shall ensure that recipients are free to exercise their rights and that the exercise of those rights does not adversely affect the way the BH I/DD Tailored Plan or its Network providers treat the recipient.
- viii. The BH I/DD Tailored Plan shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against recipients in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any network provider of the BH I/DD Tailored Plan.
- e. Recipient Complaints and Appeals
 - i. The Department is committed to ensuring that recipients understand and can freely exercise their complaints and appeals rights and resolve issues efficiently with minimal burden to the recipient or their Authorized Representative. The BH I/DD Tailored Plan shall educate the recipient on their rights and provide reasonable assistance with understanding and navigating the complaints and appeals processes.
 - ii. Recipient Complaints and Appeals General Requirements
 - a) The BH I/DD Tailored Plan shall establish and maintain a complaints and appeals system for reviewing and resolving recipient complaints and appeals for State-funded Services as required in 10A NCAC 27G.7000 and 10A NCAC 27I.0600. Components of the system shall include a complaint and plan level appeal process for recipients of State-funded Services, a plan level appeal process for utilization review decisions to deny, reduce, suspend, or terminate State-funded Services, and access to the State MH/DD/SA Appeals Panel under N.C. GEN. STAT. § 122.C – 151.4.
 - b) The BH I/DD Tailored Plan shall, while adhering to the required Utilization Management Program, employ strategies to resolve complaint and appeals at the lowest level of escalation that meets a recipient's needs and in a manner that does not discourage recipients from exercising their rights. The BH I/DD Tailored Plan shall provide recipients reasonable assistance in completing forms and taking other procedural steps related to a complaint or appeal including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability.
 - c) The BH I/DD Tailored Plan shall establish complaints procedures as per 10A NCAC 27G.7001 – 7004, 10A NCAC 27G.0601 – 0608 and 27G.0810-0812.

iii. Recipient Complaint Process

- a) The BH I/DD Tailored Plan shall develop and maintain a Recipient Complaint Policy following the process outlined in 10A NCAC 27G.7002. The Recipient Complaint Policy is subject to Department review and approval.
- b) The BH I/DD Tailored Plan shall allow a recipient or Authorized Representative to file a complaint with the BH I/DD Tailored Plan, verbally or in writing, at any time.
- c) The BH I/DD Tailored Plan's recipient complaint process shall include acknowledgement, in writing, within five (5) Business Days of receipt of each complaint. This communication shall include whether the complaint will be addressed informally or by conducting an investigation.
- d) The BH I/DD Tailored Plan shall use the Department-defined Notice of Acknowledgement of Receipt of Complaint to notify the recipient of receipt of the complaint.
- e) For an informal process, the BH I/DD Tailored Plan shall provide written notice of resolution of the complaint to the recipient and, as applicable, the recipient's Authorized Representative within fifteen (15) Business Days from the date the BH I/DD Tailored Plan receives the complaint.
- f) For a formal investigation, the BH I/DD Tailored Plan shall complete the investigation within thirty (30) Calendar Days from the date the BH I/DD Tailored Plan receives the complaint. Upon completion of the investigation, the BH I/DD Tailored Plan shall submit a written report of the findings within fifteen (15) Calendar Days of the date of completion of the report. 10A NCAC 27G.7003.
- g) The BH I/DD Tailored Plan shall adhere to the complaint requirements detailed in *Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities* for grievances filed by recipients obtaining services in DSOHF facilities.

iv. Internal Plan Appeals for Provision of State-funded Services

- a) The BH I/DD Tailored Plan shall have an established internal recipient appeal process for the provision of State-funded Services per 10A NCAC 27G.7002.
- b) If the complainant is not satisfied with the informal process, the complainant may file an appeal in writing to the BH I/DD Tailored Plan. The appeal must be received within fifteen (15) Business Days from the date of the informal resolution letter.
- c) The BH I/DD Tailored Plan Behavioral Health Director or designee shall convene an appeal review committee according to 10A NCAC 27G.7002(b)(3)(J) and issue an independent decision after reviewing the appeal review committee's recommendation. The decision shall be dated and mailed to the appellant by the BH I/DD Tailored Plan within twenty (20) Business Days from receipt of the appeal.
- d) When the BH I/DD Tailored Plan refers the complaint to the State or local government agency responsible for the regulation and oversight of the provider, the BH I/DD Tailored Plan shall send a letter to the complainant informing him or her of the referral and the contact person at the agency where the referral was made. The BH I/DD Tailored Plan shall contact the State or local government agency where the referral was made within eighty (80) Business Days of the date the BH I/DD Tailored Plan received the complaint to determine the actions the State or local government agency has taken in response to the complaint. The BH I/DD Tailored Plan shall communicate the status of the State or local government agency's response to the complainant and to the client's home BH I/DD Tailored Plan, if different.

v. Internal Plan Appeals for Utilization Review Decisions

- a) The BH I/DD Tailored Plan shall have an established internal recipient appeal process for utilization review decisions to deny, reduce suspend, or terminate a State-funded Services as outlined under 10A NCAC 2G.7004.
- b) Notice of Adverse Utilization Review Decisions

1. The BH I/DD Tailored Plan shall send to the recipient or Authorized Representative(s) notification letters regarding utilization review decisions for State-funded Services. The letter shall be dated and mailed no later than the next work day following the review decision to deny, reduce, suspend, or terminate a State-funded Service.
 2. The letter shall include information regarding the reason for the decision and any available options or considerations while the appeal is under review.
 3. An appeal regarding a State-funded Services utilization review decision must be filed only by a recipient or Authorized Representative. The appeal must be received in writing by the BH I/DD Tailored Plan within fifteen (15) Business Days of the date of the notification letter.
 4. The BH I/DD Tailored Plan shall acknowledge receipt of the appeal in writing in a letter to the appellant dated the next working day after receipt of the appeal.
 5. The BH I/DD Tailored Plan may authorize interim services until the final review decision, as set forth in 10A NCAC 271 .0609, is reached.
 6. The clinical review shall be conducted by an employee(s) or contractor(s) of the BH I/DD Tailored Plan not involved in the utilization review decision that is the subject of the appeal. The clinical reviewer(s) clinical credentials shall be at least comparable to those of the person who rendered the initial utilization review decision.
 7. The clinical reviewer(s) shall complete a clinical review of the appeal and shall uphold or overturn the original decision.
 8. The BH I/DD Tailored Plan shall notify the appellant in writing of the clinical review decision in a letter dated and mailed within seven (7) Business Days from receipt of the appeal request and shall separately notify the provider regarding the service authorization.
 9. If the clinical review overturns the initial utilization review decision, the decision letter shall state the date on which the denied service shall be authorized or the date on which the suspended, reduced or terminated service shall be reinstated.
 10. In cases in which the decision upholds the previous decision, the BH I/DD Tailored Plan shall inform appellants in writing of the opportunity to appeal a decision regarding a State-funded service to the DMH/DD/SAS Non-Medicaid Appeals Panel according to 10A NCAC 271 .0600 and N.C. Gen. Stat. § 143B-147(a)(9).
- vi. State Non-Medicaid Appeals Panel
- a) The BH I/DD Tailored Plan shall comply with 10A NCAC 271 .0600 and N.C. Gen. Stat. § 143B-147(a)(9), and Department guidance related to the State Non-Medicaid Appeals Panel.
 - b) Upon receipt of the panel's findings and decisions, the BH I/DD Tailored Plan shall issue a final decision informed by these findings. The BH I/DD Tailored Plan shall issue the decision in writing within ten (10) Calendar Days of receipt of the panel's findings and decisions.
 - c) Neither the panel findings and decisions nor the BH I/DD Tailored Plan decision shall be interpreted as an agency decision granting a recipient the right to appeal by requesting a contested case hearing pursuant to Chapter 150B of the General Statutes.

2. Services

a. State-funded BH, I/DD and TBI Services

- i. The BH I/DD Tailored Plan shall promptly provide, arrange, purchase or otherwise make available all medically necessary BH, I/DD and TBI services required under this Contract to all its recipients, subject to available funding as determined by the Department. Services shall be delivered consistent with the standard of care and meet Department quality standards and expectations.
- ii. The BH I/DD Tailored Plan shall provide all State-funded BH, I/DD and TBI services listed in this Contract subject to available resources.

- iii. Nothing in this Contract shall be construed or interpreted as creating an entitlement to non-Medicaid services.
- iv. Covered services:
 - a) Consistent with N.C. Gen. Stat. § 108D-60(9), the BH I/DD Tailored Plan shall be responsible for covering state appropriated and block grant funded non-Medicaid BH, I/DD and TBI services subject to available resources, as determined by the Department.
 - b) The BH I/DD Tailored Plan shall authorize and fund the medically necessary BH, I/DD and TBI core services listed in *Section V.C.2. Table 1: State-funded BH, I/DD, and TBI Services* according to the Department approved service definitions subject to available funding, as determined by the Department.
 - c) The BH I/DD Tailored Plan may authorize and fund medically necessary BH and I/DD non-core services listed in *Section V.C.2. First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services* according to the Department approved service definitions subject to available funding, as determined by the Department.
 - d) The Department shall retain the right to promulgate new policy and changes to policy as appropriate.
 - e) A crosswalk of the SUD services covered under the State-funded Services array to national clinical standards is provided in *Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to Covered State-funded SUD Services*.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	Core Services	Non-Core Services
All-Disability	1. Diagnostic assessment ²² 2. Facility based crisis for adults ²³ 3. Inpatient BH services 4. Mobile crisis management 5. Outpatient services ²⁴	1. BH urgent care 2. Facility based crisis for children and adolescents
Adult Mental Health	1. Assertive community treatment (ACT) ²⁵ 2. Assertive engagement 3. Case management ²⁶ 4. Community support team (CST) 5. Peer Support Services ²⁷ 6. Psychosocial rehabilitation	1. Partial hospitalization

²² Diagnostic assessment may be provided through Telehealth.

²³ This service is referred to as Professional Treatment Services in a Facility-Based Crisis Program in the North Carolina Medicaid program.

²⁴ The BH I/DD Tailored Plan may authorize and fund medically necessary office based opioid treatment (OBOT) services.

²⁵ The Department is exploring updates to its state-funded ACT service definition to better coordinate medical care to the extent it is available for recipients

²⁶ This service may include critical time intervention, case management, and resource intensive case management (RICM).

²⁷ Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	Core Services	Non-Core Services
	<ul style="list-style-type: none"> 7. Mental health recovery residential services²⁸ 8. Individual placement and support-supported employment (IPS-SE)²⁹ 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management 	
Child Mental Health	<ul style="list-style-type: none"> 1. High fidelity wraparound (HFW)³⁰ 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement 	<ul style="list-style-type: none"> 1. Mental health day treatment
I/DD and TBI ³¹	<ul style="list-style-type: none"> 1. Residential Supports 2. 2. Day Supports Group 3. 3. Community Living & Support 4. 4. Supported Living Periodic 5. 5. Supported employment¹³ 6. 6. Respite 7. Adult Day Vocational Programs (ADVP) 	<ul style="list-style-type: none"> 1. TBI long term residential rehabilitation services
Substance Use Disorder - Adult	<ul style="list-style-type: none"> 1. Ambulatory detoxification 2. Assertive engagement 3. Case management³² 4. Clinically managed population specific high intensity residential services³³ 5. Outpatient opioid treatment 6. Non-hospital medical detoxification 7. Peer supports³⁴ 	<ul style="list-style-type: none"> 1. Social setting detoxification services

²⁸ This category of services may include group living and supervised living among other services.

²⁹ The SAMHSA Supported Employment Evidence-Based Practices Kit can be found at: <https://store.samhsa.gov/product/supported-employment-evidence-based-practices-ebp-kit/sma08-4364>

³⁰ The Department intends allocate funding for slots for HFW services.

³¹ I/DD and TBI care management will be only be provided by the BH I/DD Tailored Plan.

³² This service may include critical time intervention, case management, and RICCM.

³³ The Department is working to add this service to its array by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan will be required to cover this service upon notification from the Department.

³⁴ Peer supports include individual and group services.

Section V.C.2 First Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	Core Services	Non-Core Services
	8. Substance use residential services and supports ³⁵ 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (supported employment) 15. Community Support Team 16. BH Comprehensive Case Management	
Substance Use Disorder - Child	1. Multi-systemic therapy 2. SAIOP 3. Substance use residential services and supports 4. High fidelity wraparound (HFW) 9 5. Assertive Engagement	1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to State-funded SUD Services		
ASAM Level of Care	ASAM Service Title	State-funded Service Title
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment

³⁵ This category of services will be covered on an interim basis until the Department completes its implementation of the 1115 SUD waiver and updates to the service definitions for SUD services to completely align with the ASAM criteria.

Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to State-funded SUD Services		
ASAM Level of Care	ASAM Service Title	State-funded Service Title
3.1	Clinically managed low intensity residential services	SUD halfway house services
3.3	Clinically managed population-specific high-intensity residential programs	Clinically managed population-specific high-intensity residential programs
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
4	Medically managed intensive inpatient services	Inpatient BH services
OTP	Opioid treatment program	Outpatient opioid treatment
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.2-WM	Clinically managed residential withdrawal	Social setting detoxification services
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

- v. Alternative Services
 - a) The BH I/DD Tailored Plans shall submit any State Funded Alternative service definitions to the Department using the Department’s standardized Alternative Service Request Form, prior to implementation for approval.
- vi. Cost Sharing
 - a) The BH I/DD Tailored Plan shall not require recipients to pay any copayment for State-funded BH, I/DD, and TBI services consistent with NC Medicaid’s policy for covered BH I/DD and TBI services.
 - b) The BH I/DD Tailored Plan shall also prohibit providers from requiring recipients to pay any copayment for State-funded BH, I/DD, and TBI services.
- vii. Utilization Management
 - a) UM Program Policy
 - 1. The BH I/DD Tailored Plan shall develop an UM program for State-funded Services to evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of requests for authorization of State-funded Services against established service definitions. As long as the UM policies and procedures clearly state they apply to State-

- funded services, the UM policies and procedures may apply to other BH I/DD operations, including without limitation, the PIHP.
2. The BH I/DD Tailored Plan shall not delegate its UM program to a Subcontractor.
 3. Subject to Department review and approval, the UM program shall contain written policies and procedures, for, at a minimum, the following:
 - i. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
 - ii. Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
 - iii. Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
 - iv. Timeframes for decision making related to service authorizations in accordance with timeframes outlined in the Contract;
 - v. Protecting recipients from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to appeal the denial or reduction or termination of a service;
 - vi. Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization of State-funded Services; and
 - vii. Dissemination of guidelines to all affected providers and, upon request, to recipients.
 4. The BH I/DD Tailored Plan shall document the UM program, including referral and prior authorization processes for State-funded Services, in a written UM Program Policy and submit to the Department for review one hundred fifty (150) Calendar Days after Contract Award.
 5. The BH I/DD Tailored Plan shall revise the UM Program Policy based on changes requested by the Department. The BH I/DD Tailored Plan shall submit to the Department any changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.
 6. The BH I/DD Tailored Plan shall post the UM Program Policy on its publicly available website for providers and recipients, or in other forms as requested by the provider or recipient, at no cost. The BH I/DD Tailored Plan shall include a prominent reference to the web address of the UM Program Policy in both its provider and Recipient Handbooks.
 7. The BH I/DD Tailored Plan shall conduct training and education with providers on changes to the UM program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.C.4.c. Provider Relations and Engagement*.
 8. The BH I/DD Tailored Plan shall make the CMO or designee available to discuss and report on the UM program, as requested by the Department.
- b) Person-Centered Planning
1. The BH I/DD Tailored Plan shall review and accept or reject Person-Centered Plans submitted with authorization requests for recipients receiving State-funded Services that require Person-Centered Plans (including all recipients transitioning out of State hospitals and adult care homes or diverted from admission to adult care homes and members diverted from adult care homes who are eligible for Plan services), and shall require contracted providers to comply with the requirements established in the Department's Records Management and Documentation Manual.
 2. Approval or denial of service or treatment authorization requests associated with a complete Person-Centered Plan satisfies this requirement.
- c) Prior Authorization

1. The BH I/DD Tailored Plan shall use a standardized prior authorization request form developed by the Department.
- d) Service Authorization and Noticing Requirements
1. The BH I/DD Tailored Plan shall provide written notice, using the Department developed template, to recipients on decisions related to authorization of State-funded Services in accordance with 10A NCAC 27G .7004. The written notice shall include the following:
 - a) The basis for such decisions; and
 - b) Sufficient details that inform recipients of the decision, which will provide them with information necessary to determine if they wish to appeal.
 2. For standard authorization decisions, the BH I/DD Tailored Plan shall provide notice as expeditiously as the recipient's condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services.
 3. The BH I/DD Tailored Plan may receive a possible extension of up to fourteen (14) Calendar Days if the recipient requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the recipient's interest.
 4. If the BH I/DD Tailored Plan extends the timeframe beyond fourteen (14) Calendar Days, the BH I/DD Tailored Plan shall provide the recipient and provider with a written notice of the reason for the decision to extend the timeline and inform the recipient of the right to file an appeal if he or she disagrees with that decision.
 5. For expedited authorization decisions, the BH I/DD Tailored Plan shall provide notice no later than seventy-two (72) hours after receipt of the request for service.
 6. The BH I/DD Tailored Plan may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the recipient requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the recipient's interest.
 7. If the BH I/DD Tailored Plan extends the timeframe beyond seventy-two (72) hours, the BH I/DD Tailored Plan shall provide the recipient and provider with a written notice of the reason for the decision to extend the timeline and inform the recipient of the right to file an appeal if he or she disagrees with that decision.
 8. The BH I/DD Tailored Plan shall require providers to use the following BH or other Department approved level-of-care determination and screening tools at part of the BH I/DD Tailored Plan's UM program. The Department reserves the right to change these required screening tools. If this occurs, the Department will notify the BH I/DD Tailored Plan in writing:
 - i. Substance use: American Society for Addiction Medicine (ASAM) for medical necessity reviews for all populations except children ages zero (0) through twelve (12).
 - ii. Mental health:³⁶
 - a) Reserved.
 - b) Reserved.
 - c) Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department.
- viii. State Operated Health Care Facilities

³⁶ The Department is actively exploring using other assessment tools for mental health services.

- a) The BH I/DD Tailored Plan shall comply with the authorization, admission and discharge requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and *Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the BH I/DD Tailored Plan shall first make every effort to identify and suggest an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with IDD, TBI or dementia.
- b) Prior to referral or authorization of any potential recipient 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. Gen. Stat. § 122C-261 and any other applicable North Carolina law governing the admission of individuals with intellectual disabilities to a State psychiatric hospital.
- c) For recipients 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 such recipients have such a high level of disability that alternative care is inappropriate, consistent with N.C. Gen. Stat. § 122C-261(e)(4).
- d) In determining whether such recipients 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.

3. Care Management and Prevention

a. Model Overview and Objectives

- i. The Department believes that recipients of State-funded Services with the highest needs will benefit from care management to avoid unnecessary emergency department visits, hospitalizations and readmissions, and promote linkages to Medicaid and other resources.
- ii. Under BH I/DD Tailored Plans, the Department intends to implement a two-part approach to provide care and case management to a subset of recipients with the highest needs depending on whether the recipient has a behavioral health condition or I/DD and TBI diagnosis as detailed below.

b. Case Management for Recipients with Behavioral Health Conditions

- i. For recipients with behavioral health diagnoses, the Department intends to add new case management service definitions for child and adult recipients with mental health and/or SUD needs to its State-funded service array as detailed in *Section V.C.2. Services*. The child service definition will focus on High-Fidelity Wraparound, while the adult service definition will focus on other interventions. The Department intends to release these service definitions at least six months prior to BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan must offer these services beginning at BH I/DD Tailored Plan launch.
- ii. The BH I/DD Tailored Plan shall hire a State-funded BH Care Management Coordinator to develop policies, practices, and systems that support the provision of case management services as detailed in *Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services*.
 - a) The State-funded BH Care Management Coordinator shall be responsible for the following activities:
 - 1. Assessing the case management provider network and working with the network management staff to identify gaps in the case management provider network based upon

the Network Access Plan as detailed in *Section V.C.4.a.xi.* and waiting list information as detailed in *Section V.C.1.a.xiii.*

2. Monitoring the delivery of case management services, including reviewing service authorizations for case management services to ensure fidelity of the services delivered, service plans, comprehensive clinical assessments, and person-centered plans.
 3. Ensuring that potential referral sources (e.g., hospitals, community providers, law enforcement agencies, DSS) are aware of case management providers in their area.
 4. Providing support to case management providers to develop a toolkit of medical, behavioral, social and other programs, services, and supports for recipient linkages, leveraging NCCARE360 and 211.org for social services.
 5. Assisting case management providers with identifying and coordinating appropriate placement for recipients with complex needs that are creating barriers to securing an appropriate disposition, including but not limited to recipients who:
 6. Are placed at an inappropriate level of care or are at risk of being discharged from their current placement due to their complex needs;
 7. Have a medical co-morbidity (including pregnancy);
 8. Have co-occurring mental health, SUD, I/DD, and/or TBI disorders;
 9. Have complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions; or
 10. Have a legal history affecting ability to live in congregate settings and/or in proximity to children.
- iii. Qualifications for the State-Funded BH Care Management Coordinator
- a) The BH I/DD Tailored Plan shall ensure that State-funded BH Care Management Coordinator(s) have the following minimum qualifications:
 1. Be a Master's-level fully Licensed Clinical Social Worker (LCSW), Licensed (Licensed Clinical Mental Health Counselor (LCMC), or Licensed Psychological Associate (LPA), or Registered Nurse (RN) and
 2. Three (3) years of supervisory experience of staff working directly with individuals with a BH condition who have complex needs.
 - iv. The BH I/DD Tailored Plan shall ensure recipients with complex needs as described in *Section V.C.3.b.ii.a) 5.* are placed in a timely manner in appropriate settings.
- c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations
- i. The BH I/DD Tailored Plan shall provide care management to a subset of uninsured high needs recipients with I/DD or TBI diagnoses.
 - ii. Children and adults with I/DD and TBI diagnoses, as defined by N.C. Gen. Stat. §§ 122C-3(12A) and 122C-3(38a) respectively, shall be eligible for care management delivered through the BH I/DD Tailored Plan if they are found ineligible for Medicaid and meet all of the following criteria:
 - a) Are not connected to or are disengaged from community-based services that are available to meet their clinical needs;
 - b) Require coordination between two or more agencies, including medical or non-medical providers and there are no natural or community supports that can provide this coordination;
 - c) Are expected to have difficulty engaging in treatment services without additional support;
 - d) They are ineligible for provider-based case management services; and
 - e) They meet one of the following criteria:
 1. Reside in or are at risk of entry into institutional settings (e.g., state developmental facilities, ICF-IIDs, state psychiatric facilities or adult care homes);
 2. Are justice-involved;

3. Have behavioral complexity resulting in recurrent crisis service usage (e.g., emergency department, BH urgent care and facility crisis); or
 4. Are at risk for out of home placement from legal guardians.
- iii. The BH I/DD Tailored Plan shall be responsible for ensuring that a recipient does not receive duplicative care or case management from multiple sources.
 - iv. The BH I/DD Tailored Plan shall develop a standard methodology and processes for verifying eligibility and prioritizing eligible potential recipients with I/DD or TBI diagnoses for care management.
 - a) The BH I/DD Tailored Plan shall store the results of all reviews of eligibility for care management in a system of record and transmitted monthly in an electronic format to be determined by the Department.
 - b) The BH I/DD Tailored Plan shall share the methodology including the data systems it will use to verify eligibility criteria for care management services with the Department at least annually or as requested by the Department. The BH I/DD Tailored Plan shall verify an individual's eligibility for care management services against its own claims data or against State data resources to which it has access (e.g., NCTracks).
 1. For individuals identified as potentially eligible for Medicaid, the BH I/DD Tailored Plan shall refer them to the county DSS office for assistance.
 2. For those individuals determined eligible for state-funded care management services, the BH I/DD Tailored Plan shall score and prioritize recipients based on need for care management.
 3. The Department shall not specify scoring or prioritization criteria at this time beyond the criteria specified in *Section V.C.3.c.vi.b*), though the Department expects such criteria are consistently applied to engage individuals in care management given available funding.
 - v. The BH I/DD Tailored Plan shall develop and maintain a waiting list for potential recipients with I/DD or TBI diagnoses who are waiting to receive care management consistent with the requirements in *Section V.C.1.a.xii*.
 - a) The BH I/DD Tailored Plan shall report the waiting list to the Department on a weekly basis.
 - vi. Referrals for care management delivered by the BH I/DD Tailored Plan
 - a) The BH I/DD Tailored Plan shall accept referrals for potential recipients who could benefit from care management from all sources, including, but not limited to:
 1. BH I/DD Tailored Plan staff;
 2. Providers (e.g., hospital, facility or community-based providers);
 3. State agencies;
 4. Community based organizations;
 5. Law enforcement; and
 6. Self/guardian/legal representative.
 - b) The BH I/DD Tailored Plan shall prioritize referrals for potential recipients who have an immediate risk in the next three (3) months for one of the criteria specified in *Section V.C.3.c.vi*.
 - vii. Care management comprehensive assessment for care management for recipients with I/DD or TBI diagnoses delivered by the BH I/DD Tailored Plan
 - a) The BH I/DD Tailored Plan shall develop a standardized person-centered Care Management Comprehensive Assessment of a qualifying recipient's healthcare needs, functional needs, accessibility needs, strengths and supports, goals, and other characteristics that will inform the recipient's ongoing Individual Support Plan (ISP) and treatment.
 - b) The BH I/DD Tailored Plan shall develop methodologies and tools for conducting the Care Management Comprehensive Assessment, as appropriate for differing recipient demographics and needs.

- c) The Care Management Comprehensive Assessment shall include, at a minimum, the following domains:
 - 1. Recipient's immediate care needs;
 - 2. Recipient's current services and providers;
 - 3. Functional needs, accessibility needs, strengths and goals;
 - 4. Other state or local services currently used;
 - 5. Physical health conditions, including dental conditions;
 - 6. Current and past mental health and substance use status and/or disorders, including tobacco use disorders;
 - 7. Physical disabilities;
 - 8. I/DD;
 - 9. Detailed medication history a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies
 - 10. Available informal, caregiver or social supports;
 - 11. Standardized Unmet Health-Related Resource Need questions to be provided by the Department, covering the Department's four (4) priority domains: housing, food, transportation and interpersonal safety;
 - 12. Any other ongoing conditions that require a course of treatment or regular care monitoring;
 - 13. Exposure to trauma;
 - 14. Risks to the health, well-being, and safety of the recipient and others (including sexual activity, potential abuse/exploitation and exposure to secondhand smoke and aerosols);
 - 15. Cultural considerations (e.g., ethnicity, religion, language, reading level, health literacy, etc.);
 - 16. Employment/community involvement;
 - 17. Education (including individualized education plan and lifelong learning activities)
 - 18. Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
 - 19. Self-management and planning skills; and
 - 20. Receipt of and eligibility for entitlement benefits.
- d) The BH I/DD Tailored Plan shall make its best effort to complete the Care Management Comprehensive Assessment for every eligible recipient of State-funded care management subject to available funding, as described in *Section V.C.3.*, who has been referred to the BH I/DD Tailored Plan for care management within fourteen (14) Calendar Days of referral.
- e) The BH I/DD Tailored Plan shall ensure that the Care Management Comprehensive Assessment is conducted in a location that meets the recipient's needs.
- f) The BH I/DD Tailored Plan shall ensure that care managers make a best-effort attempt to complete the assessment in-person, realizing that in limited instances it will be necessary to complete the assessment via HIPAA compliant technology conferencing tools (e.g., audio, video and/or web).
- g) The BH I/DD Tailored Plan shall ensure the results of the Care Management Comprehensive Assessment are shared with the recipient's behavioral health, I/DD, and TBI providers within fourteen (14) Calendar Days of completion to inform care planning and treatment planning, with the recipient's consent to the extent required by law. The BH I/DD Tailored Plan shall not withhold necessary State-funded BH, I/DD or TBI services for recipients while awaiting completion of the Care Management Comprehensive Assessment.

viii. Development of the ISP for Recipients with I/DD or TBI Diagnoses

- a) The BH I/DD Tailored Plan shall develop a standardized template for ISPs for recipients of State-funded care management with an I/DD or TBI. The BH I/DD Tailored Plan shall submit the ISP template to the Department for approval as part of the State-Funded Care Management Policy for Recipients with I/DD and TBI described in *Section V.C.3.c.xiv*. Required elements of the ISP are described in more detail below.
- b) The BH I/DD Tailored Plan shall ensure that the ISP is developed and presented in a manner understandable to the recipient, including consideration for the recipient's reading level and alternate formats.
- c) The BH I/DD Tailored Plan shall ensure that each ISP incorporates results of the Care Management Comprehensive Assessment, claims analysis, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
 - 1. NC SNAP
 - 2. SIS®, as available
- d) Each ISP shall contain, at a minimum:
 - 1. Measurable goals;
 - 2. Clinical needs including any I/DD-related, TBI-related, behavioral health-related, or dental needs;
 - 3. Interventions including addressing medication management, including access and adherence;
 - 4. Intended outcomes;
 - 5. Social, educational, and other services needed by the recipient;
 - 6. Strategies to increase social interaction, employment, and community integration;
 - 7. Emergency/natural disaster/crisis plan;
 - 8. Strategies to mitigate risks to the health, well-being, and safety of recipients and of others;
 - 9. Information about Advance Directives, including psychiatric advance instructions, as appropriate; and
 - 10. Strategies to improve self-management and planning skills.
- e) For eligible recipients for whom the BH I/DD Tailored Plan has completed a Care Management Comprehensive Assessment, the BH I/DD Tailored Plan shall use the results of the Care Management Comprehensive Assessment to develop an ISP for recipients with I/DD and TBI needs.
- f) The BH I/DD Tailored Plan shall be responsible for ensuring that the ISP is complete and reviewing it for quality control.
- g) The BH I/DD Tailored Plan shall ensure that each ISP is individualized and person-centered and is developed using a collaborative approach including recipient and family participation where appropriate.
- h) The BH I/DD Tailored Plan shall make best efforts to complete an ISP within thirty (30) Calendar Days of the completion of the Care Management Comprehensive Assessment.
 - 1. "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the recipient's home or working with a known provider to meet the recipient at an appointment, to contact the recipient if the first attempt is unsuccessful
- i) The BH I/DD Tailored Plan shall ensure that development of the ISP does not delay the provision of needed State-funded BH, I/DD or TBI services to a recipient in a timely manner, even if that recipient is waiting for an ISP to be developed.

- j) The BH I/DD Tailored Plan shall ensure that each ISP is documented and stored and made available to the recipient and the following representatives within fourteen (14) Calendar Days of completion of the ISP:
 - 1. Other providers authorized to deliver care to the recipient;
 - 2. The recipient's legal representative (as appropriate);
 - 3. The recipient's caregiver (as appropriate, with consent);
 - 4. Social service providers (as appropriate, with consent); and
 - 5. Other individuals identified and authorized by the recipient.
- ix. Care management functions for recipients with I/DD or TBI diagnoses delivered by the BH I/DD Tailored Plan
 - a) The BH I/DD Tailored Plan shall ensure that each recipient who is actively engaged in care management provided by the BH I/DD Tailored Plan receives care management according to their ISP.
 - b) The BH I/DD Tailored Plan shall ensure that care management includes:
 - 1. Conducting health and social needs assessments and developing ISPs;
 - 2. Coordinating and providing referral, information and assistance in obtaining and maintaining State-funded Services;
 - 3. Coordinating social services and services geared toward a recipient's unmet health-related resource needs;
 - 4. Providing referral, information, and assistance in obtaining and maintaining low or no cost medical services (e.g., from federally qualified health centers (FQHCs) and rural health centers (RHCs), community-based resources and social support services);
 - 5. Conducting continuous monitoring of progress toward goals identified in the ISP through contacts with the recipient;
 - 6. Following up on referrals;
 - 7. Conducting transitional care management (as described below); and
 - 8. Working with recipients' providers to help coordinate resources during a crisis event, as determined feasible and appropriate.
 - c) The BH I/DD Tailored Plan shall ensure that care management addresses unmet health-related resource needs, including the following activities at a minimum:
 - 1. Provide referral, information and assistance in obtaining and maintaining community-based resources and social support services, including:
 - 2. Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers)
 - 3. Food and nutrition supports (e.g., SNAP, WIC)
 - 4. Housing
 - 5. Transportation
 - 6. Employment services
 - 7. Education
 - 8. Child welfare services
 - 9. Domestic violence services
 - 10. Legal services
 - 11. Services for justice-involved populations
 - 12. Other services that help individuals achieve their highest level of function and independence
 - 13. Provide assistance securing Medicaid enrollment for recipients who may be eligible, including assistance at initial application with filling out and submitting applications, and gathering and submitting required documentation, including in-person assistance when it is the most efficient and effective approach.

14. Connect recipients to programs and resources that can assist in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.
- d) The BH I/DD Tailored Plan shall have a single care management data system across Medicaid and State-funded Services.
 - e) The BH I/DD Tailored Plan shall maintain a Medicaid and State-funded Services care management data system capable of the following functions, recognizing that certain functions will not be relevant to SFS;
 1. Ingesting and using available BH, I/DD and TBI claims, and encounter data (including those captured by “shadow claims”), clinical data, risk stratification information and/or unmet health-related needs data;
 2. Maintaining up-to-date documentation of recipients obtaining care management and assignments of individual recipients to care managers;
 3. Electronically documenting and storing the Care Management Comprehensive Assessment;
 4. Electronically documenting and storing the ISP;
 5. Identifying risk factors for individual recipients;
 6. Monitoring and quickly responding to changes in a recipient’s health status;
 7. Tracking a recipient’s referrals;
 8. Developing reports and summaries of care records for other care providers (as necessary); and
 9. Supporting data analytics and performance measurement, and sending quality measures (where applicable).
 - x. Transitional care management for recipients with I/DD or TBI diagnoses obtaining care management delivered by the BH I/DD Tailored Plan
 - a) The BH I/DD Tailored Plan shall oversee care transitions for recipients obtaining care management through the BH I/DD Tailored Plan who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, emergency department visits, or adverse outcomes.
 - a) The BH I/DD Tailored Plan shall develop a process for identifying recipients already obtaining care management in transition who are at risk of readmissions and other poor outcomes. This process shall take into account discharges from inpatient, residential, or facility-based services including behavioral health urgent care, facility-based crisis services, clinically managed population-specific high-intensity residential program, ICF-IID, or NC START.
 - b) The BH I/DD Tailored Plan must ensure that its contracts with institutions in the BH I/DD Tailored Plan provider network (hospitals, residential settings, rehabilitation settings, State Operated Health Care Facilities, and other treatment settings) establish policies and procedures for transitional care management that require the institution to:
 1. Permit the care manager to engage in and help coordinate the discharge planning process;
 2. To the maximum extent feasible, notify the BH I/DD Tailored Plan of recipient admissions/pending discharges to integrate the BH I/DD Tailored Plan into the discharge/transition planning process; and
 3. Share relevant information (including the recipient’s current ISP, initial and final discharge plans, and medical information) among transition/discharge planning team recipients and the recipient’s care manager.

- c) As part of transitional care management, the BH I/DD Tailored Plan shall ensure that there is a clinically appropriate process for following up with a recipient undergoing transitions, including:
 - 1. Same-day or next-day outreach; and
 - 2. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits).
- xi. Location of Care Management for Recipients with I/DD or TBI Diagnoses
 - a) The BH I/DD Tailored Plan shall provide care management services in-person, at provider- or community-based settings, to recipients to the maximum extent possible.
 - b) The BH I/DD Tailored Plan shall ensure that the care manager provides a minimum of one (1) visit to the recipient's home, office setting, homeless shelter, libraries, streets or other community settings to assess a recipient's current functioning and level of need.
 - c) The BH I/DD Tailored Plan shall ensure that the care manager contacts the recipient on a weekly basis to ensure the recommended support has been provided.
 - d) The BH I/DD Tailored Plan shall ensure that care managers thoroughly document care management services delivered, including noting phone numbers, meeting locations, conversation lengths, and dates.
- xii. Duration of Care Management for Recipients with I/DD or TBI Diagnoses
 - a) Care management delivered by the BH I/DD Tailored Plan is intended to serve as a short-term engagement service and not as long-term method of service delivery.
 - b) The BH I/DD Tailored Plan shall ensure that the duration of care management is short term, generally not to exceed 90 days.
 - c) To the maximum extent possible, the BH I/DD Tailored Plan shall aim to provide care management to eligible recipients until the recipient's need has been addressed to the greatest possible degree, including linkages to care and secured placement, as applicable.
- xiii. Staffing and Training Requirements for Care Managers Serving Recipients with I/DD or TBI Diagnoses
 - a) The BH I/DD Tailored Plan shall employ care manager(s) to provide care management services to eligible State-funded Services recipients with I/DD and TBI.
 - b) The BH I/DD Tailored Plan shall ensure that care managers serving recipients with I/DD and TBI needs meet the following qualifications:
 - 1. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area, and
 - 2. At least two (2) years of experience working directly with individuals with I/DD or TBI.
 - c) The BH I/DD Tailored Plan shall ensure that the caseload size for a care manager does not exceed forty (40) recipients.
 - d) The BH I/DD Tailored Plan shall ensure that care managers are supervised by supervising care managers. The supervising care managers must have the following minimum qualifications:
 - 1. 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
 - 2. A Master'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 three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI.
 - e) Care Management Training for Care Managers Serving Recipients with I/DD or TBI Diagnoses

1. The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes the domains the following domains at a minimum in addition to any training requirements specified in N.C. General Statute § 122c-115.4:
2. BH I/DD Tailored Plan eligibility and services
 - a) BH I/DD Tailored Plan eligibility criteria;
 - b) Principles of integrated and coordinated physical and BH care and I/DD and TBI services;
 - c) BH crisis response; and
 - d) Knowledge of Innovations and TBI waiver eligibility criteria.
3. Whole-person health and unmet resource needs
 - a) Understanding and addressing ACEs, trauma, and trauma-informed care;
 - b) Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the recipient navigate available social supports and resources at the recipient's local level; and
 - c) Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect recipients.
4. Community integration
 - a) Independent living skills;
 - b) Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities;
 - c) Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community; and
 - d) Available programs and resources to assist recipients in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.
5. Health promotion
 - a) Common physical comorbidities of recipients;
 - b) Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease);
 - c) Common environmental risk factors including but not limited to the health effects of exposure to second and thirdhand tobacco smoke, and e-cigarette aerosols and liquids and their effects on family and children;
 - d) Standard of care for tobacco treatment, including both counseling and FDA approved tobacco treatment medications;
 - e) Brief tobacco use intervention and referral to treatment;
 - f) Self-management and self-help recovery resources (including substance use recovery);
 - g) Roles and responsibilities for medication management; and
 - h) Use of IT in Care Management Comprehensive Assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360.
6. Other care management skills
 - a) Transitional care management best practices;
 - b) Supporting health behavior change, including motivational interviewing;
 - c) Person-centered needs assessment and care planning, including LTSS needs;
 - d) Preparing recipients for and assisting them during emergencies and natural disasters;

- e) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training recipients on proper practices, particularly for recipients receiving care in the home or community settings, or as recipients transition across care settings.
 - f) General understanding of virtual (e.g., Telehealth) applications in order to assist recipients in using the tools
 - g) Understanding needs of the justice-involved population; and
 - h) Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment.
7. I/DD or TBI-specific topics
- a) Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers;
 - b) Understanding HCBS, related planning, and 1915(c) services and requirements;
 - c) Accessing and using assistive technologies to support individuals with I/DD and TBI;
 - d) Understanding the changing needs of individuals with I/DD and TBI as they age; and
 - e) Educating recipients with I/DD and TBI about consenting to physical contact and sex.
8. Additional trainings for care managers and supervisors serving recipients with LTSS needs
- a) Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission.
9. The BH I/DD Tailored Plan shall ensure care managers and supervising care managers serving its recipients are trained on all the topics described in *Section V.C.3.c.xii.e*.
10. The BH I/DD Tailored Plan must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.
11. The BH I/DD Tailored Plan shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.
12. The BH I/DD Tailored Plan shall identify core modules that care managers must complete before being deployed to serve recipients; care managers must complete the remaining training modules within thirty (30) days of being deployed to serve recipients.
- xiv. State-Funded Care Management Policy for Recipients with I/DD and TBI
- a) The BH I/DD Tailored Plan shall submit its State-funded Care Management Policy for Recipients with I/DD and TBI for review and approval by the Department within one hundred fifty (150) Calendar Days after Contract Award. The BH I/DD Tailored Plan must submit an updated version of the State-funded Care Management Policy for Recipients with I/DD and TBI sixty (60) Calendar Days prior to BH I/DD Tailored Plan launch and at the beginning of each contract year.
 - b) The State-funded Care Management Policy for Recipients with I/DD and TBI shall include the BH I/DD Tailored Plan's policies and processes for:
 - 1. Methodology for prioritizing potential recipients with I/DD and TBI for care management;
 - 2. Care Management Comprehensive Assessments, including but not limited to:
 - a) Assessment tools/questions used;
 - b) Expected volume of Care Management Comprehensive Assessment monthly and annually; and

- c) Method of conducting the Care Management Comprehensive Assessment based on recipient needs or other factors;
 - 3. ISP development with recipients, including standardized ISP template, approach for ensuring that ISPs are individualized and person-centered and that the recipient and the recipient's family, advocates, caregivers, and/or legal guardians are actively involved;
 - 4. Proposed locations of care management delivery, including whether the services will be delivered in-person, via two-way real time video and audio conferencing, or telephonically;
 - 5. Training and qualification of care managers including timing/frequency of training, curricula, how completion of trainings will be tracked, training modalities (e.g., in-person versus online), how competencies will be assessed and ongoing continuing education;
 - 6. Linkages with community resources for all recipients as needed, including for those identified as having unmet health-related resource needs;
 - 7. Provision of information and navigation regarding community providers of social services;
 - 8. Transitional care management;
 - 9. Diversion;
 - 10. Requisite health IT infrastructure technologies and data privacy security policies; and
 - 11. Identify and address health disparities and incorporating health equity into their internal and external policies and procedures.
 - d. Diversion from Institutional Settings
 - i. Diversion Overview
 - a) In addition to the diversion requirements identified in *Section V.B.3.ii.(xii) Diversion from Institutional settings*, the BH I/DD Tailored Plan shall assume primary responsibility for identifying non-Medicaid covered potential recipients who are being considered for admission to an ACH, and performing diversion activities, as described in this Section.
 - b) The BH I/DD Tailored Plan shall provide the diversion reports in the form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
 - ii. Eligibility for Diversion
 - a) The BH I/DD Tailored Plan shall be responsible for identifying non-Medicaid covered potential recipients eligible for state-funded diversion activities.
 - 1. Non-Medicaid covered potential recipients shall be eligible for state-funded diversion activities if they meet the TCL eligibility criteria set forth in the Settlement Agreement and LME-MCO Communication Bulletin #J281 dated March 14, 2018.
 - 2. The Department retains the right to modify eligibility criteria for state-funded diversion activities.
 - iii. Staffing Requirements
 - a) Diversion activities shall be performed by a BH I/DD Tailored Plan-based Diversion Specialist.
 - b) The BH I/DD Tailored Plan shall ensure that a Diversion Specialist has the following minimum qualifications:
 - 1. Must be knowledgeable about community services and supports, including supportive housing.
 - 2. Must be a 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 Registered Nurse (RN), in North Carolina; and have one (1) year of relevant supervisory experience working with individuals with SMI unless they meet the following conditions:

3. Individuals with relevant and direct experience providing diversion services under TCLI may continue to provide diversion services without meeting the minimum qualifications for Diversion Specialists described in this Section.
 4. The BH I/DD Tailored Plan must ensure that a Diversion Specialist who is not an RN can consult with a BH I/DD Tailored Plan-based RN or other BH I/DD Tailored Plan-based medical staff to assess the medical needs of the recipient receiving diversion services.
- c) The BH I/DD Tailored Plan shall conduct training for Diversion Specialists that addresses the following domains:
1. Eligibility for BH I/DD Tailored Plan services, including state-funded services, and low- or no-cost services such as those available through a FQHC.
 2. Whole-person health and unmet resource needs, including LTSS needs and navigating social supports and local resources.
 3. Programs that support community integration, including independent living skills, Permanent Supportive Housing, employment resources and supports, education supports and other types of productive activity.
 4. Transitional care management best practices, including person-centered needs assessment and care planning, and LTSS needs.
 5. Assessing living arrangements for health and safety issues.
 6. For Diversion Specialists working with recipients with LTSS needs:
 7. Methods for coordinating with supported employment resources.
- d) The Department reserves the right to specify the training curriculum that BH I/DD Tailored Plans must use for diversion.
- e) The Department shall establish caseload requirements for BH I/DD Tailored Plan-based Diversion Specialists.
- iv. Diversion Activities
- a) The BH I/DD Tailored Plan shall perform the following diversion activities in a timely manner to ensure diversion is successful:
1. Screen and assess the recipient for eligibility for State-funded Services, Medicaid eligibility, and other entitlement programs beyond Medicaid.
 2. Educate the recipient on the choice to remain in the community and the services that would be available to support that decision.
 3. Coordinate and provide referral, information and assistance in obtaining and maintaining State-funded Services.
 4. Coordinate social services and services geared toward a recipient's unmet health-related resource needs.
 5. Provide referral, information, and assistance in obtaining and maintaining low or no cost medical services (e.g., from FQHCs and RHCs, community resources and social support services).
 6. Determine if the recipient is eligible for supportive housing, if needed.
 7. For those who choose to remain in the community:
 - i. Develop a Community Integration Plan (CIP) that clearly documents that the recipient's decision to remain in the community was based on informed choice, and the degree to which the recipient's decision has been implemented.
 - ii. Integrate the recipient's CIP as an addendum in the recipient's Care Plan if the recipient enrolls in Medicaid.
 - iii. For recipients with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.

8. Refer all non-Medicaid covered recipients who choose to enter an institutional setting or ACH for in-reach services described in *Section V.C.3.e. In-Reach and Transition from Institutional Settings*.
- b) The BH I/DD Tailored Plan shall ensure all diversion activities are documented and stored in the system required by the Department and on a schedule provided by the Department, and made available to the Department for review upon request.
- e. In-Reach and Transition from Institutional Settings
 - i. In-Reach and Transition Overview
 - a) The BH I/DD Tailored Plan shall have primary responsibility for the in-reach and transition activities described in this Section.
 1. In-reach activities shall be conducted with the goal of identifying and engaging non-Medicaid covered potential recipients receiving care in a setting described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services* who may be able to have their needs safely met in a community setting.
 2. Transition activities shall be conducted with the goal of facilitating the relocation of a non-Medicaid covered recipient receiving services in a setting described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services* to a community setting, while ensuring the appropriate level of services and supports that recipient requires.
 - b) The BH I/DD Tailored Plan shall ensure all in-reach and transition activities are documented and stored in the system required by the Department and on a schedule provided by the Department, and made available to the Department for review upon request.
 - c) The BH I/DD Tailored Plan shall provide the in-reach and transition reports in the form and frequency as described in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
 - ii. Eligibility for In-Reach and Transition Services
 - a) All non-Medicaid covered potential recipients with SMI residing in an ACH or state psychiatric hospital who meet the TCLI eligibility criteria set forth in the Settlement Agreement and LME-MCO Communication Bulletin #J281 dated March 14, 2018, subject to the availability of State funds, shall be eligible for state-funded in-reach and transition activities.
 1. The Department retains the right to modify eligibility criteria for state-funded in-reach and transition activities.
 - iii. The BH I/DD Tailored Plan shall verify the in-reach staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements* perform the following in-reach activities, beginning within seven (7) days of admission and occurring on a regular basis until the recipient is referred for transition services described in *Section V.C.3.e.iv. Transition Activities*.
 - a) Identify candidates for in-reach services. The BH I/DD Tailored Plan, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
 1. Facility referrals;
 2. Information provided by the Department;
 3. Stakeholder and family/guardian referrals; and
 4. Automatic in-reach trigger points the BH I/DD Tailored Plan shall establish.
 - b) Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the recipient and the recipient's family members and/or guardians are accurately and fully informed about community-based options available to them, including supportive housing.
 - c) Facilitate and accompany the recipient and the recipient's family members and/or guardians on visits to community-based services.

- d) Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing and Medicaid eligibility.
- e) To the maximum extent possible, explore and address the concerns of the recipient and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for Permanent Supportive Housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns.
- f) For recipients who decline the opportunity to transition or decline Permanent Supportive Housing that would allow them to transition:
 - 1. Continue to engage the recipients and/or their family members or guardians about the opportunity to transition to a more integrated setting and develop and implement individualized strategies to address concerns and objections to placement in an integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department in collaboration with BH I/DD Tailored Plan.
 - 2. Clearly document that the recipient's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the recipient of available community services, including supportive housing.
 - 3. While the recipient remains in an ACH or state psychiatric hospital, continue to monitor the individual and continue to provide in-reach and transition activities.
- g) Provide the recipient and/or their family members or guardians opportunities to meet with other individuals with SMI who are living, working and receiving services in integrated settings.
- h) Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI to live in their home/community.
- i) For recipients who are identified for transition, refer the recipients to a BH I/DD Tailored Plan-based transition coordinator or DSOHF Admission Through Discharge Manager (see *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*) assigned to the recipient by the BH I/DD Tailored Plan and ensure a timely, Warm Handoff from the in-reach staff.
- j) Additional required activities for recipients who may be eligible for supportive housing:
 - 1. Ensure the recipient and the recipient's family members and/or guardians are accurately and fully informed about all available Permanent Supportive Housing options.
 - 2. Facilitate and, if necessary, accompany the recipient and the recipient's family members and/or guardians on visits to Permanent Supportive Housing settings.
- iv. The BH I/DD Tailored Plan shall verify the transition staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements* perform the following transition activities:
 - a) Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care upon referral from the from the BH I/DD Tailored Plan in-reach staff as designated in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*.
 - b) Collaborate with facility staff to assist the recipient with completing a Medicaid application prior to discharge.
 - c) Collaborate with the following individuals, specialists, and provider types as applicable depending on recipient's needs, participating in all transition meetings to ensure effective and timely discharge and transition to community:
 - 1. The recipient and/or the recipient's family or guardian
 - 2. Facility providers
 - 3. Facility discharge planners

4. Provider who will be delivering state-funded case management to the recipient or care manager, if applicable or care manager performing Tailored Care Management (for individuals transitioning to Medicaid upon release)
 5. The recipient's community-based PCP, if applicable
 6. Peer support specialist or other individuals determined to have appropriate shared lived experience
 7. Educational specialists
 8. Other community providers and specialists as appropriate in the transition planning process, including physical health providers, and BH providers.
- d) Work with the recipient's community providers as appropriate so that they are actively engaged in the transition planning process prior to the recipient's discharge.
 - e) Assist the recipient, prior to discharge, either by phone or in-person, to identify qualified community providers and clinical specialists as needed, including assisting the recipient and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
 - f) Collaborate with the recipient and/or their family members or guardians, Peer Support Specialists when available, facility providers, and other relevant community service providers to make arrangements for individualized state-funded or low or no cost community supports and services needed to be in place upon discharge.
 - g) Collaborate with the recipient and/or their family members or guardians, the facility provider, and selected community provider(s) prior to the recipient's discharge to identify and prioritize the most critical services necessary and available to address the recipient's specific needs, including complex BH, primary care and medical needs, which may be met through referrals to free or no cost providers (e.g., FQHC and RHC).
 - h) Schedule post-discharge appointments for critical services based upon the recipient's identified needs, including LTSS, to occur at the earliest time necessary to ensure a successful transition and no later than seven (7) Calendar Days following discharge.
 - i) When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
 - j) Assist the recipient and/or the recipient's family members or guardians in initiating selected community service options.
 - k) Work with receiving providers and/or agency if applicable to identify if any specific training is needed by the receiving providers and/or agency if applicable to ensure a seamless transition.
 - l) Address any identified barriers, to the maximum extent possible, to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), resource identification, referrals to qualified providers and care manager, and training of family or guardians and natural supports prior to the recipient's discharge.
 1. Transition staff shall assess settings that the recipient is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.C.3.e.xii. In-Reach and Transition Policy*.
 - m) When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the recipient's individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.
 1. If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any

- necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the recipient's discharge.
2. Make best efforts to ensure that the information contained in the discharge service order, the ninety (90)-day transition plan and the discharge summary are made available to the community providers who will be serving the recipient after discharge.
- n) Verify the discharge service order, the transition plan and the discharge summary are made available to the care manager performing Tailored Care Management (for recipients transitioning to Medicaid upon discharge) or the provider offering State-funded case management.
- o) Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct patient population served, and the discharge and transition responsibilities included in the Department contract including those set forth in this Section.
- p) Following discharge, ensure the transition coordinator performs the following activities:
1. Ensure recipient is receiving needed transition-related services.
 2. Coordinate and facilitate thirty (30)-day post-discharge meetings with the recipient and the recipient's family members or guardians, the provider delivering state-funded case management to the recipient, and community provider(s) including NC START (if applicable) to promptly address any areas of concern identified following transition of the recipient from the facility to the community.
 3. Convene follow-up post-discharge meetings every thirty (30) days until any issues or areas of concern are addressed.
- q) Additional required activities for recipients who may be eligible for supportive housing:
1. Collaborate with the recipient and/or the recipient's family members or guardians and the BH I/DD Tailored Plan's housing specialist to make arrangements for housing services needed to be in place upon discharge.
 2. Assist the recipient and/or the recipient's family members or guardians in initiating housing-related services and supports, including but not limited to: locating and securing housing; ensuring the home environment is safe and move-in ready; and other ongoing tenancy supports that enable the recipient to maintain their housing.
 3. Ensure transition is completed within ninety (90) days of receiving a housing slot.
- r) Referral to Care Management
1. The BH I/DD Tailored Plan shall assign recipients transitioning out of a state psychiatric hospital or ACH to a care manager in Tailored Care Manager model (for recipients transitioning to Medicaid), or to a provider offering the State-funded case management service or other state-funded service with case management functions (e.g. CST, ACTT).
 2. Assignment or referral shall happen upon referral from the transition coordinator or DSOHF Admission Through Discharge Manager prior to discharge if the recipient has not transferred to another service that includes a case management function.
 3. The BH I/DD Tailored Plan shall ensure a Warm Handoff to the recipient's assigned care manager or provider offering the case management service definition.
 4. The Warm Handoff to the recipient's assigned care manager or provider offering the case management service definition shall take place upon discharge.

5. The transition coordinator or DSOHF Admission Through Discharge Manager shall ensure the care manager or provider offering the case management service meets with the recipient and/or their family members or guardians prior to discharge.
 6. The transition coordinator shall remain a part of the recipient’s care team, as applicable, following the Warm Handoff until ninety (90) days post-discharge. During this time the transition coordinator shall remain available to the care manager or provider offering the case management service for consult.
- s) The BH I/DD Tailored Plan shall assign a member of the BH I/DD Tailored Plan clinical leadership (i.e. clinical Director-level or above) to attend and participate in case discussions and transition planning for recipients with complex needs identified by facility clinical leadership, such as recipients with co-occurring disorders or a history of aggression and/or serious self-harm.
- v. Staffing Requirements
- a) The BH I/DD Tailored Plan may operate its in-reach and transition activities utilizing shared staffing and infrastructure with its Medicaid member in-reach and transition activities.
 - b) As described in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that in-reach activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based peer support specialist.
 - c) As described in *Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the following parties are responsible for transition activities:
 1. For recipients transitioning from an ACH or state psychiatric hospital to supportive housing, transition activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based transition coordinator.
 2. For all other recipients transitioning from a state psychiatric hospital, transition activities described in *Section V.C.3.e.iii.* shall be coordinated and/or performed by the DSOHF Admission Through Discharge Manager.

Section V.C.3.e.v.c. Table 1. In-Reach and Transition Staffing Requirements			
	Setting	In-Reach Staff Position	Transition Staff Position
1.	State Psychiatric Hospital	BH I/DD Tailored Plan-Based Peer Support Specialists	<p><i>For recipients transitioning to supportive housing: BH I/DD Tailored Plan-Based Transition Coordinators</i></p> <p><i>For all other recipients: DSOHF Admission Through Discharge Manager</i></p>
2.	ACH	BH I/DD Tailored Plan-Based Peer Support Specialists	BH I/DD Tailored Plan-Based Transition Coordinators

- d) Transition Supervisor Requirements
1. The BH I/DD Tailored Plan shall ensure that all BH I/DD Tailored Plan-based in-reach and transition staff working with recipients who are in or transitioning out of a state psychiatric hospital or ACH are supervised by a transition supervisor.
 2. The BH I/DD Tailored Plan shall ensure Transition Supervisors have no caseload but will provide coverage for other in-reach and transition staff’s vacation and sick leave.

3. The BH I/DD Tailored Plan shall ensure Transition Supervisors are responsible for providing guidance to Peer Support Specialists, Transition Coordinators, and DSOHF Admission Through Discharge Manager working with recipients transitioning out of a state psychiatric hospital or an ACH.
 4. The BH I/DD Tailored Plan shall ensure Transition Supervisors attend and participate in case discussions and transition planning for recipients with complex needs identified by facility clinical leadership, such as recipients with co-occurring disorders or a history of aggression and/or serious self-harm.
 - e) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager per state psychiatric hospital associated with the BH I/DD Tailored Plan's region
 - f) The BH I/DD Tailored Plan shall ensure all in-reach and transition staff report potential rights violations of recipients residing in ACHs in accordance with General Statute 131D.
- vi. In-Reach and Transition Staff Qualifications
- a) The BH I/DD Tailored Plan shall ensure that Peer Support Specialists serving recipients residing in an ACH or state psychiatric hospital have the following minimum qualifications:
 1. NC Certified Peer Support Specialist Program Certification; and
 2. Specific background and expertise working with people with SMI and their families or guardians, and
 3. Must be knowledgeable about community services and supports, including supportive housing.
 - b) The BH I/DD Tailored Plan shall ensure that DSOHF Admission Through Discharge Managers serving residents of state psychiatric hospitals have the following minimum qualifications:
 1. Master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), or bachelor's-level registered nurse (RN) plus one (1) year of experience working directly with individuals with SMI.
 - c) The BH I/DD Tailored Plan shall ensure that Transition Coordinators meet the following minimum qualifications:
 1. Master's degree in a human services field or licensure as a registered nurse (RN) plus one (1) year of relevant experience working directly with individuals with SMI; or
 2. Bachelor's degree in a human services field plus three (3) years of relevant experience working directly with individuals with SMI.
 - d) The BH I/DD Tailored Plan shall ensure that Transition Supervisors overseeing BH I/DD Tailored Plan-based in-reach and transition staff meet the minimum qualifications of a supervising care manager as described in *Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services*. Transition Supervisors shall also meet the following minimum qualifications:
 1. Must be knowledgeable about resources, supports, services and opportunities required for safe community living for populations receiving in-reach and transition services, including LTSS, BH, therapeutic, and physical health services.
 - e) The BH I/DD Tailored Plan may submit to the Department for approval alternate minimum qualifications for in-reach and transition staff as part of the BH I/DD Tailored Plan In-Reach and Transition Policy as described in *Section V.C.3.e.xii. In-Reach and Transition Policy*.
- vii. In-Reach and Transition Staff Training
- a) In addition to the training domains described in *Section V.C.3.c.xiii. Staffing and Training Requirements for Care Managers Serving Recipients with I/DD or TBI Diagnoses*, the BH I/DD Tailored Plan shall develop a separate training module for in-reach and transition staff that addresses the following domains:

1. Full knowledge of the array of available community services and supports that ensure the health and well-being and safe community living for recipients working with in-reach and transition staff
 2. Engagement methods including assertive engagement and active listening skills.
 3. Motivating and working with a recipient's family or guardian and facility staff, including cultural and linguistic needs of a recipient and the recipient's family or guardian.
 4. Developing an interdisciplinary transition plan.
 5. Fair housing laws including tenancy rights, such as reasonable accommodations and housing inspections for health and safety, and components of the Permanent Supportive Housing model during pre-tenancy, tenancy, and post-tenancy phases, including the process for assessing living arrangements for health and safety issues.
- viii. The Department reserves the right to establish caseload requirements for BH I/DD Tailored Plan-based in-reach and transition staff serving recipients in and transitioning out of a state psychiatric hospital or ACH and will release any additional requirements in forthcoming guidance.
- ix. The BH I/DD Tailored Plan shall permit their in-reach and transition staff to transport recipients and the recipient's family or guardians when needed to fulfill the required in-reach and transition activities described in this Section.
- x. The BH I/DD Tailored Plan shall be subject to any additional in-reach and transition requirements issued by the Department, including those developed as part of North Carolina's updated Olmstead Plan.
- xi. The BH I/DD Tailored Plan shall ensure that one recipient does not receive in-reach and transition services that are duplicative of other care or case management services.
- xii. In-Reach and Transition Policy
- a) The BH I/DD Tailored Plan shall submit an In-Reach and Transition Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award and annually thereafter.
 - b) The scope of this policy includes all BH I/DD Tailored Plan recipients eligible for state-funded in-reach and transition services as described in *Section V.C.3.e.ii. Eligibility for In-Reach and Transition Services*.
 - c) The In-Reach and Transition Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing in-reach and transition requirements described in *Section V.B.3.e. In-Reach and Transition from Institutional Settings*, including:
 1. Policies and procedures for outreach and engagement of recipients eligible to receive state-funded in-reach and/or transition services.
 2. Training plan for in-reach and transition staff.
 3. Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support recipient transitions to more integrated settings.
 - d) The In-Reach and Transition Policy shall include a checklist that transition staff will use to assess the safety and appropriateness of settings that BH I/DD Tailored Plan recipients will transition to when leaving a state psychiatric hospital or ACH. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards and are consistent across BH I/DD Tailored Plans.
- f. System of Care
- i. System of Care Background
 - a) The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina's System of Care is to provide

evidence-based, trauma-informed/resiliency developed BH services to all children, youth and their families.

- b) The BH I/DD Tailored Plan shall use a System of Care approach, including use of specific strategies and protocols described in the BH I/DD Tailored Plan System of Care Policy (*Section V.C.3.f.iii. System of Care Policy*) for all children and youth recipients ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving behavioral health or substance abuse services, including special populations with a dual I/DD and mental health disorder at risk of out-of-home placement or unable to return from out-of-home placement; youth with dual physical and mental health or SUD diagnoses with or without the risk of out-of-home placement; youth and young adults transitioning from child service systems into adult service systems; and youth involved in the child welfare and/or the juvenile justice system.
 - c) The System of Care's core elements are:
 - 1. Family-driven, youth-guided services;
 - 2. Interagency collaboration;
 - 3. Service coordination through a single facilitator;
 - 4. Individualized, strength-based, trauma-informed, resilience-oriented approach;
 - 5. Culturally and Linguistically Competent care;
 - 6. Evidence-based or informed services provided in a home or community setting; and
 - 7. Family and youth involvement in regional and state policy development, implementation, and evaluation.
- ii. System of Care Staffing Requirements
- a) The BH I/DD Tailored Plan shall employ or contract with the following dedicated System of Care staff:
 - 1. At least one (1) System of Care Coordinator per three (3) counties for the Region in which it operates; and
 - 2. At least one (1) Family Partner per three (3) counties for the Region in which it operates.
 - b) BH I/DD Tailored Plan System of Care Coordinators and Family Partners shall be responsible for comprehensive System of Care planning, implementation, coordination, and training related to required core functions within the Region in which it operates. System of Care Coordinators and Family Partners shall develop, facilitate, and evaluate the following required System of Care functions and responsibilities throughout the Region in which the BH I/DD Tailored Plan operates:
 - 1. Serve as staff to each county local Community Collaborative in the Region in which the BH I/DD Tailored Plan operates and shall recruit and maintain membership that includes family recipients and youth who are receiving or have received public BH services, child-serving agencies and a variety of community partners.
 - 2. Work with Community Collaboratives to:
 - i. Influence the development of a broad and appropriate service array to meet the range of BH needs of children being serviced under the System of Care framework.
 - ii. Develop the capacity of the Community Collaborative to gather and use data for System of Care decision making.
 - iii. Support BH workforce development through systems partners jointly developing training plans and sharing resources to implement those plans.
 - iv. Develop and implement a strategic communication plan that promotes access to and utilization of BH services, deepens local leadership's understanding of the System of Care framework, and builds public support for local Systems of Care.
 - v. Foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, work

with care managers to ensure that youth and families are leading their person-centered planning processes, and provide and support leadership opportunities for youth and families.

3. Work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of System of Care principles and processes, and provide or facilitate regular consultation, technical assistance and training to provider agencies in System of Care implementation fidelity.
 4. Work with community agencies in identifying and responding to community needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and SUD treatment and recovery services.
 5. Regularly identify and respond to consultation, technical assistance and training needs of the Community Collaboratives, provider agencies, families and BH I/DD Tailored Plan staff, and either directly provide such System of Care consultation, technical assistance, and training or facilitate the provision of such activities.
 6. Take an active role in promoting BH I/DD Tailored Plan and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.
 7. Complete and submit BH I/DD Tailored Plan System of Care Reports to the Department. These reports shall be submitted to the Department in accordance with the Department's requirements.
 8. Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits in order to support a high level of statewide coordination, networking, monitoring, and evaluation for and with System of Care Coordinators and staff.
- c) The BH I/DD Tailored Plan shall ensure System of Care Coordinators and Family Partners are trained on all the topics described in this Section.
- d) The BH I/DD Tailored Plan shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:
1. Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system;
 2. Partnering with families and youth in Care Plan development, implementation, and evaluation process;
 3. Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive and implementation is shared across sectors;
 4. Developing, supporting and expanding relationships among systems;
 5. Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and
 6. Child and family team care management and HFW.
- iii. System of Care Policy
- a) The BH I/DD Tailored Plan shall submit a System of Care Policy for review and approval by the Department within one hundred fifty (150) Calendar Days after Contract Award and annually thereafter. As long as the System of Care Policy clearly states that it applies to the BH I/DD Tailored Plan, the System of Care Policy may apply to other LME/ MCO operations, including, without limitation, the PIHP.

- b) The scope of this policy includes pediatric and adolescent recipients ages three (3) up to eighteen (18) with a mental health disorder and/or SUD disorders who are receiving behavioral health or substance abuse services, including recipients with a dual I/DD and mental health diagnosis.
- c) The System of Care Policy shall include a brief description of the BH I/DD Tailored Plan's history and experience coordinating recipients' care under the System of Care framework, including examples of specific successes and challenges to date in meeting the needs of children with BH needs.
- d) The System of Care Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing the System of Care as required in the *Section V.C.3.f.ii. System of Care Staffing Requirements*:
 - 1. Integrating into the System of Care framework and applying the System of Care core elements into its approach for covering services for child and youth recipients with BH needs and their families.
 - 2. Ensuring that the BH I/DD Tailored Plan is an active partner within a recipient's System of Care.
 - 3. Supporting coordinated multi-system care delivery through:
 - i. Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
 - ii. Conducting outreach to families with lived experience to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;
 - iii. Instituting effective and timely cross-system communication, including for children in crisis; and
 - iv. Collaborating with system partners to ensure that children receive needed services in the least restrictive setting.
 - 4. Describing how the BH I/DD Tailored Plan will work with local and State public agency partners to:
 - a) Reduce the number and length of out-of-home placements for children receiving public BH services;
 - b) Ensure timely access to an appropriate service array of evidenced-based home- and community-based care for children receiving State-funded BH services;
 - c) Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography.
 - 5. Describing how the BH I/DD Tailored Plan will develop capacity to strengthen existing and build new relationships with local and State public agency partners youth and/or family members with lived experience with a child in the BH system and local child and family support education and/or advocacy groups, including but not limited to:
 - a) Local school systems;
 - b) County government;
 - c) Juvenile justice system;
 - d) Child welfare system;
 - e) Public health system;
 - f) Private and local community-based providers;
 - g) Child and Family Advisory Committees;
 - h) Community Collaboratives; and

- i) The DMH/DD/SAS System of Care Coordinator.
- g. Prevention and Population Health Management Programs
 - i. The BH I/DD Tailored Plan shall engage in public awareness campaigns, including federally and state-supported campaigns designed to reduce the stigma associated with BH, I/DD and TBI needs and promote prevention, wellness, healthy behaviors and wellness.
 - ii. The BH I/DD Tailored Plan shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by recipients and to improve the emotional health and well-being of their recipients.
- h. Relocation of Recipients Following Emergency Residential Care Facility Closures
 - i. The Department understands that the safe and prompt relocation of recipients residing in licensed residential care facilities that suddenly close requires coordination across multiple Divisions, local services agencies and BH I/DD Tailored Plans.
 - ii. The BH I/DD Tailored Plan shall assist, and in some cases lead, the transition of care and relocation of recipients in licensed residential care facilities subject to Emergency Closure in accordance with the Department’s Operational Guide for a Coordinated Response to a Sudden Closure of an Adult Residential Care Facility or as otherwise defined by the Department, and additional guidance provided by the Department.³⁷
 - iii. Emergency Closures of Adult Care Homes:
 - a) The Department has developed an intra-Departmental Emergency Closure “Adult Care Home (ACH) Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions – DHSR, DAAS, and DMH/DD/SAS – BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program (housed within the Area Authorities on Aging).
 - b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closure “ACH Response Hub” upon notification of an Emergency Closure of a licensed group home where members reside.
 - c) The BH I/DD Tailored Plan shall be responsible for relocating recipients following Emergency Closures of ACHs and coordinating with the local DSS to appropriately and quickly transition care. The Department will play an active role in assisting the BH I/DD Tailored Plan in facilitating such care transitions.
 - 1. Conduct a site visit of the ACH that is closing;
 - 2. Identify recipients who are residents;
 - 3. Meet with recipients and/or guardians;
 - 4. Implement relocation plan for recipients;
 - 5. Link recipients to services as appropriate;
 - 6. Review recipient medication needs and manage personal items;
 - 7. Participate in daily morning situation calls;
 - 8. Submit discharge information to local DSS contact person;
 - 9. Follow up with relocated recipients; and
 - 10. Participate in debrief conference call after the closure.
 - iv. Emergency Closures of Group Homes
 - a) The Department has developed an intra-Departmental Emergency Closure “Group Home Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of group

³⁷ The Department’s Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Care Facility is available here: https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf.

homes in order to safely relocate displaced residents and is comprised of the following Divisional partners: DHSR, DMH/DD/SAS, DHB and DAAS.

- b) The BH I/DD Tailored Plan shall coordinate with the Department's Emergency Closure "Group Home Response Hub" upon notification of an Emergency Closure of a licensed group home where members reside.
- c) The BH I/DD Tailored Plan shall be responsible for relocating recipients following Emergency Closures of group homes including:
 - 1. Conduct a site visit of group home that is closing;
 - 2. Identify recipients who are residents;
 - 3. Meet with recipients and/or guardians;
 - 4. Implement relocation plan for recipients;
 - 5. Link recipients to services as appropriate;
 - 6. Review recipient medication needs and manage personal items;
 - 7. Participate in daily morning situation calls;
 - 8. Submit discharge information to the Department;
 - 9. Follow up with relocated recipients; and
 - 10. Participate in debrief conference call after the closure.

4. Providers

a. Provider Network

- i. Providers are the backbone of North Carolina's State-funded Services, and the Department has a rich tradition of partnering with the provider community to support the Department's overall vision of creating a healthier North Carolina. The Department seeks BH I/DD Tailored Plans that share and support this tradition.
- ii. The Department seeks a BH I/DD Tailored Plan with a robust State-funded Network to meet the BH, I/DD, and TBI needs of recipients within its Region, including those with limited English proficiency, physical disability or BH I/DD needs. The BH I/DD Tailored Plan shall demonstrate that its State-funded Network will meet Department's availability, access, fidelity and quality goals and requirements as well as that it is willing to act to continuously improve its delivery of health care services to recipients.

iii. Availability of Services

- a) The BH I/DD Tailored Plan shall establish and maintain a State-funded Network that is sufficient to ensure that all services are covered under the Contract as detailed in *Section V.C.2.a. State-funded Behavioral Health, I/DD and TBI Services*. State-funded BH, I/DD, and TBI services are available and accessible to recipients in a timely manner as funds are available, as determined by the Department, including those recipients with limited English proficiency or physical or BH I/DD needs, including those on medication assisted treatment (MAT). The BH I/DD Tailored Plan shall enter into a written contract with each Network provider, the terms of which are further specified herein.
- b) The BH I/DD Tailored Plan shall ensure that no incentive is given to Providers, monetary or otherwise, for withholding medically necessary services.

iv. Crisis Services

- a) Consistent with N.C. Gen. Stat. § 122C-117(a)(14), the BH I/DD Tailored Plan shall provide a comprehensive crisis services system that includes a twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year crisis response service and access to a full array of crisis services.
- b) To promote effective linkages between I/DD crisis service providers, and mobile crisis providers, the BH I/DD Tailored Plan will include within all mobile crisis provider contracts a requirement that a formal, written affiliation agreement be established and maintained with

the I/DD crisis service providers in their Region. The agreements will be developed collaboratively between the mobile crisis teams and I/DD crisis services providers and will outline the roles and responsibilities of both parties.

v. Outpatient Commitment

- a) The BH I/DD Tailored Plan shall ensure the availability of qualified providers of services provided under Outpatient Commitment to recipients who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment.
- b) Consistent with the requirements in N.C. Gen. Stat. § 122C-263, the BH I/DD Tailored Plan shall be able to accept a copy of the Outpatient Commitment order for members who are served by Network outpatient treatment physicians and centers.
- c) 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.
- d) Once the BH I/DD Tailored Plan is notified of a recipient's Outpatient Commitment order, the BH I/DD Tailored Plan shall refer the recipient to case management services for its recipients who are under an Outpatient Commitment order in accordance with *Section V.C.3. Care Management and Prevention*.

vi. Cross Area Service Programs

- a) Any BH I/DD Tailored Plan that wishes to receive State or non-Medicaid federal funding for a Cross Area Service Program (CASP) to provide comprehensive regional or statewide services to individuals residing in multiple BH I/DD Tailored Plan Regions, shall collaborate with the Department to identify and obtain approval to designate a provider to receive such designated CASP funds to serve the needs of an identified population.
- b) The BH I/DD Tailored Plan shall contract with all CASPs located throughout the state that will be listed in forthcoming Department guidance. The BH I/DD Tailored Plan shall use a standard contract for all providers who are CASP according to forthcoming Department guidance.
- c) The BH I/DD Tailored Plan shall not approve or terminate a CASP contract without Department approval.
- d) The BH I/DD Tailored Plan shall identify, use and track CASP funding and services as approved by the State General Assembly and designated in Department allocation letters.
- e) The BH I/DD Tailored Plan shall develop relationships with the NC START team that is responsible for its Region.

vii. Telehealth Services

- a) The BH I/DD Tailored Plan is encouraged to use Telehealth as a tool for facilitating access to needed services in a clinically appropriate manner that are not available from providers within the BH I/DD Tailored Plan's State-funded Network.
- b) The BH I/DD Tailored Plan shall be permitted to include Telehealth in its Request for Exception to the Department's BH I/DD Tailored Plan Network adequacy standards, as clinically appropriate.
- c) The BH I/DD Tailored Plan shall not require a recipient to receive the services via Telehealth if there are other alternatives available.
- d) Access to Telehealth providers shall not count toward meeting State-funded Network adequacy standards, unless approved as part of an exception to State-funded Network requirements.

viii. SUD Residential Treatment Services

- a) The BH I/DD Tailored Plan shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VII. Second Revised and Restated Attachment G.2 Required Standard Provisions of BH I/DD Tailored Plan and Provider Contracts for State-funded Services*.

- b) The Department intends to establish State-funded Network adequacy standards for SUD residential treatment services.
- ix. Furnishing of Services
- a) The BH I/DD Tailored Plan shall meet the State-funded Network time or travel distance and requires State-funded Network providers to meet appointment wait time standards established by the Department as described in *Section VII. First Revised and Restated Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*, unless otherwise approved by the Department in accordance with the requirements herein.
 - 1. The BH I/DD Tailored Plan shall monitor Network providers regularly to determine compliance with the timely access requirements.
 - 2. The BH I/DD Tailored Plan shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
 - 3. The Department may adopt new or amend the State-funded Network time or travel distance, appointment wait time, or other adequacy standards from time-to-time through an amendment to the Contract or through Notice to the BH I/DD Tailored Plan as defined in Section III D 32. Notices. BH I/DD Tailored Plan shall comply with the new or amended standards as directed by the Department, but the BH I/DD Tailored Plan shall have no less than ninety (90) Calendar Days prior notice to comply with any new or amended network adequacy standards adopted by the Department.
 - b) The BH I/DD Tailored Plan shall meet and require its State-funded Network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services. The BH I/DD Tailored Plan shall ensure that State-funded Network providers offer hours of operation that are not less than the hours of operation offered to Medicaid members.
 - 1. The Department may require after hours and weekend hours to address the needs of the recipient.
 - c) Notwithstanding the foregoing, the BH I/DD Tailored Plan need not contract with more providers than necessary to meet the needs of its enrollees receiving State-funded services.
 - d) The BH I/DD Tailored Plan shall ensure that covered services are available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
 - e) The BH I/DD Tailored Plan shall ensure that State-funded Network providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all recipients with relevant physical or BH I/DD needs.
 - f) The BH I/DD Tailored Plan shall promote the delivery of services by State-funded Network providers in a Culturally and Linguistically Competent manner to all recipients, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation or gender identity.
 - 1. The BH I/DD Tailored Plan shall assist providers with meeting these requirements including educating providers about the availability of the Cultural and Linguistic Competency resources, how to access the resource, the provider's responsibility in providing access to interpreter services, and the provider's responsibility for having sufficient interpreter capacity.
 - 2. The BH I/DD Tailored Plan shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.
 - g) The BH I/DD Tailored Plan is encouraged to contract with providers outside of the BH I/DD Tailored Plan's Region to ensure services are available to meet recipients' accessibility needs.

- h) An individual recipient's accessibility and BH I/DD Tailored Plan's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.
- x. Exceptions to Network Requirements
 - a) State-funded Network adequacy measures ensure the BH I/DD Tailored Plan's ability to deliver the services promised by providing reasonable access to a sufficient number of in-network psychiatrists, and all BH, I/DD and TBI services included under the terms of the Contract. Recognizing that there are circumstances which cannot be remedied by the BH I/DD Tailored Plan's alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to State-funded Network requirements in a time-limited manner. However, the Department shall partner with BH I/DD Tailored Plans to find innovative ways to develop or foster provider capacity or otherwise meet the network requirements of State-funded Services.
 - b) The BH I/DD Tailored Plan may request Department approval for an exception to meeting the State-funded Network adequacy standards in a specific Region for a specific provider type. Requests must:
 - 1. Be made in writing;
 - 2. Describe efforts to negotiate in good faith;
 - 3. Include justification for the exception and a description of how State-funded Services recipient needs for the specific Region and provider type will be met; and
 - 4. Include the BH I/DD Tailored Plan's plan to address recipient needs and remedy the network deficiency, including an estimated time-line to close the network gap.
 - c) The Department's approval of an exception request to the BH I/DD Tailored Plan Network adequacy standards will be limited to a specific time frame. Forty-five (45) Calendar Days before an exception/alternative arrangement is set to expire, the BH I/DD Tailored Plan shall submit a new request for the exception/alternative arrangement or inform the Department the exception/alternative arrangement is no longer needed.
- xi. Assurances of Adequate Capacity and Services
 - a) The BH I/DD Tailored Plan shall develop a Network Access Plan for both Medicaid and State-funded Services and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's BH I/DD Tailored Plan Network adequacy standards (as found *Section VII. First Revised and Restated Attachment F.2. BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*), federal and state law where applicable, and the terms of this Contract.
 - 1. The BH I/DD Tailored Plan's Network Access Plan must:
 - 2. Demonstrate compliance, or submit plans for compliance before launch of BH I/DD Tailored Plan, with all the following components:
 - a) Maintains a State-funded Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of State-funded Services recipients in the Region.
 - b) Include procedures to address the following:
 - 1) Referrals;
 - 2) Disclosures and notices to recipients of BH I/DD Tailored Plan services and features; and
 - 3) Coordination and continuity of care.
 - 3. Demonstrate the BH I/DD Tailored Plan's efforts to:
 - a) Address the needs of all recipients, including those with limited English proficiency or illiteracy;
 - b) Address the needs of Historically Marginalized Populations;

- c) Ensure that State-funded Network providers provide physical access, reasonable accommodations, and accessible equipment for recipients with relevant physical, BH or I/DD needs;
 - d) Assist the Department, as directed, to assess the capacity of select providers to ensure that recipients residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:
 - 4) Behavioral health residential treatment facilities licensed under 10A NCAC 27G.1300, .1700, .1900, .3100, .3200, 3400, .4100, .4300, .5600,
 - 5) Adult care homes licensed under 10A NCAC 13F and 13G
 - e) Support and sustain providers, in rural and other traditionally underserved areas as well as providers representative of Historically Marginalized Populations.
4. Include the BH I/DD Tailored Plan's:
- a) Efforts to establish a Network that meets the State-funded Network adequacy standards.
 - b) Quantifiable and measurable process for monitoring and assuring the sufficiency of the State-funded Network to meet the health care needs of all recipients on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a calendar quarter.
 - c) Factors used to build the State-funded Network, including a description of the criteria used to select providers for the network.
 - d) Process and methodology to understand the distribution of recipient health care needs against available providers and provider capacity to serve those needs.
 - e) Plan to provide in-network access, compliant with the Department's State-funded Network adequacy standards, to children to the full range of age-appropriate BH and I/DD providers:
 - 1) Method for ensuring children's BH and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in child health development, and
 - 2) Approach to assure children's access to child psychologists and child and adolescent psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).
 - f) Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
 - g) Geographical location of providers in the State-funded Network in relation to where recipients reside.
 - h) The BH I/DD Tailored Plan shall describe how it will address Cultural and Linguistic Competency for specific populations, such as people with TBI, people with disabilities, people who are blind or visually impaired, people who are deaf or hard of hearing, recipients who are in the Armed Services, veterans and their families, pregnant women with SUD, people who identify themselves as LGBTQ+, people who are in jails or prisons, youth in the juvenile justice system, justice-involved populations more broadly, HMPs, and other vulnerable populations.

- i) Strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:
 - 1) Ambulatory detoxification, substance abuse non-medical community residential treatment, substance abuse medically monitored residential treatment, and SUD residential recovery services and supports, medication assisted treatment and adolescent SUD treatment services, including how the BH I/DD Tailored Plan shall analyze and monitor utilization of these services, develop clinical practice guidelines related to appropriate utilization of these services, configure a continuum of access to these services, pursue other efforts to enhance access and develop provider capacity for these services;
 - 2) First episode psychosis programs (FEP), including how the BH I/DD Tailored Plan shall: analyze and monitor utilization of FEPs, develop clinical practice guidelines related to appropriate utilization of FEP and educate and train providers, and pursue efforts to enhance access and develop FEP capacity with a focus on recipients between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect recipients to existing programs, conduct active surveillance of those at-risk); and
 - 3) Case management services for recipients with behavioral health conditions, including how the BH I/DD Tailored Plan shall analyze and monitor utilization of these services, develop clinical practice guidelines related to appropriate utilization of these services, pursue other efforts to enhance access and develop provider capacity for these services.
- 5. The Network Access Plan must be provided as follows:
 - i. Thirty (30) Calendar Days after Contract Award;
 - ii. As specified by the Department;
 - iii. Annually; and
 - iv. Within thirty (30) Calendar Days of a Significant Change, including merger or county disengagement.
 - v. The demonstration shall be that the BH I/DD Tailored Plan has the capacity to serve the expected number of recipients on a regional basis.
- 6. The Network Access Plan shall be subject to Department review and approval. The BH I/DD Tailored Plan shall amend the Network Access Plan as directed by the Department.
- 7. Detail how the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies, and procedures.
- b) Ongoing Monitoring and Significant Changes in the Provider Network
 - 1. At least once a calendar quarter, the BH I/DD Tailored Plan shall monitor its Provider Network for a Significant Change that would affect adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards established by the Department as described in *First Revised and Restated Attachment E.2. Second Revised and Restated BH I/DD Tailored Plan Network Adequacy Standards for State-funded Services*.
 - 2. The BH I/DD Tailored Plan shall report the results of the monitoring for significant change performed during a calendar quarter in the quarterly submission for that calendar quarter of the Network Data Details Extract Report described in *First Revised and Restated Attachment J. First Revised and Restated Reporting Requirements*..

3. If the BH I/DD Tailored Plan determines a significant change has occurred that negatively affects adequate capacity and/or services and compliance with the time/distance and/or appointment wait time standards, the BH I/DD Tailored Plan shall prepare and concurrently submit the following information to the Department when the BH I/DD Tailored Plan submits the quarterly Network Data Details Extract Report that documents the significant change.
 4. An updated Network Access Plan, including an updated attestation of compliance with the time/ distance and/or appointment wait time standards established by the Department; and
 5. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.
 - c) The BH I/DD Tailored Plan and its Network providers shall comply and cooperate with DMH/DD/SAS and DHHS vendors during annual validation activities of the BH I/DD Tailored Plan's State-funded network and compliance with State-funded network requirements.
- b. Provider Network Management
- i. The BH I/DD Tailored Plan shall manage its State-funded Network to meet availability, accessibility, and quality goals and requirements. The BH I/DD Tailored Plan shall have a monitoring program to ensure providers are meeting recipient needs and program requirements.
 - ii. Reserved.
 - iii. Provider Contracting
 - a) The BH I/DD Tailored Plan's contracts with State-funded providers shall comply with the terms of this Contract, state and federal law, and include required standard contracts clauses listed in *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services.*
 - b) The BH I/DD Tailored Plan shall develop contract templates that comply with the requirements of this Contract and submit those to Department for approval no later than thirty (30) Calendar Days after the Contract Award.
 1. The BH I/DD Tailored Plan may utilize proposed contract templates submitted as part of the Applicant's Application Proposal prior to approval with notification to the provider that the contract is subject to amendment based upon Department review and approval.
 2. Upon approval by the Department, the BH I/DD Tailored Plan shall update submitted templates to reflect all changes requested by the Department as a condition of approval, whether or not the template has been utilized in contracting with a provider. The BH I/DD Tailored Plan shall discontinue use of previously submitted contract templates once an amended version is approved.
 3. After launch of the BH I/DD Tailored Plan, The BH I/DD Tailored Plan shall submit newly developed contract templates to the Department for approval at least ninety (90) Calendar Days before use with providers.
 4. During contract negotiations with a provider, the BH I/DD Tailored Plan may, without the Department's prior approval, make amendments to a previously approved provider contract template.
 - a) Any change to a standard provision required by *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services,* is limited to those provisions outlined in *Section VII. Second Revised and Restated Attachment G.2.,* except for a change to a provision related to subsections 1.w., 1.x., 1.y., or 1.z., which must be prior approved by the Department.

- b) Any change to a standard provision required in *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, must be prior approved by the Department.
- c) Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.
- c) The BH I/DD Tailored Plan may only make changes to the provisions required in *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, when directed to do so by the Department. The BH I/DD Tailored Plan shall not employ or contract with any provider appearing on one of the Exclusion Lists.
- d) The BH I/DD Tailored Plan shall offer to contract with a provider in writing.
 - 1. All offers shall include the standard provisions for provider contracts found in *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services*, including the prescribed provisions located therein.
 - 2. If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the BH I/DD Tailored Plan may consider the request for inclusion in the State-funded Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the BH I/DD Tailored Plan shall not consider the request rejected.
 - 3. The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers, including non-medical service providers, or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan.
- e) The BH I/DD Tailored Plan may require individual practitioners, as a condition of contracting with the BH I/DD Tailored Plan for State-funded Services, to agree to participate in the BH I/DD Tailored Plan's Medicaid network. The BH I/DD Tailored Plan shall not automatically enroll the provider in any other product offered by BH I/DD Tailored Plan. This requirement shall not apply to facility providers. The BH I/DD Tailored Plan shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the BH I/DD Tailored Plan's final decision. The notice shall include the reason for the BH I/DD Tailored Plan's decision, the Provider's right to appeal that decision, and how to request an appeal.
- f) The BH I/DD Tailored Plan shall, with regard to payment to any provider or Subcontractor that is "related to" the BH I/DD Tailored Plan, comply with the requirements in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
- g) Provider contracts shall specify the federal aid category when federal funds are utilized to reimburse the provider.
- h) The BH I/DD Tailored Plan shall include in contracts with providers the responsibility for compliance with service record documentation and retention in accordance with *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
- i) If the BH I/DD Tailored Plan is notified that a contracted provider has abandoned records, the BH I/DD Tailored Plan shall submit a formal report to the Department.
- j) If the BH I/DD Tailored Plan is notified that a contracted provider has potentially violated State or federal laws, rules or regulations governing health information privacy and security including

- but not limited to the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, 110 Stat. 1938 (“HIPAA”), as amended by title XIII of Division A and title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), 45 CFR Parts 160, 162 and 164 (HIPAA Privacy and Security Rule), and N.C. Gen. Stat. §§ 122C-52 through 122C-56, the BH I/DD Tailored Plan shall notify the provider in writing of the potential violation and monitor and follow up with the provider regarding any required compliance steps such as risk assessments, mitigation efforts, notification of affected individuals, and submission of reports to the Department or the US Department of Health and Human Services, Office of Civil Rights.
- k) If a provider’s contract is terminated or if the provider closes network operations, but continues to have operations elsewhere in the state, the BH I/DD Tailored Plan shall permit the provider to provide copies of medical records of individuals to the BH I/DD Tailored Plan or submit a plan for maintenance and storage of all records for approval by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall retain the sole discretion to approve or disapprove such a plan.
 - l) The BH I/DD Tailored Plan shall perform the following activities as soon as the BH I/DD Tailored Plan is made aware of the abandonment of any medical records of individuals served pursuant to this Contract in their Region:
 - 1. The BH I/DD Tailored Plan shall notify the applicable Department Division(s) based on funding source and licensure, i.e. NC Medicaid, DMH/DD/SAS and/or DHSR.
 - 2. The BH I/DD Tailored Plan shall contact the provider via trackable mail informing them of their report to the Department regarding the abandonment.
 - 3. The BH I/DD Tailored Plan shall secure the records and complete an inventory log of the records.
 - m) The BH I/DD Tailored Plan shall include in contracts with providers the responsibility for compliance with service record documentation and retention in accordance with *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
 - n) The BH I/DD Tailored Plan shall include a provision in the provider contract regarding a provider’s right to file a grievance or appeal (as described in *Section V.C.4.e. Provider Grievances and Appeals*) in its contract with providers. The BH I/DD Tailored Plan shall include a notice in all provider contracts that the internal appeal process with the BH I/DD Tailored Plan must be completed before seeking other legal or administrative remedies under federal or state law.
 - o) The BH I/DD Tailored Plan shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a recipient who is their patient regarding:
 - 1. The recipient’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - 2. Any information the recipient needs to decide among all relevant treatment options.
 - 3. The risks, benefits, and consequences of treatment or non-treatment.
 - 4. The recipient’s right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
 - p) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires providers notify the BH I/DD Tailored Plan when a recipient in a high acuity clinical setting is being discharged.
 - q) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires providers transmit a recipient’s eligibility information the BH I/DD Tailored Plan. Information may include insurance status and income level.

- r) The BH I/DD Tailored Plan may utilize evergreen contracts (i.e. a contract that automatically renews), with State-funded providers on the condition that the contract also includes the reasons the contract may be terminated or non-renewed.
- s) The BH I/DD Tailored Plan shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.
- t) In contracting with providers, the BH I/DD Tailored Plan shall comply with all applicable Chapter 58 statutes in accordance with *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services.*
- u) The BH I/DD Tailored Plan shall include in provider contracts that State-funded Services Participating Providers shall not submit claim or encounter data for services covered by BH I/DD Tailored Plans as State-funded Services directly to the Department.
- v) DSOHF Facilities
 - 1. The BH I/DD Tailored Plan shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the facilities:
 - i. Julian F Keith ADATC;
 - ii. R.J. Blackley ADATC;
 - iii. Lakeside;
 - iv. Woodsite Treatment Center;
 - v. Cherry Hospital;
 - vi. Broughton Hospital;
 - vii. Central Regional Hospital;
 - viii. Caswell Developmental Center;
 - ix. J. Iverson Riddle Developmental Center;
 - x. Murdoch Developmental Center; and
 - xi. Whitaker Psychiatric Residential Treatment Facility.
 - 2. The BH I/DD Tailored Plan shall consider these DSOHF facilities to have successfully completed the State's Centralized Credentialing and Re-credentialing Process (CCRP) and are enrolled as a provider in the NC Medicaid program.
 - 3. The BH I/DD Tailored Plan shall use a Department-developed contract template to contract with these DSOHF facilities to be delivered after Contract Award.
- iv. Critical Incident Reporting
 - a) The BH I/DD Tailored Plan shall establish a process for timely identification, response, reporting, and follow-up to recipient incidents.
 - b) The BH I/DD Tailored Plan shall require contracted providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System.
 - c) The BH I/DD Tailored Plan shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of recipients.
 - d) The BH I/DD Tailored Plan shall report information on incidents and deaths in accordance with Department procedures.
 - e) The BH I/DD Tailored Plan shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Second Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-Funded Services.*

- f) The BH I/DD Tailored Plan shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
 - g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for recipients obtaining services in a DSOHF facilities as detailed in *Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Health Care Facilities Providers.*
- v. Program Integrity
- a) The BH I/DD Tailored Plan shall develop policies and procedures to perform monitoring and auditing of provider payment. The BH I/DD Tailored Plan shall provide those policies and procedures to the Department upon request for review, or as otherwise required by this Contract.
 - b) The BH I/DD Tailored Plan shall require State-funded Network providers and out-of-network providers to have policies and procedures that recognize and agree that State-funded Services as “the payer of last resort.”
- vi. Credentialing and Re-credentialing Process
- a) To help recognize the Department’s aim of engaging and supporting providers, the Department is establishing a centralized credentialing process for both Medicaid and State-funded Services providers. State-funded Services providers shall enroll in Medicaid, using the same credentialing and recredentialing standards and criteria as Medicaid providers in Section V.B. 4.ii.(viii).
 - b) Each provider that is credentialed to provide only State-funded Services (“State-funded only provider) at BH I/DD Tailored Plan launch shall enroll in Medicaid during its next recredentialing period. The period between BH I/DD Tailored Plan launch and when all State-funded only providers are credentialed with Medicaid will be considered the “State-funded Only Provider Credentialing Transition Period.” During the State-funded Only Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall monitor and maintain credentialing records for State-funded only providers to ensure continued compliance with credentialing requirements and ensure that each State-funded only provider transitions to Medicaid enrollment during its recredentialing period. These records shall be made available to DMH/DD/SAS for inspection if requested.
- vii. Network Provider System Requirements
- a) The BH I/DD Tailored Plan shall accurately and timely load into the BH I/DD Tailored Plan’s claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.
 - b) Unless otherwise written in the contract, the BH I/DD Tailored Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a State-funded Service or item already provided to a recipient and billed to the BH I/DD Tailored Plan by the provider:
 1. Newly credentialed provider attached to a new contract within ten (10) Business Days after completing contracting;
 2. Newly credentialed hospital or facility provider attached to a new contract within fifteen (15) Business Days after completing contracting;
 3. Newly credentialed provider attached to an existing contract within five (5) Business Days after completing contracting;

4. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) Business Days after completing receipt of notification of the change through the Department;
 5. Change in existing contract terms within thirty(30) Calendar Days of the effective date after the change; and
 6. Changes in provider service location or demographic data or other information related to recipient's access to services must be updated no later than thirty (30) Calendar Days after the BH I/DD Tailored Plan receives updated provider information.
- c) Payment should be made on the next payment cycle following the requirement outlined above.
 - d) In no case shall a provider be loaded into the Provider Directory during a timeframe in which the provider cannot receive payment in accordance with the BH I/DD Tailored Plan's current payment cycle.
- viii. Network Provider Credentialing and Re-credentialing Policy
- a) The BH I/DD Tailored Plan shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2). BH I/DD Tailored Plan shall apply these criteria consistently to all providers. .
 - b) Network Contracting Decisions
 1. The BH I/DD Tailored Plan shall establish and maintain a process to make network contracting determinations in accordance with BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy.
 2. The BH I/DD Tailored Plan shall provide written notice of network contracting decisions to providers within five (5) Business Days of determination of the provider's status as an active State-funded Services Enrolled provider.
 - c) Provider Disenrollment and Termination
 1. Payment Suspension at Re-Credentialing:
 - i. The BH I/DD Tailored Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise fail to meet Department requirements.
 - ii. The BH I/DD Tailored Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information within the Department's allotted timeframes, the Department will terminate the provider from its State-funded provider network.
 - iii. The BH I/DD Tailored Plan shall not be liable for interest or penalties for late claim payment related to payment suspension at re-credentialing.
 - iv. The BH I/DD Tailored Plan shall address payment suspension in its Provider Manual
 2. Termination as a State-funded Services Provider by the Department:
 - i. The BH I/DD Tailored Plan shall remove any provider from the claims payment system and terminate the provider's contract within one (1) Business Day of receipt a notice from the Department that the Provider is terminated as a State-funded Services provider. This applies to all providers regardless of the provider's network status.
 - ii. If the BH I/DD Tailored Plan suspended provider payment, then upon notice by the Department that the provider is terminated from State-funded Services, the BH I/DD Tailored Plan shall release applicable claims and deny payment for dates of service after the date of termination from the State-funded Services network.

- iii. There are no appeal rights against the BH I/DD Tailored Plan for a provider terminated or sanctioned, including suspension of provider payment, by the Department.
- 3. BH I/DD Tailored Plan Provider Termination
 - i. The BH I/DD Tailored Plan may terminate a provider from its State-funded Network with or without cause. Any decision to terminate must comply with the requirements of the Contract. The BH I/DD Tailored Plan shall comply with the program integrity provider termination requirements outlined in *Section V.A.3.ii. Program Integrity for Medicaid and State-funded Services*.
 - ii. The BH I/DD Tailored Plan must provide written notice to the Network provider of the decision to terminate to the provider. The notice, at a minimum, must include:
 - a) The reason for the BH I/DD Tailored Plan’s decision;
 - b) The effective date of termination;
 - c) The provider’s right to appeal the decision; and
 - d) How to request an appeal.
 - iii. The BH I/DD Tailored Plan shall report data to the Department on the number of providers terminated by provider type in a format dictated by the Department for the Network Access Report identified in *Section VII. First Revised and Restated Attachment J. Reporting Requirements*.
- 4. Recipient Notice of Provider Disenrollment/Termination
 - i. The BH I/DD Tailored Plan shall notify each recipient who, at a minimum was seen in the previous twelve (12) months by a terminated provider, of the provider’s termination from the State-funded Network. The BH I/DD Tailored Plan shall:
 - a) Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the BH I/DD Tailored Plan.
- ix. Provider Directory
 - a) The BH I/DD Tailored Plan shall develop a consumer-facing provider Network Directory of all State-funded Network providers including the required information for all such providers.
 - b) The Network Directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance the Contract, and as specified by Department.
 - c) The BH I/DD Tailored Plan shall ensure that the consumer-facing Network Directory:
 - 1. Be in a format that is machine-readable and readily accessible;
 - 2. Is placed in a location on the BH I/DD Tailored Plan’s website that is prominent and readily accessible by recipients;
 - 3. Includes accurate and updated provider information, including fidelity evaluation scores, consistent with Contract requirements;
 - 4. Is provided in an electronic form which can be electronically retained and printed; and
 - 5. Is available in paper form without charge upon recipient request and if requested, is provided within five (5) Business Days.
 - d) The BH I/DD Tailored Plan shall update:
 - 1. The paper directory at least monthly and clearly identify the date of the update; The paper directory can be updated once per quarter if a mobile directory is enabled; and
 - 2. The electronic version of the consumer-facing directory no later than ten (10) Business Days after the BH I/DD Tailored Plan receives updated provider information and clearly identify the date of the update.

- e) The BH I/DD Tailored Plan shall provide the Department with a copy of both the electronic and paper versions of the Network Directory as follows:
 - 1. At the request of the Department during the Readiness Review;
 - 2. Annually; and
 - 3. Any time there has been a Significant Change in BH I/DD Tailored Plan operations that impacts the content of the directory.
 - f) The State-funded Network Directory should include the following information, at a minimum, in a format to be prescribed by the Department:
 - 1. Provider name;
 - 2. Provider demographics (first, middle, and last name, gender);
 - 3. Provider DBA Name;
 - 4. Provider Service Location Name;
 - 5. Provider type;
 - 6. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - 7. Street address(as) of service location(s);
 - 8. County(ies) of service location(s);
 - 9. Telephone number(s) at each location;
 - 10. After hours telephone number(s) at each location;
 - 11. Provider Specialty by location;
 - 12. Where a provider is accepting new recipients;
 - 13. Whether a provider serves Medicaid and NC Health Choice beneficiaries;
 - 14. Whether BH provider is serving children and adolescents;
 - 15. Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
 - 16. Whether provider has completed Cultural and Linguistic Competency training,;
 - 17. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment; and
 - 18. A telephone number at the BH I/DD Tailored Plan where a recipient can call to confirm the information in the directory.
 - g) As long as the BH I/DD Tailored Plan Provider Directory clearly identifies which providers are available under which health plan, a unified Provider Directory may apply to other BH I/DD Tailored Plan Operations without limitation the PIHP.
- c. Provider Relations and Engagement
- i. Providers are critical partners in ensuring that State-funded Services are readily accessible to recipients. The BH I/DD Tailored Plan shall engage and support providers through a call center and online provider portal as well as provide training and education on State-funded Services and providers' rights within the program.
 - ii. Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
 - a) The BH I/DD Tailored Plan shall operate a Provider Relations function that includes a Provider Support Service Line consistent with the applicable standards found in *Section V.A.2. Program Operations*. The Provider Support Service Line shall comply with the requirements set forth in *Section V.A.1.iv . Third Party (Subcontractor) Contractual Relationships* if the BH I/DD Tailored Plan use a Subcontractor to provide or operate the service line (see V.A.2.a. Service Lines for Medicaid and State-funded Services). The Provider Support Service Line may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - b) The BH I/DD Tailored Plan shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web

portal shall include access to the Provider Manual. The provider web Provider portal may apply to other LME/ MCO operations, including, without limitation, the PIHP.

- c) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) Calendar Days of executing a contract with the Provider for participation in its State-funded Network. The Provider Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.
 - d) The BH I/DD Tailored Plan shall develop and maintain a Provider Support Plan as described in *Section V.C.5.a. Quality Management and Quality Improvement* and make it available to Department upon request.
- iii. Provider Education and Training
- a) The BH I/DD Tailored Plan shall provide periodic and reasonable education specific to the State-funded Services requirements, policies and procedures, as well as training and technical assistance on all BH I/DD Tailored Plan-specific administrative and clinical policies and requirements to State-funded Network providers.
 - b) The BH I/DD Tailored Plan shall communicate with State-funded Network providers, or include in its training and technical assistance, information as requested by Department.
 - c) The BH I/DD Tailored Plan shall provide training to State-funded Network providers within thirty (30) Calendar Days of a provider joining the Network. Additional training will be provided as determined by the BH I/DD Tailored Plan and as requested by Department.
 - d) The BH I/DD Tailored Plan shall make training materials available on the provide Web portal as determined appropriate by the BH I/DD Tailored Plan and upon request by State-funded Network providers or Department.
 - e) The BH I/DD Tailored Plan shall develop a Provider Training Plan that outlines training topics and dates. The BH I/DD Tailored Plan Provider Training Plan shall reference and acknowledge the broader role the BH I/DD Tailored Plan has in supporting Department initiatives, including how the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures. As long as the Provider Training Plan, clearly states that it apply to the BH I/DD Tailored Plan, the Provider Training Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP.
 - f) The BH I/DD Tailored Plan shall submit the Provider Training Plan to the Department as follows:
 - 1. Upon award of this contract;
 - 2. When material changes are made to the Provider Training Plan; and
 - 3. Annually.
- iv. Provider Manual
- a) The BH I/DD Tailored Plan shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the BH I/DD Tailored Plan and State-funded Services. At a minimum, the Provider Manual must cover the following subject matter:
 - 1. Covered services;
 - 2. Eligibility for state-funded services, including federal funding restrictions and requirements;
 - 3. Care management (including in-reach, transition management and diversion) delivered through the BH I/DD Tailored Plans;
 - 4. UM program;
 - 5. Provider responsibilities;
 - 6. Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-

- reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
7. Telehealth;
 8. Network adequacy and access standards;
 9. Billing, claim editing, SNIP editing and clearinghouse requirements;
 10. Cultural and Linguistic Competency and accessibility requirements;
 11. Care management and discharge planning requirements;
 12. Department-required documentation requirements;
 13. Provider appeals and grievance process;
 14. Complaint or grievance investigation and resolution procedures;
 15. Performance improvement procedures including recipient satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
 16. Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of services requirements;
 17. Interest and penalty provisions for late or under-payment by the BH I/DD Tailored Plan;
 18. Recipient rights and responsibilities;
 19. Recipient cost sharing requirements; and
 20. Provider program integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other state and federal requirements.
- b) The BH I/DD Tailored Plan shall also include in the Provider Manual providers' obligations to:
1. Monitor and audit provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
 2. Retain patient records for the mandated period;
 3. Ensure that all documentation regarding services provided is timely, accurate, and complete;
 4. Ensure BH I/DD Tailored Plan for State-funded Services is the payer of last resort; and
 5. To report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment.
- c) The BH I/DD Tailored Plan shall include standardized language in the Provider Manual as requested by the Department.
- d) The BH I/DD Tailored Plan shall submit Provider Manual to Department for approval thirty (30) Calendar Days after Contract Award. The BH I/DD Tailored Plan shall not use or distribute the Provider Manual prior to approval by Department.
- e) The BH I/DD Tailored Plan shall review and update the Provider Manual annually to reflect changes to applicable state laws, rules and regulations, Department or BH I/DD Tailored Plan policies, procedures, bulletins, guidelines or manuals, or BH I/DD Tailored Plan business processes as necessary. Within the Provider Manual, the BH I/DD Tailored Plan shall track and maintain a list of revisions made to the manual, including a summary of the revisions, the section and page number of the revisions, and the date the revisions were completed.
- f) The BH I/DD Tailored Plan may update the provider manual once per quarter in the event of substantive updates or revisions that impact providers or BH I/DD Tailored Plan business. Unless directed by the Department, the BH I/DD Tailored Plan shall not update the provider manual more than once per quarter during the Contract Year. Submissions of the provider manual to the Department by the BH I/DD Tailored Plan during the Contract Year shall not replace or eliminate the requirement to annually review and update the provider manual in accordance with this section.

- g) When seeking review and approval of the provider manual, the BH I/DD Tailored Plan shall submit the provider manual to Department for approval within fifteen (15) Calendar Days of making substantive updates. The BH I/DD Tailored Plan shall not post, print or enforce the updates until the BH I/DD Tailored Plan has received approval from the Department.
 - h) The BH I/DD Tailored Plan shall have fifteen (15) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process.
 - i) The BH I/DD Tailored Plan shall make the provider manual available, within five (5) Calendar Days of approval from the Department, in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
 - j) The BH I/DD Tailored Plan shall have five (5) Calendar Days to return an updated version of the provider manual if any revisions are requested by the Department during the review and approval process.
 - k) The BH I/DD Tailored Plan shall make the Provider Manual available in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
- v. Provider Survey
- a) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Provider Relations staff via standardized provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary. The BH I/DD Tailored Plan shall:
 1. Make provider surveys available after each web, call center or in-person interaction;
 2. Conduct surveys and internal audits intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and perception of the call center/website convenience and effectiveness; and
 3. Provide reports, including the results of provider surveys and BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, to the Department on a regular basis as determined by the Department, and ad hoc as requested.
- d. Provider Payments
- i. Provider payment requirements are established to comply with State law, encourage continued provider participation in the State-funded BH, I/DD and TBI services Network to ensure recipient access, and support safety net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of BH I/DD Tailored Plan steerage to other providers. Nothing in this section is meant to preclude the BH I/DD Tailored Plan from using different reimbursement amounts for different specialties for practitioners in the same specialty.
 - ii. The BH I/DD Tailored Plan shall assist the Department in complying with all federal laws, state laws, PI or audit requirements, investigations, findings or corrective action plans related to provider payments.
 - iii. The BH I/DD Tailored Plan shall timely reimburse providers for duly authorized services provided and billed, contingent upon receipt of timely payments from the Department.
 - iv. The BH I/DD Tailored Plan shall institute the following provider reimbursement policies for State-funded Services:
 - a) All payments for services to providers shall be subject to review and audit for their conformity with applicable state and federal laws, rules and regulations and requirements contained in any applicable contract between the BH I/DD Tailored Plan and the provider.
 - b) The BH I/DD Tailored Plan may use different reimbursement methodologies or reimburse at amounts for different specialties or for different practitioners in the same specialty; and will

- establish measures that are designed to maintain quality of services and control cost consistent with its responsibilities to recipients.
- c) The BH I/DD Tailored Plan may establish rates specific to a provider, as the BH I/DD Tailored Plan determines necessary and appropriate. The BH I/DD Tailored Plan may offer different rates to different providers offering the same services according to the BH I/DD Tailored Plan's established plan with criteria, such as paying enhanced rates for evidence-based practices or for positive outcomes.
 - d) The BH I/DD Tailored Plan shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any denied claims billed shall be returned to the provider with an explanation for the denial.
 - v. State Owned and Operated Facilities Payments
 - a) The BH I/DD Tailored Plan shall reimburse facilities that are state-owned and operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) according to the rates and their respective effective dates established by the Department.
 - vi. Payment Limitations
 - a) Upon request by the Department, the BH I/DD Tailored Plan shall submit information on payments to related providers and Subcontractors and provide a demonstration of how payment levels for related providers and Subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are value-based payment arrangements in place.
 - e. Provider Grievances and Appeals
 - i. The BH I/DD Tailored Plan shall handle provider appeals and grievances promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The BH I/DD Tailored Plan shall have in place a provider appeals and grievance system, distinct from that offered to recipients, that includes a grievance process for providers to bring issues to the BH I/DD Tailored Plan, an appeals process for providers to challenge certain BH I/DD Tailored Plan decisions, and information regarding access to a state level review through the North Carolina Office of Administrative hearings. The BH I/DD Tailored Plan shall be transparent with providers regarding its appeals and grievance processes and procedures. The BH I/DD Tailored Plan shall ensure the Grievances and Appeals system complies with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan delegates any activities to a Subcontractor.
 - ii. The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) Calendar Days after Contract Award. The BH I/DD Tailored Plan shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.
 - iii. The BH I/DD Tailored Plan shall have a process to and staff capable of reviewing provider grievance and appeal outcomes to identify trends, and existing operational or clinical opportunities to improve the provider experience.
 - iv. The BH I/DD Tailored Plan shall not discriminate against or retaliate against any provider based on any action taken by the provider under Provider Grievances and Appeals Section of the Contract or under the recipient appeals process of the Contract taken on behalf of a recipient.
 - v. Grievances
 - a) The BH I/DD Tailored Plan shall have a process in place to receive and resolve grievances with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
 - b) The BH I/DD Tailored Plan shall accept and resolve provider grievances regarding the BH I/DD Tailored Plan referred from the Department.

- c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit grievances through the BH I/DD Tailored Plan provider web portal.
 - d) The BH I/DD Tailored Plan shall provide information regarding provider grievances to Department in a form and frequency as outlined in *Section VII. First Revised and Restated Attachment J. Reporting Requirements* and upon request.
- vi. Appeals
- a) The BH I/DD Tailored Plan shall offer providers appeal rights as described in *Section VII. Second Revised and Restated Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Providers*.
 - b) The BH I/DD Tailored Plan shall provide written notice of provider's right to appeal with the notice of decision giving rise to the provider's right to appeal.
 - c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit appeals through the BH I/DD Tailored Plan provider web portal.
 - d) The BH I/DD Tailored Plan shall accept a written request for an appeal from the provider within thirty (30) Calendar Days on which:
 - 1. Provider receives written notice from the BH I/DD Tailored Plan of the decision giving rise to the right to appeal; or
 - 2. BH I/DD Tailored Plan should have taken a required action and failed to take such actions.
 - e) The BH I/DD Tailored Plan shall acknowledge receipt of each appeal request within five (5) Calendar Days of receipt of the request.
 - f) The BH I/DD Tailored Plan shall extend the timeframe by thirty (30) Calendar Days for providers to request an appeal for good-cause shown as determined by the BH I/DD Tailored Plan.
 - 1. BH I/DD Tailored Plan shall document in its Grievances and Appeals Policy its policy and procedure for extending the timeframe for submission of an appeal request.
 - 2. The BH I/DD Tailored Plan shall consider the voluminous nature of required evidence/supporting documentation, and appeal of an adverse quality decision as good-cause reasons to extend the timeframe.
 - g) The BH I/DD Tailored Plan shall provide information regarding provider appeals to Department upon request.
 - h) The BH I/DD Tailored Plan Grievances and Appeals Policy shall provide that a provider must exhaust the BH I/DD Tailored Plan internal appeals process before seeking recourse under any other process permitted by contract or law.
- vii. Resolution of Appeal
- a) The BH I/DD Tailored Plan shall establish a panel to review and make decisions on provider appeals. The panel must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal.
 - b) The BH I/DD Tailored Plan shall provide written notice of decision of the appeal within thirty (30) Calendar Days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the BH I/DD Tailored Plan. Notice shall include information regarding further appeal rights, if any.
 - c) The BH I/DD Tailored Plan shall allow providers to be represented by an attorney during the appeals process.
- viii. Appeals of Suspension or Withhold of Provider Payment
- a) The BH I/DD Tailored Plan shall limit the issue on appeal in cases of suspension or withhold or provider payment to whether the BH I/DD Tailored Plan had good-cause to commence the withhold or suspension of provider payment. BH I/DD Tailored Plan shall not address whether the provider has or has not committed fraud or abuse.

- b) The BH I/DD Tailored Plan shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.
 - c) The BH I/DD Tailored Plan shall offer the provider an in-person, telephone, or virtual hearing when provider is appealing whether BH I/DD Tailored Plan has good cause to withhold or suspend payment to the provider.
 - d) The BH I/DD Tailored Plan shall schedule the hearing and issue a written decision regarding whether BH I/DD Tailored Plan had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's appeal. Upon a finding that BH I/DD Tailored Plan did not have good-cause to suspend or withhold payment, BH I/DD Tailored Plan shall reinstate any payments that were withheld or suspended within five (5) Business Days.
 - e) The BH I/DD Tailored Plan shall pay interest and penalties for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.
- ix. Notice to Department
- a) The BH I/DD Tailored Plan shall provide notice to the Department of any provider appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by BH I/DD Tailored Plan, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the appeal.
 - b) The BH I/DD Tailored Plan shall notify Department if a provider has sued BH I/DD Tailored Plan in any administrative or general court of justice for actions related to State-funded Services. Such notice must be provided within five (5) Business Days of being served.

5. Quality

a. Quality Management and Quality Improvement

- i. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. For BH I/DD Tailored Plans, which are tasked with caring for North Carolinians with complex BH, I/DD, and TBI needs, the Department intends to incorporate additional standards and opportunities related to the unique aspects of the BH I/DD Tailored Plan State-funded Services population. The Department intends to promote the highest quality of care for BH, I/DD, and TBI needs and to promote integration among BH, I/DD, and TBI providers.
- ii. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. DMH/DD/SAS's Quality Management plan outlines the Division's Quality Management Program, its values, guiding principles and improvement initiatives for providing access to high quality BH, SUD services and I/DD and TBI supports.
- iii. As North Carolina transitions its Medicaid program and State-funded services system to BH I/DD Tailored Plans, the Department will work with the BH I/DD Tailored Plan to develop a data-driven, outcomes-based continuous QI process. The QI process will build upon the Department's experience and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards BH I/DD Tailored Plans and, in turn, providers for advancing quality goals and health outcomes.
- iv. The BH I/DD Tailored Plan shall have an IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations. The BH I/DD Tailored Plan shall engage with the Department and

its designees to share quality data reported by the BH I/DD Tailored Plan and receive quality data calculated by the BH I/DD Tailored Plan or its designees.

- v. The BH I/DD Tailored Plan shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and QAPI Plan, and DMH/DD/SAS's Quality Management plan.

- a) QAPI Plan

1. The BH I/DD Tailored Plan shall submit an annual combined QAPI Plan for Medicaid, NC Health Choice, and State-funded services, delineating the BH I/DD Tailored Plan's plans for performance improvement programs and other quality improvement efforts. The Department expects the BH I/DD Tailored Plan to submit a combined QAPI Plan for Medicaid, NC Health Choice, and State-funded services.
2. The BH I/DD Tailored Plan shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
3. The QAPI plan shall include the following elements for State-funded services:
 - i. If the BH I/DD Tailored Plan intends to implement a PIP specified by the Department that are relevant to State-funded Services, a discussion of how the PIP will promote high-quality State-funded Services;
 - ii. Collection and submission of all quality performance measurement data required by the Department;
 - iii. Mechanisms to detect both underutilization and overutilization of services;
 - iv. Mechanisms to assess the quality and appropriateness of care for recipients;
 - v. Mechanisms to assess the quality and appropriateness of care provided to recipients needing home and community-based services for BH, I/DD, and TBI, including assessment of care between settings and a comparison of services and supports received with those set forth in the recipient's treatment/service plan;
 - vi. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group;
 - vii. Participation in efforts by the Department to prevent, detect, and remediate critical incidents; and
 - viii. Mechanisms to assess and address health disparities, including findings from the disparity report
4. The BH I/DD Tailored Plan shall participate in monthly BH I/DD Tailored Plan Quality Director Meetings.
5. The BH I/DD Tailored Plan shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.
6. The BH I/DD Tailored Plan shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of each BH I/DD Tailored Plan's overall QAPI program design as directed by the Department.
7. If the BH I/DD Tailored Plan selects a PIP that is relevant to its State-funded Services recipients, it should report its performance on quality measures that apply to both Medicaid and State-funded populations separately for each population.
8. How the BH I/DD Tailored Plan is addressing health disparities and incorporating health equity into their internal and external policies and procedures.

- vi. Quality Measures

- a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in *Section VII. First Revised and Restated Attachment E.2. BH I/DD Tailored Plan Quality Metrics for State-funded Services* that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and financial accountability for a select set of measures to be specified by the Department.
 - b) The BH I/DD Tailored Plan shall calculate and report on those measures identified by the Department in *Section VII. First Revised and Restated Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*. The Department will monitor other measures that are not designated in *Section VII. First Revised and Restated Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*, and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance reports. The Department reserves the right to add, remove, or modify measures in *Section VII. First Revised and Restated Attachment E. Table 2: Survey Measures and General Measures for State-funded Services*.
 - c) The BH I/DD Tailored Plan is financially accountable for measures indicated in *Section VI.A. Table 3: State-funded BH I/DD Tailored Plan Liquidated Damages for Performance Measures*. The Department reserves the right to add, remove, or modify measures in *Section VI.A. Table 3: State-funded BH I/DD Tailored Plan Liquidated Damages for Performance Measure*.
 - d) The BH I/DD Tailored Plan shall incorporate populations receiving State-funded Services into measures included in *Section VII. First Revised and Restated Attachment E: Tables 1-6 Survey Measures and General Measures for Medicaid* where applicable and shall stratify results of these measures to distinguish between Medicaid members and State-funded Services recipients.
 - e) The BH I/DD Tailored Plan shall submit to the Department all data necessary for the Department to calculate the BH I/DD Tailored Plan's performance on State-funded Services measures.
 - f) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plans prior to launch and annually thereafter.
 - g) The BH I/DD Tailored Plan shall, where applicable, incorporate populations receiving State-funded Services into their QAPI and quality improvement activities.
- vii. Measurement of Outcomes
- a) The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas of quality of life, functional status assessment and recipient satisfaction. This measurement will involve the use of surveys that may be administered by providers or third-party contractors and may involve the development and piloting of novel survey instruments.
 - b) The BH I/DD Tailored Plan shall support the administration of surveys as requested by the Department. This support may include conducting outreach to members and providers, incorporating in provider contracting requirements related to survey administration, and conducting analysis of internal data to support survey piloting, quality assurance, and performance improvement.
 - c) The BH I/DD Tailored Plan shall ensure administration of the NC-TOPPS interview tool to recipients in a form and manner specified by the Department.

- d) The Department is also exploring administrative data from other State agencies to support measurement of outcomes outside of the health care system for State-funded services recipients.
- viii. Disparities Reporting and Tracking
 - a) The BH I/DD Tailored Plan shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
 - 1. Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plan after Contract Award and annually thereafter.
 - b) The BH I/DD Tailored Plan shall address disparities as determined by the Department during review of the BH I/DD Tailored Plan's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.
 - 1. The Department will define the disparity strata to be applied for each measure after Contract Award and annually thereafter.
- ix. The BH I/DD Tailored Plan shall be an active partner in Healthy NC 2030 (<https://nciom.org/healthy-north-carolina-2030/>) goals' planning by participating at a minimum as follows:
 - a) Joining planning meetings;
 - b) Designating a senior level clinical staff person to engage in public health issue discussions; and
 - c) Aligning QI activities to support Healthy NC 2030 goals.
- x. Public Health Reporting and Tracking
 - a) The BH I/DD Tailored Plan shall work with the Department to target areas of collaboration and develop programs as part of Quality Improvement efforts that can:
 - 1. Performance Improvement Projects (PIPs)a)For Medicaid and NC Health Choice, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program. See Section V.B.5.i. (xiii) Performance Improvement Projects. For State Funded Services, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program, these PIPs not required to be conducted separate from Medicaid, data related to State Funded Services must be separated from Medicaid when the same PIP is conducted. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in the document. Remove barriers (e.g., services coverage, implementation challenges, recipient education); and
 - 2. Require select quality initiatives to be embedded in QAPIs, including PIPs.
- xi. Performance Improvement Projects (PIPs)
 - a) For Medicaid and NC Health Choice, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program. See *Section V.B.5.i. (xiii) Performance Improvement Projects*. For State Funded Services, the BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program, these PIPs not required to be conducted separate from Medicaid, data related to State Funded Services must be separated from Medicaid when the same PIP is conducted. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in the document.
 - b) To the extent that the BH I/DD Tailored Plan's Medicaid and NC Health Choice PIPs apply to non-clinical and clinical areas relevant to State-funded services, the BH I/DD Tailored Plan shall include State-funded services and recipients in the PIP. The BH I/DD Tailored Plan shall ensure the PIP:
 - 1. Is designed to achieve significant improvement in health outcomes as part of the annual BH I/DD Tailored Plan QAPI program review; and

- 2. Includes measurement of performance using quality indicators as part of the annual BH I/DD Tailored Plan QAPI program review.
 - c) Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
 - d) The BH I/DD Tailored Plan shall conduct at least one (1) non-clinical PIP on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
 - e) All BH I/DD Tailored Plans shall be required to develop and execute one (1) clinical performance improvement project annually that is related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional or ACH settings.
 - f) The BH I/DD Tailored Plan shall comply with validation and research activities related to surveys, including survey instruments under development, that are required by the Department.
 - xii. External Quality Review
 - a) The BH I/DD Tailored Plan shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO. This may include a consolidated approach assessing both Medicaid and State-funded Services.
 - b) The BH I/DD Tailored Plan shall participate in the annual Consumer Assessment of Healthcare Providers and Systems survey (CAHPS), Provider Survey , the Consumer Perception of Care survey, and the National Core Indicators (NCI) survey.
6. Claims Management
- a. Provider Claims
 - i. Claims Processing and Reprocessing Standards
 - a) The BH I/DD Tailored Plan shall have the automated capability to identify, process, and reprocess claims as required by this Contract. Prior to paying a claim, the BH I/DD Tailored Plan shall validate that the provider is eligible to be paid by the Department.
 - b) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the BH I/DD Tailored Plan's network and the Department or other investigatory agencies have not initiated a payment suspension or withhold.
 - c) The BH I/DD Tailored Plan shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.
 - ii. The BH I/DD Tailored Plan shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate recipient enrollment or program/service changes.
 - iii. The BH I/DD Tailored Plan shall capture and retain the IP address/location and the user login/user name for all claims submitted via an on-line portal.
 - iv. The BH I/DD Tailored Plan shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect.
 - v. Any denied claims billed shall be returned to the provider with an explanation for the denial.
 - b. BH I/DD Tailored Plan Submission of Claims
 - i. The Department collects and uses BH and I/DD service claims data for many purposes including, but not limited to, Federal reporting, budgeting, services verification, State-funded BH, I/DD, and TBI services quality improvement activity, fraud/waste/abuse monitoring, measurement of utilization patterns and access to care, and research studies.
 - ii. The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely claims data to support the administration, clinical operations, care

management, administrative policies, and financial responsibilities and objectives associated with State-funded BH, I/DD, and TBI services.

- iii. The BH I/DD Tailored Plan shall report all services provided using DMH funding (i.e., not Medicaid) through the NC Tracks claims system (or current State claims system), unless the BH I/DD Tailored Plan chooses to reimburse the provider for an allowable service or support that cannot otherwise be reported as a claim and which must be reported to the State on a non-UCR basis.
- iv. For services paid for pursuant to UCR-funded methodology, the BH I/DD Tailored Plan shall enroll members into the appropriate benefit plan and report service units to NC Tracks.
- v. The BH I/DD Tailored Plan shall report the claim through NC Tracks to capture service events regardless if the BH I/DD Tailored Plan does not reimburse providers on a FFS basis (e.g., case rates and other funding methods).
- vi. The BH I/DD Tailored Plan shall only bill the Department for the amount paid to the provider and shall not bill the state for an amount that exceeds the amount paid to the provider.
- vii. The BH I/DD Tailored Plan shall ensure that claims submission contains accurate and complete content to allow either (a) claims payment through the appropriate source of non-Medicaid federal funds- not included in single stream funding or (b) processing as shadow claims data that is accepted in NC Tracks (not denied).
- viii. The BH I/DD Tailored Plan shall adhere to requirements set forth in allocation letters, when such requirements are consistent with terms of the Contract.
- ix. The BH I/DD Tailored Plan shall be responsible for ensuring all recipients receiving State-funded Services possess a unique identifier that can be used to link and monitor transitions and service use between Medicaid and State-funded Services. The BH I/DD Tailored Plan shall check CNDS for existing identifier assignments prior to assigning a new identifier.
- x. Submission timeframes
 - a) The BH I/DD Tailored Plan shall submit to NC Tracks an electronic claim for every service reimbursed by the BH I/DD Tailored Plan:
 1. Within fifteen (15) Calendar Days of the close of the month in which the service was paid or processed, or
 2. The Department's timely filing deadline for prior year dates of service, whichever comes first.
- xi. The BH I/DD Tailored Plan shall correct ninety percent (90%) of claim denials in NC Tracks within thirty (30) Calendar Days and ninety five (95%) within forty-five (45) Calendar Days.
- xii. The BH I/DD Tailored Plan shall not be deemed in non-compliance with these standards if the issues cannot be corrected due to issues arising from NC Tracks.
- xiii. The BH I/DD Tailored Plan shall conduct data validation of all data it submits to NC Tracks.

7. Financial Requirements

a. Payment Plan

- i. The Department shall distribute to each BH I/DD Tailored Plan not less than one twelfth (1/12) of each BH I/DD Tailored Plan's Single Stream Fund (SSF) base allocation on a monthly basis, subject to adjustments and availability of funds allocated by the General Assembly for this purpose.
- ii. The Department shall distribute to each BH I/DD Tailored Plan other state funding, special categorical, and federal block grant funds according to the methodology outlined in related allocation letters. BH I/DD must comply with all terms and conditions set forth in related allocation letters.
- iii. The Department shall reimburse BH I/DD Tailored Plans for Non-UCR State Special Categorical funds and Non-UCR Federal funds after the BH I/DD Tailored Plan has expended the funds and reported the expenses on the Financial Status Report (FSR).

- iv. When Non-UCR funding is paid to providers under contract with the BH I/DD Tailored Plan, both the provider and the BH I/DD Tailored Plan must have incurred the expense prior to the BH I/DD Tailored Plan reporting the expenses to the Department.
- b. Services Funding
 - i. The BH I/DD Tailored Plan shall use State and federal non-Medicaid funds to purchase services included in the State-funded Service array, approved as an alternative service or as specified on the allocation letter.
 - ii. Non-UCR Expenditures
 - a) The BH I/DD Tailored Plan may choose to pay for unique services or fund innovative projects using funds that cannot be reported through the UCR/claims methodology
 - b) The BH I/DD Tailored Plan shall submit a non-UCR service request to the Department using the Department's template.
 - c) The Department intends to release further guidance on the UCR/claims methodology prior to BH I/DD Tailored Plan launch.
 - d) The Department shall ensure that non-UCR expenditures meet federal block grant requirements, including MOE.
 - e) If the non-UCR funds are in support of a service that is also eligible to bill through NC Tracks, the BH I/DD Tailored Plan shall assure that the combination of total UCR and non-UCR funding paid is no more than the actual cost of the service provided to State-funded Services recipients.
 - f) For Federal funds and Special Categorical State funds, the BH I/DD Tailored Plan shall submit the Fund Realignment Request Form to move funds from UCR to Non-UCR, with an explanation for the transfer attached.³⁸
 - 1. The Department shall issue an approval, denial or a request for more information regarding the Fund Realignment request within fifteen (15) Calendar Days of receipt.
 - 2. If no timely response is received, the BH I/DD Tailored Plan may proceed as if approved.
- c. Administrative Funding
 - i. The BH I/DD Tailored Plan shall be allowed to expend up to ten percent (10%) of the amount of SSF expended in that fiscal year on administrative expenses.
 - ii. Unless determined otherwise by the Department, the BH I/DD Tailored Plan is responsible for covering administrative costs related to management of the expenditures described in this Section within this amount, as well as BH I/DD Tailored Plan functions described more fully in this Scope of Services.
 - i. The BH I/DD Tailored Plan shall provide evidence of all administrative expenditures for each function listed above on the monthly Financial Reporting tool, and, upon request, provide backup documentation including its cost allocation methodology for administrative expenses across Medicaid and State-funded Services.
- d. Changes in Funding
 - i. The Department may adjust the State and federal funding in accordance with the formula used for BH I/DD Tailored Plans.
 - ii. Subject to funding source or other legal requirements, and as determined by the Department the BH I/DD Tailored Plan may, during the term of this Contract:
 - a) In the case of expansion of funding, use up to ten percent (10%) of expansion service funding for administrative expenses.
 - b) In the case of reduced or de-allocated funding, use up to ten percent (10%) of the expended amount for the year for administrative expenses.

³⁸ This form is also used to move funds between accounts or from Non-UCR to UCR.

- iii. In the event the Department receives an expansion or reduction in federal block grant funding, allocations to BH I/DD Tailored Plans may be adjusted by the Department in accordance with the requirements set forth by the grant award.
 - iv. The BH I/DD Tailored Plan shall follow the Department's currently approved block grant funding plans, and requirements set forth in the allocation letters.
 - e. Disallowances
 - i. Any funds or part thereof transferred by the Department to the BH I/DD Tailored Plan shall be subject to reimbursement by the BH I/DD Tailored Plan to the Department in the event the expenditure of those funds is disallowed pursuant to a State or federal audit.
 - ii. When those funds are disallowed by the Department, the BH I/DD Tailored Plan may recoup those funds back from the provider and the provider shall have no right of appeal.
 - f. Settlement Methodology
 - i. The Department shall provide guidance on the settlement process, including required documentation in advance of settlement review. A review will be scheduled upon completion of the BH I/DD Tailored Plan contracted certified external audit and the close of the timely filing deadline each year. The Department shall complete the written report and send to the BH I/DD Tailored Plan within one hundred twenty (120) days after the review is completed. As part of the settlement process:
 - a) The BH I/DD Tailored Plan shall submit all allowable SSF shadow and other UCR claims for the period July 1 through June 30 each fiscal year.
 - b) The BH I/DD Tailored Plan shall submit records of Non-UCR expenses as required by the Department.
 - ii. The BH I/DD Tailored Plan shall supply, in a timely manner, all documentation necessary to complete the settlement process. Failure to provide adequate documentation may result in settlement expenditure disallowances.
 - iii. The Department shall provide preliminary findings to the BH I/DD Tailored Plan in draft report format to provide the BH I/DD Tailored Plan with an opportunity ask questions and provide clarifying information including but not limited to additional documentation to the Department.
 - iv. If the final settlement report indicates that the BH I/DD Tailored Plan must submit a payback of funds, the resolution and appeals process will be conducted in accordance with G. S. 150B.
 - a) If a payback of funds is required, the BH I/DD Tailored Plan shall not use state single stream funding, block grant, or any other State-funded Service dollars to satisfy the payback of funds.
 - b) Contractor shall not reduce services as a result of having to submit any payback of funds.
 - v. The BH I/DD Tailored Plan shall cooperate with all financial requirements, monitoring and audits as requested by the Department.
 - g. Performance Monitoring
 - i. The BH I/DD Tailored plan shall cooperate with routine performance monitoring and audits, as well as targeted monitoring otherwise required by the Department. The Department shall provide guidance on the routine monitoring process, including required documentation in advance of review.
 - a) The BH I/DD Tailored Plan shall supply, in a timely manner, all documentation necessary to complete the routine or targeted monitoring.
 - b) If a monitoring or performance audit results in findings, refund or corrective action plan, the Department shall provide preliminary findings to the BH I/DD Tailored Plan in draft report format to provide the BH I/DD Tailored Plan with an opportunity ask questions and provide clarifying information including but not limited to additional documentation to the Department.

- c) Failure to provide adequate documentation may result in expenditure disallowances, corrective action plans, or any other remedies permitted by this document.
 - ii. If the final performance monitoring report indicates that the BH I/DD Tailored Plan must submit a payback of funds or take other actions, the resolution and appeals process will be conducted in accordance with G. S. 150B.
- h. Federal Grant Maintenance of Effort
 - i. The BH I/DD Tailored Plan shall meet or exceed the Department's designated MOE requirements necessary to meet federal grant requirements. Restrictions on the Expenditure of Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Funds and Community Mental Health Block Grant (CMHBG or MHBG) Funds
 - ii. The BH I/DD Tailored Plan not use CMHBG and SAPTBG funds to provide or purchase inpatient hospital services, except for SAPTBG funds that may be used as described in 45 CFR 96.135(c).
 - iii. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to make cash payments or allow the purchase of any cash equivalents (e.g., gift cards) for payments to or use by any recipients or intended recipients of BH and I/DD services.
 - iv. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.
 - v. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e., Federal funds may not be used to satisfy any condition for any State, local or other funding match requirement).
 - vi. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds to provide financial assistance to any entity other than a public or nonprofit private entity.
 - vii. The BH I/DD Tailored Plan shall not use CMHBG and SAPTBG funds towards the annual salary of any BH I/DD Tailored Plan, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.
 - viii. SAPTBG Restrictions
 - a) The BH I/DD Tailored Plan shall not use SAPTBG funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
 - b) The BH I/DD Tailored Plan shall not use SAPTBG funds to provide individuals with treatment services in penal or correctional institutions of the State.³⁹
 - ix. The BH I/DD Tailored Plan shall not use PATH formula grants funds:
 - a) For inpatient psychiatric treatment costs or inpatient substance abuse treatment costs;
 - b) To support emergency shelters or construction of housing facilities; or
 - c) To make cash payments or allow the purchase of any cash equivalents (e.g., gift cards) for payments to or use by any recipients or intended recipients of BH and I/DD services, except as permitted by 45 CFR § 96.135(a).
- i. Financial Viability
 - i. The BH I/DD Tailored Plan must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C.

³⁹ This includes jails, prisons, adult and juvenile detention centers and juvenile training centers.

- ii. The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund its BH I/DD Tailored Plan capital reserves at twelve and a half percent (12.5%)⁴⁰ of total expected annual BH I/DD Tailored Plan Medicaid capitation.
 - a) If a BH I/DD Tailored Plan fails to meet the Medicaid risk reserve standards outlined in *Section V.B.7.iii.(vii) Financial Viability* by Day 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan must submit a viable plan outlining how the BH I/DD Tailored Plan will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section V.A.1.vi. Readiness Review Requirements*.
 - iii. The BH I/DD Tailored Plan must, by at least ninety (90) days before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-110, contingent upon legislative authority.
 - iv. The BH I/DD Tailored Plan shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%). Financial reporting should be inclusive of both Medicaid and State funds.
 - v. The BH I/DD Tailored Plan shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as Cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the Period measured in days. Financial reporting should be inclusive of both Medicaid and State funds.
 - vi. The BH I/DD Tailored Plan shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.
 - vii. The Department may, at its discretion, implement a risk corridor program to provide additional protection to the BH I/DD Tailored Plan to address any uncertainty associated with pricing assumptions and access to additional capital for the BH I/DD Tailored Plan, compared to other commercial plans operating Medicaid Managed Care programs in North Carolina. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.
8. Technical Specifications
- a. Data Exchange Model
 - i. Electronic Data Interchange (EDI) and Other Integrations
 - a) Integrations between the BH I/DD Tailored Plan, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.
 - b) The BH I/DD Tailored Plan shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 142.308(d).

⁴⁰ 12.5% of expected annual BH I/DD Tailored Plan capitation is used as a proxy for appropriate Risk Based Capital (RBC) solvency standards. 300% RBC is approximately equal to 1.5 months of claims, or approximately 12.5%.

- c) If the BH I/DD Tailored Plan stores, transmits, or maintains data or information in an encrypted format, the BH I/DD Tailored Plan will, at the Department's request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
 - d) The BH I/DD Tailored Plan will work with the Department or its designated Vendor to establish and manage all integration.
 - e) Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the BH I/DD Tailored Plan's ability to deliver recipient services, it must be reported immediately. The BH I/DD Tailored Plan will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at its discretion will track issues reported by the BH I/DD Tailored Plan and may require a more comprehensive corrective action plan if the Department identifies trends in the BH I/DD Tailored Plan's performance.
- ii. Retransmissions
 - a) If the BH I/DD Tailored Plan receives an unintelligible transmission from the Department or Department vendor, the BH I/DD Tailored Plan will immediately notify the Department and the Department shall retransmit as soon as the errors are remediated.
 - b) If the BH I/DD Tailored Plan is notified by the Department or the Department's vendor of the receipt of an unintelligible transmission, the BH I/DD Tailored Plan shall retransmit as soon as the errors are remediated.
 - c) For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparseable xml, etc.), or is incomplete.
 - iii. Test Data Transmission
 - a) The BH I/DD Tailored Plan will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those needed for daily operations. This may include data exchanges between the Department and the BH I/DD Tailored Plan. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.
- b. Service Claims and Eligibility Data
 - i. The BH I/DD Tailored Plan shall have the ability to send and receive the current version of the HIPAA transactions including:
 - a) 834-recipient enrollment and eligibility maintenance
 - b) 835-Remittance advice
 - c) 837I-Institutional claims
 - d) 837P-Professional claims
 - e) 999-Batch acknowledgment for 5010 version
 - f) 270 Eligibility Request
 - g) 271 Eligibility Response
 - h) 276 Claim Status Request
 - i) 277 Claim Status Response
 - j) 277U (Unsolicited) Claim Status Response (pending claims)
 - c. Provider Identification Numbers (NPIs, APIs)
 - i. In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the BH I/DD Tailored Plan must assign unique identifiers to providers, including physicians, and

- must require that providers use these identifiers when submitting claims data to the BH I/DD Tailored Plan.
- ii. The BH I/DD Tailored Plan is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.
 - iii. The BH I/DD Tailored Plan shall include the NPI of the network provider on all claims data that is submitted to the Department.
- d. Provider Directory
- i. The BH I/DD Tailored Plan shall develop a Provider Directory in accordance with *Section V.C.4.b. Provider Network Management*.
 - a) The BH I/DD Tailored Plan should use the National Provider Identifier (NPI) enrolled with the Department as the unique provider identifier. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by NC DHHS' system should be used.
 - b) The BH I/DD Tailored Plan shall ensure the Provider Directory aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if the BH I/DD Tailored Plan delegates this activity to a Subcontractor
- e. Technology Documents
- i. The BH I/DD I/DD Tailored Plan shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.
 - ii. Security Compliance Plan: The BH I/DD Tailored Plan shall provide a plan that details how the BH I/DD Tailored Plan will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the Security Compliance Plan shall be updated annually and resubmitted to the Department for review. As long as the Security Compliance Plan, clearly states that it applies to the BH I/DD Tailored Plan, the Security Compliance Plan may apply to other LME/ MCO operations, including, without limitation, the PIHP. The plan must include at a minimum:
 - a) Approach to recipient data protection including internal programs and policies;
 - b) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
 - c) Approach to complying with HITECH and HIPAA;
 - d) Process and procedures necessary to comply with 42 CFR Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:
 1. Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 CFR Part 2; and
 2. Where appropriate, secure Recipient consent prior disclosing Recipient protected health information covered under 42 CFR Part 2 requirements and; establish functionality or procedures to remove or redact information protected by 42 CFR Part 2 prior to disclosure of the information.
 - e) Approach to risk analysis and assessment associate with NIST;
 - f) Processes for monitoring for monitoring for security vulnerabilities including the use of external organization such as US CERT;
 - g) Processes and plans for vulnerability and breach management including response processes; and
 - h) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software)

- iii. Claims Implementation Approach. The BH I/DD Tailored Plan shall provide a plan that shows how the BH I/DD Tailored Plan will implement its encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
 - a) Approach to meeting performance, accuracy, and timeliness requirements;
 - b) Operating model including staffing and technology to process and submit encounters;
 - c) Reference data management process including how the State's reference data (if applicable) will be integrated into the encounter management process;
 - d) Change management plan including how changes to the encounter submission infrastructure are tested and implemented; and
 - e) QA and Process improvement processes including how errors detected by the State's Processing System are addressed by the Applicant, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Applicant's processes.
- iv. System Interface Design. The BH I/DD Tailored Plan shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
 - a) Detailed design by interface showing the Applicant's approach to meeting the requirements defined by the State;
 - b) Approach to managing EDI transactions including technology;
 - c) Technical integration architecture including the Applicant's technical approach to integrating multiple internal systems with external partners;
 - d) Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
 - e) Software and platform testing processes for new interfaces including the data management approach.
- v. System Test Plan. The BH I/DD Tailored Plan shall develop and maintain a System Test Plan inclusive of the BH I/DD Tailored Plan's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. As long as the System Test Plan, clearly states that it apply to the BH I/DD Tailored Plan, the System Test Plan may apply to other LME/MCO operations, including, without limitation, the PIHP. The Test Plan shall be submitted to the Department annually at the end of each Contract Year by July 31 and otherwise upon request by the Department and shall include:
 - a) High level description of the scope of each testing phase;
 - b) Applications or Systems that are part of the testing;
 - c) Integrations that are part of the testing;
 - d) Testing techniques or tools that will be used for testing;
 - e) Test environment; and
 - f) Test metrics and reporting of defects.
- f. BH I/DD Tailored Plan Data Management and Health Information Systems
 - i. The following section contains high-level information on Health Information System and recipient data that will be established, maintained, analyzed, and reported by the BH I/DD Tailored Plan:
 - a) The BH I/DD Tailored Plan shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the BH I/DD Tailored Plan 's

operations as well as satisfying the reporting requirements detailed in this RFA which may include but are not limited to utilization, claims, grievances and appeals.

- b) The BH I/DD Tailored Plan shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act.
 - c) The BH I/DD Tailored Plan shall collect and maintain data on recipient and provider characteristics and interactions as specified by the state and on all services furnished to recipients through a claims processing system or other methods as specified by the Department.
 - d) All data, reports, and information submitted by the BH I/DD Tailored Plan on behalf of the Providers (including Providers within or outside of its networks) shall be validated by the BH I/DD Tailored Plan as accurate and complete prior to submission.
 - e) The BH I/DD Tailored Plan shall collect data from Providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
 - f) The BH I/DD Tailored Plan shall make all collected data available to the Department.
 - g) Specific reporting requirements are set for in *Section VII. First Revised and Restated Attachment J. Reporting Requirements.*
- g. Test Environments
- i. The Contractor shall have at least two (2) dedicated testing environments – one (1) for Systems Integration Testing, and one (1) for End to End testing. The environments shall use the appropriate data sets (production or synthetic) as defined by the Department.
 - ii. The Contractor shall ensure test environments are compliant with all security requirements defined by North Carolina State and the Department’s Privacy and Security Office to support testing with production data.
 - iii. The Contractor shall have test environments available and configured within one hundred twenty (120) days of the Department’s written notice.
 - iv. The Contractor shall have the ability to refresh test environments from production data as needed for testing, as well as the ability and capacity to ingest production sized files with limited to no down time.

VI. Contract Performance for Medicaid and State-funded Services

A. Contract Compliance and Performance

1. The Contractor shall comply with all terms, conditions, requirements, performance standards as set forth in the Contract and any amendments thereto, including any rules, policies, or procedures incorporated pursuant to the Contract, as well as all applicable laws and regulations.
2. The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity including but not limited to, remedial actions, intermediate sanctions, liquidated damages, and/or termination of the Contract in the event that the Department determines, in its sole discretion, that the Contractor has violated any provision of the Contract, or if the Contractor does not comply with any other applicable North Carolina or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract, which shall include, but may not be limited to the following:
 - a. Fails substantially to provide medically necessary covered services;
 - b. Imposes on members and recipients’ premiums or cost share that are in excess of the premiums or cost share permitted by the Department;

- c. Acts to discriminate among members and recipients on the basis of their health status or need for health care services;⁴¹
 - d. Misrepresents or falsifies information that it furnishes to CMS, SAMHSA, or to the State;
 - e. Misrepresents or falsifies information that it furnishes to a member or recipient, potential member or recipient, or provider;
 - f. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information;
 - g. For Medicaid only:
 - i. Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations;
 - ii. Fails to comply with the requirements for physician incentive plans as required by 42 C.F.R. §§ 422.208 and 422.210; or
 - h. For State-funded Services only:
Violates any of the other applicable requirements of the Substance Abuse Prevention and Treatment Block Grant, Community Mental Health Services Block Grant, or State law or regulations related State-funded Services.
3. Risk Level Assignment
- a. Upon the discovery of a violation of the terms, conditions, or requirements of this Contract or of applicable law (each considered a “Violation”), the Department shall assign the Violation into one of four risk levels:
 - i. **Level 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members’ or recipients’ access to care or services; and/or jeopardize the integrity of Medicaid Managed Care or State-funded Services.
 - ii. **Level 2:** Action(s) or inaction(s) that jeopardize the integrity of Medicaid Managed Care or State-funded Services but does not necessarily jeopardize member(s) or recipients(s) health, safety, and welfare or reduces access to care.
 - iii. **Level 3:** Action(s) or inaction(s) that diminish the effective oversight and administration of Medicaid Managed Care or State-funded Services.
 - iv. **Level 4:** Action(s) or inaction(s) that inhibit the efficient operation of Medicaid Managed Care or the provision of State-funded Services.
 - b. The Department’s decision to impose specific remedial action(s), intermediate sanction(s) and/or liquidated damages against the Contractor will include consideration of some or all of the following factors:
 - i. Risk Level assignment
 - ii. The nature, severity, and duration of the violation;
 - iii. The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, Program Integrity);
 - iv. Whether the Violation resulted from negligent or willful conduct;
 - v. Whether the violation (or one that is substantially similar) has previously occurred;
 - vi. The timeliness in which the Contractor self-reports a violation;
 - vii. The Contractor’s history of compliance;

⁴¹ This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services. 42 C.F.R. § 438.700(b)(3).

- viii. The good faith exercised by the Contractor in attempting to stay in compliance (including self-reporting by the Contractor); or
 - ix. Any other factor the Department deems relevant based on the nature of the violation.
 - x. The Department may impose additional remedial actions, intermediate sanctions, or liquidated damages if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.
 - xi. The Department also may elevate the violation to a higher Risk Level if the same noncompliant behavior continues, or if the Contractor fails to comply with the originally imposed action.
- c. Additional detail on risk level assignment is included in *Section VII. First Revised and Restated Attachment K. Risk Level Matrix for Medicaid and State-funded Services*.

B. Notice of Deficiency

1. Except for the appointment of temporary management imposed pursuant to the Contract, the Department shall provide the Contractor with written notice of any remedial action, intermediate sanction, or liquidated damages against the Contractor or termination of the Contract for cause, detailing the nature of the Violation or noncompliance, the risk level assigned to the Violation, any actions the Department seeks to impose against the Contractor, and, if applicable, the method and timeframes by which the Contractor may dispute the claim of the Violation or noncompliance and the imposed actions.
2. Within three (3) Business Days of full remediation of the identified Violation(s) in the Notice of Deficiency, or within another timeframe as requested by the Department, the Contractor shall provide the Department with written notice confirming the date that the Violation or noncompliance was resolved and the actions the Contractor took to remediate the Violation or noncompliance.

C. Remedial Actions

1. **Remedial Actions:** Prior to the imposition of intermediate sanctions or liquidated damages or contemporaneously with, if the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may require the Contractor to take or to engage in the following remedial actions to address identified violation(s) or other noncompliance:
 - a. Immediate remediation of the Violation or non-compliant behavior or practice, as determined by the Department, in a manner consistent with the nature of the Violation or noncompliance;
 - b. Submission and implementation of a Corrective Action Plan; or
 - c. Participation in additional education or training.
2. **Corrective Action Plans (CAPs):** Contractor shall accept and implement a Department defined CAP or develop a CAP for Department approval as required in this Section.
 - a. Following notification of the original Violation giving rise to the CAP, the Contractor shall immediately cease the noncompliant behavior and take actions to mitigate the harm caused by the Violation until an approved CAP is implemented.
 - b. Any CAP required to be submitted by the Contractor shall, at a minimum, identify the following:
 - i. The Violation or finding resulting in a request for corrective action by the Department;
 - ii. A description of how the Violation or finding resulting in a request for corrective action will be remediated;

- iii. The timeline for the implementation and completion of each corrective action(s) included in the CAP; and
 - iv. The name of the responsible person(s) who will lead each of the corrective action activities and the person responsible for the overall implementation of the CAP.
 - c. Any CAP submitted by the Contractor shall be subject to approval by the Department.
 - d. The Contractor shall submit the CAP within fifteen (15) Calendar Days, or another timeframe as determined by the Department depending on the nature of the Violation, from the date of the Notice of Deficiency requiring the CAP.
 - e. Upon receipt, the Department may accept the CAP as submitted, accept the CAP with specified modifications, or reject the CAP.
 - f. If the Department requests modifications or rejects the CAP, the Contractor shall revise or submit a new CAP within ten (10) Calendar Days, or, depending on the nature of the violation, within a timeframe determined by the Department that addresses the concerns identified.
 - g. The Contractor shall complete the corrective action(s) contained in the CAP within the time period approved by the Department.
 - h. The Contractor shall provide updates to the Department on the implementation of the CAP and the remediation of the findings resulting in the CAP at the interval requested by the Department.
- 3. **Effective Date of Remedial Actions**
 - a. The effective date for any required remedial action is the date of the written Notice of Deficiency. Any time frames regarding Contractor action will be calculated from the date of the Notice of Deficiency.
 - b. A remedial action is not contestable under the dispute resolution process described in this Section, and the Contractor shall be required to complete the remedial action within the timeframe provided in the Notice of Deficiency, except for a requirement to submit and implement a CAP that shall be completed in accordance with Contract requirements.

D. Intermediate Sanctions

- 1. **Imposition:** If the Department, in its sole discretion, determines that the Contractor is in violation of the Contract or any other applicable law, the Department may impose the following intermediate sanctions against the Contractor:
 - a. Suspension, recoupment, or withholding of payment;
 - b. Suspension of all or part of marketing activities;
 - c. Suspension of part of the Contract;
 - d. Exclusion from participation in Medicaid Managed Care and/or State-funded Services;
 - e. Any other additional sanctions allowed under North Carolina or federal law or regulation; or
 - f. For Medicaid only:
 - i. Civil Monetary Penalties (CMP) in accordance with 42 C.F.R. § 438.704;
 - ii. Appointment of temporary management of the Contractor in accordance with 42 C.F.R. § 438.706(a);⁴²
 - iii. Notification to members of their right to terminate their enrollment with the Contractor without cause;
 - iv. Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction;

⁴² If the Department imposes temporary management because the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. Part 438, the Department will notify affected members of their right to terminate enrollment in the Contractor without cause.

2. **Effective Date of Intermediate Sanctions**

- a. If the Contractor elects not to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day following the expiration of the period to dispute or such other date determined by the Department and included in the written Notice of Deficiency.
- b. If the Contractor elects to dispute the imposition of an intermediate sanction as provided in the Contract, the imposed sanction shall become effective the next calendar day of the date on the written final decision issued by the Department.
- c. The Department shall not be required to delay the appointment of temporary management to provide the Contractor the opportunity to dispute the imposition of the sanction before imposing temporary management. The Department shall not terminate temporary management until it determines that the Contractor can ensure that the noncompliant behavior resulting in the temporary management will not reoccur.

E. Liquidated Damages

1. If the Contractor is determined by the Department, in its sole discretion, to be in violation with the terms, conditions, requirements, and/or performance standards of the Contract, it is presumed by the Contractor that the Department will be harmed, and the Department shall be entitled to monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.
2. The actual damage sustained by the Department as a result of the Contractor's failure to meet the requirements of this Contract will be extremely difficult or impossible to ascertain with precise accuracy. Therefore, the Department and the Contractor agree that if the Contractor is in violation of the terms, conditions, requirements and/or performance standards of the Contract, the Department may assess liquidated damages against the Contractor in accordance with the Contract.
3. Following receipt of a Notice of Deficiency assessing liquidated damages, the Department may continue to assess damages in accordance with the Contract until such time as the Department, in its sole discretion, determines the Violation(s) has been cured.
4. The Department, in its sole discretion, reserves the right to assess a general liquidated damage in an amount commensurate with the Violation, as applicable, for any violation not specifically listed in *Section VII. First Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*; provided, however, that no violation of any Contract requirement related solely to State-funded Services not specifically listed in *Section VII. First Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages* shall exceed on hundred, twenty-five dollars (\$125.00) per day, per occurrence, and/or per member.
5. Liquidated damages assessed by the Department do not affect the Contractor's rights or obligations with respect to any third-party including beneficiaries or providers.

F. Payment of Liquidated Damages and other Monetary Sanctions

1. If the Contractor elects not to dispute the assessment of liquidated damages or other monetary sanctions, the assessed amounts shall be due and payable within fifteen (15) Calendar Days of the date of the written Notice of Deficiency assessing the liquidated damages or other monetary sanctions.
2. If the Contractor elects to dispute the assessment of liquidated damages or other monetary sanctions, but does not prevail, the liquidated damages or other monetary sanctions shall be due and payable within ten (10) Calendar Days of the date on the written notice of the final decision issued by the Department upholding its original decision to impose the liquidated damages or other monetary sanctions (including a final decision modifying the amount owed).

3. If the Contractor fails to pay liquidated damages or other monetary sanctions by the applicable due date, the Contractor shall be subject to interest and a late payment penalty in accordance with N.C. Gen. Stat. § 147-86.23 and N.C. Gen. Stat. § 105.241.21 until the past due amount is paid.
4. The Department shall reserve the right to recoup any monies owed to the Department from assessed liquidated damages or other monetary sanctions by withholding the amount (including interest and late payment penalties) from future payments owed to the Contractor. The Department shall provide written notice to the Contractor prior to withholding a portion of the payment for assessed liquidated damages or other monetary sanctions. For Medicaid only, actions taken by the Department to withhold a portion of a capitation payment for assessed liquidated damages or other monetary sanctions shall not be considered a withhold arrangement as defined in 42 C.F.R. § 438.6(a).
5. For State-funded Services, the Contractor shall not use state single stream funding, block grant, or any other State-funded Service dollars to pay for the assessed liquidated damage, nor shall Contractor reduce services as a result of having liquidated damages assessed against it to pay for the assessed liquidated damage.

G. Dispute Resolution for Contract Performance

1. The Contractor shall exhaust the dispute resolution process described in this Section to dispute the imposition of intermediate sanctions, the assessment of liquidated damages, CAPs, and/or for cause termination of the Contract whether pursuant to 42 C.F.R. § 438.708 (for Medicaid Services) or otherwise by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.
2. The Contractor shall have the right to dispute certain contract performance actions by the Department, including the imposition of CAPs, intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the Contractor shall not have the right to dispute the Department's decision to require the Contractor to perform a remedial action.
3. **Dispute Resolution Procedures**
 - a. To initiate a dispute, the Contractor shall submit a written request for a dispute resolution within fifteen (15) Calendar Days of the date of the Notice of Deficiency imposing the Department's intended action. The Department may extend the Contractor's deadline to request dispute resolution for good cause if the Contractor requests an extension within ten (10) Calendar Days of the date on the written notice.
 - b. The Contractor shall include in the written request for dispute resolution all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits).
 - c. The Contractor waives any dispute not raised within thirty (30) Calendar Days of the date of the Notice of Deficiency, unless the Department grants an extension.
 - d. The Contractor also waives any arguments, materials, data, and information it fails to raise in writing within thirty (30) Calendar Days (unless the Department grants an extension) of the date of the Notice of Deficiency for dispute resolution and in any subsequent legal, equitable, or administrative proceeding (to include the Office of Administrative Hearings, NC Superior Court, or federal court).
 - e. The Department shall review the dispute resolution request and any evidence and information submitted and issue a written final decision within sixty-five (65) Calendar Days of the Contractor's request for dispute resolution. The Department shall have the right to extend its deadline to issue the final decision for good cause and shall notify the Contractor of any extension and the reason for such extension.

- f. The final decision issued by the Department following dispute resolution shall not be subject to further review or appeal within the Department.
4. **For Medicaid Only: Hearing Prior to Termination of Contract with Cause**
 - a. The Contractor shall be entitled to a hearing only in the event that the Department seeks to terminate its Contract for cause pursuant to 42 C.F.R. § 438.708 as provided in the Termination for Cause Section of the Contract.
 - b. At least fifteen (15) Calendar Days prior to the hearing, the Contractor shall receive written notice of the hearing that includes the date, time, place, nature of the hearing, and whether the hearing shall be held in-person or by telephone.
 - c. The hearing may be conducted even if the Contractor fails to appear at the hearing after receiving proper notice.
 - d. At the hearing, the burden shall be on the Contractor to demonstrate that the Department's decision to terminate the Contract with cause pursuant to 42 C.F.R. § 438.708 should be reversed.
 - e. Following the hearing, the Contractor shall receive a written final decision within sixty-five (65) Calendar Days of the date of the scheduled hearing, unless the deadline to issue the final decision is extended for good cause. If the deadline is extended, the Contractor shall be notified of the extension and the reason for such extension.
 - f. In a final decision affirming termination of the Contract, the Department shall provide the effective date for termination to the Contractor, and give the Contractor's members and recipients notice of the termination and information, consistent with 42 C.F.R. § 438.10, of their options for receiving Medicaid or State-funded Services after the Contract is terminated.
5. **Legal Representative:** The Department and the Contractor may be represented by legal counsel throughout the dispute resolution process.

H. Notice to External Agencies

1. **For Medicaid Only:** The Department shall provide written notice to CMS in accordance with 42 C.F.R. § 438.724 no later than thirty (30) Calendar Days after the Department imposes or lifts an intermediate sanction for any violation described in 42 C.F.R. § 438.700.
2. The Department shall provide notice as required by law to any other state or federal agency for Violations of the terms, conditions, or requirements of this Contract or applicable laws or regulations by the Contractor.

I. Publication of Contract Compliance Issues

1. The Department may publish on its website on a quarterly basis a list of Contractors subject to remedial action(s), intermediate sanction(s) and/or liquidated damages during the prior quarter, the risk level assigned to Violation(s), the type of actions imposed on the Contractor, and the basis for the actions taken by the Department.
2. The Department shall not publish, as final, any actions that are under dispute with the Contractor or any remedial action(s), intermediate sanction(s) and/or liquidated damages that have been waived or lifted by the Department.

J. Right to Waive or Modify

The Department, in its sole discretion, may waive, modify, or lift the imposition of any action taken against a Contractor for any good cause as determined by the Department, which includes the right of the Department to suspend the imposition of a remedial action, liquidated damages, or an intermediate

sanction while the Contractor works to resolve the underlying Violation that resulted in the action taken by the Department.

K. Performance Standards and Service Level Agreements

1. The Department has established performance standards for the measures listed in Tables 3-5 of *Section VII. First Revised and Restated Attachment P. Performance Metrics, Services Level Agreements and Liquidated Damages* and corresponding liquidated damages for any performance standard that is not met.
2. The Contractor shall meet the requirements of the Contract, including the performance standards and service level agreements specified in *Section VII. First Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages*.
3. If the Contractor fails to meet any performance standard, the Department may assess liquidated damages as provided in *Section VI. Contract Performance for Medicaid and State-funded Services*, and for Medicaid, impose any other remedial action or intermediate sanction, in accordance with *Section VI. Contract Performance for Medicaid and State-funded Services* for the period in which the deficiency occurs and until the Department, in its sole discretion, determines the deficiency has been cured.

L. Withholds for Medicaid

1. The BH I/DD Tailored Plan shall participate in the Department's withhold program.
2. The withhold program will conform to 42 C.F.R. § 438.6.
3. The withhold program will be effective eighteen (18) months following the date of Standard Plan launch, or at a later date as determined by the Department.

First Revised and Restated Request for Application 30-2020-052-DHB BH I/DD Tailored Plan, Section VII. RFA Attachments

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Second Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services

The Department requires that the BH I/DD Tailored Plan staff the following roles to fulfill the requirements of the North Carolina Medicaid Managed Care Program and/or State-funded Services.

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	<ul style="list-style-type: none"> N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	<p>These individuals are responsible for overseeing assigned care managers.</p> <p>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.</p> <p>For Medicaid, these individuals are responsible for ensuring fidelity to the Tailored Care Management model.</p> <p>For State-funded Services, this position only services recipients with I/DD and TBI.</p>	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements If serving members with BH conditions, must: <ul style="list-style-type: none"> 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) 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: <ul style="list-style-type: none"> A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<p>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</p> <ul style="list-style-type: none"> ○ A Master’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 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	<p>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.</p> <p>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</p>	<ul style="list-style-type: none"> ● Must meet North Carolina Residency requirements ● Must be a Master’s level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or RN ● Must have three (3) years of supervisory experience working directly with complex individuals with a BH condition

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	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.	
4. Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	<p>For Medicaid, these individuals shall be responsible for providing integrated whole-person care management under the Tailored Care Management model, including coordinating across physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.</p> <p>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.</p>	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must hold 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. • 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

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements
6. Full-Time Transition Supervisor(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements Must meet the care manager supervisor qualifications described above and outlined in <i>Section V.B.3.ii.(xiv)(c) Care Manager Qualifications</i>. BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
7. Full-Time Transition Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	<p>This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements <p>Transition Coordinators serving individuals with SMI:</p> <ul style="list-style-type: none"> 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.

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<p>Transition Coordinators serving individuals with I/DD or TBI:</p> <ul style="list-style-type: none"> • Must hold a Master’s degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD or TBI; or • Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
8. Full-Time Peer Support Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members and recipients with BH diagnoses residing in a state psychiatric hospital or an ACH.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must have NC Certified Peer Support Specialist Program Certification
9. Full-Time In-Reach Specialist(s) for North Carolina Medicaid Managed Care Program	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must hold a Bachelor’s degree in a human services field • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<ul style="list-style-type: none"> BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff
10. Diversion Specialist(s) for State-Funded Services	These individuals are responsible for performing diversion functions and activities described in <i>Section V.C.3.d.iv. Diversion Activities</i> for recipients eligible to receive diversion services as described in <i>Section.V.C.3.d.ii. Eligibility for Diversion</i> .	Diversion Specialists: <ul style="list-style-type: none"> Must meet North Carolina Residency requirements 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 one (1) year prior 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.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements Must hold high school diploma or GED Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid or State-funded BH services
12. System of Care Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan’s core System of Care functions.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements Must hold: <ul style="list-style-type: none"> a Master’s degree in a human services field plus two (2) years of experience working in

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<ul style="list-style-type: none"> or with child public service systems; or ○ a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems
<p>13. DSOHF Admission Through Discharge Manager for North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>These individuals are responsible for:</p> <ul style="list-style-type: none"> • Coordinating and/or performing transition functions and activities described in <i>Section V.B.3.viii.(iv)</i> and <i>Section V.C.3.e.iv</i> 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 <i>Section V.B.3.viii.(iv)</i> and <i>Section V.C.3.e.iv</i> <p>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.</p>	<p>DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals:</p> <ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. <p>DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers:</p> <ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must hold: <ul style="list-style-type: none"> ○ a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; ○ a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<ul style="list-style-type: none"> ○ 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.	<ul style="list-style-type: none"> ● Must meet North Carolina Residency requirements
15. Member and Recipient Complaint and Grievance Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates member and recipient complaints and grievances in a timely manner.	<ul style="list-style-type: none"> ● Must meet North Carolina Residency requirements
16. Full-Time Member and Recipient Complaint and Grievance Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient complaints and grievances in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> ● For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing complaints and grievances
17. Full-Time Peer Review and/or Member and Recipient Appeal Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient appeals in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> ● Peer reviewers must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing appeals
18. Full-Time Member and Recipient Services and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communication with members and recipients.	<ul style="list-style-type: none"> ● Must meet North Carolina Residency requirements

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
19. Provider Relations and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communications between the BH I/DD Tailored Plan and providers.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements
20. Provider Network Relations Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals support the Provider Network Director in network development and management.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements
21. Provider Complaint, Grievance, and Appeal Coordinator for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements
22. Pharmacy Director for the Pharmacy Service Line for the North Carolina Medicaid Managed Care Program	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • Must be a North Carolina registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
23. Full-Time Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	<ul style="list-style-type: none"> • 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 Program and State-funded Services	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements • 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. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
25. PBM Liaison for the North Carolina Medicaid Managed Care Program	If the BH I/DD Tailored Plan partners with a third-party PBM, this individual serves as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements
27. Reserved.	N/A	N/A
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.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements
29. Special Investigations Unit (SIU) Lead for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	<ul style="list-style-type: none"> Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, or pre-law, or have at least five (5) years of relevant experience Must complete CLEAR training or provide a timeframe as to when it will be complete
30. Special Investigations Unit (SIU) Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	<ul style="list-style-type: none"> Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law, or criminal justice, have at least three (3) years of relevant experience

Section VII. Second Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
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.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements
32. Waiver Contract Manager for the North Carolina Medicaid Managed Care Program	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1115 Waiver and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements Minimum of seven (7) years of management experience, preferably in human services

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

First Revised and Restated Attachment B. Table 1: Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies 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. First Revised and Restated 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 1L-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. First Revised and Restated 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. First Revised and Restated 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	<p>SSA, Title XIX, Section 1905(a)(9)</p> <p>42 C.F.R. § 440.90</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4</p> <p>NC Health Choice State Plan Section 6.2.5 NC Clinical Coverage Policy 1D-1, Refugee Health Assessments Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments</p> <p>NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments</p>	YES	YES
Dietary Evaluation and Counseling and Medical Lactation Services	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c)</p> <p>NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services</p>	YES	YES
Durable medical equipment (DME)	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3</p> <p>NC Health Choice State Plan Section 6.2.12, 6.2.13</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies</p>	YES	YES

Section VII. First Revised and Restated 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
	<p>NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies</p> <p>NC Clinical Coverage Policy 5B, Orthotics & Prosthetics</p>		
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	<p>SSA, Title XIX, Section 1905(a)(4)(B)</p> <p>42 U.S.C. 1396(d)(r)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p> <p>NC Clinical Coverage EPSDT Policy Instructions</p> <p><i>Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members</i></p>	YES	NO
Family planning services	<p>SSA Title XIX, Section 1905(a)(4)(C)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p> <p>NC Health Choice State Plan Section 6.2.9</p> <p>NC Clinical Coverage Policy 1E-7, Family Planning Services</p>	YES	YES
Federally qualified health center (FQHC) services	<p>SSA, Title XIX, Section 1905(a)(2) (C)</p> <p>42 C.F.R. § 405.2411</p> <p>42 C.F.R. § 405.2463 42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p>	YES	YES

Section VII. First Revised and Restated 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	YES	YES
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.I, Pages 13, 13a-13a.4	YES	YES

Section VII. First Revised and Restated 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. First Revised and Restated 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
	<p>North Carolina Medicaid State Plan, Att. 3.1-E</p> <p>NC Health Choice State Plan, Section 6.2.1</p> <p>NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services</p> <p>NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services</p> <p>NC Clinical Coverage Policy 2A-3, Out of State Services</p>		
Inpatient psychiatric services for individuals under age 21	<p>SSA, Title XIX, Section 1905(a)(16)</p> <p>42 C.F.R. § 440.160</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17</p> <p>NC Health Choice State Plan Section 6.2.10</p> <p>NC Clinical Coverage Policy 8B, Inpatient BH Services</p>	YES	YES
Inpatient and Outpatient BH services (Covered by both Medicaid and NCHC)	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35</p> <p>NC Health Choice State Plan Sections 6.2.11, 6.2.18, 6.2.19</p> <p>NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed:</p> <p>Mobile Crisis Management</p> <p>Diagnostic Assessment</p>	YES	YES

Section VII. First Revised and Restated 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. First Revised and Restated 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
	<p>NC Clinical Coverage Policy 8G – Peer Supports</p> <p>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)</p>		
Laboratory and X-ray services	<p>42 C.F.R. § 410.32</p> <p>42 C.F.R. § 440.30</p> <p>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</p> <p>NC Health Choice State Plan, Section 6.2.8</p> <p>NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing</p> <p>NC Clinical Coverage Policy 1S-2, HIV Tropism Assay</p> <p>NC Clinical Coverage Policy 1S-3, Laboratory Services</p> <p>NC Clinical Coverage Policy 1S-4, Genetic Testing</p> <p>NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring</p> <p>NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures</p>	YES	YES

Section VII. First Revised and Restated 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
	<p>NC Clinical Coverage Policy 1K-2, Bone Mass Measurement</p> <p>NC Clinical Coverage Policy 1K-6, Radiation Oncology</p> <p>NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services</p>		
Maternal Support Services	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1)</p> <p>NC Clinical Coverage Policy 1M-2, Childbirth Education</p> <p>NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention</p> <p>NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment</p> <p>NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care</p> <p>NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit</p>	YES	NO
Non-emergent transportation to medical care	<p>42 C.F.R. § 431.53</p> <p>42 C.F.R. § 440.170</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18</p> <p>Non-Emergency Medical Transportation Managed Care Policy</p>	YES	NO
Nursing facility services	<p>SSA, Title XIX, Section 1905(a)(4)(A)</p> <p>42 C.F.R. §440.40</p>	YES	YES

Section VII. First Revised and Restated 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
	<p>42 C.F.R. §440.140</p> <p>42 C.F.R. §440.155</p> <p>NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9</p> <p>NC Clinical Coverage Policy 2B-1, Nursing Facility Services</p> <p>NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities</p>		
Obstetrics	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)</p> <p>NC Clinical Coverage Policy 1E-3, Sterilization Procedures</p> <p>NC Clinical Coverage Policy 1E-4, Fetal Surveillance</p> <p>NC Clinical Coverage Policy 1E-5, Obstetrics</p> <p>NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home</p>	YES	NO
Occupational therapy	<p>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</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.24</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p>	YES	YES

Section VII. First Revised and Restated 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. First Revised and Restated 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
	<ul style="list-style-type: none"> • 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. First Revised and Restated 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	<p>North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h</p> <p>NC Clinical Coverage Policy 9, Outpatient Pharmacy Program</p> <p>NC Clinical Coverage Policy 9A, Over-the-Counter-Products</p> <p>NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program</p> <p>NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17</p> <p>NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older</p>	YES	YES
Physical therapy	<p>SSA, Title XIX, Section 1905(a)(11)</p> <p>42 C.F.R. § 440.110</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 5A, Durable Medical Equipment</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p> <p>NC Clinical Coverage Policy 10B, Independent Practitioners (IP)</p>	YES	YES

Section VII. First Revised and Restated 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.I, 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. First Revised and Restated 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. First Revised and Restated 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 Dilatation		

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SERVICE	KEY REFERENCES^{1,2}	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	<p>NC Clinical Coverage Policy 1B, Physician's Drug Program</p> <p>NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty</p>		
Podiatry services	<p>SSA, Title XIX, Section 1905(a)(5)</p> <p>42 C.F.R. § 440.60</p> <p>G.S. § 90-202.2</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a</p> <p>NC Clinical Coverage Policy 1C-1, Podiatry Services</p> <p>NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care</p>	YES	YES
Prescription drugs and medication management	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 440.120</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h</p> <p>NC Health Choice State Plan, Sections 6.2.6, 6.2.7</p> <p>NC Preferred Drug List</p> <p>NC Beneficiary Management Lock-In Program</p> <p>NC Clinical Coverage Policy 9, Outpatient Pharmacy Program</p> <p>NC Clinical Coverage Policy 9A, Over-The-Counter Products</p>	YES	YES

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SERVICE	KEY REFERENCES ^{1,2}	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	<p>NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program</p> <p>NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures</p> <p>NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17</p> <p>NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters <i>Section V.B.2.iii. Pharmacy Benefits</i> of the Contract</p>		
Private duty nursing services (PDN)	<p>SSA, Title XIX, Section 1905(a)(8)</p> <p>42 C.F.R. § 440.80</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b</p> <p>NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older</p> <p>NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age</p>	YES	NO
Prosthetics, orthotics and supplies	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 440.120</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b</p>	YES	YES

Section VII. First Revised and Restated 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

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SERVICE	KEY REFERENCES^{1,2}	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1</p> <p>NC Health Choice State Plan Section 6.2.5</p> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>		
Services for individuals age 65 or older in an institution for mental disease (IMD)	<p>SSA, Title XIX, Section 1905(a)(14)</p> <p>42 C.F.R. § 440.140</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b</p> <p>NC Clinical Coverage Policy 8B, Inpatient BH Services</p>	YES	NO
Speech, hearing and language disorder services	<p>42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16</p> <p>NC Health Choice State Plan Sections 6.2.14, 6.2.22</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p> <p>NC Clinical Coverage Policy 10B, Independent Practitioners (IP)</p>	YES	YES
Telehealth, Virtual Patient Communications and Remote Patient Monitoring	<p>42 C.F.R. § 410.78</p> <p>NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring</p>	YES	YES

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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

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SERVICE	KEY REFERENCES ^{1,2}	COVERED BY	
		MEDICAID	NC HEALTH CHOICE
	<p>for Multiple Myeloma and Primary Amyloidosis</p> <p>NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms</p> <p>NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma</p> <p>NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin’s Lymphoma</p> <p>NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells</p> <p>NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood</p> <p>NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)</p> <p>NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy</p> <p>NC Clinical Coverage Policy 11B-1, Lung Transplantation</p>		

Section VII. First Revised and Restated 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
	<p>NC Clinical Coverage Policy 11B-2, Heart Transplantation</p> <p>NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation</p> <p>NC Clinical Coverage Policy 11B-4, Kidney Transplantation</p> <p>NC Clinical Coverage Policy 11B-5, Liver Transplantation</p> <p>NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation</p> <p>NC Clinical Coverage Policy 11B-7, Pancreas Transplant</p> <p>NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants</p>		
Ventricular Assist Device	<p>North Carolina Medicaid State Plan, Att. 3.1-E, Page 2</p> <p>NC Clinical Coverage Policy 11C, Ventricular Assist Device</p>	YES	YES
Vision Services	<p>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</p> <p>NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21</p> <p>NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older</p>	YES	YES

First Revised and Restated Attachment C. Approved Behavioral Health In Lieu of Services for Medicaid

Section VII. First Revised and Restated Attachment C. Table 1: Department-Approved Behavioral Health In Lieu of Services for Medicaid lists 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. First Revised Attachment C. Table 1: Department-Approved Behavioral Health In Lieu of Services for Medicaid
<ul style="list-style-type: none">• Behavioral Health Urgent Care/ Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)• Institution for Mental Disease for acute psychiatric care• Rapid Care Services• Family Centered Treatment• Long Term Community Support• High Fidelity Wraparound

First Revised and Restated Attachment D. Anticipated Contract Implementation Schedule

The following represents the current *anticipated dates* for key activities, deliverables, and implementation of BH I/DD Tailored Plan services beginning on December 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. First Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	Key Milestone	Description	Tentative Date
1.	Contract Award	The date the Department will award the Managed Care Contract for BH I/DD Tailored Plans	6/11/2021
2.	Commencement of BH I/DD Tailored Plan Implementation Planning	The date the BH I/DD Tailored Plan Implementation Team must be ready to commence Implementation Planning activities	6/11/2021
3.	Draft Implementation Plan	The date the BH I/DD Tailored Plan's Implementation Plan Draft must be submitted to the Department	Contract Award + fourteen (14) days
4.	Identification of additional resources for Implementation Team	The date the BH I/DD Tailored Plan must identify any additional resources needed to support the implementation activities	Contract Award + twenty (20) days
5.	Submission of BH I/DD Tailored Plan Operating Plan	The date the BH I/DD Tailored Plan's Operating Plan must be submitted to the Department	Contract Award + thirty (30) days
6.	Submission of key technology deliverables	The date the BH I/DD Tailored Plan submits to the Department: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Network Access Plan • Provider Contract Templates • Credentialing and Re-credentialing Policy • Provider Manual 	Contract Award + thirty (30) days

Section VII. First Revised and Restated 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. First Revised and Restated 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: <ul style="list-style-type: none"> • 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. First Revised and Restated 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 <ul style="list-style-type: none"> • 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	December 1, 2022
34.	TCM Auto Assignment	The date that TCM auto assignment must be completed for members enrolling in BH I/DD Tailored Plans at launch	December 1, 2022

Section VII. First Revised and Restated Attachment D. Table 1: Anticipated Contract Implementation Dates			
Milestone Reference Number	Key Milestone	Description	Tentative Date
35.	Commencement of Marketing Activities	The date the BH I/DD Tailored Plan is allowed to begin marketing activities	Eight (8) weeks prior to open enrollment
36.	BH I/DD Tailored Plan Launch	The date the BH I/DD Tailored Plan must begin delivering health care services to members and recipients	December 1, 2022
37.	Funding of Risk Reserves	The BH I/DD Tailored Plan must meet the capital requirements as outlined in <i>Section V.B.7.iii.(vii) Financial Viability</i> and <i>Section V.C.7.i. Financial Viability</i>	December 1, 2022

First Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics

1. BH I/DD Tailored Plan Quality Metrics for Medicaid

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be provided no later than six (6) months prior to BH I/DD Tailored Plans launch, or when the Department releases the data required for such reports, whichever is later. The BH I/DD Tailored Plan will also be required to report the Innovations and TBI waiver measures listed in *Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures* and *Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with BH I/DD Tailored Plans around these performance measures.

Section VII. First Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric			
Ref #	NQF #	Measure Name	Steward
1.	NA	Child and Adolescent Well-Care Visit	NCQA
2.	NA	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	CMS
3.	0038	Childhood Immunization Status (Combo 10)	NCQA
4.	0108	Follow-up for Children Prescribed ADHD Medication	NCQA
5.	Reserved	N/A	N/A
6.	1407	Immunizations for Adolescents	NCQA

Section VII. First Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric

Ref #	NQF #	Measure Name	Steward
7.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA
8.	NA	Well-Child Visits in the First 30 Months of Life	NCQA
9.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA
10.	NA	Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	NC DHHS

Section VII. First Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult

Ref #	NQF #	Measure Name	Steward
1.	0105	Antidepressant Medication Management	NCQA
2.	0032	Cervical Cancer Screening	NCQA
3.	0033	Chlamydia Screening in Women	NCQA
4.	0059	HbA1c Poor Control (>9.0%) ¹	NCQA
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA

¹Pending additional information regarding the collection of clinical data

Section VII. First Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures: Adult			
Ref #	NQF #	Measure Name	Steward
6.	3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC
7.	0018	Controlling High Blood Pressure	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA
9.	0039	Flu Vaccinations for Adults	NCQA
10.	0576	Follow-up After Hospitalization for Mental Illness	NCQA
11.	0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
12.	1768	Plan All Cause Readmissions	NCQA
13.	0418/ 0418e	Screening for Depression and Follow-up Plan ²	NCQA
14.	2940	Use of Opioids at High Dosage in-Persons Without Cancer	PQA
15.	2950	Use of Opioids from Multiple Providers in-Persons Without Cancer	PQA
16.	NA	Rate of Screening for Unmet Resource Needs	NC DHHS
17.	NA	Total Cost of Care	IBM Watson Health Cost of Care Model

Section VII. First Revised and Restated 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 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. First Revised and Restated Attachment E.1. Table 3: Survey Measures and General Measures: Maternal

Ref #	NQF #	Measure Name	Steward	Frequency	Submission
2.	NA	Prenatal and Postpartum Care	NCQA	Annually Calendar Year	June 1
3.	NA	Rate of Screening for Pregnancy Risk	NC DHHS	N/A	N/A

Section VII. First Revised and Restated Attachment E.1. Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction

Ref #	NQF #	Measure Name	Steward
1.	0006	CAHPS Survey	AHRQ

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of Innovations waiver applicants who received a preliminary screening for potential eligibility	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi-Annually 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.	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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
7.	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of Innovations waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of PCPs that are completed in accordance with DHB requirements.	NC DHHS	Semi-Annually 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
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
17.	Proportion of individuals whose annual ISP was revised or updated	NC DHHS	Semi-Annually 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
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
32.	Number and percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly 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
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
39.	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver (ages 3 and older) who received at least one waiver service who also received a primary care or preventative health service.	NC DHHS	Quarterly 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
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

Section VII. First Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	Measure Name	Steward	Measurement Period	Submission
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. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	Measure Name	Steward	Measurement Period	Submission
1.	Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 11
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

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI 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.	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
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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. First Revised and Restated 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

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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
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

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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
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

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
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
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

Section VII. First Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Submission
33.	Percent of restrictive interventions that are documented according to state policy.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	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. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services				
Ref #	Measure	Steward	Measurement Period	Report Due
1.	Initiation of Services	NC DHHS	Quarterly 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	a. February 15 b. May 15

Section VII. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services

Ref #	Measure	Steward	Measurement Period	Report Due
			b. October – December c. January – March d. April - June	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. July – September b. October – December c. January – March d. April - June	a. February 15 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

Section VII. First Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services

Ref #	Measure	Steward	Measurement Period	Report Due
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

First Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards

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

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

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

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

In order to ensure that all members have timely access to all covered health care services, BH I/DD Tailored Plans shall ensure its network meets, at a minimum, the following time/distance standards as measured from the member's residence for adult and pediatric providers separately through geo-access mapping at least annually. Certain service types not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include: hospitals, pharmacies, occupational, physical, or speech therapists, , LTSS, and nursing facilities.

For purposes of network adequacy standards for physical health providers/services, except as otherwise noted, adult services are those provided to a member who is 21 years of age or older and pediatric (child/children) services are those provided to a member who is less than 21 years of age.

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time/distance standards found in *Distance Standards* for BH service types in *Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid* and *Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid*.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	Service Type	Urban Standard	Rural Standard
1	Primary Care ¹	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5	Obstetrics ²	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7	Outpatient BH Services	<ul style="list-style-type: none"> ≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of members <i>Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i> 	<ul style="list-style-type: none"> ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of members <i>Research-based BH treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i>
8	Location-Based Services	<ul style="list-style-type: none"> <i>Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient</i> 	<ul style="list-style-type: none"> <i>Psychosocial rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive</i>

¹ Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.

² Measured on members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	Service Type	Urban Standard	Rural Standard
		<p><i>Program, and Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of members</p> <ul style="list-style-type: none"> • <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard 	<p><i>Outpatient Program, and Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of members</p> <ul style="list-style-type: none"> • <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard
9	Crisis Services	<ul style="list-style-type: none"> • <i>Professional treatment services in facility-based crisis program:</i> The greater of: <ul style="list-style-type: none"> ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • <i>Facility-based crisis services for children and adolescents:</i> ≥ 1 provider within each BH I/DD Tailored Plan Region • <i>Non-Hospital Medical Detoxification:</i> ≥ 2 provider within each BH I/DD Tailored Plan Region • <i>Ambulatory Detoxification, Ambulatory withdrawal management with extended on-site monitoring, Clinically managed residential withdrawal:</i> ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region • <i>Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult):</i> 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.	

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	Service Type	Urban Standard	Rural Standard
15	Residential Treatment Services	<ul style="list-style-type: none"> • <i>Residential Treatment Facility Services:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region, • <i>Substance Abuse Medically Monitored Residential Treatment:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (<i>refer to 10A NCAC 27G.3400</i>) • <i>Substance Abuse Non-Medical Community Residential Treatment:</i> <ul style="list-style-type: none"> ○ <i>Adult:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (<i>refer to licensure requirements to be determined by the Department</i>) ○ <i>Adolescent:</i> Contract with all designated CASPs within the BH I/DD Tailored Plan's Region ○ <i>Women & Children:</i> Contract with all designated CASPs within the BH I/DD Tailored Plan's Region • <i>Substance Abuse Halfway House:</i> <ul style="list-style-type: none"> ○ <i>Adult:</i> Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (<i>Refer to 10A NCAC 27G.5600E</i>)³ ○ <i>Adolescent:</i> Access to ≥1 program per BH I/DD Tailored Plan Region (<i>Refer to 10A NCAC 27G.5600E</i>) • <i>Psychiatric residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID:</i> Not subject to standard 	
16	1915(c) HCBS Waiver Services: NC Innovations	<ul style="list-style-type: none"> • <i>Community Living & Support, Community Navigator, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living:</i> ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region. • <i>Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:</i> ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • <i>Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification:</i> Not subject to standard 	
17	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver	<ul style="list-style-type: none"> • <i>Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:</i> ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. 	

³ BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	Service Type	Urban Standard	Rural Standard
	participating counties only)	<ul style="list-style-type: none"> • <i>Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region.</i> • <i>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</i> 	

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	Service Type	Definition
1.	Outpatient BH Services	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<p><i>Inpatient Hospital – Adult</i></p> <ul style="list-style-type: none"> • 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

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	Service Type	Definition
		<p><i>Inpatient Hospital – Adolescent / Children</i></p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Partial hospitalization (adults and children)
6.	Residential Treatment Services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment

Section VII. First Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	Service Type	Definition
		<ul style="list-style-type: none"> • Supported Living • Vehicle Modifications
9.	1915(c) HCBS Waiver Services: NC TBI Waiver	<ul style="list-style-type: none"> • Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Remote supports • Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Supported living • Vehicle Modifications

BH I/DD Tailored Plans is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations,	Within thirty (30) calendar days
1a	Preventive Care Services – child, birth		Within fourteen (14) calendar days for member less than six (6) months of age

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
	through 20 years of age	mammograms and pap smears	Within thirty (30) calendar days for members six (6) months or age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) calendar days
Prenatal Care			
5	Initial Appointment – 1 st or 2 nd 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 3 rd 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	Within twenty-four (24) hours

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
		wounds, sudden onset of stomach pain and severe, non-resolving headache.	
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 <i>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</i>	Within two (2) hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to <i>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</i>	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 <i>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</i>	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
12	Emergency Services for SUDs	Refer to <i>Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and</i>	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
		<i>Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients</i>	
13	Urgent Care Services for Mental Health	Refer to <i>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</i>	Within twenty-four (24) hours
14	Urgent Care Services for SUDs	Refer to <i>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</i>	Within twenty-four (24) hours
15	Routine Services for Mental Health	Refer to <i>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</i>	Within fourteen (14) calendar days
16	Routine Services for SUDs	Refer to <i>Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health</i>	Within forty-eight (48) hours

Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
		<i>Choice Members and State-funded Recipients</i>	

The BH I/DD Tailored Plan is required to use the following provider types as “specialty care” providers for purposes of Section VII. First Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time or Distance Standards for Medicaid and Section VII. First Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid as found in this attachment:

Section VII. First Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	Service Type
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

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

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

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

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

In order to ensure that all members have timely access to all covered health care services, BH I/DD Tailored Plans shall ensure its network meets, at a minimum, the following time or distance standards as measured from the member’s residence for adult and pediatric providers separately through geo-access mapping at least annually. Offeror should reference *Section VII. 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. First Revised and Restated Attachment F.2. Table 2 Classifications of Service Category for Behavioral Health Time or Distance Standards*:

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a member who is less than 18 years of age.

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
1	Outpatient BH Services	≥ 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients ¹	≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients
2	Location-Based Services [^]	<ul style="list-style-type: none"> <i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient,</i> 	<ul style="list-style-type: none"> <i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient,</i>

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

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
		<p><i>Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients</p> <ul style="list-style-type: none"> • <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard 	<p><i>Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP):</i> ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients</p> <ul style="list-style-type: none"> • <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard
3	Crisis Services [^]	<ul style="list-style-type: none"> • <i>Facility based crisis for adults:</i> The greater of: <ul style="list-style-type: none"> ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates for the most recent year available). • <i>Non-Hospital Medical Detoxification:</i> ≥ 2 provider within each BH I/DD Tailored Plan Region • <i>Ambulatory Detoxification :</i> ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region 	
4	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5.	Reserved		
6	Community/Mobile Services [^]	<p>Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.</p> <p>High Fidelity Wraparound ≥ 2 provider within one hour</p>	
		<p><i>Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of</i></p>	<p><i>Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45 miles of residence for at least 95% of recipients</i></p>

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
		<i>residence for at least 95% of recipients²</i>	
7	Residential Treatment Services	<ul style="list-style-type: none"> • <i>Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region</i> • <i>Substance Abuse Halfway House:</i> <ul style="list-style-type: none"> ○ <i>Adult: Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)³</i> ○ <i>Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)</i> • <i>Substance Abuse Medically Monitored Community Residential Treatment: Access to ≥1 licensed provider</i> • <i>Substance Abuse Non-Medical Community Residential Treatment:</i> <ul style="list-style-type: none"> ○ <i>Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department)</i> ○ <i>Adolescent: Contract with all designated CASPs within the BH I/DD Tailored Plan’s Region</i> ○ <i>Women & Children: Contract with all designated CASPs within the BH I/DD Tailored Plan’s Region</i> • <i>Substance Use Residential Supports & Mental Health Recovery Residential Services: To be determined</i> 	
8	Employment and Housing Services	<ul style="list-style-type: none"> • <i>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.</i> • <i>Individual Placement and Support-Supported Employment (Adult MH): 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients.</i> • <i>I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services, IDD Supported Employment:100% of eligible</i> 	

² The Department defines recipients for the purposes of network adequacy as those who received State-funded Services in the previous year.

³ BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house services.

Section VII. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	Service Type	Urban Standard	Rural Standard
		<p>recipients must have access to ≥ 1 provider agency within each BH I/DD Tailored Plan Region.</p> <ul style="list-style-type: none"> • <i>Clinically Managed Population-specific High Intensity Residential Programs</i>: To be determined • <i>TBI long-term residential rehabilitation services</i>: 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. First Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards and Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards.*

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
1	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
2	Location-Based Services [^]	Psychosocial Rehabilitation		Y			
		Substance Abuse Comprehensive Outpatient				Y	
		Substance Abuse Intensive Outpatient Program				Y	Y
		Outpatient Opioid Therapy				Y	
3	Crisis Services [^]	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y	
		Ambulatory Detoxification				Y	

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards

Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
4	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y	Y
5.	Reserved						
6	Residential Treatment Services	Substance Abuse Halfway House				Y	Y
		Substance Abuse Medically Monitored Residential Treatment				Y	
		Substance Abuse Non-Medical Community Residential Treatment				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			
		Clinically managed population specific high intensity residential services					Y
7	Community/Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards

Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
		Transition Management Service		Y			
		High Fidelity Wraparound			Y		Y
		Intensive In-home			Y		Y
		Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y
8	Employment and Housing Services	I/DD & TBI Day Supports	Y				
		Community Living & Support	Y				
		I/DD & TBI Residential Services	Y				
		Supported Employment	Y				
		Residential Supports	Y	Y			
		Respite Services	Y		Y		Y
		Individual Placement and Supports (IPS)-Supported Employment		Y			Y
		TBI Long-term Residential Rehabilitation Services	Y				
		Clinically Managed Population-specific High					Y

Section VII. First Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards						
Reference Number	Service Type	Classification	Disability Group			
			I/DD or TBI	Adult MH	Child MH	Adult SUD
		Intensity Residential Programs				

BH I/DD Tailored Plans is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:

Section VII. First Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
BH Care/I/DD			
1	Mobile Crisis Management Services	Refer to <i>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</i>	Within two (2) hours
2	Facility-Based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	Refer to <i>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</i>	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
3	Emergency Services for Mental Health	Refer to <i>Section VII. Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and</i>	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

Section VII. First Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
		<i>Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients</i>	
4	Emergency Services for SUDs	Refer to <i>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</i>	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 <i>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</i>	Within twenty-four (24) hours
6	Urgent Care Services for SUDs	Refer to <i>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</i>	Within twenty-four (24) hours
7	Routine Services for Mental Health	Refer to <i>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</i>	Within fourteen (14) calendar days

Section VII. First Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
8	Routine Services for SUDs	Refer to <i>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</i>	Within forty-eight (48) hours

Second Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts

1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid

The BH I/DD Tailored Plan shall develop and implement contracts with providers to meet the requirements of the Contract. The BH I/DD Tailored Plan's provider contracts shall, at a minimum, comply with the terms of the Contract, state and federal law, and include required standard contracts clauses.

1. Contracts between the BH I/DD Tailored Plan and providers, must, at a minimum, include provisions addressing the following:

- a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
- b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid member materials issued in conjunction with the Medicaid Managed Care Program.
 - (a) In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored plan utilizes the definition as found in Section II.A. of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section
- c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the State includes an extension option.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination.
- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 1. Transition of administrative duties and records; and
 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation

requirements as outlined in the State's Credentialing and Re-credentialing Policy and the timeframe within which the provider must notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

- i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
- ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 1. During the provider credentialing transition period, no less frequently than every five (5) years.
 2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. **Liability Insurance:** The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost, and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.
- h. **Member Billing:** The contract must address the following:
 - i. That the provider shall not bill any member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the member requests to receive the service; and
 - ii. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- i. **Provider Accessibility:** The contract must address provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
 - i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
 - ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
 - iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the provider.
- j. **Eligibility Verification:** The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the BH I/DD Tailored Plan, before rendering health care services.
- k. **Medical Records:** The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
 - i. Maintain confidentiality of member medical records and personal information and other health records as required by law;

- ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
 - iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
- l. Member Appeals and Grievances: The contract must address the provider's obligation to cooperate with the member in regard to member appeals and grievance procedures.
 - m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
 - n. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
 - o. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the BH I/DD Tailored Plan's web-based billing process.
 - p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.
 - q. Utilization Management (UM): The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
 - r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.
 - s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
 - t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.B.4.v. Provider Grievances and Appeals*.
 - u. Assignment: Provisions on assignment of the contract must include that:

- i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
- v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- w. Interpreting and Translation Services: The contract must have provisions that indicate:
 - i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
 - ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
 - iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- x. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
- y. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.
- z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.
- aa. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- bb. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).

- v. G.S. 58-50-280 (a) through (d).
- vi. G.S. 58-50-285 (a) and (b).
- vii. G.S. 58-51-37 (d) and (e).
- cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.
- dd. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in *Section V.B.4.iv. Provider Payments* of the BH I/DD Tailored Plan Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the BH I/DD Tailored Plan shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Section VII. Attachment H. Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement. When a BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.
- ee. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH/IDD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.
- ff. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.
- gg. Physician Advisor Use in Claims Dispute: The contract must indicate that the BH I/DD Tailored Plan shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

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

- a. AMH Provider Manual
- b. Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
- c. Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members

- d. Section VII. Attachment M.5. Care Management for High-Risk Pregnancy 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

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

- i. The United States Department of Health and Human Services or its designee;
- ii. The Comptroller General of the United States or its designee;
- iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee
- iv. The Office of Inspector General
- v. North Carolina Department of Justice Medicaid Investigations Division
- vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
- vii. The North Carolina Office of State Auditor, or its designee
- viii. A state or federal law enforcement agency.
- ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

3. Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

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

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

2. The [Provider] shall submit all claims to the [Company] for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service 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 penalties. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.
- v. Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] penalties equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.
- vi. The [Company] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to requests the interest or the liquidated damages.
- h. Contract Effective Date.
1. The contract shall at a minimum include the following in relation to the effective date of the contract.
 2. The effective date of any [Provider] added under this [Agreement] shall be the later of the effective date of this [AGREEMENT] or the date by which the [Provider's] enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).
- i. Tobacco-free Policy.
1. The contract with a provider shall at a minimum include the following in relation to the implementation of a tobacco-free policy unless the provider is a residential provider facility described below.
 2. [Provider] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include

buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting [Provider] from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients [Provider] serves.

3. Contracts with facilities that are owned or controlled by the provider and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required:

4. [Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:

(1) Indoor use of tobacco products shall be prohibited in all settings that are owned/operated by [Provider].

(2) For outdoor areas of campus, [PROVIDER] shall:

i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and

ii. Prohibit staff/employees from using tobacco products anywhere on campus.

2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services

The BH I/DD Tailored Plan shall develop and implement contracts with providers to meet the requirements of the Contract. The BH I/DD Tailored Plan's provider contracts shall, at a minimum, comply with the terms of the Contract, state law, and include required standard contracts clauses.

1. Contracts between the BH I/DD Tailored Plan and Providers, must, at a minimum, include provisions addressing the following:

- a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices that constitute the entire contract between the parties.
- b. Definitions: The contract must define technical State-funded Services terms used in the contract, and if those definitions are referenced in other documents distributed to providers and recipients, ensure that definitions are consistent.
 - i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section III.A.* of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.
- c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the state includes an extension option.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD

Tailored Plan to immediately suspend some or all activities under a network contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division.

- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 - 1. Transition of administrative duties and records; and
 - 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and to notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
 - i. The provider's obligations to be an enrolled State-funded Services provider, and the grounds for termination if the provider does not maintain enrollment.
 - ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 - 1. During the provider credentialing transition period, no less frequently than every five (5) years.
 - 2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.
- h. Recipient Billing: The contract must address the following that the provider shall not bill any State-funded Services recipient for covered services. This provision shall not prohibit a provider and recipient from agreeing to continue non-covered services at the recipient's own expense, as long as the provider has notified the recipient in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the recipient requests to receive the service.
- i. Provider Accessibility: The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
 - i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
 - ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
 - iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A Provider's competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the Provider.

- j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility before rendering health care services and reporting of eligibility information to the BH I/DD Tailored Plan.
- k. Medical Records: The contract must require that providers:
 - i. Maintain confidentiality of recipient medical records and personal information and other health records as required by law;
 - ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
 - iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
- l. Recipient Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the recipient in regard to recipient appeals and grievance procedures.
- m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
- n. Provider Network: The contract must include a provider network provision that ensures that LGBTQ recipients who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
- o. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider must be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in BH I/DD Tailored Plan's web-based billing process.
- p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and UM requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.
- q. Utilization Management: The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.

- s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
- t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Complaint and Appeals as found in *Section V.C.4.e. Provider Grievances and Appeals*.
- u. Assignment: Provisions on assignment of the contract must include that:
 - i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
- v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- w. Interpreting and Translation Services: The contract must have provisions that indicate:
 - i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
 - ii. The provider must ensure the provider's staff is trained to appropriately communicate with recipients with various types of hearing loss.
 - iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- x. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- y. Chapter 58 requirements: The contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- z. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.
- aa. Providers Subject to Other Payment Directives: For all contracts with providers subject to specific payment provisions as found in *Section V.C.4.iv. Provider Payments*, a provision that indicates the terms and conditions of each applicable payment methodology/requirement.

- bb. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.
- cc. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.
- dd. Physician Advisor Use in Claims Dispute: The contract must indicate that the BH I/DD Tailored Plan shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

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

a. Compliance with state laws

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

b. Hold Recipient Harmless

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

c. Liability

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

d. Non-discrimination: Equitable Treatment of Recipients:

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

e. Access to provider records

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

- i. NC DHHS, its State-funded Services personnel, or its designee;
- ii. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
- iii. The North Carolina Office of State Auditor, or its designee;
- iv. A state law enforcement agency; and
- v. Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

g. Provider ownership disclosure

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

Second Revised and Restated Attachment H. Addendum for Indian Health Care Providers

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

1. Purpose of Addendum; Supersession.

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

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.

- 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 IHCA Section 601, 25 U.S.C. § 1661.
- e. "Indian tribe" has the meaning given in the IHCA Section 4(14), 25 U.S.C. § 1603(14).).
- f. "Tribal health program" has the meaning given in the IHCA Section 4(25), 25 U.S.C. § 1603(25).
- g. "Tribal organization" has the meaning given in the IHCA Section 4(26), 25 U.S.C. § 1603(26).).
- h. "Urban Indian organization" has the meaning given in the IHCA 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 IHCA.

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

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

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

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

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

6. Agreement to Pay IHCP.

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

b. The State shall make a supplemental payment to the IHCP to make up the difference between the amount the BH I/DD Tailored Plan pays and the amount the IHCP would have received under FFS or the applicable encounter rate published annually by the IHS if the amount the IHCP receives from the BH I/DD Tailored Plan is less than the amount they would have received under FFS or the applicable encounter rate.

7. Persons Eligible for Items and Services from IHCP.

- a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCA, 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 IHCA, 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 IHCA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.

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

17. Hours and Days of Service.

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

18. Coordination of Care/Referral Requirements.

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

19. Sovereign Immunity.

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

20. Endorsement.

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

APPROVALS

For the BH I/DD Tailored Plan:

For the IHCP:

Date: _____

Date: _____

Signature: _____

Signature: _____

Applicable Federal Laws Referenced in Section 8 of this Addendum

(a) The IHS as an IHCP:

- (1) Anti-Deficiency Act, 31 U.S.C. § 1341;
- (2) ISDEAA, 25 U.S.C. § 450 et seq.;
- (3) Federal Tort Claims Act (“FTCA”), 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Federal Privacy Act of 1974 (“Privacy Act”), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) IHCA, 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) IHCA, 25 U.S.C. § 1601 et seq.;
- (3) FTCA, 28 U.S.C. §§ 2671-2680;
- (4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
- (6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:

- (1) IHCA, 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.

Second Revised and Restated 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. Second Revised and Restated Attachment I.1. Table 1: Provider Appeals for Medicaid, NC Health Choice Providers, and State-funded Services Providers	
Reference Number	Appeal Criteria
For Participating Providers	
1	<p>A Participating Provider has the right to appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a Participating provider for the following reasons:</p> <ul style="list-style-type: none"> a) Finding of or recovery of an overpayment by the BH I/DD Tailored Plan; b) Withhold or suspension of a payment related to waste or abuse concerns; c) Contract termination for cause or finding of contract violation d) Corrective action by the BH I/DD Tailored Plan; and e) Determination to de-certify an AMH+ or CMA (applicable to Medicaid providers only).
For Non-Participating Providers	
2	<p>An Non-Participating provider may appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a Participating Provider for the following reasons:</p> <ul style="list-style-type: none"> a) Disputes regarding an out-of-network payment arrangement, such as a single-case agreement; 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.

First Revised and Restated 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 *First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services* and *First Revised and Restated 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 *First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *First Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *First Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Alerts and Notifications for Medicaid*.

The BH I/DD Tailored Plan shall also submit select reports that apply only to State-funded Services, as identified in *First Revised and Restated 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; and in-reach visits, diversion activities, transition planning and leasing and service information for individuals transitioning out of State hospitals and transitioning out of or diverted from adult care homes.
 - 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 and shall participate in data quality improvement initiatives specified 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. First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Administration 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
B. Members and Recipients		
1. Member and Recipient Services Quality Assurance Report	Quarterly report of survey results which measures member and recipient ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member and Recipient Marketing and Educational Activities Report	Quarterly summary of member and recipient marketing and educational activities, including number/type of events hosted, event locations and number of members and recipients reached.	Quarterly
3. Member and Recipient Appeals and Grievances Report	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
4. 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
5. SED In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; To be reported overall, by diagnosis (I/DD, TBI, SMI, SED), and by setting (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH). Average length of stay; total number of members and percentage in PRTF, members under age 18 in State psychiatric facility, and members receiving residential treatment levels II/program type III, and IV.	Quarterly

Section VII. First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
6. TBI In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
7. IDD In Reach, Diversion, Transition Activity Report	Number and percentage of members eligible for In reach activities who are engaged for in reach activities; number and percentage of members who began transition planning following in reach; number and percentage of members eligible for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities; number and percentage of members age 18 and above identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported overall, by diagnosis (e.g., I/DD, TBI, SMI, SED), and by setting in reached and where member was discharged e.g., (ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/program type, III, and IV, ACH).	Quarterly
C. Care Management		
1. Reserved	N/A	N/A
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. First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
2. 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 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
2. Provider Contracting Determinations and Activities Report	Quarterly report providing the turn-around-time and statistics for provider contracting and service functions, including issuance to the provider of a Quality Determinations, Provider Welcome Packets, and other quality determination activities made during the reporting period, including break down of data by provider type and by specified turn-around time periods.	Quarterly
3. Network Adequacy Annual Submission Report	Annual report demonstrating the geographical location of providers in the Provider Network in relationship to where members or recipients live.	Annually
4. Timely Access Behavioral Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category.	Annually
5. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
6. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
7. 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

Section VII. First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
8. Suspended and Terminated Providers Report	Monthly report on suspended/terminated providers and provider payments	Monthly
9. NEMT Provider Contracting Report	Non emergency provider contracting report at a detailed and summary level from the TPs	First and Third Friday each month
10. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly
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
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
5. Secondary Call Center Service Line Report	Monthly secondary call center service line utilization and statistics	Monthly
6. BH SFS Waitlist / Rate of Institutionalization Report	Quarterly report capturing metrics of individuals being placed on waitlists, including type of services requested, reason for removal from waitlist, and dates of requesting and receiving services	Quarterly
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	Quarterly

Section VII. First Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
	service, provider rendering services, and total amount paid and recovered/avoided.	
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. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer	Quarterly

Section VII. First Revised and Restated Attachment J. Table 2: BH I/DD Tailored Plan Data Extracts for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Providers		
1. Network Data Details Extract	Quarterly report containing demographic information on network providers. <i>Note: Ad-hoc upon request.</i> Ad hoc report will be requested no less than 10 days in advance or mutually agreed upon timeframe	Quarterly
B. Quality and Value		
1. Reserved	N/A	N/A

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Members		
1. 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 Circumstances Report	Weekly report used to notify NC Medicaid of changes in member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
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. 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
7. Monthly Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. <i>*Note*</i> If the date the extract is being submitted is prior to 7/1/2022, the extract would include member eligibility as of 7/1/2022	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. Pharmacy Benefit Determination/	Monthly that lists prior approval requests by individual member, service type, determination date, and approval status.	Monthly

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
Prior Authorization Report		
3. ProDUR Alert Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
4. Top GCNs and GC3s	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
5. Ad Hoc and Trigger Report	Quarterly report highlighting the prospective and retrospective drug utilization review activities and initiatives.	Quarterly
6. Pharmacy Financial Arrangements Attestation	Annual pharmacy financial arrangements attestation.	Annually
7. EPSDT Reports	Quarterly report listing volume of approvals and denials, types of services required, and total paid claims.	Quarterly
8. Non-Emergency Medical Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
9. Annual Prevention and Population Health Report	Annual report of all members outreached, utilization and key program metrics.	Annually
10. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
11. Healthy Opportunities Pilot Program Report	<p><i>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.</i></p> <p><i>Further guidance on Pilot-related reporting frequency, format and content will be provided by the Department prior to service launch.</i></p>	<i>To be defined by Department in further guidance</i>
12. Crossover-Related NEMT Appointments Scheduled	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
13. Ongoing Status Reports on	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

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
Transitions of Care		
14. Quarterly Admission & Readmission Report	Quarterly summary report of admission and readmission.	Quarterly
15. NEMT Annual Review Report	Non emergency annual review report at a detailed and summary level from the TPs	Annual
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 and Ad Hoc
2. Care Needs Screening Report	Quarterly report of member screening results, including Healthy Opportunity & Care Needs Screening of members who have opted out of Tailored Care Management or who are ineligible for Tailored Care Management due to receipt of a duplicative service.	Quarterly
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. AMH Tier Status Change Report	Monthly reporting on tracking AMH tier changes and the associated decision reasoning.	Monthly
5. AMH Contracting Report	Monthly report of AMH medical home payments.	Monthly
6. Nursing Facility Transitions Report	Quarterly report listing BH I/DD Tailored Plan members discharged from a nursing facility and to where they were discharged.	Quarterly
7. 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
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
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

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
2. 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. 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
6. Local Health Department Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: local health departments. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each Local Health Department the amounts in accordance with the invoice summary.	Quarterly
7. Public Ambulance Provider Directed Payment Invoice Report	Quarterly report to support additional directed payments to certain providers: public ambulance providers. BH I/DD Tailored Plans will leverage the template to use their data to calculate the Directed Payment and submit it as an "invoice" to NC Medicaid for payment. BH I/DD Tailored Plans will also be required to provide detailed claims data to substantiate the invoice. The invoice summary component will be validated and returned to the BH I/DD Tailored Plan as an enclosure from NC Medicaid with formal instructions to pay each	Quarterly

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
	Public Ambulance Provider the amounts in accordance with the invoice summary.	
8. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination	Monthly
9. Summary UNC_ECU Physician Claims Report	Quarterly report. BH I/DD Tailored Plans will leverage template to support Directed Additional Utilization Based Payments / Directed Payments for UNC and ECU Physicians.	Quarterly
10. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. BH I/DD Tailored Plans will include records of members where no payment was received from the State or payment received differed from the amount expected. BH I/DD Tailored Plans will only include member records with discrepancies on this report to the State. The BH I/DD Tailored Plan Capitation Reconciliation Report will be submitted on a monthly cadence. BH I/DD Tailored Plans will indicate expected values and values observed on ASC x12 834 monthly file for members.	Monthly
11. PCP Provider Contracting and Integration Report	Weekly PRCP Provider contracting and integration status report	Weekly
F. Quality and Value		
1. Quality Measures Report	Annual BH I/DD Tailored Plan performance on quality measures.	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. Reserved	N/A	N/A
I. Financial Requirements		
1. UNC Vidant Hospital Directed Payment Report Data – Outpatient	Quarterly report to support additional directed payments for outpatient services to certain providers: UNC Health Care System hospitals and Vidant Medical Center. BH I/DD Tailored Plans will be required to populate the template with detailed claims data necessary to support DHB calculation of a directed payment. NC Medicaid will furnish to the BH I/DD Tailored Plan the directed payment amount with formal instructions to pay each provider their directed payment amount.	Quarterly
2. UNC Vidant Hospital	Quarterly report to support additional directed payments for inpatient services to certain providers: UNC Health Care System hospitals and	Quarterly

Section VII. First Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
Directed Payment Report Data – Inpatient	Vidant Medical Center. BH I/DD Tailored Plans will be required to populate the template with detailed claims data necessary to support DHB calculation of a directed payment. NC Medicaid will furnish to the BH I/DD Tailored Plan the directed payment amount with formal instructions to pay each provider their directed payment amount.	Weekly & Ad Hoc
3. Claims Monitoring Report	Weekly summary of claims that have been received, paid, pending, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pending claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	
4. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted quarterly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others.	Quarterly
5. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the TP template is still in a the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Bi-Annual

Section VII. First Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Members		
1. 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

Section VII. First Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
2. Medical Prior Authorization Extract	Monthly extract providing information on medical prior approval requests by individual member, service type, determination date, and approval status.	Monthly
3. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly
4. Eligible Mothers for Low Birth Weight Extract	Eligible mothers (covered by PHP from 16 weeks gestation or earlier) of all live singleton deliveries within measurement period for low birth weight measure.	Quarterly

Section VII. First Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Medicaid Alerts and Notifications for Medicaid

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
1. Nursing Facility Admission Anticipated Disenrollment Alert	<p>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.</p> <p>Ad hoc report, including all data elements and format, will be requested no less than 10 days in advance or mutually agreed upon timeframe</p>	Ad hoc

Section VII. First Revised and Restated 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. Reserved	N/A	N/A
B. Care Management and Prevention		
1. Traumatic Brain Injury (TBI) Report	Annual and quarterly report on administration of State-funded TBI programming expenditures and associated services.	Annually
2. TBI Screening Report	Quarterly report on call center screenings that identify recipients with potential TBI and their access to mental health, SUD, I/DD, or other services.	Quarterly
3. TBI Annual Report	The annual report consists of a combination of both quantitative and qualitative information, which provides a more holistic understanding of service usage, trends and network adequacy for the TBI population within North Carolina’s publicly funded service	Annual

Section VII. First Revised and Restated 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
	system.	
4. 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
5. 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
C. Quality and Value		
1. Quarterly Quality Measures Report	<p>The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006¹. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.</p> <p>These performance indicators describe an observed level of activity (percent of persons that received a service for a MH, I/DD, or SUD condition or that received a timely follow-up service), but do not explain why the level is as it is. Results do not reveal the substantial “behind-the-scene” activities, processes and interactions involving service providers, LME-MCO and state staff, consumers, and family members, and cannot reveal which factors account for differences in measured levels of quality. Identifying and understanding these factors require additional investigation and may serve as the starting point for program management initiatives or quality improvement efforts.</p> <p>The performance indicators in this report were chosen to reflect:</p> <ul style="list-style-type: none"> • accepted standards of care, • fair and reliable measures, and • readily available data sources. 	Quarterly
D. Financial Requirements		
1. Information on Appropriate Use of Block Grant and State-Funds	<p>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.</p> <p>Any ad hoc reporting, including all data elements and format, will</p>	Annually

Section VII. First Revised and Restated 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
	be requested no less than 10 days in advance or mutually agreed upon timeframe	
2. Block Grant Report	Monthly report submitted to the State's Consumer Data Warehouse (CDW) on demographics, outcomes measures, and other record types not available through claims (e.g., recipient living situation, consumer surveys, services and utilization, readmissions, social connectedness, and employment), as determined by the Department.	Monthly
3. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Narrative Compliance Report	Bi-annual narrative report on compliance with target and outcome prevention activities and measures for priority populations, as detailed in the SAPTBG.	Bi-annually
4. 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 <i>Section V.C.7. Financial Requirements</i> 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
5. Substance Abuse Prevention and Treatment Block Grant (SAPTBG) Compliance Report	Bi-annual report detailing fiscal expenditures by CSAP prevention strategy and IOM target, as well as persons served by risk category and demographics.	Bi-Annual

First Revised and Restated 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. First Revised and Restated Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	Examples of Noncompliant Behavior and/or Practices
<p>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</p>	<p>Failure to substantially and materially provide medically necessary covered services</p> <p>Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract</p> <p>Imposing on members premiums or cost sharing that are in excess of that permitted by the Department</p> <p>Failure to substantially and materially meet minimum care management and care coordination requirements</p> <p>Failure to substantially and materially meet minimum Transition of Care Policy requirements</p> <p>Failure to substantially and materially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception)</p> <p>Denying coverage for out-of-network care when no reasonable access to an in-network provider is available</p> <p>Systemic or repeated failure to resolve member and provider appeals and grievances within specified timeframes</p>

Section VII. First Revised and Restated Attachment K. Table 1: Risk Level Matrix for Medicaid

Level	Examples of Noncompliant Behavior and/or Practices
	<p>Failure to maintain BH I/DD Tailored Plan license in good standing with DOI</p> <p>Systemic or repeated failure to timely submit accurate and/or complete encounter data in the required file format</p> <p>Misrepresenting or falsifying information that it furnishes to CMS or to the Department</p> <p>Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation</p> <p>Failure to substantially and materially comply with the claims processing requirements and standards</p> <p>Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)</p> <p>Failure to substantially and materially comply with the Preferred Drug List requirements</p> <p>Continuing substantially and materially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation</p> <p>More than one Level 2 violations within a contract year</p>
<p>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</p>	<p>Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract</p> <p>Failure to comply with established rate floors and fee schedules as required under the Contract</p> <p>Failure to make additional directed payments to certain providers as required under the Contract</p> <p>Failure to make provider contracting decisions within required timeframes</p> <p>Failure to comply with member services requirements (including hours of operation, call center, and online portal)</p>

Section VII. First Revised and Restated Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	Examples of Noncompliant Behavior and/or Practices
	<p>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</p> <p>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</p>
<p>LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program</p>	<p>Systemic or repeated 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</p> <p>Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)</p> <p>Systemic or repeated failure to notify the Department and members of terminated network providers within required timeframes</p> <p>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</p> <p>Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines)</p> <p>Using unapproved member notices, educational materials, and handbooks and marketing materials</p> <p>Engaging in prohibited marketing activities and practices</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation</p> <p>Three or more Level 4 violations within a contract year</p>
<p>LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation of the managed care program</p>	<p>Systemic or repeated submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports)</p>

Section VII. First Revised and Restated Attachment K. Table 1: Risk Level Matrix for Medicaid	
Level	Examples of Noncompliant Behavior and/or Practices
	<p>Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation</p> <p>Failure to comply with time frames for distributing (or providing access to) Member Handbooks, identification cards, provider directories, and educational materials to members (or potential members)</p> <p>Failure to meet minimum requirements requiring coordination and cooperation with external entities</p> <p>EQRO or other program audit reports with non-substantial findings</p> <p>Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements)</p> <p>Failure to timely furnish a policy, handbook, directory, or manual upon request by a member or potential member as required under the Contract</p>

Section VII. First Revised and Restated Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	Examples of Noncompliant Behavior and/or Practices
<p>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</p>	<p>Failure to substantially and materially provide medically necessary covered services</p> <p>Imposing arbitrary utilization guidelines, quantitative coverage limits, or prior authorization requirements prohibited under the Contract</p> <p>Failure to substantially and materially meet minimum case management and care coordination requirements</p> <p>Failure to substantially and materially meet or failure to require network providers to meet the network adequacy standards established by the Department (without an approved exception)</p>

Section VII. First Revised and Restated Attachment K. Table 2: Risk Level Matrix for State-funded Services

Level	Examples of Noncompliant Behavior and/or Practices
	<p>Systemic or repeated failure to resolve recipient complaints and appeals and provider appeals and grievances within specified timeframes</p> <p>Systemic or repeated failure to maintain BH I/DD Tailored Plan license in good standing with DOI</p> <p>Systemic or repeated failure to timely submit accurate and/or complete encounter data in the required file format</p> <p>Misrepresenting or falsifying information that it furnishes to the Department</p> <p>Engaging in unlawful discriminatory practices as prohibited under the Contract or under state or federal law or regulation</p> <p>Failure to substantially and materially comply with the claims processing requirements and standards</p> <p>Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 2 violation</p> <p>More than one Level 2 violations within a contract year</p>
<p>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</p>	<p>Failure to maintain a compliance system to identify and investigate allegations of fraud, waste, or abuse as required under the Contract</p> <p>Failure to make quality determinations for provider contracting within required timeframes</p> <p>Failure to comply with recipient services requirements (including hours of operation, call center, and online portal)</p> <p>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</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 3 violation</p> <p>Two or more Level 3 violations within a contract year</p>

Section VII. First Revised and Restated Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	Examples of Noncompliant Behavior and/or Practices
<p>LEVEL 3 Action(s) or inaction(s) that diminish the effective oversight and administration of State-funded Services</p>	<p>Systemic or repeated 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</p> <p>Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)</p> <p>Systemic or repeated failure to notify the Department and recipients of terminated network providers within required timeframes</p> <p>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</p> <p>Failure to implement and maintain required policies, plans, and programs (e.g. drug utilization review program, fraud prevention plan, clinical practice guidelines)</p> <p>Using unapproved recipient notices, educational materials, and handbooks and marketing materials</p> <p>Engaging in prohibited marketing activities and practices</p> <p>Continuing substantially similar noncompliance and failure to comply with previously imposed action(s) resulting from a Level 4 violation</p> <p>Three or more Level 4 violations within a contract year</p>
<p>LEVEL 4 Action(s) or inaction(s) that inhibit the efficient operation State-funded Services</p>	<p>Systemic or repeated submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports)</p> <p>Failure to establish, maintain, and/or participate on required advisory committees as required by the Department or by state or federal law or regulation</p> <p>Failure to comply with time frames for distributing (or providing access to) Recipient Handbooks, provider directories, and educational materials to recipients (or potential recipients)</p>

Section VII. First Revised and Restated Attachment K. Table 2: Risk Level Matrix for State-funded Services	
Level	Examples of Noncompliant Behavior and/or Practices
	<p>Failure to meet minimum requirements requiring coordination and cooperation with external entities</p> <p>EQRO or other program audit reports with non-substantial findings</p> <p>Failure to meet staffing requirements (including experience and training, staffing levels, notice of personnel changes, and location requirements)</p> <p>Failure to timely furnish a policy, handbook, directory, or manual upon request by a recipient or potential recipient as required under the Contract</p>

First Revised and Restated Attachment L. Managed Care Terminology Provided to the BH I/DD Tailored Plan for Use with Members Pursuant to 42 C.F.R. § 438.10

Key terms below are defined as they are intended to be used with Members and do not conflict with the definitions in *Section II. Definitions and Abbreviations* of this contract.

1. **Appeal:** If NC Medicaid Direct makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an appeal when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask NC Medicaid Direct for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." Appeals and grievances are different.
2. **Co-Payment:** 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):** Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.
4. **Emergency Medical Condition:** A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.
5. **Emergency Medical Transportation:** Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.
6. **Emergency Room Care:** Care you receive in a hospital if you are experiencing an emergency medical condition..
7. **Emergency Services:** Services you receive to treat your emergency medical condition.
8. **Excluded Services:** Services that are not covered by the PHP.
9. **Grievance:** A complaint about your provider, care or services. Contact NC Medicaid Direct and tell them you have a "grievance" about your services. Grievances and appeals are different.
10. **Habilitation Services and Devices:** Health care services that help 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 health insurance.
12. **Home Health Care:** Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.
13. **Hospice Services:** Special services for patients and their families during the final stages of illness and after death. Hospice services include certain physical, psychological, social, and spiritual services that support terminally ill individuals and their families or caregivers.
14. **Hospitalization:**): Admission to a hospital for treatment that lasts more than 24 hours.
15. **Hospital Outpatient Care:** Services you receive from a hospital or other medical setting that do not require hospitalization.

16. **Medically Necessary:** Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
17. **Network:** A group of doctors, hospitals, pharmacies, and other health care experts contracted by the PHP to provide health care services.
18. **Non-participating provider:** A provider that is not in NC Medicaid Direct's provider network.
19. **Participating Provider:** A provider that is in NC Medicaid Direct's provider network.
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):** Organization providing you with health insurance.
22. **Preauthorization:** Approval you must have from NC Medicaid Direct before you can get or continue getting certain health care services or medicines.
23. **Premium:** The amount you pay for your health insurance every month. Most Medicaid and NC Health Choice beneficiaries do not have a premium..
24. **Prescription Drug Coverage:** Refers to how the PHP helps pay for its Members' prescription drugs and medications.
25. **Prescription Drugs:** A drug that, by law, requires a provider to order it before a beneficiary can receive it.
26. **Primary Care 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 doctor or clinic where you get your primary care (immunizations, well-visits, sick visits, visits to help you manage an illness like diabetes.) Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. Your PCP should be your first call for care before going to the emergency department.
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 who is trained and practices in a specific area of medicine.
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

First Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy

a. Background

The Department will ensure that Medicaid¹ 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

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

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

- a. In accordance with Section 4.(5). of Session Law 2015-245, as amended,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:
- b. Beneficiaries being served by the Innovations waiver;³
- c. Beneficiaries being served by the TBI waiver;⁴
- d. Beneficiaries being served by Transitions to Community Living Initiative (TCLI);
- e. Beneficiaries on the waiting list for the Innovations waiver;
- f. Beneficiaries on the waiting list for the TBI waiver;
- g. Beneficiaries who have used a Medicaid service that will only be available through a BH I/DD Tailored Plan as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
- h. Beneficiaries who have used a BH, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
- i. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina;
- j. Beneficiaries who have a qualifying I/DD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;

¹ "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.

- k. Beneficiaries who have a qualifying mental health diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;^{5,6}
- l. Beneficiaries who have a qualifying SUD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;⁷
- m. Beneficiaries who have had two (2) or more psychiatric hospitalizations or readmissions within eighteen (18) months;
- n. Beneficiaries who have had an admission to a State psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode(s) in a State-owned facility;
- o. Beneficiaries who have had two (2) or more visits to the emergency department for a psychiatric problem within eighteen (18) months; and
- p. Beneficiaries who have had two (2) or more episodes using BH crisis services within eighteen (18) months.
- q. The Department will employ the processes described below to identify existing Medicaid and NC Health Choice beneficiaries as eligible for a BH I/DD Tailored Plan.
- r. In the period prior to Standard Plan launch:
 - s. 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.
 - t. 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.
- u. In the period between Standard Plan and BH I/DD Tailored Plan launch:
 - v. 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.
 - w. 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.

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.

- x. 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.
- y. 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.
- z. 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.
- aa. 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.
- bb. The Department will transmit BH I/DD Tailored Plan assignment to the BH I/DD Tailored Plan through an 834 eligibility file.
- cc. 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).
- dd. 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).
- ee. 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.
- ff. Period after BH I/DD Tailored Plan implementation (ongoing enrollment)
- gg. 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.
- hh. 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

- a. The Department will allow a beneficiary who is enrolled in a Standard Plan, the Statewide Specialized Foster Care Plan, or NC Medicaid Direct (and not part of an excluded group) to request to enroll in a BH I/DD Tailored Plan if the beneficiary is not otherwise identified through available data.
- b. The Enrollment Broker will provide information to beneficiaries via phone, chat, website, and mail on how to request to enroll in a BH I/DD Tailored Plan.
- c. Beneficiaries may request to enroll in a BH I/DD Tailored Plan using one of the following forms:
 - i. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form
 - ii. Request to Enroll in a BH I/DD Tailored Plan: Provider Form
 - iii. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form
- d. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form, the beneficiary (or guardian/legally responsible person) submits a form that indicates whether the beneficiary meets at least one of the eligibility criteria for a BH I/DD Tailored Plan as outlined in Section 4.(5) of Session Law 2015-245, as amended.⁸
- e. The beneficiary's care manager may assist the beneficiary to complete the form. If the care manager assists the beneficiary to complete the form, the care manager must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
- f. The beneficiary must provide either documentation of their needs or contact information for their provider with permission for the Department to contact the provider.

⁸ Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

- g. The beneficiary (or authorized representative⁹) must sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.
- h. Request to Enroll in a BH I/DD Tailored Plan: Provider Form
 - a. 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.
 - b. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
 - c. 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.
 - d. The beneficiary or authorized representative or provider transmits the completed form.
 - e. The Enrollment Broker will transmit the request to the Department for review within twenty-four (24) hours of receipt.
 - f. 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:
 - i. Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form will be reviewed in eight (8) Calendar Days
 - j. Request to Enroll in a BH I/DD Tailored Plan: Provider Form will be reviewed in five (5) Calendar Days
 - k. 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.
 - l. Request for a Beneficiary Enrolled in a Standard Plan Needing a Service Only Available in the BH I/DD Tailored Plans
 - m. 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.
 - n. 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.
 - o. 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.
 - p. 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

⁹ Authorized representative refers to the beneficiary's legal guardian.

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

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

- a. The Department believes that certain members of groups that are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The Department is exploring a legislative change to allow certain groups of beneficiaries that are otherwise excluded or delayed from Medicaid Managed Care to become eligible for a limited set of benefits from Medicaid Managed Care on the basis of BH I/DD Tailored Plan eligibility.
- b. Pending legislative change, beneficiaries who are enrolled in both full Medicare and Medicaid and are determined to be BH I/DD Tailored Plan eligible will be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for coverage of BH, I/DD, and TBI benefits (limited Medicaid Managed Care).
- c. The Department is also considering a similar approach for beneficiaries who are medically needy, participate in the NC HIPP program, or served through CAP/C or CAP/DA and determined to be BH I/DD Tailored Plan eligible to be auto-assigned into the beneficiary's regional BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI benefits (limited Medicaid Managed Care).
- d. The Department will transmit the auto-assignment to the assigned BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the date the beneficiary is determined to meet BH I/DD Tailored Plan eligibility. Because the beneficiary is otherwise excluded or delayed from Medicaid Managed Care, the beneficiary will not be permitted to choose a Standard Plan during the coverage year; however, the beneficiary will have the option to move back to NC Medicaid Direct.

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

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

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

- a. At a member's annual Medicaid renewal, if a member is redetermined eligible for Medicaid, continues to be eligible for a BH I/DD Tailored Plan, and has not elected to enroll in a Standard Plan, the Department will auto-assign the member into the same BH I/DD Tailored Plan from the prior eligibility year, provided that the member's Medicaid county of eligibility remains in the same BH I/DD Tailored Plan Region.
- b. If the member's eligibility has moved to a county that is part of a different BH I/DD Tailored Plan Region, the Department will auto-assign the member into the BH I/DD Tailored Plan in the member's new county of eligibility.
- c. The member will continue to have the opportunity to elect to enroll in a Standard Plan at any point during the coverage year. Members who are excluded from Standard Plan enrollment have the opportunity to elect to enroll in NC Medicaid Direct at any point during the coverage year.
- d. The member may select a Standard Plan at his or her Medicaid redetermination if he or she is not excluded from Standard Plans. If the member selects a Standard Plan, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit the Standard Plan selection to the Standard Plan through an 834 eligibility file. Coverage of the member by the Standard Plan will begin on the first day of the next month in which the member selected the Standard Plan. Members who are excluded from Standard Plan enrollment may elect to enroll in NC Medicaid Direct at their Medicaid redetermination.
- e. If a member is determined based on data reviews to no longer be eligible for BH I/DD Tailored Plan but still eligible for Medicaid and the member believes that they are still eligible, the member will have the opportunity to submit a Request to Enroll in a BH I/DD Tailored Plan.
- f. If a member is determined to no longer be eligible for Medicaid, the member will be notified and disenrolled from the BH I/DD Tailored Plan by the Department.

h. Special Enrollment Cases

Exempt populations

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

by Standard Plan or delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan or delivery system.¹¹

- e. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system at redetermination and at any point during the year,
- f. Deemed newborns
- g. The Department shall enroll deemed newborns in a Standard Plan or Tribal Option (as eligible) regardless of the mother's enrollment in a BH I/DD Tailored Plan. To enroll in a BH I/DD Tailored Plan the beneficiary must meet Tailored Plan eligibility criteria.

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

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.

i. Member requested disenrollment

- a. 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.
- b. 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
- c. 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.
- d. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
- e. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
- f. The Enrollment Broker will process disenrollment requests in accordance with the following:
- g. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
- h. The Enrollment Broker will notify the Department of its decision by the next business day following receipt of the request.

ii. 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.

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.

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.

- 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

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

iv. Disenrollment required by the Department

- a. The Department may disenroll a member from Medicaid Managed Care for any of the following reasons:
 - 1. Loss of eligibility
 - a) 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.
 - b) 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
 - 2. Change in Medicaid eligibility category
 - a) 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.
 - 3. Nursing facility long-term stays

¹³ 42 C.F.R. § 438.56(e).

¹⁴ 42 C.F.R. § 438.56(g).

- a) 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
 - b) The BH I/DD Tailored Plan shall utilize the Department-developed standardized process for monitoring length of stay for members in nursing facilities to ensure members receive appropriate levels of care and to report to the Department members who need to be disenrolled due to stays that exceed ninety (90) calendar days.
- v. 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:
 - a) 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.
 - b) The BH I/DD Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.
 - c) 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.
 - d) 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.
- vi. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.
- vii. 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 Center¹⁶ or a DMVA-operated Veterans Home¹⁷ 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.
 - c. 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.
 - d. The Department will notify the member and the BH I/DD Tailored Plan of the disenrollment and the disenrollment effective date.

¹⁵ Session Law 2015-245, as amended by Session Law 2018-49.

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>

- e. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.
- f. 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.

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

The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes. The Department shall provide written notice to each BH I/DD Tailored Plan of such change no later than sixty (60) days prior to the effective date of such change, unless shorter notice period is required by a federal or state law or regulatory change, with the Parties executing a Contract Amendment to incorporate such modifications.

First Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid and NC Health Choice Members

a. Background

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

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

- 1) Accept members and be listed as a PCP in the BH I/DD Tailored Plan’s member-facing materials for the purpose of providing care to members and managing their healthcare needs.
- 2) Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.
- 3) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- 4) Provide direct patient care a minimum of thirty (30) office hours per week.
- 5) Provide preventive services, in accordance with Section VII. Attachment M.2. Table 1: Required Preventive Services.
- 6) Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan’s medical record documentation guidelines.
- 7) Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
- 8) Transfer copies of the member’s medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
- 9) Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan’s network adequacy standards.
- 10) Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.
- 11) Review and use member utilization and cost reports provided by the BH I/DD Tailored Plan for the purpose of AMH-level UM and advise the BH I/DD Tailored Plan of errors, omissions or discrepancies if they are discovered.

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

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

Section VII. First Revised and Restated Attachment M.2. Table 1: Required Preventive Services

		Required for providers who serve the following age ranges (the age ranges are not displayed to the provider on this screen; the age ranges will be used in PEGA workflow for approval and verification purposes)											
Reference Number	AMH Preventative Health Requirements	0 to 3	0 to 6	0 to 11	0 to 18	0 to 21	0 to 121	3 to 17	7 to 120	11 to 18	11 to 121	18 to 121	21 to 121
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

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

a. Background

- 1) Prior to BH I/DD Tailored Plan launch, the Department will implement a direct process to certify provider organizations to deliver Provider-based Care Management under the Tailored Care Management model as AMH+ practices or CMAs as described below and in the BH I/DD Tailored Plan Provider Manual for Tailored Care Management [https://files.nc.gov/ncdma/DRAFT Tailored-Care-Management-Provider-Manual_20191205.pdf](https://files.nc.gov/ncdma/DRAFT_Tailored-Care-Management-Provider-Manual_20191205.pdf). This certification process will require providers to apply to the Department and be assessed against the criteria in this policy.
- 2) AMH+ practices will be primary care practices actively serving as AMH Tier 3 practices, whose providers have experience delivering primary care services to the BH I/DD Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the BH I/DD Tailored Plan eligible population, each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD diagnosis; an I/DD; or a TBI. "Active" patients are those with at least two encounters with the AMH+ applicant's practice team in the past 18 months. AMH+ practices will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services. To be eligible to become an AMH+, the practice must intend to become a network primary care provider for BH I/DD Tailored Plans. While the Department expects only a minority of AMH Tier 3 practices to be ready to obtain certification as AMH+ practices at BH I/DD Tailored Plan launch, the Department's vision is that the Tailored Care Management model will stimulate integration of Tailored Care Management within primary care practices over time.
- 3) CMAs will be provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the BH I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model. To be eligible to become a CMA, an organization's primary purpose at the time of certification must be the delivery of NC Medicaid, 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.

i. Eligibility

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

j. Organizational Standing and Experience Criteria

- 1) The organization must demonstrate that its past experience positions it to provide Tailored Care Management to the BH I/DD Tailored Plan population, specifically the subpopulation(s) for which it proposes to become a certified Tailored Care Management provider.
- 2) All organizations entering the certification process, including prospective AMH+ practices, will be required to indicate one or more of the following specialty designation type(s):
 - i. Mental health and SUD
 - a. Adult
 - b. Child/adolescent

- ii. I/DD (not enrolled in the Innovations Waiver)
 - iii. TBI (not enrolled in the TBI Waiver)
 - iv. Innovations Waiver
 - v. TBI Waiver
 - vi. Co-occurring I/DD and behavioral health
 - a. Adult
 - b. Child/adolescent
- 3) Organizations that specialize in BH must demonstrate their capacity to serve populations with both mental health and SUD needs. The organization must offer an array of services that are aligned with the needs of the target population(s) in North Carolina. The Department has a general expectation that each organization will be able to show at least a two (2) year history of providing services to the BH I/DD Tailored Plan population in North Carolina. However, the Department encourages organizations to build new capacity for Tailored Care Management as it rolls out.
 - 4) The organization must have active, working relationships with community providers that offer a wide scope of clinical and social services, including strong reciprocal relationships among relevant BH, I/DD, and primary care providers, in order to facilitate referrals among providers as well as provide formal and informal feedback and opportunities to share best practices.
 - 5) The organization must have the capacity and financial sustainability to establish care management as an ongoing line of business.
 - 6) Tailored Care Management must be recognized by the organization’s leadership and governing body as integral to the mission of the organization and as such be supported by a budget and management team appropriate to maintain Tailored Care Management as a high-functioning service line.
 - 7) The organization must be able to demonstrate that it has the appropriate structures in place to oversee the Tailored Care Management model.
 - 8) The Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look for evidence of a strong governance structure.
 - 9) Organizations may demonstrate strong governance by showing that they have a governing board and bylaws in place; a committee structure that enables appropriate oversight of budget, other fiduciary matters, compliance, and conflicts of interest; and board approval of the application submitted by the organization.

k. Staffing Criteria

- 1) AMH+ practices and CMAs must meet the same care management staffing requirements as the BH I/DD Tailored Plan. *See Section V.B.3.ii.(xiv) Staffing and Training Requirements.*
- 2) The evaluation of each provider organization’s application for AMH+ or CMA certification will include gaining an understanding of the role of any CIN or Other Partner in supporting or facilitating Tailored Care Management.
- 3) Where the AMH+ practice or CMA proposes to rely on CIN or Other Partner-employed care managers to carry out Tailored Care Management, the Department (prior to BH I/DD Tailored Plan launch) or BH I/DD Tailored Plan (beginning at BH I/DD Tailored Plan launch) will look to ensure that care management is sufficiently integrated with the organization’s practice team, as Tailored Care Management requires.

- 4) Certification will include an evaluation of whether the AMH+ or CMA has managerial control of care management staff, defined as the opportunity, at minimum, to:
 - a. Approve hiring/placement of a care manager
 - b. Require a replacement for any care manager whose performance the AMH+ or CMA deems unsatisfactory.
- 5) CINs and Other Partners supporting AMH+ practices and CMAs may take many forms, and the Department encourages innovation and market movement to support the Tailored Care Management model.
- 6) Arrangements with CINs or Other Partners must include strong clinical leadership at the CIN or Other Partner level that has deep experience in NC Medicaid or NC Health Choice and/or has supported similar efforts in other states.
- 7) Any subsidiaries of LME/MCOs, BH I/DD Tailored Plans or other health plans may not be considered CINs or Other Partners for the purposes of Tailored Care Management with the following exception:
 - a. That AMH+ practice or CMA may decide to enter into arrangements with a BH I/DD Tailored Plan as an "Other Partner" for use of its IT products or platforms for care management, in order to meet the care management data system requirements.
- 8) AMH+ practices and CMAs must meet the same requirements for clinical consultants as the BH I/DD Tailored Plan. See *Section V.B.3.ii.(xiv)(b)*.

I. Population Health and HIT Criteria

- 1) The AMH+ or CMA must have implemented an EHR or an electronic clinical system of record that is in use by the AMH+ practice or CMA's providers that may electronically to record, store, and transmit their assigned members' clinical information, including medication adherence.
- 2) The AMH+ or CMA must use a single care management data system, whether or not integrated within the same system as the EHR or clinical system of record, which allows care managers to perform the following care management functions, at minimum:
 - a) Maintain up-to-date documentation of Tailored Care Management member lists and assignments of individual members to care managers;
 - b) Electronically document and store the Care Management Comprehensive Assessment and re-assessment;
 - c) Electronically document and store the Care Plan or ISP;
 - d) Incorporate claims and encounter data;
 - e) Provide access to ; and electronically share, if requested – member records with the member's care team to support coordinated care management, as well as the member, in accordance with federal, state, and Department privacy, security, and data-sharing requirements
 - f) Track referrals; and
 - g) Allow care managers to:
 - 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).
- 3) The AMH+ practice or CMA must receive and use enrollment data from the BH I/DD Tailored Plan to empanel the population in Tailored Care Management: To support outreach, engagement, assessment, and care planning, the AMH+ practice or CMA (or CIN or Other Partner on its behalf) must be able to:
 - a. Receive, in machine-readable format, and maintain up-to-date records of acuity tiers by member, as determined and shared by the BH I/DD Tailored Plan;
 - b. Receive, in machine-readable format, and maintain up-to-date records of any other risk scoring completed and shared by the BH I/DD Tailored Plan; and
 - c. Electronically reconcile the Tailored Care Management assignment lists received from the BH I/DD Tailored Plan with its list of patients/clients for whom it provides Tailored Care Management.
 - 4) The same requirements for use of ADT information apply at the BH I/DD Tailored Plan level and AMH+ or CMA level. See *Section V.B.3.ii.(xv)(d) ADT Feeds for Organizations Providing Tailored Care Management*
 - 5) The same requirements for use of “NCCARE360” apply at the BH I/DD Tailored Plan level and AMH+ or CMA level. See *Section V.B.3.ii.(x) Ongoing Care Management*
 - 6) The Department expects that during the first two contract years, BH I/DD Tailored Plans, AMH+ practices, and CMAs will rely on the standardized acuity tiering methodology described above Section *V.B.3.ii.(x)(k)* as the primary method for segmenting and managing their populations.
 - 7) As described in *V.B.3.ii.(xv)(c) Risk Stratification*, BH I/DD Tailored Plans will have the option of establishing their own risk stratification methodologies beyond acuity tiering; if they do so, they will be required to share all risk stratification results and methodologies used with AMH+ practices and CMAs.
 - 8) By Contract Year 3, as the Tailored Care Management model matures, AMH+ practices and CMAs will be expected to develop their own risk stratification approach, refining the data and risk stratification scores they receive from BH I/DD Tailored Plans to incorporate critical clinical, unmet health-related resource, and other data to which they have access. Additionally, AMH+ practices and CMAs’ use of patient registries to track patients by condition type/cohort is encouraged, but not required.
 - 9) Annually, the AMH+ practice or CMA must evaluate the Tailored Care Management services it provides to ensure that the services are meeting the needs of empaneled beneficiaries and refine the services as necessary. The AMH+ practice or CMA should use a combination of clinical data, care management encounter data and quality scores to generate a set of internal targets and set annual goals for improvement.

m. Quality Measurement Criteria

- 1) After the launch of BH I/DD Tailored Plans, AMH+ practices and CMAs will be required to gather, process, and share data with BH I/DD Tailored Plans for the purpose of quality measurement and reporting.
- 2) The Department will publish quality measure requirements each year. Elements of the list may be modified on a quarterly basis, but new measures will be added only during annual updates.

- 3) AMH+ practices and CMAs may need to perform tasks including:
 - a. Abstracting data from patient charts;
 - b. Performing quality assurance to validate the accuracy of data in patient charts that is used for quality measurement purposes;
 - c. Using additional codes to fully document patient status and needs in order to improve the accuracy of quality measurement; and
 - d. Explaining to patients the purpose of certain state-sponsored surveys, how the state and BH I/DD Tailored Plans will use survey results, and how their information will be kept confidential.
- 4) As covered in *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*, BH I/DD Tailored Plans will be required to share interim performance reports with AMH+ practices and CMAs.

n. Other Tailored Care Management Criteria

- 1) AMH+ practices and CMAs must develop policies for communicating and sharing information with beneficiaries and their families and other caregivers with appropriate consideration for language, literacy, and cultural preferences, including sign language, closed captioning, and/or video capture. “Robocalls” or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting beneficiaries.
- 2) AMH+ practices and CMAs must meet the same contact requirements as the BH I/DD Tailored Plan. *See Section V.B.3.ii.(x) Ongoing Care Management*
- 3) AMH+ practices and CMAs must meet the same requirements for Care Management Comprehensive Assessment that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*
- 4) AMH+ practices and CMAs must meet the same requirements for Care Plans and ISPs that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(viii) Development of Care Plan/Individual Support Plan*
- 5) AMH+ practices and CMAs must meet the same requirements for the composition of a care team that apply at the BH I/DD Tailored Plan level.
- 6) By BH I/DD Tailored Plan launch, the AMH+ practice or CMA must demonstrate the ability to electronically and securely transmit the Care Plan or ISP to each member of the multidisciplinary care team. *See Section V.B.3.ii.(ix).Care Team Formation*
- 7) AMH+ practices and CMAs must meet the same requirements for ongoing care management that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(x) Ongoing Care Management*
- 8) AMH+ practices and CMAs must meet the same requirements related to addressing Unmet Health-Related Resource Needs that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(x) Ongoing Care Management*
- 9) AMH+ practices and CMAs must meet the same requirements for transitional care management that apply at the BH I/DD Tailored Plan level. *See Section V.B.3.ii.(xi) Transitional Care Management.*
- 10) Care managers based at AMH+s and CMAs, as well as any supporting CINs or Other Partners, will be required to undergo the same training requirements as care managers based at BH I/DD Tailored Plans. *See Section V.B.3.ii.(xiv) Staffing and Training Requirements.*

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

a. Background

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

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

- a) 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:
 - a. Complete the standardized risk-screening tool at each initial visit.
 - b. 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.
 - c. Commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks' gestation.
 - d. Commit to decreasing the cesarean section rate among nulliparous women.
 - e. 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.
 - f. 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.
 - g. 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).
 - h. Ensure comprehensive postpartum visits occur within fifty-six (56) days of delivery.
- b) 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.

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

a. Background

- 1) "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*.
- 2) 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.
- 3) After Contract Year 1, Care Management for High-Risk Pregnancy shall be fully subsumed into the Tailored Care Management model.

b. Scope

- 1) 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

- 1) 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

- 1) 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.
- 2) 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

- 1) 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.
- 2) 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.
- 3) 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.
- 4) 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.

- 5) 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

- 1) 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.
- 2) LHD shall utilize assessment findings, including those conducted by the BH I/DD Tailored Plan, to determine level of need for care management support.
- 3) LHD shall document assessment findings in the care management documentation system.
- 4) 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.
- 5) LHD shall assign case status based on level of patient need.

g. Care Management for High-Risk Pregnancy: Interventions

- 1) 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.
- 2) LHD shall provide care management services based upon level of patient need as determined through ongoing assessment.
- 3) LHD shall develop person-centered Care Plans, including appropriate goals, interventions and tasks.
- 4) LHD shall utilize NCCARE360 to identify and connect members with additional community resources.
- 5) 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.
- 6) 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

- 1) 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.
- 2) LHD shall establish a cooperative working relationship and mutually agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers.
- 3) 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.

- 4) LHD shall ensure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population.
 - 5) LHD shall ensure awareness of BH I/DD Tailored Plan members' "in network" status with providers when organizing referrals.
 - 6) 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**
- 1) LHD shall work with the BH I/DD Tailored Plan to ensure program goals are met.
 - 2) 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.
 - 3) 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.
 - 4) 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**
- 1) 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.
 - 2) 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.
 - 3) 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.
 - 4) 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**
- 1) LHD shall employ care managers meeting pregnancy care management competencies, defined as having at least one of the following qualifications:
 - a. Registered nurses
 - b. 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.
 - c. 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.
 - 2) 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.
 - 3) 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.

- 4) 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.
- 5) 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.
- 6) LHD shall ensure that pregnancy care managers demonstrate:
 - a. Proficiency with the technologies required to perform care management functions
 - b. Motivational interviewing skills and knowledge of adult teaching and learning principles
 - c. Ability to effectively communicate with families and providers
 - d. Critical thinking skills, clinical judgment and problem-solving abilities
- 7) 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:
 - a. Provision of program updates to care managers
 - b. Daily availability for case consultation and caseload oversight
 - c. Regular meetings with direct service care management staff
 - d. Utilization of reports to actively assess individual care manager performance
 - e. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual
- 8) 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.
 - a. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.

First Revised and Restated Attachment M. 6. Reserved

First Revised and Restated Attachment M. 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 based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider. For network providers of Medicaid BH, I/DD, and TBI services, the BH I/DD Tailored Plan has the authority to maintain a closed network for these services as set forth in Section 4.(10)(a)(1)(IV) of Session Law 2018-48. The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the BH I/DD Tailored Plan in selection and retention of network providers for Medicaid BH, I/DD, and TBI services.

b. Scope

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

c. Policy Statement

The BH I/DD Tailored Plan shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Re-credentialing Policy.

d. Provider Enrollment and Credentialing

- a. The Department, or Department designated vendor, will implement a Centralized Credentialing and Re-credentialing Process (CCRP) with the following features:
- b. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid or Health Choice programs (or both) or as a State-funded Services provider.
- c. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider or State-funded Services Enrolled provider.
- d. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.
- e. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid or State-funded Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).
- f. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan

accrediting organization. The applicable data and processing standards shall be consistent with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.

- g. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid or State-funded Services Enrolled provider, with the application serving for enrollment as a NC Medicaid Direct provider and a Medicaid Managed Care provider.
- h. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the NC Medicaid Direct program or provide State-funded services.
- i. Providers will be reverified and recredentialed as permitted by the Department in the Contract.
- j. A BH I/DD Tailored Plan shall use its Provider Credentialing and Re-credentialing Policy to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the BH I/DD Tailored Plan will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid or State-funded Services Enrolled provider in accordance with the standards contained in this Policy
- k. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The BH I/DD Tailored Plan shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

e. Provider Credentialing and Re-credentialing Policy

- a. The BH I/DD Tailored Plan shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The Policy, at a minimum, must:
- b. Meet the requirements specified in 42 C.F.R. § 438.214;
- c. Meet the requirements specified in this Contract;
- d. Follow this Policy and any applicable requirements from the Contract, and address acute, primary, mental health, substance use disorders, and long-term services and supports providers;
- e. Establish that the BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.
- f. Establish a documented process for determining if a provider is an active Medicaid Enrolled provider or State-funded Services provider;
- g. Prohibit BH I/DD Tailored Plan from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).
- h. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.
- i. Prohibit BH I/DD Tailored Plan to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;
- j. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers or State-funded Services providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and

- k. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH, I/DD, and TBI services. At a minimum, these standards shall assess a provider's ability to deliver care.
- l. Identify standards and establish a documented process for making network contracting decisions on State-funded Services providers.
- m. Describe the information that providers will be requested to submit as part of the contracting process.
- n. Describe the process by which the BH I/DD Tailored Plan will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).
- o. If BH I/DD Tailored Plan requires a provider to submit additional information as part of its contracting process, the BH I/DD Tailored Plan's policy shall include a description of all such information.
- p. BH I/DD Tailored Plan shall make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates BH I/DD Tailored Plan shall re-credential providers as follows:
- q. The BH I/DD Tailored Plan shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
- r. After the Provider Credentialing Transition Period, no less frequently than every three (3) years.
- s. BH I/DD Tailored Plan shall follow this Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.
- t. BH I/DD Tailored Plan shall have discretion to make network contracting decisions consistent with the Policy.

First Revised and Restated Attachment M. 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.

- 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

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

Attachment M. 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

- 1) Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.
- 2) Adult Facility-Based Crisis Services: a state-funded crisis service for the purpose of network adequacy standards.
- 3) Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.
- 4) Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.
- 5) Non-Hospital Medical Detoxification (adults only): a crisis service for the purpose of network adequacy standards.
- 6) Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
- 7) Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
- 8) Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- 9) Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- 10) Acute Care Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- 11) Hospitals with Adult Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- 12) Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- 13) Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- 14) Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- 15) Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
- 16) Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

- 17) Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
- 18) Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.
- 19) 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.
- 20) 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.
- 21) Urgent Care for Mental Health:
 - a. Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
 - b. Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.
- 22) 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.
- 23) 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.
- 24) Urgent care for SUD:
 - a. Services to treat a condition in which the person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person's substance use is in need of prompt assistance to avoid further deterioration in the person's condition which could require emergency assistance for BH appointment wait-time standards.
 - b. Services to treat a condition in which a person displays a condition which could without diversion and intervention, progress to the need for emergent services/care for the purposes of the BH appointment wait-time standards.
- 25) 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.
- 26) Specialized Services: as partial hospitalization for children and adults for the purposes of the network adequacy standards.

First Revised and Restated Attachment M. 10. Reserved

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

1) Background

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

Indian Health Care Provider (IHCP) refers to a “health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by state recognized tribes are not considered IHCPs.

In the event there are Tribal entities that are not IHS providers but are eligible to enroll as a Medicaid provider as an atypical health provider, the Office of the Chief of the Eastern Band of the Cherokee (EBCI) shall provide a “Tribal Provider Attestation.” This “Tribal Provider Attestation” letter from the EBCI Chief’s office shall be submitted to 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 applicable AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The BH I/DD Tailored Plan shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with 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 encounters per day (single day of service) such as but not limited to follows:
 - (1) Medical
 - (2) Dental;
 - (3) Behavioral; and,
 - (4) One (1) other such as optical
 - (5) The BH I/DD Tailored Plan shall reimburse I/T/U pharmacies for pharmacy claims based on the rate and payment logic set forth in the North Carolina Medicaid State Plan (a maximum of two (2) pharmacy AIR per patient per day):
 - (a) High-cost drugs are excluded and are paid based on DHBs outpatient pharmacy 'lessor of logic'
 - (b) If more than 2 drugs are filled, additional drugs beyond the 2 will be paid at \$0 and should be used by the Tailored Plan for medication reconciliation.
- 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 M. 12. Healthy Opportunities Screening Questions

The screening questions listed below shall be incorporated into the BH I/DD Tailored Plan’s Care Needs Screening tool in accordance with *Section V.C.6.a.iv.a) 3.* and *Section V.C.8.e.i* of the Contract.

Health Screening Questions

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn’t have money to get more?		
Housing / Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don’t have food for tonight, you don’t have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

First Revised and Restated 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 community provider (e.g., BH community provider or hospital/emergency department) shall complete and submit a Regional Referral Form available on the Department's website² 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;
 - 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.

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>.

- vi. 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).
 - vii. 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.
 - 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:

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.

- 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:
 - o The State Developmental Center sends the EAR to the BH I/DD Tailored Plan; and
 - o 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.)

First Revised and Restated Attachment O. Reserved

First Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

It is agreed by the Parties that no performance metric or SLA will be determined as unmet and no liquidated damages will be assessed or punitive action taken against Contractor where the fault of such purported non-compliance is significantly, materially or predominantly caused by a third-party, including by the Department. A subcontractor of the Contractor is not a third-party.

Table 1: Liquidated Damages for Medicaid Compliance Issues

Section VII. First Revised and Restated 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.	\$2,500 per calendar day
2.	Failure to comply with conflict of interest requirements described in <i>Section III.D.15. Disclosure of Conflicts of Interests</i> and <i>Section V.A.1.ix.(xiii) Conflicts of Interest</i> .	\$5,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by <i>Section III.D.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition</i> .	\$500 per calendar day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in <i>Section III.D.17. Disclosure of Ownership Interest</i> .	\$1,250 per entity disclosure/attestation for each disclosure/attestation that is not received or is received and signed by an entity that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in <i>Section III.D.46 Subcontractors</i> .	Up to \$25,000 per occurrence
Members		
6.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in <i>Section V.B.1.iv. Marketing</i>	\$2,500 per occurrence
7.	Failure to comply with member enrollment and disenrollment processing timeframes as described in <i>Section V.B.1.i.(v) Medicaid Managed Care Enrollment and Disenrollment</i> .	\$250 per occurrence per member

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
8.	Failure to comply with timeframes for providing member Welcome Packets, handbooks, identification cards, and provider directories as described in <i>Section V.B.1.iii. Member Engagement.</i>	\$125 per occurrence per member
9.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in <i>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</i>	Up to \$25,000 per occurrence
10.	Failure to comply with member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in <i>Section V.B.1.vi. Member Grievances and Appeals.</i>	\$250 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.	\$2,500 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 <i>Section V.B.1.vi. Member Grievances and Appeals.</i>	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 <i>Section V.B.1.vi. Member Grievances and Appeals.</i>	\$500 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 <i>Section V.B.1.ii. Transition of Care.</i>	\$50 per calendar day, per member AND The value of the services the BH I/DD Tailored Plan failed to cover during the applicable transition of care period, as determined by the Department.

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
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.	\$2,500 per occurrence per member
16.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package and V.B.2.iii. Pharmacy Benefits.</i>	\$2,500 per standard authorization request \$3,750 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 <i>Section V.B.4.i. Provider Network.</i>	\$500 per occurrence
18.	Failure to follow Department required Clinical Coverage Policies as specified <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package.</i>	\$1,250 per occurrence
19.	Failure to timely update pharmacy reimbursement schedules as required by as specified <i>Section V.B.2.iii. Pharmacy Benefits.</i>	\$1,250 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 <i>Section V.B.2.iv. Non-Emergency Transportation.</i>	\$250 per occurrence per member
21.	Failure to comply with driver requirements as defined in the Department’s NEMT Policy.	\$750 per occurrence per driver
22.	Failure to comply with the assessment and scheduling requirements as defined in the Department’s NEMT Policy.	\$125 per occurrence per member
23.	Failure to comply with vehicle requirements as defined in the Department’s NEMT Policy.	\$750 per calendar day per vehicle
24.	Failure to timely notify the Department that the BH I/DD Tailored Plan lowered a provider’s AMH Tier status	\$500 per calendar day
Care Management		
25.	Failure to timely develop and furnish to the Department its Care Management Policy as required by <i>Section V.B.3.ii. Tailored Care Management</i>	\$125 per calendar day

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
26.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in the <i>Section V.B.3.ii. Tailored Care Management</i> (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	\$250 per deficient/missing care management comprehensive assessment or plan
27.	Failure for Plan to adhere to the quarterly minimum contact requirements for a member’s acuity tier by panel as described in <i>Section V.B.3.ii.(x) Ongoing Care Management</i> .	\$1000 per month where panel contact were less than 50% of contacts
28.	Failure to comply with minimum Transitional Care Management requirements as described in <i>Section V.B.3.ii. Tailored Care Management</i> .	\$125 per occurrence per member
29.	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 <i>Section V.B.3.ii.(xix) Oversight</i> .	\$250 per calendar day
30.	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 <i>Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management</i> . (liquidated damage to begin in second contract year)	Up to \$50,000 per percentage below the requirement each calendar year
31.	Failure to comply with federal conflict-free case management requirements for members enrolled in the Innovations or TBI waiver	\$250 per occurrence per member
32.	Failure to timely notify the Department of a notice of underperformance sent to an LHD or the termination of a contract with an LHD.	\$250 per calendar day
33.	Failure to implement and maintain an Opioid Misuse Prevention and Treatment Program and Member Lock-In Program as <i>described in Section V.B.3.i. Prevention and Population Health Programs</i> .	\$1,000 per occurrence
34.	<i>For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:</i> 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 <i>Section V.B.3.x. Healthy Opportunities</i> .	\$50 per identified instance of duplicated service delivery AND Refund of the BH I/DD Tailored Plan’s Pilot program budget for total amount spent on Pilot service that was duplicated for each identified instance of duplication

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
35.	<i>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.</i>	\$125 per occurrence AND Refund of the BH I/DD Tailored Plan’s Pilot program budget for total amount spent on Pilot service in each identified instance
Providers		
36.	Failure to update online and printed provider directory with accurate provider information as required by <i>Section V.B.4.ii. Provider Network Management.</i>	\$500 per confirmed incident
37.	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 <i>Section V.B.4.ii. Provider Network Management.</i>	\$50 per calendar day per member for failure to timely notify the affected member or Department
38.	Failure to notify a provider of the network contracting decision within five (5) Business Days of verification of the provider’s status as a Medicaid Enrolled provider.	\$50 per calendar day per provider
39.	Failure to submit timely initial and updated, compliant Network Access Plan as described in <i>Section V.B.4.i. Provider Network</i>	\$2,500 per calendar day
40.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in <i>Section V.B.4.i. Provider Network</i> (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
41.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department’s specifications	\$125 per calendar day
42.	Failure to maintain accurate provider directory information as required by <i>Section V.B.4.ii. Provider Network Management</i>	\$100 per calendar day per provider
Quality and Value		
43.	Failure to submit quality measures including audited HEDIS results within the timeframes specified in <i>Section V.B.5.a. Quality Management and Quality Improvement.</i>	\$2,500 per calendar day
44.	Failure to timely submit appropriate PIPs to the Department as described in <i>Section V.B.5.i. Quality Management and Quality Improvement.</i>	\$500 per calendar day

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
45.	Failure to timely submit QAPI to the Department as described in <i>Section V.B.5.i. Quality Management and Quality Improvement.</i>	\$500 per calendar day
46.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in <i>Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.</i>	\$50,000 per month for every month beyond the month NCQA accreditation must be obtained until such time as the BH I/DD Tailored Plan is terminated in accordance with <i>Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.</i>
Claims and Encounter Management		
47.	Failure to timely submit monthly encounter data set certification.	\$500 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 <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements.</i>	\$1,000 per calendar day
49.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements.</i>	\$500 per calendar day
50.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in <i>Section V.B.7.ii. Medical Loss Ratio</i> and <i>Section VII First Revised and Restated Attachment J. Reporting Requirements.</i>	\$1,000 per calendar day
51.	Failure to timely and accurately submit financial reports in accordance with <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> or comply with any other ad-hoc request for financial reporting as directed by the Department.	\$500 per calendar day
Compliance		
52.	Failure to establish and maintain a Special Investigative Unit as described in <i>Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services.</i>	\$2,500 per calendar day that the Department determines the BH I/DD Tailored Plan is not in compliance

Section VII. First Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
53.	Failure to timely submit on an annual basis the Compliance Program report as described in <i>Section V.K.1. Compliance Program</i> and <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per calendar day
54.	Failure to timely submit the Recoveries from Third Party Resources Report described in <i>Section V.A.3.iv. Third Party Liability (TPL) for Medicaid</i> and <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> .	\$125 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.	\$1,250 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.	\$125 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 <i>Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services</i> and <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> .	\$1,000 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.	\$250 per member per occurrence

Section VII. First Revised and Restated 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.	\$250 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.	\$250 per member per occurrence, not to exceed \$5,000,000
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.	\$250 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.	\$500 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.	\$250 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).	\$ 10,000 per occurrence per plan or program
65.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	\$250 per calendar day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved CAP
66.	Engaging in gross customer abuse of Members by Contractor service line agents as prohibited by <i>Section V.A.2.(xxiv) Gross Customer Abuse</i>	\$1,000 per occurrence
67.	Failure to timely report incidents of gross customer abuse to the Department in accordance with <i>Section V.A.2.(xxiv) Gross Customer Abuse</i>	\$250 per Business Day the Contractor fails to timely report to the Department.

Table 2: Liquidated Damages for State-Funded Services Compliance Issues

Section VII. First Revised and Restated 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 <i>Section III.D.15. Disclosure of Conflicts of Interests and Section V.A.1.ix.(xiii) Conflict of Interest..</i>	\$2,500 per occurrence
2.	Failure to timely provide conflict of interest or criminal conviction disclosures as required by <i>Section III.D.15. Disclosure of Conflicts of Interests and Section III.D.16. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition.</i>	\$250 per calendar day
3.	Failure to require and ensure compliance with ownership and disclosure requirements as required in <i>Section III.D.17 Disclosure of Ownership Interest.</i>	\$625 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements.
4.	Failure to perform necessary oversight of Subcontractors as described in <i>Section III.D.46 Subcontractors.</i>	Up to \$12,500 per occurrence
Providers		
5.	Failure to update online and printed provider directory as required by <i>Section V.C.4.b. Provider Network Management.</i>	\$250 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 <i>Section V.C.4.b. Provider Network Management.</i>	\$50 per calendar day per recipient for failure to timely notify the affected recipient or Department
7.	Failure to notify a provider of the network contracting decision within five (5) Business Days of verification of the provider’s status as a State-funded provider	\$25 per calendar day per provider
8.	Failure to submit timely initial and updated, compliant Network Access Plan as described in <i>Section V.C.4.a. Provider Network</i>	\$500 per calendar day
9.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in <i>Section V.C.4.a. Provider Network</i> (excludes Department approved exceptions to the network adequacy standards).	\$625 per month for failure to meet any of the listed standards, either individually or in combination

Section VII. First Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
10.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	\$125 per calendar day
11.	Failure to maintain accurate provider directory information as required by <i>Section V.C.4.b. Provider Network Management</i> .	\$50 per confirmed incident
Claims Management		
12.	Failure to timely submit monthly claims data set certification.	\$250 per calendar day
Financial Requirements		
13.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per calendar day
14.	Failure to timely and accurately submit monthly financial reports in accordance with <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> or comply with any other ad-hoc request for financial reporting as directed by the Department.	\$250 per calendar day
Compliance		
15.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$625 per incident for failure to fully cooperate during an investigation
16.	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
17.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in as described in <i>Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services</i> and <i>Section VII. First Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per calendar day

Section VII. First Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
Technical Specifications		
18.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	\$125 per recipient per occurrence
19.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of recipient PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	\$125 per recipient per occurrence
20.	Failure by the BH I/DD Tailored Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	\$125 per recipient per occurrence, not to exceed \$2,500,000
Directives and Deliverables		
21.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	\$125 per calendar day that the Department determines the BH I/DD Tailored Plan is not in compliance
22.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	\$250 per occurrence per committee
23.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	\$125 per calendar day the unapproved agreement or materials are in use
24.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	\$5,000 per occurrence per plan or program
25.	Failure to provide a timely and acceptable corrective action plan or comply with a CAP as required by the Department.	\$125 per calendar day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved corrective action

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

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	\$5,000 per service line per month
2.	Call Response Time/Call Answer Timeliness – Member and Recipient Service Line	The BH I/DD Tailored Plan shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
3.	Call Wait/Hold Times – Member and Recipient Service Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
4.	Call Abandonment Rate – Member and Recipient Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
5.	Call Wait/Hold Times – Behavioral Health Crisis Line	The BH I/DD Tailored Plan shall answer at least ninety-eight percent (98%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$15,000 per month
6.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	\$15,000 per month
7.	Call Response Time/Call Answer Timeliness – Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
8.	Call Wait/Hold Times – Provider Support Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month

Section VII. First Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
9.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$5,000 per month

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

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
Enrollment and Disenrollment					
1.	Member Enrollment Processing	The BH I/DD Tailored Plan shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the BH I/DD Tailored Plan to its system to trigger enrollment and disenrollment processes.	Daily	\$500 per twenty-four (24) hour period Note: Effective one (1) month prior to BH I/DD Tailored Plan launch
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	\$5,000 per month

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
3.	Member Appeals Resolution - Expedited	The BH I/DD Tailored Plan shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	\$5,000 per month
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	\$2,500 per month
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	\$50,000 per quarter or the estimated lost rebates as calculated by the Department, whichever is greater

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
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 (<i>Section V.B.3.ii. (xviii) Certification of AMH+ Practices and CMAs</i>).	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the BH I/DD Tailored Plan divided by the total number of certified AMH+ practices and CMAs.	Monthly	\$25,000 per month
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	\$25,000 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 or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
9.	Call Wait/Hold Times - Nurse Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
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 or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
12.	Call Wait/Hold Times - Pharmacy Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 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
14.	Call Response Time/Call Answer Timeliness - NEMT Member Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period..	Monthly	\$10,000 per month
15.	Call Wait/Hold Times - NEMT Member Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
16.	Call Abandonment Rate – NEMT Member Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice 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
17.	Call Response Time/Call Answer Timeliness - NEMT Provider Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month
18.	Call Wait/Hold Times - NEMT Provider Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$10,000 per month

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
19.	Call Abandonment Rate – NEMT Provider Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice 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
20.	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 payment 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
21.	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 payment 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
22.	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 payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	\$100 per claim per calendar day

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
23.	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	\$12,500 per month
24.	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	\$25,000 per week
25.	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	\$5,000 per month
26.	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.	Daily Monthly	\$5,000 per month

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
Website Functionality					
27.	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
28.	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
29.	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 inquiries include communications received via email, fax, web or other communications received electronically by the BH I/DD Tailored Plan (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	\$100 per occurrence

Section VII. First Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
30.	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	\$50,000 per year

Table 5: Metrics, SLAs and Liquidated Damages for State-Funded Services

Section VII. First Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
1.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility Based Crisis Services for Mental Health Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	\$50,000 per quarter
2.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for Substance Use Disorder Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within 1-7 days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within 1-7 days of discharge.	Quarterly	\$50,000 per quarter
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. First Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
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

Attachment O. Reserved.

Attachment R. Subcontractor Identification Form

The Contractor must complete a *Subcontractor Identification Form* for each known Subcontractor, as defined in Contract Section III. A Definitions, who will be used to meet the Contract requirement or otherwise perform any services pursuant to the Contract.

By submitting this Attachment after Contract Execution in accordance with the *Contract Section III. D. General Terms and Conditions, 43. SUBCONTRACTORS*, the Contractor:

1. Certifies that the information provided in this Attachment is true to the best of its information and belief; and
2. Acknowledges the requirements set forth in the Terms and Conditions related to Subcontractors and the resulting obligations, including requiring Department approval of any Subcontractors used in the performance of the Contract; and
3. Agrees to notify the Department of any material changes to the information provided in this Attachment that arise during the term of the Contract.

A: Subcontractor Identification	
1. Business Information. Provide the requested Information in the space provided:	
Legal Name of Subcontractor	
Name Used for Business if Different	
FEIN/Taxpayer ID	
Address	
Contract Executed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Term of Contract	
Name of Contact Person Title Phone Number Email Address	

2. Scope of Subcontracted Services. Identify the scope of services and activities that will be provided by the Subcontractor; cite specific Sections of the Contract as applicable:	
3. Is Subcontractor a government entity? If no, complete Section B: Historically Underutilized Businesses below.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

B: Historically Underutilized Businesses (HUB)	
1. Is proposed non-government entity Subcontractor owned by a HUB?	
<input type="checkbox"/> Yes (if yes, complete Question 2) <input type="checkbox"/> No (if no, skip to Question 3) <input type="checkbox"/> Unknown (if unknown, skip to Question 3)	
<p>Owned means at least fifty-one percent (51%) of the business is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in question b. below, or in the case of a corporation, at least fifty-one percent (51%) of the stock is owned by one or more citizens or lawful permanent residents of the United States who are members of at least one of the groups listed in Question 2. below.</p>	
2. Identify the Type of minority business group(s). Check all that apply.	
<input type="checkbox"/> Black A person having origins in any of the black racial groups of Africa. <input type="checkbox"/> Hispanic A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race. <input type="checkbox"/> Asian American A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands. <input type="checkbox"/> American Indian A person having origins in any of the original Indian peoples of North America. <input type="checkbox"/> Female <input type="checkbox"/> Disabled A person with a disability as defined in G.S. 168-1 or G.S. 168A-3. <input type="checkbox"/> Disadvantaged A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.	

3. Is the proposed non-government Subcontractor **operated** by a HUB?

- Yes** (if yes, complete Question 4)
- No** (if no, skip to Question 5)
- Unknown** (if unknown, skip to Question 5)

Operated means the management and daily business operations are controlled by one or more owners of the business who are citizens or lawful permanent residents of the United States of at least one of the groups listed in Question 4. below

4. Identify the type of minority business group(s). Check all that apply.

- Black** A person having origins in any of the black racial groups of Africa.
- Hispanic** A person of Spanish or Portuguese culture having origins in Mexico, South or Central America, or the Caribbean islands, regardless of race.
- Asian American** A person having origins in any of the original peoples of the Far East, Southeast Asia, Asia, Indian continent, or Pacific islands.
- American Indian** A person having origins in any of the original Indian peoples of North America.
- Female**
- Disabled** A person with a disability as defined in G.S. 168-1 or G.S. 168A-3.
- Disadvantaged** A person who is socially and economically disadvantaged as defined in 15 U.S.C. § 637.

5. Is the proposed non-government Subcontractor Certified with North Carolina as a HUB?

- Yes** **No** **Unknown**

Attachment S. National Correct Coding Initiative Confidentiality Agreement

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL CORRECT CODING INITIATIVE EDITS CONFIDENTIALITY AGREEMENT

This Agreement is made effective upon the date of execution of Contract #30-2022-007-DHB-#, by and between the North Carolina Department of Health and Human Services, Division of Health Benefits (“Department”) and TP Entity Name (“Contractor”). The Department and Contractor may be collectively referred to as the “Parties.”

I. BACKGROUND

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and is intended to reduce improper coding that may result in inappropriate payments of Medicare Part B claims and Medicaid claims. In 2010, Section 6507 of the Patient Protection and Affordable Care Act amended Section 1903(r) of the Social Security Act and required CMS to notify state Medicaid agencies of the NCCI Methodologies used in the Medicare Part B program that were compatible with Medicaid. As of October 2010, state Medicaid agencies have been required to incorporate the Compatible Medicaid NCCI Methodologies in their systems for processing applicable Medicaid Fee-for-Service (FFS) claims which are submitted with, and reimbursed on the basis of, Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes from the following types of providers: (1) practitioners and ambulatory surgical centers; (2) services provided to outpatients in hospitals (including services rendered in emergency rooms, observation units, laboratories, and radiology departments, and other diagnostic and therapeutic services); and (3) providers of durable and home medical equipment.

The implementation of the NCCI Edits is mandatory for all Medicaid FFS programs, but the application of the Compatible Medicaid NCCI Methodologies to FFS claims processed by managed care organizations within states’ Medicaid managed care programs is optional. In accordance with federal law, the Department has implemented the Compatible Medicaid NCCI Methodologies into its FFS program, NC Medicaid Direct, and has opted to use the Compatible Medicaid NCCI Methodologies its Medicaid Managed Care program and share the Non-public State Medicaid NCCI Edit Files, provided by CMS to the Department, with the Prepaid Health Plans (PHPs) for processing claims that are paid by the PHPs on a FFS basis.

II. PURPOSE

This Agreement sets forth the terms and conditions under which the Department will share with Contractor the Non-public State Medicaid NCCI Edit Files posted by CMS on a quarterly basis to the secure Regional Information Sharing Systems (RISSNET) portal that is only accessible to state Medicaid agencies. The Agreement further specifies Contractor’s obligations for use and disclosure of the Non-public State Medicaid NCCI Edit Files once provided to Contractor by the Department.

III. DEFINITIONS

- 1. COMPATIBLE MEDICAID NCCI METHODOLOGIES.** The six NCCI Methodologies used in the Medicare Part B program and determined by CMS as compatible methodologies for claims filed in Medicaid: (1) a methodology with procedure-to-procedure edits for practitioner and ambulatory surgical center services; (2) a methodology with procedure-to-procedure edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services); (3) a methodology with procedure-to-procedure edits for durable medical equipment; (4) a methodology with medically unlikely edits for practitioner and ambulatory surgical center services; (5) a methodology with medically unlikely edits for outpatient services in hospitals; and (6) a methodology with medically unlikely edits for durable

medical equipment. Although the Medicare methodologies are compatible for Medicaid, the actual edits used are not identical between programs.

2. **CONTRACTED PARTIES.** Any contractor or subcontractor (including Commercial Off-the-Shelf (COTS) software vendors) which assist Contractor with implementation of claims processing or encounter data, and who must use the Non-public Medicaid NCCI Edit Files for processing purposes.
3. **NATIONAL CORRECT CODING INITIATIVE (NCCI).** The CMS-developed coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology Manual and national and local policies and edits to promote correct coding and control improper coding that may lead to inappropriate payment of claims under Medicaid.
4. **NCCI EDITS.** Edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits: (1) NCCI edits, or procedure-to-procedure edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons; and (2) MUEs, or units-of service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
5. **NCCI METHODOLOGIES.** NCCI methodologies have four components: (1) a set of edits; (2) definitions of types of claims subject to the edits; (3) a set of claims adjudication rules for applying the edits; and (4) a set of rules for addressing provider/supplier appeals of denied payments for services based on the edits.
6. **NON-PUBLIC MEDICAID NCCI EDIT FILES.** The quarterly Medicaid NCCI edit files that are not accessible by the general public and are only made available to state Medicaid agencies by CMS and posted by CMS on the secure RISSNET portal.

IV. AGREEMENT

The Parties agree to the following provisions of this Agreement:

1. **USE AND DISCLOSURE**

- a. The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with Contractor when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
- b. Contractor is required to incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the Contractor pays on an FFS basis. The NCCI editing should occur prior to current procedure code review and any other editing by the Contractor's claims payment systems.
- c. Contractor agrees to use any non-public information from the Non-public Medicaid NCCI Edit Files only for business purposes directly related to the implementation of the Compatible Medicaid NCCI Methodologies in the State of North Carolina.
- d. Except as otherwise permitted in this Agreement, after the start of the calendar quarter, Contractor may disclose only nonconfidential information that is also available to the general public about the Non-public Medicaid NCCI Edit Files found on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
- e. Contractor may share the Non-public Medicaid NCCI Edit Files with a Contracted Party assisting with the implementation of the State's Medicaid NCCI program in the processing of claims or encounter data, only after execution of the appropriate confidentiality agreements that include the same restrictions on use and disclosure as contained herein. Such agreements with any Contracted Party shall be provided to the Department upon request.

2. RESTRICTIONS ON USE AND DISCLOSURE

- a. Except as permitted by this Agreement, Contractor shall not disclose, publish, or share with any party, not involved in the implementation of the Compatible Medicaid NCCI Methodologies covered by this Agreement, the Non-public Medicaid NCCI Edit Files.
- b. Contractor shall not publish or otherwise share new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edits Files with individuals, medical societies, or any other entities, unless it is a Contracted Party, prior to the posting of the Medicaid NCCI Edits on the Medicaid NCCI webpage (<https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html>).
- c. Contractor shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.
- d. Contractor shall not release to the public any non-public information contained in the Non-public Medicaid NCCI Edit Files, at any time. Only the Department shall have the discretion to release additional information for selected individual edits or limited ranges of edits from the files posted on the secure RISSNET portal.
- e. Contractor shall not use the Non-public Medicaid NCCI Edit Files for any non-Medicaid purpose, at any time.

3. **REPORTING.** Contractor shall report in writing to the Department any unauthorized access, uses, or disclosures of the Non-public Medicaid NCCI Edit Files by Contractor, or by its Contracted Party, within twenty-four (24) hours after it becomes aware of the unauthorized access, use, or disclosure. Notice shall be provided to the Department Contract Administrators in accordance with the terms and conditions of *Section III.B.11. Contract Administrators* of the Contract which are incorporated herein by reference. In addition, Contractor shall reasonably cooperate with the Department to mitigate the damage or harm of any such incidents of unauthorized access, use, or disclosure of the Non-public Medicaid NCCI Edit Files.

4. GENERAL TERMS AND CONDITIONS.

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. The Department may impose remedial actions, intermediate sanctions, liquidated damages and/or terminate the Contract in accordance with the terms and conditions of *Section III.B.45. Termination* and *Section V. Contract Performance* of the Contract, which are incorporated herein by reference, for violations of this Agreement.

5. TERM AND TERMINATION:

- a. **Term.** This Agreement shall be effective as of the effective date stated above and shall terminate when the Contract expires or terminates, whichever occurs first.
- b. **Termination Without Cause.** The Department may terminate this Agreement without cause by providing thirty (30) Calendar Days written notice of the termination to Contractor.
- c. **Termination for Cause.** Any use of the Non-public Medicaid NCCI Edit Files, except as contemplated under this Agreement or approved in writing by the Department, shall be a violation of the Agreement and any such violation shall be considered a material breach of the Agreement. A material breach of this Agreement by Contractor shall be considered sufficient basis for the Department to terminate this Agreement for cause. Upon the Department’s knowledge of a material breach by Contractor, the Department may, at its discretion:
 - i. Provide an opportunity for Contractor to cure the breach or end the violation, and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department; or
 - ii. Immediately terminate this Agreement and/or the Contract as specified in Section VI.4. *GENERAL TERMS AND CONDITIONS* of this Agreement.
- d. **Effect of Termination.** Upon termination of this Agreement, for any reason, all the following shall occur:
 - i. The Department shall cease sharing the Non-public Medicaid NCCI Edit Files covered by this Agreement with Contractor; and
 - ii. Contractor shall only be allowed to continue using any Non-public Medicaid NCCI Edit Files shared by the Department prior to the termination of this Agreement for the remainder of the calendar quarter in which the edits are effective.
- e. **Survival.** All terms and conditions regarding the restrictions on use and disclosure of the Non-public Medicaid NCCI Edit Files set forth in this Agreement shall survive the termination of this Agreement and shall remain fully enforceable by Department against Contractor.

TP Representative Name, Title

TP Entity Name

Date

Attachment T. BH I/DD Tailored Plan Catchment Areas

The Department has defined six (6) Tailored Plan Catchment Areas within North Carolina. See **Table 1: List of Counties by Tailored Plan Catchment Area** for the counties included in each of the six (6) Tailored Plan Catchment Areas.

Table 1: List of Counties by Tailored Plan Catchment Area

Tailored Plan	Counties in Catchment Area
Alliance	Cumberland, Durham, Johnston, Mecklenburg, Orange and Wake.
Eastpointe	Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Warren, Wayne, and Wilson.
Partners	Burke, Cabarrus, Catawba, Cleveland, Davie, Forsyth, Gaston, Iredell, Lincoln, Rutherford, Stanly, Surry, Union, and Yadkin.
Sandhills	Anson, Davidson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, and Rockingham
Trillium	Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Currituck, Dare, Gates, Halifax, Hertford, Hyde, Jones, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington.
Vaya	Alexander, Alamance, Alleghany, Ashe, Avery, Buncombe, Caldwell, Caswell, Chatham, Cherokee, Clay, Franklin, Graham, Granville, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Person, Polk, Rowan, Stokes, Swain, Transylvania, Vance, Watauga, Wilkes, and Yancey.

First Revised and Restated RFA 30-2020-052-DHB

Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments

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VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments

1. Instructions

The Applicant must complete and submit *Section VIII: Second Revised and Restated Applicant's Proposal and Response* with its offer.

The Applicant's Proposal and Response must be submitted in accordance with Department guidelines and the directives herein. The Applicant's Proposal and Response must be typed, page numbered, single-spaced, and in at least a 12-point font on Letter-sized (8 ½" x 11") paper with 1" margins. Page numbers must be in the format "Page X of Y." The Applicant may use a different, but legible, size font for section headings, footers, tables, graphics, and exhibits. Larger graphics, exhibits, charts, and diagrams may be printed as a foldout on a larger size paper if letter-sized paper is not feasible.

As described in *Section II. General Procurement Information and Notice to Applicants* of the RFA, the Applicant must submit fifteen (15) bound copies of its offer. The order of pages in Section VIII. Attachment Q cannot be altered from the MS Word template provided by the Department. All supporting documentation should be included at the end of Attachment Q. Application Response and Completed Attachments in the corresponding order of Attachment Q. Application Response and Completed Attachments with notation at the top of each page notating what the documentation is meant to support {example: *Section VIII.5. BH I/DD Tailored Plan Key Personnel: Resume of Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program Director* or *Section VIII.2. Minimum Qualification Response*}. A response whose page order has been altered risks a lower score or elimination from consideration.

The MS Word template of the *Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments* may be requested by contacting Medicaid.Procurement@dhhs.nc.gov.

2. First Revised and Restated Minimum Qualifications Response

The Applicant must demonstrate it meets Minimum Qualifications to have its response evaluated by the Department. The Applicant must agree to the terms below by checking the boxes and providing the information, documentation, including letters, or other details to demonstrate its adherence to each requirement, as applicable and required herein, and signing below.

1. Attestation of Eligibility to Apply and Acknowledgement

- The Applicant certifies it is a local political subdivision of the State and operates as a LME/MCO, as that term is defined in G.S § 122C-3(20c), as of the issuance date of this RFA are due pursuant to this RFA. The Applicant further certifies it is applying only for the Region(s) in which it is operating as an LME/MCO at the time the Applicant submits its Application in response to this RFA; the Applicant acknowledges that there may be an opportunity to respond to Supplemental Evaluation Questions to be considered to fill an Empty Region.

2. Agreement to Terms and Condition

- The Applicant agrees and accepts, without exception, all of the terms and conditions, including confidentiality, privacy and security protections and public records and trade secrets protections, specified in Section III. The Applicant may suggest modifications to the terms and conditions per the instructions in *Section II.C.3.c* and acknowledges such suggestions are not part any subsequent Contract unless explicitly accepted by the Department in accordance with *Section II.C.3.c*.

3. Agreement to Conflict of Interest Requirements

- The Applicant agrees to comply with the Conflict of Interest requirements within this RFA, as outlined in *Section III.D.15. Disclosure of Conflicts of Interests* and *Section V.A.1.ix.(xiii) Conflict of Interest*.

4. Agreement to Performance Bond Requirements

- The Applicant agrees to comply with the Performance Bond requirements within this RFA, as outlined in *Section III.C.37. Performance Bond*.

5. Certification of Location within the United States

- The Applicant certifies the Applicant is not located outside of the United States in accordance with 42 C.F.R. § 438.602(i).

By completing and signing this Minimum Qualifications Response, the Applicant affirms adherence to the required Minimums Qualifications and attests the information provided herein is accurate, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the Applicant.

Applicant Signature

Date

Printed Name and Title

3. First Revised and Restated Applicant’s Response to Evaluation Questions

Applicant must respond to the questions in the Section VIII. First Revised and Restated Attachment Q. Application Response and Completed Attachments, excluding those included in *Section VIII. Second Revised and Restated Attachment Q.17. Supplemental Evaluation Questions for Empty Region(s)* unless otherwise notified by the Department. The Department encourages the Applicant to suggest innovative ways to fulfill the requirements of the Contract rather than rely solely on how business is conducted today.

The Applicant must confirm adherence to and describe its approach to meet the requirements of the Contract. This includes providing a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature and/or detailed information specifically tailored for the North Carolina Medicaid Managed Care program.

The Department requests the Applicant adhere to the page guidelines for each section listed *Section VIII. Second Revised and Restated Attachment Q.3. Table 1: Response Page Guidelines* below. The page guidelines assigned in the table below are not related to the evaluation criteria and should not be interpreted as a reference to evaluation weight or importance. Completion of tables within questions will not be counted toward page guidelines where noted within each evaluation question. Supplemental materials, such as samples, draft plans and policies, requested as part of the Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments will not be counted toward page guidelines where noted within each evaluation question. The Applicant’s detailing of any limitations and/or issues with meeting the Department’s expectations or requirements will not be counted toward page guidelines. The Applicant must describe these limitations/issues in the separate field provided within the evaluation question. Additional supplemental materials provided beyond what is requested in the evaluation questions may not be considered for evaluation.

The Applicant may use an additional ten (10) pages in total if it needs additional space to provide a complete response to questions. The Applicant may use the ten (10) pages on one question or spread the additional pages across several questions, so as long as the total number of additional pages does not exceed ten (10) pages. The Applicant shall indicate in each question if the additional pages are utilized.

For each question, the Applicant shall describe the fully integrated approach the Applicant will provide to fulfill the requirements of the Contract, as well as identify the entity whose experience is included and that the Applicant is proposing to perform the requirements of the Contract. Where requirements between Medicaid and State-funded Services align, questions are aligned to enable the Applicant to provide a single, comprehensive response. For specific evaluation questions, the Department requests that the experience and approach of specific partner(s) be reflected in the response.

Section VIII. 3. Table 1: Response Page Guidelines				
Question #s	RFA Section	RFA Section reference	Number of Pages	Applicability to Medicaid, State-funded Services or Both
			N/A	- -
1-5	Qualifications and Experience	-	5 pages, Applies to Question 3 only	
6-81	Scope of Services	-	538	
6-13	Integration	-	69	

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
6	Third Party (Subcontractor) Contractual Relationships; Member Grievances and Appeals; Utilization Management; Provider Network Management; and Provider Directory	V.A.1.iv., V.B.1.vi., V.B.2.i.(v), V.B.4.ii, and V.B.8.v.	15	Both
7	Staffing and Facilities	V.A.1.ix	7	Both
8	Service Lines	V.A.2.i.	7	Both
9	Provision of the Benefits Package	V.B.2.i. and V.C.2.a.	5	Both
10	Reserved	Reserved	N/A	
11	Benefits Package and Utilization Management	V.B.2.i. and V.C.2.a.	7	Both
12	Pharmacy Benefits	V.B.2.iii.	8	Medicaid Only
13	Provider Network	V.B.4.i. and V.C.4.a.	20	Both
14-17	Financial Management		30	
14	Capitation Payments	V.B.7.i	8	Medicaid Only
15	Medical Loss Ratio	V.B.7.ii.	2	Medicaid Only
16	Financial Management and Financial Viability	V.B.7.iii. and V.B.7.iii.(vii)	10	Medicaid Only
17	Financial Requirement for State-funded Services questions	V.C.7.	10	State-funded Services Only
18-28	Care Management		103	
18	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
19	Tailored Care Management	V.B.3.ii.	8	Medicaid Only
20	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
21	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
22	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
23	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
24	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
25	Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver and Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waivers	V.B.3.iv. and V.B.3.ii.(xiii)	10	Medicaid Only
26	Tailored Care Management Data Strategy	V.B.3.11. and V.C.3.	10	Both
27	Transitional Care Management	V.B.3.i., V.B.3.ii.(xi), V.B.3.iii., and V.B.3.v.	10	Medicaid only

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
28	Case/Care Management and Prevention	V.C.3.a.; V.C.3.b.; and V.C.3.c.	20	State-funded Services Only
29-34	Providers		32	
29	Provider Network Management	V.B.4.ii. and V.C.4.b.	10	Both
30	Provider Relations and Engagement	V.B.4.iii. and V.C.4.c.	3	Both
31	Provider Payments	V.B.4.iv. and V.C.4.d.	4	Both
32	Provider Grievances and Appeals	V.B.4.v. and V.C.4.e.	5	Both
33	Engagement with Federally Recognized Tribes	V.A.4.i.	5	Medicaid Only
34	Community Crisis Services Plan	V.A.4.v.	5	Both
35-42	Benefits & Services		68	
35	Provisions of the Benefits Package	V.B.2.i. and V.C.2.a.	10	Both
36	In Lieu of Services & Value-Added Services	V.B.2.i.(vii) and V.B.2.i.(viii)	No Limit	Medicaid Only
37	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	V.B.2.ii.	8	Medicaid Only
38	Non-Emergency Medical Transportation	V.B.2.iv.	5	Medicaid Only
39	Diversion from Institutional Settings	V.B.3.ii.(xii) and V.C.3.d.	10	Both
40	In-Reach and Transition from Institutional Settings	V.B.3.viii. and V.C.3.e.	16	Both
41	In-Reach and Transition from Institutional Settings	V.B.3.viii.	16	Medicaid Only
42	Development of Housing Opportunities for Members and Recipients	V.A.4.iv.	3	Both
43-53	Members & Recipients		59	
43	Advance Directives	V.A.1.viii.	1	Both
44	Eligibility and Enrollment for BH I/DD Tailored Plans	V.B.1.i.	7	Medicaid Only
45	Eligibility for State-funded Behavioral Health, I/DD and TBI Services	V.C.1.a.	7	State-funded Services Only
46	Transitions of Care	V.B.1.11.	7	Medicaid Only
47	Member Grievances and Appeals	V.B.1.vi.	8	Medicaid Only
48	Recipient Complaints and Appeals	V.C.1.e.	8	State-funded Services Only
49	Member Engagement & Recipient Engagement	V.B.1.iii. and V.C.1.b.	8	Both

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
50	Marketing	V.B.1.iv. and V.C.1.c.	4	Both
51	Member and Recipient Rights and Responsibilities	V.B.1.v. and V.C.1.d.	2	Both
52	AMHs as PCPs and PCP Choice and Assignment	V.B.1.vii. and V.B.1.vii.(ii)	2	Medicaid Only
53	Engagement with Community and County Organizations	V.A.4.ii.	5	Both
54-60	Compliance		22	
54	Compliance Program	V.A.3.i.	3	Both
55	Program Integrity	V.A.3.ii.	3	Both
56	Fraud, Waste, and Abuse	V.A.3.iii.	4	Both
57	Third Party Liability (TPL)	V.A.3.iv. and V.A.3.v.	1	Both
58	Medicaid Service Recipient Explanation of Medical Benefits (REOMB)	V.A.3.vi.	1	Medicaid
59	Confidentiality	III.E.	7	Both
60	Service Level Agreements	VI.B	3	Both
61-66	Quality & Population Health		45	
61	Prevention and Population Health Management Programs	V.B.3.ix. and V.C.3.g.	10	Both
62	Healthy Opportunities	V.B.3.x.	11	Medicaid Only
63	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	5	Both
64	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	2	Both
65	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	2	Both
66	Value-Based Payments	V.B.5.ii.	15	Medicaid Only
67-81	Administration & Management		110	
67	Entity Requirements	V.A.1.ii.	4	Both
68	Reserved.	Reserved	N/A	
69	National Committee for Quality Assurance (NCQA) Accreditation	V.A.1.iii.	2	Medicaid Only
70	Implementation and Readiness Review Requirements	V.A.1.v. and V.A.1.vi.	5	Both
71	Non-Discrimination	V.A.1.vii.	2	Both
72	Staff Training	V.A.2.iii.	4	Both
73	Reporting	V.A.2.iv.	3	Both

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
74	BH I/DD Tailored Plan Policies	V.A.2.v.	2	Both
75	Business Continuity	V.A.2.vi.	3	Both
76	Integration with Other Department Partners	V.A.4.iii.	2	Both
77	Claims	V.B.6.i.	7	Medicaid Only
78	Encounters	V.B.6.ii.	16	Medicaid Only
79	Claims for State-funded Services	V.C.6.	10	State-funded Services Only
80	Technical Specifications	V.B.8. and V.C.8	25	Both
81	Technical Specifications	V.B.8. and V.C.8	25	Both
	Use Cases	-	35	-
	Additional Pages Determined by Applicant		10	
	TOTALS		583	

The Evaluation Questions are listed below. By February 2, 2021, the Applicant is required to answer the questions as stated herein, with the exception of the supplemental questions in *Section VIII. Section VIII. Second Revised and Restated Attachment Q.17. Supplemental Evaluation Questions for Empty Region(s)* which will be due at a later date, if needed and as communicated by the Department.

Qualifications and Experience

Evaluation Question	
1.	<p>The Applicant shall provide the following:</p> <ul style="list-style-type: none"> a. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written b. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers) c. List of board members and their organizational affiliations
Response	

Evaluation Question	
2.	<p>The Applicant shall provide information requested in <i>Section VIII.3. Table 2: Entities Performing Core Operations</i> for each entity, including, Subcontractors, business partners, and any other individual or organization:</p> <ul style="list-style-type: none"> a. That will perform core Medicaid operations, as defined in <i>Section V.A.1.ii.(iii) BH I/DD Tailored Plan Operating Plan</i>, for the Applicant under the Contract; and b. That will perform core State-funded operations, as defined in <i>Section V.A.1.ii.(iii) BH I/DD Tailored Plan Operating Plan</i>, for the Applicant under the Contract. <p>The Applicant shall include a response describing their contract(s) with an entity that holds a North Carolina PHP license issued by the North Carolina Department of Insurance, pursuant to N.C. Gen. Stat. § 108D-60(5), and how the contract(s) will adhere to the requirements described in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships for Medicaid and State-funded Services</i>.</p> <p>The Applicant shall be fully transparent in describing the experience of its partner entities and shall include all experience, both positive and negative, related to the entity’s role(s) or responsibilities. The Department may exercise, at its sole discretion, in the BH I/DD Tailored Plan RFA evaluation process, whether or not to consider the experience or to what extent the experience applies for entities not performing core operations.</p> <p>Applicant must fill out one (1) table for each entity, including Subcontractors, business partners, and any other entities that meet the criteria listed in 2.a. and/or 2.b. above. Completed tables shall not be counted toward the Applicant’s total page guidelines.</p>
Response	

Section VIII. 3. Table 2: Entities Performing Core Operations

Section VIII. 3. Table 2: Entities Performing Core Operations	
Name of Entity Performing Core Operation(s) _____	Response
Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/>	
Identify and define Medicaid and State-funded Services core operation(s) that entity will perform. Identify whether the entity is providing core operation(s) for either Medicaid or State-funded services or both for each core service. Note that for care management and care coordination functions, the Applicant does not need to identify AMH+ practices and CMAs. <ul style="list-style-type: none"> • Managing Medicaid Managed Care member lives; • Managing member and recipient services, including utilization management¹ and the administration of clinical benefits and services); • Managing the provider network; • Performing care management and care coordination functions; • Performing quality management and data reporting; • Processing and paying claims; • Managing single stream funding and other non-Medicaid funds for State-funded Services; and • Assuming risk through capitated contract. 	
Primary Address	
Mailing Address	

¹ Utilization management of State-funded Services may not be delegated by Offeror.

Section VIII. 3. Table 2: Entities Performing Core Operations	
Name of Entity Performing Core Operation(s) _____ Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/>	Response
Tax ID (if organization)	
DOB (if individual)	
Tax ID Number	
Description of the entity's responsibilities and/or functions in performing activities on behalf of the Applicant as described in Applicant's Response	
Description of the entity's experience related to the role(s), responsibilities, and other operations described above	
Description of how the entity will be integrated into the Applicant's performance of their obligations under the Contract to ensure a streamlined experience for the members, providers and the Department	
Description of how any aspects of the contract that may create barriers to integrated behavioral health, I/DD and /or TBI and physical health care and operations will be addressed	
Description of how the Applicant will manage the subcontracting entity's contract performance	
Description of the proposed compensation structure between the Applicant and the subcontracting entity	
Disclosure of any potential conflicts of interest that entity providing services may have related to the Applicant, this RFA or any Contract awarded to the Applicant.	

Section VIII. 3. Table 2: Entities Performing Core Operations	
Name of Entity Performing Core Operation(s) _____ Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/>	Response
Disclose if the Applicant or any of its board members, officers or managing employees, has a direct or indirect Ownership interest or controlling interest in the entity as such terms are defined in 42 CFR 455.101. If yes, disclose whether the Applicant or its board members, officers, or managing employees have the conflict, and all of the direct and indirect owners, as well as controlling interest in the entity, including, full name, EIN or SSN (as applicable), addresses and percentage ownership/interest.	
Is the entity HUB certified as provided in G.S. 143-128.4?	

Evaluation Question	
3.	The Applicant shall describe its approach and experience in the provision of services to the populations specified in this Contract, including: <ol style="list-style-type: none"> a. Commitment to integrating the Department's goals for Medicaid Managed Care, inclusive of State-funded Services, into its day-to-day operations; b. Lessons learned from experience serving the Medicaid populations included in this Contract and how it informs the Applicant's approach to provision of services going forward; and c. Lessons learned from experience serving the State-funded populations in this Contract and how it informs the Applicant's approach to provision of services going forward.
Response	

Evaluation Question	
4.	<p>The Applicant shall disclose, in the <i>Section VIII.3. Table 3: Non-Compliance, Fines, Penalties and Sanctions in the past five (5) years</i>, whether, within the past five (5) calendar years, any federal or state agency has notified the Applicant of any non-compliance or imposed liquidated damages fines and civil penalties, or other sanctions or penalties under the DHB and/or DMH/DD/SAS LME/MCO Contracts, including any findings from the Office of the State Auditor. The Applicant’s response shall include information for the Applicant and any entity providing core operations, listed in <i>Section VIII. 3. Table 2: Entities Performing Core Operations</i>.</p> <ul style="list-style-type: none"> a. If imposed, the Applicant shall describe the non-compliance, State Auditor finding, fine, penalty amount or sanction and include the month and year of the notification or violation; the reason(s) for the finding of non-compliance or fine, penalty or sanction; and the parties involved, as applicable. b. A description of the corrective action taken to address the non-compliance or violation. c. If the non-compliance or violation(s) was the subject of an administrative proceeding or litigation, the Applicant shall indicate the result of the proceeding/litigation. <p>POTENTIAL REQUEST FOR SUPPORTING DOCUMENTATION</p> <p>The Department reserves the right to ask for additional information related to Applicant’s response to this question by issuing a Clarification.</p>
Response	

Section VIII.3. Table 3: <i>Non-Compliance, Fines, Penalties and Sanctions in the past 5 years</i>	
Entity (as identified in Question #4)	
Non-Compliance, State Auditor finding, or Fine, Penalty, or Sanction	
Month & Year of Violation	
Reason for the Non-Compliance, State Auditor finding, Fine, Penalty or Sanction	
Describe any corrective actions taken to prevent future occurrence of the problem. If answered 'No' to the question above, insert 'N/A'	
Was the Violation the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
5.	<p>a. The Applicant shall list the counties in its catchment area as of the issuance date of this RFA.</p> <p>b. Is the Applicant aware of any counties that are considering or have started the process to disengage under N.C. Gen. Stat. § 122C-115 or are likely to prior to July 1, 2022? If yes, list the counties, explain the issues and Applicant’s response.</p> <p>c. Have any of the counties expressed concerns with Applicant’s service, management or operations? If yes, list the counties, explain the issues and Applicant’s response.</p>
	Response

Scope of Services

Integration

Evaluation Question	
6.	<p>The Applicant shall confirm its adherence and describe in detail its ability to manage Subcontractors and ensure integrated approaches to plan operations and member or recipient’s care, including:</p> <p><u>For Medicaid and State-funded Services</u></p> <p>a. Overseeing subcontractors in a way that ensures whole-person, person-centered care and adheres to the Department’s expectations and requirements outlined in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships</i> for Medicaid and State-funded Services;</p> <p>b. Providing a single phone line for member- and recipient-facing services, as well as provider-facing services and provider-facing plan operations (<i>Section V.B. Medicaid</i> and <i>Section V.C. State-funded Services</i>);</p> <p><u>For Medicaid Only</u></p> <p>c. Ensuring an integrated, holistic utilization management process (<i>Section V.B.2.i.(v) Utilization Management</i>);</p> <p>d. Ensuring a compliant Medicaid appeals process (<i>Section V.B.1.vi. Member Grievances and Appeals</i>);</p> <p>e. Providing a single Medicaid and NC Health Choice Provider Network directory (<i>Section V.B.4.ii. Provider Network Management</i> and <i>Section V.B.8.v. Provider Directory</i>); and</p> <p>f. Ensuring financial integration in any risk sharing arrangements such that there are not separate pools for physical health, behavioral health, or I/DD services.</p>

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
7.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for staffing and facilities as stated in <i>Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. A description of the Applicant’s internal organizational structure for the BH I/DD Tailored Plan highlighting the Applicant's management structure and definitions of the lines of accountability, responsibility, authority, communication and coordination across the organization. b. Experience with and approach to staffing jointly for Medicaid and State-funded Services operations. c. Approach to recruitment and retention of Key Personnel and how the Applicant proposes minimizing turnover including during the transition from LME/MCO to BH I/DD Tailored Plan operations. d. Location of key personnel and offices providing core Medicaid and State-funded Services operations. e. Estimate of the number of staff anticipated to fulfill all duties and responsibilities of the Contract, including those delineated by the categories found in <i>Section VII. Attachment A: BH I/DD Tailored Plan Organization Roles & Positions</i>. Of the number of staff identified, estimate how many of those staff positions will be filled by current staff versus how many are new staff needed to meet these requirements. f. Experience with addressing workforce shortages and approach to how the Applicant will address potential BH I/DD Tailored Plan workforce shortages (i.e. UM staff, clinical expertise, provider contract management, service line staff).

	<p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Draft organizational charts, identifying which roles support Medicaid, State-funded Services, or both 2. Draft Utilization Management (UM) and Care Management leadership organizational charts
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
8.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.i. Service Lines for Medicaid and State-funded Services</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ol style="list-style-type: none"> a. Approach to establishing service lines, staffing them jointly for Medicaid and State-funded Services operations, and meeting Service Level Agreement standards; b. Approach to customizing and training member and recipient services and provider relations staff on the North Carolina Medicaid Managed Care program, State-funded Services and providing specific responses to potential customer service inquiries; c. Policies for ensuring Warm Transfers are conducted in the timeframes specified in the Contract; d. Process to immediately contact local emergency responders in instances where there is immediate danger to self or others, including monitoring the individual’s status until emergency responders arrive; e. Approach to ensure compliance with HIPAA, 42 CFR Part 2 and all other applicable federal and state confidentiality provisions;

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> f. Approach to ensure all pharmacy prior authorization requests are processed within twenty-four (24) hours for Medicaid; and g. Process to integrate the nurse line and behavioral health crisis line into the Applicant’s care management and health care delivery model for Medicaid;
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
9.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package</i> and <i>V.C.2.a. State-funded BH I/DD and TBI Services</i>.</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. The response also shall describe the Applicant’s approach to facilitating and integrating physical health, behavioral health, I/DD, TBI, LTSS and pharmacy benefits for members. b. Approach to develop expertise in administering physical health, LTSS and pharmacy benefits; c. Experience with innovative Telehealth, Virtual Patient Communication and Remote Patient Monitoring modalities and pilot programs and the proposed approach to encourage use of these modalities, including types of programs, and targeted providers, geographies (including rural), services, and members; and d. Approach to integrating carved-out services (i.e. dental services, LEAs, CDSAs, eyeglasses).

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
10.	Reserved.

Evaluation Question	
11.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's Utilization Management expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package and V.C.2.a. State-funded Behavioral Health, I/DD and TBI Benefit Package</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience with and approach to align the Applicant’s Utilization Management (UM) program with the Department's required clinical coverage policies; b. Approach to reduce provider administrative burden under the BH I/DD Tailored Plan’s UM Program, including overall provider experience for prior authorization requests; c. Experience with and approach for monitoring appropriate utilization of services and monitoring provider quality as part of the UM Program; d. Experience with, methods and approach to balance timely access to care for member and recipients with the administration of the UM Program;

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> e. Proposed evidence-based decision support tool(s) to authorize Medicaid benefits where use of the Department’s clinical coverage policies is not required; f. Approach to build expertise in UM for physical health, pharmacy, and LTSS; g. Approach to ensure that the UM program for Medicaid supports an integrated, holistic review of member’s physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy needs; Approach to ensure UM Program for Medicaid is compliant with mental health parity.
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Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

12.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.iii. Pharmacy Benefits for Medicaid</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Methods to ensure adherence to the formulary and PDL under this Contract; b. Approach to engage members in understanding the pharmacy benefit and to providing medication-related clinical services which promote appropriate medication use and adherence; c. Prior authorization process, including overall prescriber experience when requesting prior authorization; d. Approach to implementing a drug utilization review program to address opioid misuse and antipsychotic use in children; e. Integration approach with PBM (if applicable); and
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	f. Approach to provide timely, accurate and complete data to support the Department’s rebate claiming process and ensure the Department maintains current rebates levels.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
13	<p>The Applicant shall describe its provider network development strategy, including, but not limited to ensuring the development of a comprehensive network of physical health, behavioral health, I/DD, TBI, LTSS and pharmacy providers for children and adults as required and applicable in <i>Section V.B.4.i. Provider Network</i> and <i>Section V.C.4.a. Provider Network</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Innovative approaches that will be used to develop and maintain the BH I/DD Tailored Plan’s provider network to ensure network adequacy standards and highest quality care; b. Methods for monitoring and ensuring compliance with access to care standards, including the frequency of reviewing of these standards; c. Experience with and approach to how the Applicant will ensure access to care on an out-of-network basis when timely access to a Network Provider is not possible, including the Applicant’s plan to educate members on accessing out-of-network benefits; d. Methods to educate providers on North Carolina’s Medicaid Managed Care program and State-funded Services and ease the transition from LME/MCO to BH I/DD Tailored Plans; e. Strategies to recruit, support, and sustain providers in traditionally underserved areas, by health need, and overcome expected accessibility challenges;

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> f. Approach to how BH I/DD Tailored Plan will meet required time and distance standards and appointment wait time standards for adult service and pediatric service providers; g. Identified gaps between current Medicaid provider network and the network standards for Medicaid services in the BH I/DD Tailored Plan; <p><u>For State-funded Services Only</u></p> <ul style="list-style-type: none"> h. Identified gaps between current State-funded Services provider network and the network standards for State-funded Services in the BH I/DD Tailored Plan; i. Approach to how BH I/DD Tailored Plan will meet required time and distance standards and appointment wait time standards for providers; j. Strategies to recruit, support, and sustain providers representative of Historically Marginalized Populations; and k. Strategies to ensure access for State-funded Services recipients with BH conditions to case management service providers. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>Provide a draft Network Access Plan that addresses the components listed <i>Section V.B.4.i.(vii) Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)</i>.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
15.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in <i>Section V.B.7.ii. Medical Loss Ratio</i>. Response should include, but is not limited to, the Applicant's approach to ensuring accurate and timely MLR reporting.</p> <p><u>For Medicaid Only.</u></p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
16.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in <i>Section V.B.7.iii. Financial Management</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach to managing financial risk, including how financial risk will be shared across partnering entities, subject to the parameters laid out in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships</i>; b. Approach to strong financial stewardship and protecting against insolvency, including plans for meeting and maintaining minimum capital requirements as outlined in <i>Section V.B.7.iii.(vii) Financial Viability</i>. c. Sources and amounts of capital available to the Applicant, including: <ul style="list-style-type: none"> a. Amount of available capital, by source, as of January 1, 2021; b. Amount of available capital, by source, expected at the time of BH I/DD Tailored Plan launch;

	<p>c. Amount of available capital, by source, expected twelve (12) months following BH I/DD Tailored Plan launch;</p> <p>d. The Applicant's plan for finding additional capital should the Applicant experience financial hardship; and</p> <p>e. For all entities proposed to assume risk through the capitated contract as listed in Question #2, explain any State (including states other than NC) actions and entity responses related to solvency or inadequate financial management or oversight during the past ten (10) years, including all relevant details on the context and proceedings.</p> <p>f. Approach to ensure the separation of non-Medicaid revenue and expense from Medicaid revenue and expense for payment of authorized services.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count) for the Applicant or any entities identified to assume risk in Question #2, as applicable:</p> <ol style="list-style-type: none"> 1. Monthly Financial Reporting Template from the month most recently submitted to the Department. (NOTE: Applicants must provide financial reporting inclusive of the criteria described in <i>Section VII. Attachment J. Reporting Requirements</i> and currently required by the Department in the monthly Financial Reporting Template.) 2. Audited financial reporting, as described in <i>Section VII. Attachment J. Reporting Requirements</i>, from the prior two (2) years immediately preceding the year in which the Application is submitted. 3. Documentation of lines of credit that are available, including maximum credit amount and available credit amount. 4. Documentation of commitment by entities identified as providing capital needed to meet minimum capital requirements. 5. Any other documentation that speaks to the entity's financial health and any alternative arrangements or mechanisms for managing financial risk.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

17. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements as outlined in *Section V.C.7. Financial Requirements*. The response also shall include:

For State-funded Services Only

- a. Approach to managing utilization and expenditures within allocated funding while meeting or exceeding quality standards;
- b. Methods for reducing administrative costs to and maintaining financial predictability of the North Carolina state and federally funded Non-Medicaid services;
- c. Tools and measures the Applicant uses to track actual and anticipated expenditures relative to allocated funding to mitigate losses;
- d. Measures and the targets for each measure that the Applicant will use to demonstrate value to the Department;
- e. Approach to ensure the separation of Non-Medicaid revenue and expense from Medicaid revenue and expense for payment of authorized services;
- f. Tools and measures the Applicant uses to track actual and anticipated expenditures against funding categories of: Single Stream funding (UCR/claims based as well as Non-UCR based expenses), Special Categorical funding, Federal Non-UCR funding as well as State Non-UCR funding by allocated funding account number; and
- g. Approach to managing federal block grant requirements, including MOE and restriction requirements.

Response

Care Management

Evaluation Question

18. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for care management as stated in *Section V.B.3.ii. Tailored Care Management*. The response also shall include:

For Medicaid Only

- a. Approach describing how the Applicant will structure itself to ensure successful and appropriate implementation of Tailored Care Management;

	<ul style="list-style-type: none"> b. Approach for ensuring all organizations providing Tailored Care Management (AMH+ practices, CMAs, and BH I/DD Tailored Plans) provide care management that is integrated across physical health, BH, I/DD, TBI, LTSS, and pharmacy and addresses Unmet Health-Related Resource Needs to the maximum extent possible; c. Approach for coordinating across the BH I/DD Tailored Plan, NC Medicaid Direct, Medicare, and other authorized Department Business Associates (e.g., CCNC) for members who are enrolled in both full Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing; d. Approach for ensuring that members do not receive duplicative care management from multiple sources; e. Approach for ensuring utilization management is not involved in care management; and f. Approach to ensure active member engagement in Tailored Care Management, including projected percentage of members that will be actively engaged, by each contract year.
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Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

19.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Provider-based Care Management as stated in <i>Section V.B.3.ii. Tailored Care Management</i>. The response also shall include:</p> <p><u>Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for building a network of AMH+ practices and CMAs over the life of the contract, including: <ul style="list-style-type: none"> i. Approach for meeting the Department’s annual targets for the percentage of members actively engaged in provider-based care management approaches;
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	<ul style="list-style-type: none"> ii. Plan for providing ongoing technical assistance to AMH+s and CMAs in the Applicant's network and those seeking certification to enable them to become high-performing providers of Tailored Care Management; and iii. Approach for managing application and certification process for new AMH+ practices and CMAs after BH I/DD Tailored Plan launch.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
20.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management Training as stated in <i>Section V.B.3.ii. Tailored Care Management</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for implementing Tailored Care Management training for care managers and supervising care managers, including: <ul style="list-style-type: none"> i. Approach for developing the Tailored Care Management training curriculum, including plans to collaborate with other BH I/DD Tailored Plans on curriculum development; ii. Approach for training care managers across all organizations providing Tailored Care Management; and iii. Approach for assessing competency of care managers.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

21. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and Care Management Assignment as required in *Section V.B.3.ii. Tailored Care Management*. The response shall include the Applicant’s approach to:

For Medicaid Only

- a. Process for assigning each member to a care management approach and organization providing Tailored Care Management, ensuring that each approach can manage a mix of acuity tiers
- b. Approach to providing members information about their options for Tailored Care Management, including the types of care management approaches and organizations providing Tailored Care Management, and ensuring that members are not “steered” toward certain care management approaches or organizations

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

22. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and Care Management Comprehensive Assessment and Care Plan/ISP development as stated in *Section V.B.3.ii. Tailored Care Management*. The response shall include the Applicant's approach to:

For Medicaid Only

- a. Care Management Comprehensive Assessments
 - i. Approach for ensuring Care Management Comprehensive Assessments conducted by the BH I/DD Tailored Plan, AMH+ practices, and CMAs meet the requirements set in the RFA;
 - ii. Approach that the Applicant will take in varying content and approach to completing Care Management Comprehensive Assessments based on population;
 - iii. Approach to conducting outreach to BH I/DD Tailored Plan members to initiate and complete the Care Management Comprehensive Assessments; and
 - iv. Proposed strategies to screen and assess BH I/DD Tailored Plan members for Unmet Health-Related Resource Needs as part of Care Management Comprehensive Assessment.
- b. Care Plans/ISPs
 - i. Approach for ensuring Care Plans and ISPs developed across all organizations providing Tailored Care Management meet the requirements set in the RFA;
 - ii. Approach for involving multi-disciplinary care team in the development of Care Plans and ISPs;
 - iii. Approach for developing individualized and person-centered Care Plans/ISPs and ensuring the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved; and
 - iv. Approach for developing ISPs for members enrolled in the Innovations or TBI waiver beyond the requirements established in the waivers.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

23. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and care management for special populations as stated in *Section V.B.3.ii. Tailored Care Management*. The response shall include the Applicant's approach to:

For Medicaid Only

- a. Children with complex needs, as that term is defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina;
- b. Children ages zero (0) up to age three (3) receiving early intervention services;
- c. Women with high-risk pregnancies; and
- d. Members on the Innovations or TBI waitlist, and other members with LTSS needs.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

24. a. The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for integrating strategies and coordinating appropriate services to address Unmet Health-Related Resource Needs into Tailored Care Management stated in *Section V.B.3.ii. Tailored Care Management*. The response shall specify planned and past examples of methods to provide non-medical, health-related services and resources to members including:

For Medicaid Only

- a. Providing comprehensive assistance securing health-related services that can improve health and family well-being (i.e., assistance filling out and submitting applications for government assistance programs);

	<ul style="list-style-type: none"> b. Assisting individuals in securing and maintaining safe and stable housing beyond efforts conducted under TCLL; c. Assisting individuals in obtaining food; d. Assisting individuals in obtaining transportation; e. Providing access to medical-legal support for legal issues adversely affecting health; and f. Providing individuals with resources and referrals to address ACEs and trauma.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
25.	<p>Describe BH I/DD Tailored Plan’s adherence and approach to meeting Department's expectations and requirements for care management for populations enrolled in the Innovations or TBI waiver in <i>Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver and Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waivers</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for transitioning members from LME/MCO care coordination and other authorized Department Business Associates (e.g., CCNC) to Tailored Care Management, including, but not limited to: <ul style="list-style-type: none"> i. Plans for notifying beneficiaries about differences between LME/MCO care coordination and Tailored Care Management, how to access Tailored Care Management, and the benefits of Tailored Care Management;

	<ul style="list-style-type: none"> ii. Process for transitioning members' ISPs to meet Tailored Care Management requirements; and iii. Plans to train current Innovations waiver care coordinators and supervisors to meet Tailored Care Management requirements. <p>b. Approach for ensuring that Tailored Care Management for members enrolled in the Innovations or TBI waivers complies with federal conflict-free case management regulations as required by 42 C.F.R. § 441.301(c)(1)(vi).</p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
26.	<p>The Applicant shall describe its approach to meeting the Department's data use and system expectations and requirements outlined in <i>Section V.B.3.ii. Tailored Care Management</i> and <i>Section V.C.3. Care Management and Prevention</i>. The response shall describe Applicant's capabilities and experience to implement and maintain reliable:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Technology, systems, and solutions to support Tailored Care Management for Medicaid members and BH I/DD Tailored Plan-based care management for State-funded Services recipients with I/DD or TBI, hereafter collectively referred to as 'functions'; b. Data governance procedures to ensure the secure, complete, accurate, and timely collection and use of data to support these functions; c. Process to timely respond to data requests from the Department;

	<p>d. Privacy and security policies to ensure data is accessed, stored, and exchange in a protected manner as required by the Department’s standards and applicable state and federal laws;</p> <p><u>For Medicaid Only</u></p> <p>e. Processes to collect, access, integrate, link, and use identified administrative and state data to support these functions, including data that may be available through the Department from CMS to support care management activities for dual eligible members; and</p> <p>f. Processes and systems to facilitate data sharing between and among all types of Medicaid Managed Care plans (e.g., BH I/DD Tailored Plans, Standard Plans, Tribal Option), the Department (including NC Medicaid Direct), other authorized Department Business Associates, AMH+ and CMA practices, CINs or Other Partners and the member, as appropriate and required to support these functions.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>1. Anticipated technical capabilities, including the data, processes, systems, including system product/version detail, that the Applicant will use to support Tailored Care Management for Medicaid members and BH I/DD Tailored Plan-based care management for State-funded Services recipients with I/DD or TBI.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
27.	<p>The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for providing transitional care management and care transitions in <i>Section V.B.3.i. Overview, Section V.B.3.ii.(xi) Transitional Care Management, Section V.B.3.iii. Care Coordination and Care Transitions for all Members, and Section V.B.3.v. Other Care Management Programs</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <p>a. Plans for using ADT feeds and similar techniques to identify high-risk transitions, and the expected results of those efforts;</p>

	<ul style="list-style-type: none"> b. Experience with and plans for developing processes and partnerships with SNFs, NICUs, hospitals, rehabilitation facilities, residential settings, State Operated Health Facilities, ICF-IIDs, and other levels of care in order to facilitate transitions; c. Plans to partner with AMH+ practices and CMAs to provide transitional care management including data shared and roles/responsibilities; d. Plans to provide transitional care management for members who are transiting from ACT, ICF-IID, HFW, or CMARC to Tailored Care Management; and e. Any examples or plans for customization of care management, including the assessment, medication reconciliation, etc., to support transitional care management that differentiates the Applicant from other potential respondents. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Three (3), 90-day post-discharge transition plan examples for members transitioning out of three (3) different types of settings. The settings must include: <ul style="list-style-type: none"> a. A short-term acute care setting; b. A long-term care setting; and c. A third setting of the Applicant's choosing <p>The three (3) examples should include at least one (1) example of a member with BH needs and one (1) example of a member with I/DD needs.</p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
28.	<p>The Applicant shall describe its approach to meeting the Department’s expectations and requirements as outlined in <i>Section V.C.3.a. Model Overview and Objectives</i>; <i>Section V.C.3.b. Case Management for Recipients with Behavioral Health Conditions</i>; and <i>V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations</i>. The response shall include:</p> <p><u>For State-funded Only</u></p> <ul style="list-style-type: none"> a. Approach for ensuring recipients with BH conditions who have complex needs are placed in a timely manner in appropriate settings; b. The number of recipients with I/DD and TBI projected to obtain care management through the BH I/DD Tailored Plan per year; c. Approach for prioritizing eligible recipients for care management in light of expected funds available; d. Approach for developing and conducting Care Management Comprehensive Assessments; and e. Approach for developing and completing ISPs.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Providers

Evaluation Question	
29.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.4.ii. Provider Network Management</i> and <i>Section V.C.4.b. Provider Network Management</i>. Response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for managing the provider network to comply with any willing provider requirements for physical health and pharmacy services and closed network requirements for behavioral health, I/DD, and TBI services;

- b. Process for notifying members and ensuring their continued access to covered services in the event of provider termination. Include details as to how Applicant will assign a new PCP as well as maintain continuity of care for members who had scheduled appointments with the terminated provider;

State-funded Services Only

- c. Approach for managing the provider network to comply with the closed network requirements for behavioral health, I/DD, and TBI services;
- d. Process for notifying recipients and ensuring their continued access to covered services in the event of provider termination. Include details as to how Applicant will maintain continuity of care for recipients who had scheduled appointments with the terminated provider;

For Medicaid and State-funded Services

- e. Description of the BH I/DD Tailored Plan's process and policies for terminating a provider from its network. Provide one (1) State-funded Services and two (2) Medicaid historical examples of the Applicant terminating a provider with cause;
- f. Description of the BH I/DD Tailored Plan's practices and procedures to ensure contracting with Division of State-Operated Healthcare Facilities;
- g. Description of BH I/DD Tailored Plan's policies and procedures used in selection and retention of BH, I/DD, and TBI services network providers. Provide two (2) State-funded Services and three (3) Medicaid examples of the conditions under which the BH I/DD Tailored Plan would issue a provider an adverse determination during the contracting process;
- h. Description of the policies, procedures and processes the BH I/DD Tailored Plan will utilize to ensure 100% of provider network contracting determinations are completed within forty-five (45) days of receipt of complete information for a provider;
- i. Description of BH I/DD Tailored Plan's plan for establishing and maintaining a Provider Network Participation Committee. Include a description of provisions that will be implemented for Committee members to make fair determinations and how decisions will be monitored to ensure fairness;
- j. Description of the operational policies, procedures and processes the BH I/DD Tailored Plan will utilize to load the terms of the provider contracts into the BH I/DD Tailored Plan claim payment platform to accurately pay providers consistent with agreed upon contract terms;
- k. Description of BH I/DD Tailored Plan's process for enrolling providers in its network consistent with the operational timeframes and requirements including communication of the welcome notice, enrollment information, onboarding, and training; and
- l. Description of the BH I/DD Tailored Plan's strategy for developing and monitoring the consumer-facing Provider Directory, including innovative strategies for ensuring data accuracy, timely updates, and accessibility to members, including those with limited English proficiency/literacy or are deaf/hard of hearing.

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
30.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.4.iii. Provider Relations and Engagement</i> and <i>Section V.C.4.c. Provider Relations and Engagement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Description of the Online Provider Portal, including information topics accessed there and key functionality in the Online Provider Portal useful to providers.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

31. The Applicant shall confirm its adherence and describe its approach to meeting the Department’s expectations and requirements outlined in *Section V.B.4.iv. Provider Payments* and *Section V.C.4.d. Provider Payments*. The response shall include:

For Medicaid and State-funded Services

- a. Approach to ensure provider payment requirements are met. Include in your response how quickly the BH I/DD Tailored Plan can update its claim system to incorporate changes to provider contracting terms or to rate floors or schedules.
- b. Approach to negotiating rates with providers.
- c. Approach to offer providers any alternative payment arrangements in lieu of the rate floor, as applicable.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

32. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.4.v. Provider Grievances and Appeals* and *Section V.C.4.e. Provider Grievances and Appeals*. The response shall include:

For Medicaid Only

- a. A description of the BH I/DD Tailored Plan’s provider grievance and appeals processes.

For State-funded Services Only

	<p>b. A description of the BH I/DD Tailored Plan’s provider complaint and appeals processes.</p> <p><u>For Medicaid and State-funded Services</u></p> <p>c. A description of the BH I/DD Tailored Plan’s approach to educate providers on their rights within the grievance, compliant and appeals process.</p> <p>d. Identification of any provider appeal rights that will be provided in addition to those required in the Contract.</p> <p>e. A description of the Applicant’s process to self-audit the Provider Grievance and Appeals and Provider Complaint and Appeals determinations, including the frequency and how the results are used to drive improvements.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Provide up to three (3) examples each of Medicaid and State-funded services provider complaints, grievances, and/or appeals that have been received and resolved in the past three (3) years. 2. Process flows detailing the process for Medicaid and State-funded Services provider grievances, complaints and appeals
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
33.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.i. Engagement with Federally Recognized Tribes</i>. The response shall include:</p> <p><u>Medicaid Only</u></p> <ol style="list-style-type: none"> a. Approach to integrate with EBCI Public Health and Human Services (PHHS) offices; b. Approach for working with IHCP providers, including:

	<ul style="list-style-type: none"> i. Proposed training methods for Tribal Provider Contracting Specialist, if applicable ii. Proposed plan to contract with IHCPs as required under the Contract. c. Approach to integrate with State recognized tribes.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
34.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.v Community Crisis Services Plan for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Efforts to implement the Community Crisis Services Plan; b. Approach to convene the Crisis Planning Committee; and c. Plans for coordinating with Standard Plans and local communities around efforts to increase access to and secure the sustainability of non-hospital/ED-based behavioral health crisis options and alternatives to involving law enforcement in behavioral health crisis response. <p>The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements and provide a plan for addressing those limitations/issues.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page limit)</p> <ul style="list-style-type: none"> 1. Community Crisis Services Plan

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Benefits & Services

Evaluation Question	
35.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package</i> and <i>V.C.2.a. State-funded BH I/DD and TBI Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience and approach to providing mental health services across community-based and residential settings; b. Experience and approach to providing the continuum of SUD treatment and withdrawal management services across Medicaid and State-funded Services, including opioid and MAT treatment across community-based and residential settings; c. Experience and approach to providing I/DD-related benefits, including Innovations waiver services; <p><u>For State-funded Services Only</u></p> <ul style="list-style-type: none"> d. Proposed non-core State-funded Services the Applicant intends to offer.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

36. The Applicant shall describe the In Lieu of Services (ILOS) (*Section V.B.2.i.(vii) In Lieu of Services*) and Value-Added Services (*Section V.B.2.i.(viii) Value-Added Services*) that the Applicant plans to propose to the Department for approval. The response shall include:

For Medicaid Only

- a. Description of and rationale for each service;
- b. Medicaid State Plan service it is in lieu of;
- c. Proposed population to cover for each service; and,
- d. Whether the Applicant is providing the service today and its approach for monitoring efficacy and cost-effectiveness, including any adjustments to the service made based upon monitoring.

Response to this question will not count toward the Applicant’s page count limit.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
37.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach to ensuring members and providers are aware of the EPSDT program; b. The category of expanded benefits (e.g., physical health, NEMT and LTSS) where Applicant anticipates EPSDT will be most important and approach for addressing its anticipated importance; c. Description of medical necessity review process, including examples of how the Applicant has applied the process previously on at least two (2) approved and two (2) denied services; and d. Outreach methods to remind members of missed screenings and preventive services. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Current EPSDT policies.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
38.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.iv. Non-Emergency Medical Transportation</i>. The response shall include:</p>

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach to building an adequate NEMT network; b. Approach to transitioning NEMT upon BH I/DD Tailored Plan enrollment for members who were using NEMT in NC Medicaid Direct; c. Approach to utilizing innovative transportation solutions to most effectively meet needs of members; and d. Oversight model of NEMT providers to ensure member rights and maintain high member satisfaction.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

39.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for diversion of Medicaid members and potential State-funded Services recipients from placement in an institutional setting or ACH as stated in <i>Section V.B.3.ii.(xii) Diversion from Institutional Settings and V.C.3.d. Diversion from Institutional Settings</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. For adult members/potential recipients with SMI: <ul style="list-style-type: none"> i. Experience with and approach to appropriately identify, engage and divert members/potential recipients from placement in an institutional setting or ACH to a home or community-based setting; and
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	<p>ii. Experience with and approach to identify and connect members/potential recipients at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including waiver services; and</p> <p><u>For Medicaid Only</u></p> <p>b. For members under age eighteen (18) with SED</p> <p>i. Experience with and approach to appropriately identify, engage and divert members from placement in an institutional setting to a home or community-based setting; and</p> <p>ii. Experience with and approach to identify and connect members at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including Medicaid, state-funded, and waiver services.</p> <p>c. For members with I/DD</p> <p>i. Experience with and approach to appropriately identify, engage and divert members from placement in an institutional setting to a home or community-based setting; and</p> <p>ii. Experience with and approach to identify and connect members at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including Medicaid, state-funded, and waiver services.</p>
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Response

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<p>Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.</p>

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Evaluation Question

40.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for in-reach and transition of the following Medicaid members and non-Medicaid covered State-funded Services recipients from an institutional setting or ACH to a home or community-based setting as stated in <i>Section V.B.3.viii. In-Reach and Transition from Institutional Settings</i> and <i>Section V.C.3.e. In-Reach and Transition from Institutional Settings</i> s:</p> <ul style="list-style-type: none"> • Members/recipients age eighteen (18) and above admitted to or residing in a state psychiatric hospitals;
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- Members/recipients with SMI admitted to or residing in an ACH;
- Members admitted to or residing in state developmental centers, including members under age twenty-one (21) (Medicaid only); and
- Members admitted to or residing in ICF-IIDs Not Operated by the State, including members under age twenty-one (21) (Medicaid only).

For Medicaid and State-funded Services

The response shall include:

- a. Experience with and approach for ensuring successful and appropriate in-reach to members and recipients in institutional settings or ACHs who are eligible to receive in-reach and transition services and successful and appropriate transition of members/recipients in institutional settings or ACHs.
- b. Experience with and approach to identify members/recipients for in-reach and transition services, including policies, procedures and data systems.
- c. Experience with and approach to ensure individuals responsible for in-reach and transition activities are appropriately trained and supported so that they are able to provide high-quality, person-centered in-reach and transition services for the member populations they will serve, including members with SMI and I/DD
 - i. Training for individuals responsible for in-reach and transition activities, including initial and ongoing continuous education.
 - ii. Approach for coordination between individuals responsible for in-reach and transition activities and other BH I/DD Tailored Plan-based specialists who can provide additional support for complex discharges, including but not limited to the housing specialist and/or diversion specialists.
 - iii. Approach for supervision, oversight, and accountability of individuals responsible for in-reach and transition activities.
- d. Description of the Applicant’s in-reach and transition roles and responsibilities, including any overlapping responsibilities between individuals providing in-reach and transition services and rationale for the overlaps.
- e. Approach to ensure timely, Warm Handoffs:
 - i. Between in-reach staff (i.e., in-reach specialist or peer support specialist) and individuals responsible for transition activities (i.e., transition coordinator or DSOHF admission through discharge manager) when a member/recipient chooses to transition to a community setting.
 - ii. Between transition staff and the member/recipient’s care manager, provider delivering State-funded case management service, or other state-funded service with case management functions (e.g. CST, ACT), if applicable.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Current policies, procedures, and data systems, including those used to identify members/recipients for in-reach and transition services.

Response
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
41.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for in-reach and transition for the following Medicaid members from an institutional setting to a home or community-based setting as stated in <i>Section V.B.3.viii. In-Reach and Transition from Institutional Settings</i> a:</p> <ul style="list-style-type: none"> • Member under age eighteen (18) admitted to or residing in a state psychiatric hospital; • Members admitted to or residing in a PRTF; and • Members admitted to or residing in Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2. <p>For Medicaid Only</p> <p>The response shall include:</p> <ol style="list-style-type: none"> a. Experience with and approach to: <ol style="list-style-type: none"> i. Reducing the average length of stay in a PRTF, Residential Treatment Service, or state psychiatric facility for members under age eighteen (18); and ii. Reducing the total number and percentage of members under age eighteen (18) residing in a PRTF, Residential Treatment Service, or state psychiatric facility. b. Experience with and approach to ensuring successful and appropriate in-reach to members in institutional settings who are eligible to receive in-reach and transition services and successful and appropriate transition of members in institutional settings. c. Experience with and approach to identifying members for in-reach and transition services, including policies, procedures and data systems.

	<p>d. Experience with and approach to ensuring individuals responsible for in-reach and transition activities provide high-quality, person-centered in-reach and transition services for the member populations they will serve:</p> <ul style="list-style-type: none"> i. Training for individuals responsible for in-reach and transition activities, including initial and ongoing continuous education. ii. Approach for coordination between individuals responsible for in-reach and transition activities and other BH I/DD Tailored Plan-based specialists who can provide additional support for complex discharges, including but not limited to the housing specialist and/or diversion specialists. iii. Approach for supervision, oversight, and accountability of individuals responsible for in-reach and transition activities. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Current policies, procedures, and data systems, including those used to identify members/recipients for in-reach and transition services.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

42.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.iv. Development of Housing Opportunities for Medicaid Members and State-funded Recipients</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience securing and maintaining housing placements for TCLI population b. Priority populations other than TCLI and approach for targeting them for housing efforts
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Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Members & Recipients

Evaluation Question	
43.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.viii. Advance Directives for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Applicant’s current Advance Directives policy (does not count towards page guidelines) and b. Detail describing any proposed changes to the Applicant’s Advance Directives policy anticipated to meet the outlined requirements (Section V.A.1.h.) and the associated timeline for making those changes.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question

44. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans*, and the North Carolina Managed Care Enrollment Policy (*Section VII. Attachment M.1.*). The response shall include:

For Medicaid Only

- a. Necessary system interfaces to accept and process member enrollment and disenrollment, in a standard HIPAA compliant manner;
- b. Integration approach with Enrollment Broker and local DSS offices or EBCI PHHS offices; and
- c. Approach to enrolling Standard Plan beneficiaries who need a service only offered through a BH I/DD Tailored Plan into a BH I/DD Tailored Plan within twenty-four (24) hours retroactive to the date of the service-related request and ensuring that service authorizations, including expedited ones, for these members are completed in a timely manner consistent with the required timeframes.

Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question	
45.	<p>The Applicant shall describe its proposed eligibility criteria and its approach for implementing its eligibility criteria as outlined in <i>Section V.C.1.a. Eligibility for State-funded Behavioral Health, I/DD and TBI Services</i>. The response shall include:</p> <p><u>For State-funded Services Only</u></p> <ul style="list-style-type: none"> a. Proposed eligibility criteria for by disability group (e.g., mental health, SUD, I/DD and TBI), including whether the Applicant proposes to use the Department’s guidelines. The response should include: <ul style="list-style-type: none"> 1. Detailed description of the proposed eligibility criteria, including proposed income level, insurance status (i.e., whether individuals who are uninsured, have Medicaid, have other third-party coverage will be eligible for services), and any other components that will be considered (This sub-part will not be scored.) 2. Rationale for the proposed eligibility criteria 3. Process for consulting its CFAC on the proposed eligibility criteria and description of how the CFAC’s feedback was/will be incorporated 4. Approach for implementing its proposed eligibility criteria, including the role of providers in the implementation b. Approach for monitoring the implementation of the eligibility criteria c. Approach for assisting uninsured State-funded Service recipients in submitting Medicaid applications; d. Approach to managing access to State-funded Services and connecting individuals in need of State-funded Services to providers with capacity to treat them; e. Approach for developing and maintaining wait lists on the plan level for individuals waiting for State-funded Services, including any recent or planned investments in technology or system infrastructure; and f. Approach to maximizing federal Medicaid funding for Medicaid beneficiaries to expand the reach of State funds and ensure that other available coverage and payment sources are pursued first.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

46. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.ii. Transitions of Care*. The response shall include:

For Medicaid Only

- a. Approach for conducting “Warm Handoffs” during the crossover and ongoing periods for those members who were previously receiving services through a Standard Plan, another BH I/DD Tailored Plan, CCNC or other transition entities such as the Tribal Option.
- b. Approach for conducting “Warm Handoffs” on an ongoing basis after BH I/DD Tailored Plan launch, including for those members transitioning to a Standard Plan; and
- c. Experience and approach for supporting members transitioning between providers when a provider is terminated or otherwise leaves the BH I/DD Tailored Plan’s network.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

- 1. Draft transition of care process flows detailing the flow of information for members transitioning into and out of the BH I/DD Tailored Plan

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

47. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.vi. Member Grievances and Appeals*, including how the Applicant intends to identify, track and analyze member grievances, appeals, and State Fair Hearing data. The response shall include:

For Medicaid Only

- a. Approach for educating members about the grievance and appeals process, including assistance and accommodations that the BH I/DD Tailored Plan will provide to verify members understand their grievances and appeals rights and process;
- b. Confirmation of the ability to process grievance and appeal requests within the timeframes described in the Contract;
- c. Approach to meeting each of the applicable grievance and appeal timely processing standards processing of requests;
- d. Process for acknowledging receipt of member grievance and appeals requests;
- e. Protocols, procedures and staffing levels and requirements for reviewing member grievances and appeals;
- f. How information and data resulting from the grievance and appeals system is tracked and trended, including how the Applicant uses the data to make program improvements;
- g. Process for resolving grievances and appeals as expeditiously as a member's health condition requires, including how the Applicant assesses the urgency of a member's health conditions and timelines to account for the urgency of the health condition;
- h. Experience for resolving grievances and appeals at the lowest level of escalation to meet Applicant's current members' needs and methods and strategies used throughout the Applicant's approach to resolve grievance and appeals efficiently and effectively at the lowest level of escalation that meets a member's needs and in a manner that does not discourage members from exercising their rights; and
- i. Approach to complying with due process principles under the NC Innovations waiver and TBI waiver.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

- 1. Draft process flows detailing the process for members grievances and appeals.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

48. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.1.e. Recipient Complaints and Appeals*, including how the Applicant intends to identify, track and analyze member complaints, appeals, and State Non-Medicaid Appeals Panel data. The response shall include:

For State-funded Service Only

- a. Approach for educating recipients about the complaints and appeals process, including assistance and accommodations that the BH I/DD Tailored Plan will provide to ensure members understand their grievances and appeals rights and process;
- b. Confirmation of the ability to process complaints and appeals requests within the timeframes described in the Contract;
- c. Approach to meeting each of the applicable complaints and appeals timely processing standards processing of requests;
- d. Process for acknowledging receipt of recipients' complaints and appeals requests;
- e. Protocols, procedures and staffing levels and requirements for reviewing recipients' complaints and appeals;
- f. How information and data resulting from the complaints and appeals system is tracked and trended, including how the Applicant uses the data to make program improvements;
- g. Experience with, methods and strategies used throughout the Applicant's approach to resolve complaints and appeals efficiently and effectively at the lowest level of escalation that meets a recipient's needs and in a manner that does not discourage recipients from exercising their rights; and
- h. Approach for reviewing State Non-Medicaid Appeals Panel findings and decisions to inform Applicant's final decisions.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

- 1. Draft process flows detailing the process for recipients' complaints and appeals

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
49.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for engaging members and recipients prior to and after BH I/DD Tailored Plan launch, as outlined in <i>Section V.B.1.iii. Member Engagement</i> and <i>Section V.C.1.b. Recipient Engagement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Overall approach to educating and engaging members on Medicaid Managed Care and recipients on State-funded Services, and on accessing care, including Innovations and TBI waiver services, and improving overall health; b. Methods of leveraging appropriate communication to meet the diverse needs and communication preferences of members and recipients, including individuals with Limited English Proficiency and needing adaptive communication; c. Approach for making qualified interpreters (including sign language) available to members, recipients, potential members, and potential recipients when requested, and at other times as needed in accordance with the Contract; d. Description of how verbal, written and sign language translation or interpreter services are certified; e. Method to ensure member and recipient language preferences and communication needs are documented in Applicant’s information system;

	<ul style="list-style-type: none"> f. Approach to assess member and recipient satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends in member and recipient satisfaction to support ongoing improvement to the program; g. Experience with engaging consumer and family advisory groups and approach for establishing and maintaining engagement with the consumer and family advisory groups including the structure of these groups; and h. Strategies to ensure meaningful opportunities for input and incorporation of the consumer and family advisory groups' input into the design, development and implementation of BH I/DD Tailored Plan policies; and <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> i. Description of how Applicant will educate members about the differences between Standard Plans and BH I/DD Tailored Plans. j. PROVIDE SUPPORTING DOCUMENTATION (not part of page count): <ul style="list-style-type: none"> 1. Draft Welcome Packet and Member ID card aligned with the requirements of the Contract 2. Sample Member and Recipient Handbook 3. Sample educational materials with taglines (up to 3 samples) 4. Sample education materials demonstrating ability to meet Contract's requirements for translation, accessibility and Cultural and Linguistic Competency (up to 3 samples, including translations in Spanish and Chinese)
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

50. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.iv. Marketing for Medicaid* and *Section V.C.1.c. Marketing*. The response shall include:

For Medicaid and State-funded Services

- a. Proposed marketing locations, distribution methods, and activities planned for the time period between eight (8) weeks prior to and three (3) months after BH I/DD Tailored Plan launch;
- b. Demonstrated understanding of the diverse populations that the Applicant may serve throughout its covered Region (e.g., individuals living in different geographic locations, individuals with different racial and ethnic backgrounds, individuals with different literacy levels, individuals with disabilities) and approach for how the Applicant will adapt its marketing materials to reach the various populations and audiences within its covered service area; and
- c. Process to ensure marketing materials are widely available throughout the Applicant's covered Region to members, recipients, potential members, and potential recipients, and a plan for how the Applicant intends to prevent the selective distribution of its marketing materials throughout its covered Region.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

51. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.v. Member Rights and Responsibilities* and *Section V.C.1.d. Recipient Rights and Responsibilities*.

For Medicaid and State-funded Services

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
52.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.1.vii. Advance Medical Homes (AMHs) as Primary Care Providers (PCPs)</i> and <i>Section V.B.1.vii.(ii). PCP Choice and Assignment</i>.</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach to providing feedback on quality scoring results to AMH practices; and b. Methodology for PCP assignment, including any additional variables that will be used beyond those listed in the contract.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

53. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.A.4.ii. Engagement with Community and County Organizations for Medicaid and State-funded Services*. The response shall include:

For Medicaid and State-funded Services

- a. Approach to design and implement Local Community Collaboration Strategy;
- b. Approach to linking members and recipients to natural and community supports to address unmet health related resource needs;
- c. Prior experiences supporting and working with communities and community-based organizations, including participating in community collaboratives and implementing a similar strategy that the Department is looking to implement through the Contract;
- d. Approach to reducing burden associated with engagement on agencies/partners.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

56. The Applicant shall describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services*.

For Medicaid and State-funded Services

Provide two (2) Medicaid and one (1) State-funded examples of initiatives to proactively prevent fraud/waste/abuse previously enacted and the outcomes achieved; include any work with law enforcement in criminal or civil prosecution fraud cases.

- a. Approach to identify fraud and abuse. Include description of both internal and external policies and procedures.
- b. Describe staffing model for the SIU and how the SIU would work with state or federal investigators.
- c. Description of how the Applicant will work with the Department, MID or the OIG to investigate and prosecute potential fraud/waste/abuse.
- d. Description of how the Applicant will balance the tensions between paying providers timely and accurately with the Applicant's responsibility:
 - i. To monitor potential fraud/waste/abuse; and
 - ii. To cost avoid and cost recovery.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
57.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.3.iv. Third Party Liability (TPL) for Medicaid</i> and <i>Section V.A.3.v. TPL for State-funded Services</i>.</p> <p><u>For Medicaid and State-funded Services</u></p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
58.	<p>The Applicant shall describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.3.vi. Recipient Explanation of Medical Benefit (REOMB) for Medicaid</i>.</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Procedures to exclude mailing REOMBs containing potentially sensitive clinical information; and b. Actions taken based on data from REOMB mailing responses.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

59. The Applicant shall confirm its adherence and describe its approach to managing sensitive and confidential data as described *Section III.E. Confidentiality, Privacy and Security Protections*. The response shall include:

For Medicaid and State-funded Services

- a. Overall approach to customer and member data protection including internal programs and policies that minimize the risk of data breaches such as a Customer Data Protection policy.
- b. Experience in complying with Federal rules and regulations including HITECH, HIPAA, and 42 CFR Part 2;
- c. Experience with Risk Analysis and Assessments associated with NIST standards;
- d. Description of software and infrastructure development and release cycles including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software); and
- e. Description of the vulnerability and breach monitoring processes including internal Network Operations Centers, use of external parties such as US Cert, or other monitoring tools or processes.

Note: If the response includes a cloud or vendor hosted solutions, these are considered extensions of the Applicant’s infrastructure and should be included in the responses to the questions above.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

60.	Evaluation Question	Response
	The Applicant shall describe its internal monitoring activities to ensure that it meets or exceeds each of the Service Level Agreements listed in <i>Section VI.B</i> , as applicable as noted below.	
	Measure	
	Medicaid and State-funded Services	
	1. Service Line Outage	
	2. Call Response Time/Call Answer Timeliness–Member and Recipient Service Line	
	3. Call Wait/Hold Times–Member and Recipient Service Line	
	4. Call Abandonment Rate–Member and Recipient Service Line	
	5. Call Response Time/Call Answer Timeliness–Behavioral Health Crisis Line	
	6. Call Abandonment Rate–Behavioral Health Crisis Line	
	7. Call Response Time/Call Answer Timeliness–Provider Support Line	
	8. Call Wait/Hold Times–Provider Support Line	
	9. Call Abandonment Rate–Provider Support Line	
	Medicaid Only	
	10. Member Enrollment Processing	
	11. Member Appeals Resolution–Standard	
	12. Member Appeals Resolution–Expedited	
	13. Member Grievance Resolution	
	14. Adherence to the Preferred Drug List	
	15. Contracting with AMH+ and CMAs (Medicaid only)	
	16. Number of Individuals Transitioned Into Supportive Housing	
	17. Call Response Time/Call Answer Timeliness–Nurse Line	
	18. Call Wait/Hold Times–Nurse Line	
	19. Call Abandonment Rate–Nurse Line	
	20. Call Response Time/Call Answer Timeliness–Pharmacy Line	
	21. Call Wait/Hold Times–Pharmacy Line	

22. Call Abandonment Rate–Pharmacy Line	
23. Encounter Data Timeliness/ Completeness–Medical	
24. Encounter Data Timeliness/ Completeness–Pharmacy	
25. Encounter Data Accuracy–Medical	
26. Encounter Data Accuracy–Pharmacy	
27. Encounter Data Reconciliation—Medical	
28. Encounter Data Reconciliation—Pharmacy	
29. Website User Accessibility	
30. Website Response Rate	
31. Timely response to electronic inquiries	
32. Access to Primary/Preventive Care for Individuals under NC Innovations waiver	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Quality & Population Health

Evaluation Question	
61.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.3.ix. Prevention and Population Health Programs</i> and <i>Section V.C.3.g. Prevention and Population Health Management Programs</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <p>a. The Applicant’s planned prevention and population health management program designs in priority domains (opioid misuse, tobacco cessation, pregnancy intendedness, birth outcomes, diabetes prevention, hypertension), early childhood interventions, and in other areas of clinical focus. Include description of program, planned interventions at provider, member, system level and expected outcomes.</p>

	<p><u>For Medicaid and State-funded Services</u></p> <p>b. The Applicant’s planned prevention and population health management program design and description of the Applicant’s:</p> <ul style="list-style-type: none"> i. Experience and approach to reduce tobacco use, including proposed specific targets for reducing tobacco use for members with SMI, SED, SUD, I/DD, and TBI; ii. Experience and approach to address opioid misuse. Response must include two (2) examples, including interventions, impact and outcomes; and iii. Experience and approach to educating members about and referring them to programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, and suicide prevention. <p>PROVIDE SUPPORTING DOCUMENTATION: (Does not count towards page guidelines)</p> <p>1. Description of five (5) initiatives the Applicant plans to deploy to collaborate or align with public health programs at the community level (for example, with health departments) or the state level. Must include at least one community and one state-level example, the objective of each, the methodology and the intended outcome.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
62.	The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for addressing Unmet Health-Related Resource Needs for all members, as described in <i>Section V.B.3.x. Healthy Opportunities</i> . These strategies must be beyond strategies identified to integrate efforts to address unmet health-related resource needs into Tailored Care Management and should not duplicate information provided in Question 24. The response shall include:

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Applicant’s experience and approach to addressing Unmet Health-Related Resource Needs for populations included under this Contract; b. Applicant’s experience and approach to collaborating with health and health-related community stakeholders (i.e., providers, LHDs and DSS, and community-based organizations) to address members’ Unmet Health-Related Resource Needs; c. Strategies the Applicant would employ to partner with Community-Based Organizations (CBOs) and state, regional or private human service agencies to address Unmet Health-Related Resource Needs of members; d. Strategies the Applicant would employ to address key Healthy Opportunities domains (i.e., housing, food, transportation and interpersonal safety), specific to the communities in the Region the Applicant seeks to serve; and e. Applicant’s experience and approach to address Unmet Health-Related Resource Needs at the community or population-level. Detail types of community-based interventions, rationale behind activities, and health outcomes related to the population interventions.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
63.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in <i>Section V.B.5.i. Quality Management and Quality Improvement</i> and <i>V.C.5.a. Quality Management and Quality Improvement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Description of the Applicant’s quality management strategy, quality management program including staffing and tools, IT infrastructure and data analytics capabilities to support quality and value,

	<p>including how such systems will support stratification and analysis of quality measures at a regional level, and all associated standing (permanent) and innovative QM/QA/QI programs.</p> <p>b. Approach to collect data on and calculate performance on quality measures, including information regarding which of these functions the Applicant intends to perform internally and which it intends to perform jointly with others, as well as approach to ingesting and using quality data from external sources.</p>
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Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

64.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in <i>Section V.B.5.i. Quality Management and Quality Improvement</i> and <i>V.C.5.a. Quality Management and Quality Improvement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <p>a. One (1) Medicaid and one (1) State-funded services historical examples (unless unavailable in which case hypothetical examples will be accepted) of multi-year (at least three (3) years) quality improvement plans that demonstrate measure targets and planned interventions—as well as annual updates to the plan. The Applicant must give an example of how its quality improvement efforts reduced health disparities. At least one (1) measure and one (1) QI intervention should focus on BH or I/DD and one (1) measure and one (1) QI intervention should focus on physical health. In addition, at least one (1) measure and one (1) QI intervention should focus on pediatric health. A single historical example can cover more than one of these requirements (for example, a QI intervention addressing pediatric BH). The two (2) examples of quality improvement plans should describe:</p>
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	<ul style="list-style-type: none"> i. IT infrastructure used to support measure analysis and quality improvement efforts; ii. Measures results compared to national benchmarks; including measures that did not meet state targets; iii. Evidence of measure indicators; analysis to find drivers; Plan-Do-Study-Act (PDSA) or other methodological approach for evaluation; iv. Two (2) specific QI and two (2) specific performance improvement projects; v. Associated quality improvement training plans—including methodology to target Providers, with specific reference to providers of mental health, substance use disorder and home and community-based services; macro and micro practice interventions, methodology for sharing data and tools and any relationship to advanced payment (AP) or other incentive methods; vi. Associated examples of how quality data was shared with providers. Describe utilization penetration rates among providers and outcomes of using the data and tools/applications. vii. Overall impact of the QM/QA/QI interventions and performance improvement projects. <p>NOTE: The two (2) examples of multi-year quality improvement plans will not be counted toward the Applicant page count. Applicants shall present data to support their analysis of the impact; the analysis should take into consideration issues such as sample size, measurement intervals, and clinical as well as statistical significance of findings. Include measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation; interventions; planned metrics, realized metrics, and overall impact of the QM/QA/QI programs.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

65. The Applicant shall, in accordance with *Section V.B.5.i. Quality Management and Quality Improvement* and *Section V.C.5.a. Quality Management and Quality Improvement*, identify examples of at least ten (10) measures stratified by geography, race/ethnicity, and gender, **of which at least five (5) examples should be for Medicaid Services and five (5) for State-funded Services.** The Applicant shall describe the IT infrastructure and data analytic capabilities used to support the analysis, analysis of the measures, and associated QM/QA/QI programs implemented to address health disparities. These measures shall include at least one measure calculated using clinical data, as opposed to solely claims or encounter data. This question is for Medicaid and State-funded Services.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

66. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for Value Based Payments stated in *Section V.B.5.ii. Value Based Payments* , including a description of the Applicant’s approach to ensuring payments to providers increasingly encourage high value, whole person care, including by integrating the provision of services that address physical health, behavioral health, I/DD, TBI, LTSS and unmet resource-needs. The response shall include:

For Medicaid Only

- a. A description of value-based payment arrangements the Applicant has used in the past, if any. Include the corresponding HCP-LAN framework level, the location, the volume of payments and patients, and the percent of total premium flowing to providers through the VBP arrangement, and any outcome or cost measure improvements realized by the VBP arrangement in the response;
- b. A description of any barriers or challenges the Applicant faced in pursuing the above VBP arrangements and how these challenges were addressed;

- c. Approach to how the Applicant will pursue VBP contracts with its providers, including what types of arrangements it will pursue, how it will involve behavioral health and I/DD providers in its VBP arrangements, and how it will ensure that physical health, behavioral health, and I/DD services are integrated under its VBP arrangements;
- d. A description of the Applicant’s health information technology (HIT) capabilities and how it proposes to build out both its capabilities and those of its network providers over time to meet the Department’s goal of ensuring provider payments are increasingly focused on measures related to value. The response should include descriptions of the specific HIT systems, data types (e.g., claims data, EMR abstracts), data sharing and data analytic capabilities current in-place and those planned to support shared savings and risk models, including:
 - i. Measuring and tracking total cost of care;
 - ii. Risk adjustment;
 - iii. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers and the Department (including how providers will be expected to integrate and use any BH I/DD Tailored Plan-mandated population health management tools);
 - iv. Calculating and confirming the results of a range of attribution methodologies to ensure that providers, including behavioral health and DD providers, are evaluated on performance for the appropriate enrollees;
 - v. Sharing quality measurement, including of electronic clinical quality measure (eCQMs) across different practices and for specific providers within practices for attributable populations under these contracts;
 - vi. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - vii. Reporting capabilities; and
 - viii. Payment functions.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Administration & Management

Evaluation Question	
67.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.ii. Entity Requirements for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. A description of the Applicant's current governance structure (current at the time of Applicant proposal response submission); and b. Detail describing any proposed changes to the Applicant's governance structure anticipated to meet the outlined requirements (<i>Section V.A.1.ii.</i>) and the associated timeline for making those changes, including any changes to board representation other than changes in the individual board members through the ordinary course of business.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
68.	Reserved.

Evaluation Question	
69.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Accreditation for Medicaid</i>. The response shall include expected timeline to receive NCQA Health Plan Accreditation with</p>

	<p>LTSS Distinction and assume that NCQA will provide flexibility on the status of PHP licensure such that not yet obtaining a PHP license will not be a barrier to receiving Health Plan Accreditation with LTSS Distinction.</p> <p><u>For Medicaid Only</u></p>
Response	
<p>Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.</p>	

Evaluation Question	
70.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.v. Implementation for BH I/DD Tailored Plan Services</i> and <i>Section V.A.1.vi. Readiness Review Requirements</i>.</p> <p><u>For Medicaid and State-funded Services</u></p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Draft Implementation Plan (from Contract Award through 60 days after Implementation), including: <ol style="list-style-type: none"> a. Key milestones, activities and Deliverables; b. Proposed staffing and resources to support implementation and readiness; c. System and operational implementation milestones; and d. Required BH I/DD Tailored Plan, Department, and other partner resources to ensure successful implementation.

Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
71.	The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.vii. Non-discrimination for Medicaid and State-funded Services.</i> <u>For Medicaid and State-funded Services</u>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

72. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.2.iii. Staff Training for Medicaid and State-funded Services*. The response shall include:

For Medicaid and State-funded Services

- a. Experience and approach in developing trainings for staff with varying backgrounds, educational and experience levels;
- b. Strategies for ensuring training incorporates awareness and sensitivity to unique needs of member/recipient populations, including health disparities for HMPs, diverse cultural beliefs and practices, and the needs of individuals with trauma;
- c. Description of the Applicant's process and methods for providing North Carolina Medicaid Managed Care and State-funded Services training to its personnel, including:
 - i. A description of each staff training program (i.e., member and recipient services, provider relations, county and Department staff), including a summary of the topics, the materials used, and the media used in the training;
 - ii. Frequency of the initial and updated training; and
 - iii. Approach to ensuring cross-functional training with other Department Medicaid Managed Care partners (including the Enrollment Broker, the Ombudsman program, and local DSS staff) and State-funded Services partners.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

73. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.2.iv. Reporting for Medicaid and State-funded Services* and *Section VII. Attachment J. Reporting Requirements for Medicaid and State-funded Services*.

For Medicaid and State-funded Services

Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
74.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.v. BH I/DD Tailored Plan Policies for Medicaid and State-funded Services</i>.</p> <p><u>For Medicaid and State-funded Services</u></p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
75.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.vi. Business Continuity for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Approach to meeting the Department’s restoration of service timing expectations including failover site approach (active/active, active/passive and cold, warm, or hot site), technical staffing coverage, data replication and recovery processes, and approach to testing including frequency and testing coverage; b. Approach for maintaining data security during an event that causes the implementation of the business continuity plan; c. Description of the differentiation between the technical approach (system failover, data recovery, etc.) and the business approach (alternate procedures, staffing, training, etc.) including how critical functions will be met during the initial twenty-four (24) hour recovery window; d. Approach to support Department’s overall goals in ensuring continuity of and access to care during disasters or emergencies, including natural or manmade disasters as well as epidemics and pandemics. As part of the response, comment at a high level on how the approach would differ according to the type of disaster or emergency, including for epidemics/pandemics: <ul style="list-style-type: none"> i. Approach to reducing barriers to care during an emergency for Medicaid members and State-funded Services recipients, including the requirements described in <i>Section V.A.2.vi. Business Continuity for Medicaid and State-Funded Services</i>; ii. Description of policies and procedures the Applicant will have in place to facilitate appropriate access to a seventy-two (72) hour emergency supply of a prescription in cases where a pharmacist cannot fill a prescription when presented due to a prior authorization requirement and the prescriber cannot be reached; e. Description of process and procedures to ensure access to medications during a state of emergency or disaster; and f. Description of how the Applicant’s experience and lessons learned from responding to previous disasters or emergencies (e.g., COVID-19, hurricanes) have informed the Applicant’s proposed approach.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

76. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.A.4.iii. Integration with Other Department Partners for Medicaid and State-funded Services*. The response shall include:

For Medicaid Only

- a. Enrollment Broker;
- b. Ombudsman Program;

For Medicaid and State-funded Services

- c. County DSS offices;
- d. Division of Public Health;
- e. Division of Health Services Regulation; and
- f. Division of Vocational Rehabilitation Services.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

77. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.6.i. Claims*. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The completed table shall include the experience of the Applicant and any entity proposed to process and pay claims in Question #2.

For Medicaid Only

Description of policies and procedures to meet performance standards and prompt pay requirements;

	<ul style="list-style-type: none"> a. Description for how interest and penalty payments to providers for late payment will be tracked separately from the contracted payment; b. Market specific strategies for addressing potential provider payment issues, beginning with the contracting process and technical provider contract setup, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education; and c. Proposed average days to payment from claims submission for the Applicant’s proposed claims platform for pharmacy claims and medical claims (days should be separately for medical and pharmacy).
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

78.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.6.ii. Encounters</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Experience with and approach to performance management strategies to ensure complete, accurate and timely encounter data submissions are made to the Department and meet the standards required under the Contract; b. Demonstrated understanding of the importance of accurate, complete and timely Medical and Pharmacy encounter data to the Department for use in the North Carolina Medicaid and NC Health Choice programs. In addition, Applicant shall specifically include steps to support drug rebates and steps to support capturing all applicable diagnosis information on encounters to support risk adjustment;
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	<ul style="list-style-type: none"> c. Description of the Applicant’s process for verifying that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements for subsequent submission to the Department, including the frequency of verification. <ul style="list-style-type: none"> i. Explanation of how the Applicant will identify and handle the partial or complete non-submission of encounter data by a provider or subcontractor. ii. The Applicant will explain how it will achieve the timely, accurate, and complete submission of encounter data to the Department consistent with required standards and formats. iii. The Applicant will explain how data it receives from providers and subcontractors will be integrated and tested prior to submission to the Department to ensure the submission of a cohesive encounter file in accordance with DHHS requirements; d. Operating model including staffing to support the encounter development and submission process and integration and oversight of subcontractors responsible for encounter submission; e. Description of the Applicant’s past performance in complying with encounter submission SLAs including for other Medicaid customers (e.g. for subcontractors) for other Medicaid customers including the acceptance rates as percentages; f. Leading practices it has adopted to improve data quality in encounter submission, include applicable policies and procedures and the Applicant’s use of the Post Adjudicated Claims Data Reporting (PACDR) version of the X12 837 transaction; g. Procedure to work with providers and internal operations in correcting Encounter errors; and h. Describe the challenges and associated mitigation approaches with encounter data submission (including managing denied claim submission, duplicate submissions, sub capitated claims, value-based arrangements, or non-traditional services such as ILOS, value-added services, health-related resources) and specific steps taken to remediate issues. Include specific data on outcomes achieved.
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Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

79. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.C.6. Claims Management*. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The ~~completed table~~ response shall include the experience of the Applicant and any entity proposed to process and pay claims. The response shall also include:

For State-funded Services Only

- a. Description of policies and procedures to meet performance standards and prompt pay requirements;
- b. Market specific strategies for addressing potential provider payment issues, beginning with the contracting process and technical provider contract setup, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education; and
- c. Proposed average days to payment from claims submission for the Applicant's proposed claims platform;
- d. Experience with and approach to performance management strategies to ensure complete, accurate and timely claims data submissions are made to the Department and meet the standards required under the Contract;
- e. Describe experience with Claims Processing and Reprocessing Standards using automated capability to identify, process, and reprocess claims, including provider eligibility validation, state funded recipient benefit plan enrollment and in accordance to N.C. Gen. Stat. § 58-3-225;
- f. Operating model including staffing to support claims processing and reprocessing standards;
- g. Demonstrated understanding of transmittal and process data using ASC X12 standards, support provider payments, comply with data reporting requirements and be of sufficient capacity to expand as needed to accommodate recipient enrollment or program/service changes;
- h. Description of how Applicant will ensure that claims submission contains accurate and complete content to allow either (a) claims payment through the appropriate source of non-Medicaid federal funds- not included in single stream funding or (b) processing as shadow claims data that is accepted in NC Tracks (not denied);
- i. Proposed plan to minimize non-UCR payments, especially for crisis services;
- j. Procedure to work with providers and internal operations in correcting claims errors; and
- k. Describe the challenges and associated mitigation approaches with claims data submission (including managing denied claim submission, duplicate submissions, or non-traditional services) and specific steps taken to remediate issues. Include specific data on outcomes achieved.

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
80.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department’s health information system capacity expectations and requirements outlined in <i>Section V.B.8. Technical Specifications</i> and <i>Section V.C.8. Technical Specifications</i>. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Description of its current health information system(s), as used to support contracted services including, but not limited to member enrollment, claims payment and processing, encounter data reporting, prior authorization, care coordination, care management, quality management and utilization management, performance reporting, financial operations, and provider data collection and reporting. b. For each contracted service, descriptions of: <ul style="list-style-type: none"> i. How its health information systems will be used to support the service in compliance with Contract Requirements; ii. Whether any modifications or updates to its existing systems will be necessary to meet Contract Requirements and, if so, the Applicant’s plan for their completion; iii. System hardware, program, and architecture supporting the service, and its capacity to interface with external systems; iv. Draft flowcharts and diagrams that demonstrate how the system will interact with external systems, noting which components or processes may be managed by subcontractors. (Excluded from page limit.);

	<ul style="list-style-type: none"> v. System capability to store, use, and integrate required volumes of data to support the service, including its ability to scale to meet changing demands; vi. Proposed resources the Applicant will dedicate to implementing and managing the service; and vii. Applicant’s approach and process to comply with privacy and security standards.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
81.	<p>The Applicant shall confirm its adherence and describe its approach to work with State and State Contractors to implement and manage data consumption, integration, exchange, and use as described in <i>Section V.B.8. Technical Specifications</i> and <i>Section V.C.8. Technical Specifications</i>. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience and approach to developing data exchanges and interfaces, including response batch, EDI, real time, and APIs. b. Innovative approaches and experience with data exchanges focused on transmitting only necessary data for business purposes (including data sharing such as data hubs and real-time data services). c. Approach to comply with the current data exchanges detailed in the Contract. d. Approach to system and service availability including the recoverability of platforms to avoid impacts to the delivery of services to members.

	<ul style="list-style-type: none"> e. Approach to functionally testing and integrating new software releases, upgrades, and fixes prior to releasing into production (this is differentiated from the questions above around vulnerability testing). f. Approach to comply with the reconciliation processes for member and Provider, including and any gaps in the reconciliation process. g. Approach and experience in conducting root cause analysis when failures or problems are identified. h. Method to create, maintain and transmit the Provider Directory. i. Approach and experience with user acceptance testing, system integration testing, and end to end testing to support integration with the Department and Department partners, including commitment to dedicated staff, expected timelines, and testing environments and tools. j. Approach to follow the Department's Enterprise Architecture standards when creating the System Interface Design and throughout the maintenance of this documentation. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Health information system flowcharts and diagrams
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Response

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Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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4. Use Case Scenarios

The Applicant must submit its response to the following Use Cases. The Department encourages the Applicant to suggest innovative ways to fulfill the requirements of this Contract.

The use cases represent hypothetical members, recipients, providers, or entities at a specific point in time. Responses must include, at a minimum, the program and services listed within each use case. The Applicant should include any limitations or exceptions to providing the programs and services listed.

The Applicant’s response may not exceed seven (7) pages per Use Case, and may include a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature or detailed information specifically tailored for the North Carolina Medicaid Managed Care to demonstrate its ability to meet or exceed requirements.

Use Case Scenario A	
A.	<p>Emily, age 46, has had over 10 hospitalizations, emergency department visits and mobile crisis interactions related to her co-morbid illnesses of schizophrenia and alcohol use disorder over the past 180 days. She is a daily cigarette smoker for over 20 years. She has not attended any of her scheduled follow-up appointments. She is homeless in rural North Carolina and estranged from her family, who is out of state, due to her psychotic and substance use disorders. She is her own guardian and has not been willing to participate in applying for Medicaid. She had a job at a local retail store a few years ago, but lost it after relapsing on alcohol and stopping her antipsychotic medication. During her an emergency room visit yesterday for a sprained ankle after an alcohol related fall, she also tested positive for COVID-19 but was asymptomatic and was released to a local shelter with a quarantine bed. Since yesterday the shelter has had difficulty managing several disruptive behaviors (e.g., yelling, not following rules) and are considering not permitting her to remain in the shelter. The Applicant must describe how it would address Emily’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Linkage to care management; b. Behavioral health services; c. Tobacco cessation; d. Community inclusion (including housing and employment); e. Primary care services, including screenings; f. Local public health and social services interface; and g. Quarantine assistance.
Response	

Use Case Scenario B	
B.	<p>Samantha, age 30, has sickle cell disease and is diagnosed with an opioid use disorder over the past 3 years after years of challenging pain crises with limited access to quality primary or specialty medical care. She is currently working part time at a local restaurant but has limited shifts due to reduced hours during the pandemic. Samantha has limited local social supports because her family lives out of state. She is four months pregnant and desires to continue with the pregnancy. She has been started on MAT (buprenorphine) and is currently in a state funded women’s substance use treatment program. She needs to apply for Medicaid for Pregnant Women. The Applicant must describe how it would address Samantha’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Historically Marginalized Populations; b. Behavioral health services, (including State-funded Services), taking into account historically underutilized businesses; c. Long-term housing; d. Transportation; e. Benefits counseling, including assistance with applying for Medicaid; f. Care management; and, g. Physical health services including primary care, specialty health care, and prenatal services (including accessing historically underutilized businesses)
Response	

Use Case Scenario C	
C.	<p>Jimmy, age 23, is about to be released from the State Psychiatric Hospital (SPH), where he has been treated for the last eighteen (18) months for schizophrenia. He also has a history of cannabis abuse and a criminal background due to prior convictions for breaking and entering. Prior to going to the State Psychiatric Hospital, Jimmy had been receiving outpatient therapy and medication management services but rarely attended therapy, and only attended about 50% of his scheduled medication management appointments due to a mix of access issues and paranoia related to his care providers.</p> <p>Jimmy used to live with his parents and younger sister. He is not welcome back to live there due to his cannabis use and criminal history. His parents are supportive and engaged and have attended several treatment team meetings and visited regularly. They have said that they do want him to be within a 30 minute drive so they</p>

can continue to support him. Jimmy has no history of living independently. He did have a driver’s license, but it lapsed while he was in the State Psychiatric Hospital. He doesn’t have a car any longer.

Jimmy has his high school diploma and took some welding courses at the local community college, but he was unable to complete the certificate program. He has a limited work history, having past entry level positions in fast food and hasn’t been able to maintain any job for longer than three (3) months. His last job fired him for “insubordination.” Jimmy does mention that he would like to try to finish his welding certificate and work either in construction or on 18 wheelers, but he’s worried with his mental illness, substance use history, and criminal justice involvement that it is pointless. He is stable and ready to be discharged and will need assistance to reinstate his benefits (including Medicaid) and access supports for stabilization in the community.

The Applicant must describe how it would address Jimmy’s situation. The Applicant shall address the following programs and services in its response:

- a. Behavioral health services; including State-funded services;
- b. In-Reach, Transition supports (including supportive housing) and care management;
- c. Employment;
- d. Benefits counseling;
- e. Transportation; and
- f. Primary care.

Response

Use Case Scenario D

D. Edward is a 16-year-old male with Prader Willi Syndrome and mild intellectual disability who has also been diagnosed with autism spectrum disorder, obsessive-compulsive disorder, unspecified anxiety, obesity and type-2 diabetes. He lives with his mother and three (3) siblings and rarely sees his father who frequently works construction jobs out of state. Mom has relied on the support of their faith community and the school system. She has also successfully gotten Medicaid for Edward. Mom has tried to keep Edward on a highly regulated diet and plan of blood sugar checks through the years, enlisting the help of the nurse at his school to assist with this plan, but this has gotten more difficult as Edward grew into adolescence.

As Edward has gotten older, his obsessive food seeking behaviors have worsened and he has become increasingly aggressive when he does not have open access to food. He has also wanted to do more self-care and, with the assistance of his Mom and the school nurse, has had shown moderate success with skill building. After recently being started on Risperdal by his PCP to help with his behavior, Edward began to gain more weight and his most recent HgbA1C was 10.

	<p>Due to recent aggression (hitting) toward his mother and his youngest sibling (3 yo) at home, Mom had to call 911 and Edward was taken to his local Emergency Room where he has been for seven (7) days, with poor control of aggression in this unfamiliar and overly-stimulating environment. Mom is seeking residential care or ICF-IID placement as she feels Edward cannot be safe at home currently. After trying over a dozen facilities, the local hospital and his Tailored Care Manager have been unable to find a location that can accommodate Edward’s unique needs.</p> <p>The Applicant must address how it would address Edward’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Care Management; b. Unmet health related resource needs; c. Diabetes self-management education; d. Family support and resiliency; e. Primary care and specialty healthcare services, including specialty I/DD and mental health services for children (including EPSDT considerations); f. Innovations Waiver/Wait-List referral; g. Community Inclusion, including diversion; and h. Network management and contracting.
Response	

Use Case Scenario E	
E.	<p>Kyle, a 35-month-old was referred to local Children’s Developmental Service Agency (CDSA) at 17 months by his pediatrician, Dr. Smith, due to failure to thrive associated with cardiac anomalies, encephalitis, and seizures. He is currently diagnosed with autism spectrum disorder and cerebral palsy, with significant spasticity. The history of seizure activity has resolved, and Kyle no longer takes medication. His heart function has stabilized. In addition to Dr. Smith, Kyle is also followed by neurology. Kyle had been hospitalized on and off for the first 14 months of his life due to seizures, numerous viral infections and significant nutritional issues. Kyle had an NG tube from 6 months of age until he was successfully weaned from it by 20 months. He is a picky eater who is orally hypersensitive but has been able to maintain height and weight in the 25-30th percentile for his age.</p> <p>Kyle’s mom reports that CDSA services has helped Kyle make significant gains while supporting the families’ capacity to care for him. As Kyle approaches 3 years-old, his mom is really interested in preschool placement where Kyle can receive special education services.</p> <p>The most recent report from the early intervention occupational therapist included home observation and discussion with Kyle’s mom states:</p>

	<p>“Kyle was able to hold and drink from a spouted cup, but arm movements remain unsteady and he often splashes or knocks over the cup when setting it down. He can finger feed a variety of small, soft foods. He is beginning to effectively use a spoon. He continues to have choking responses to rough, hard or chewy textures. His mother reports she continues to feed baby food to maintain nutrition, while having Kyle practice using his spoon to feed himself at least half the meal. Mom has a list of foods she is gradually introducing in small bites to increase Kyle’s ability to accept the foods the family typically eats.</p> <p>Kyle has strong preferences and insists on choosing his clothes each day. Kyle can assist with dressing, but due to significant challenges in moving his arms and legs he is unable to undress or dress independently.</p> <p>Kyle has functional receptive language skills and routinely follows 2-3 step directions. Kyle uses 2-3-word phrases and can express his wishes and dislikes with both words and gestures. Kyle tantrums 1-3 times daily when he is unable to communicate his desires.</p> <p>When other children visit, Kyle wants to play, but verbally and motorically has difficulty engaging. He needs a lot of adult facilitation and direction to imitate what the other children are doing. He has a wheelchair but spends much play time out of it. When put in a standing position, he can hold a couch or chair and stand 1-2 minutes on his own. He is just beginning to try a sideways step.”</p> <p>The Applicant must describe how it would address Kyle’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Behavioral Health/I/DD Services (including Research based- behavioral health treatment (RB-BHT) and consideration of EPSDT); b. Primary care and specialty health care; c. Nutrition services; d. Occupational therapy services; e. Speech and language services; f. Care management; g. Person-center planning; and h. Family support.
Response	

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5. BH I/DD Tailored Plan Key Personnel

The following must be completed by the Applicant as required by *Section V.A.1.i. Staffing and Facilities*.

Section VIII. 5.Table 4: BH I/DD Tailored Plan Key Personnel				
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Master's degree from an accredited college or university 	
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for accounting and finance operations, including financial audit activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years' of progressive accounting experience, of which three (3) years are supervisory 	
3.	Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university • Minimum of seven (7) years' experience in a managed care organization 	
4.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a primary care physician or psychiatrist, fully licensed to practice in NC and in good standing. 	

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
		<p>members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.</p>	<ul style="list-style-type: none"> • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If a primary care physician, clinical experience with child/adolescent and adult populations is preferred. If individual does not have experience with all populations, direct medical staff reports must have experience. • If a psychiatrist, clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience) 	
5.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and manages all fraud, waste, and abuse and compliance activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university 	
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	<ul style="list-style-type: none"> • Must hold a Bachelor's degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years' experience in health care 	

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
7.	Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred 	
8.	Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and related member and provider appeals. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT) 	
9.	Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for providers services and provider relations, including all network development and management issues. Individual reports to the COO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of combined network operations, provider relations, and management experience 	

Section VIII. 5.Table 4: BH I/DD Tailored Plan Key Personnel

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
10.	Deputy Chief Medical Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for activities as assigned by the CMO including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for supporting CMO in ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If the CMO is a psychiatrist: <ul style="list-style-type: none"> ○ Must be a primary care physician fully licensed to practice in NC and in good standing. ○ Minimum of five (5) years clinical experience and two (2) years' experience in managed care ○ Clinical experience with child/adolescent and adult populations is preferred. If individual does not have child/adolescent and adult populations experience, direct medical staff reports must have experience with these populations. • If the CMO is a primary care physician: <ul style="list-style-type: none"> ○ Must be a psychiatrist fully licensed to practice in NC and in good standing ○ Minimum of five (5) years' experience in a BH and/or I/DD clinical setting and two (2) years' experience in managed care

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
			<ul style="list-style-type: none"> ○ Clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, at least one direct medical staff report must have experience) 	
11.	I/DD and TBI Clinical Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and BH benefits. Individual reports to the CMO.	<ul style="list-style-type: none"> ● Must reside in North Carolina ● Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI ● Minimum of seven (7) years of utilization review, care management, and/or rehabilitative and case management experience in I/DD care 	
12.	Director of Population Health and Care Management of North Carolina Medicaid	Individual responsible for providing oversight and leadership of all prevention/population health, care management	<ul style="list-style-type: none"> ● Must reside in North Carolina ● Minimum of five (5) years of demonstrated care management/population 	

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
	Managed Care Program and State-funded Services	and care coordination programs, including oversight of care management provided by AMH+, State-funded case management providers, and care management agencies and care management delivered by Local Health Departments	health experience in a healthcare organization serving Medicaid beneficiaries, including experience with BH and I/DD populations <ul style="list-style-type: none"> • North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT) 	
13.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the BH I/DD Tailored Plan pharmacy benefits and services.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a North Carolina-registered pharmacist with a current NC pharmacist license • Minimum of three (3) working years of Medicaid pharmacy benefits management experience 	

6. Contractor’s Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

Contract Administrator regarding day to day activities herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

7. Certification of Financial Condition

The Applicant must complete and sign this Form, and include the required documents as indicated herein.

The undersigned hereby certifies that:

- The Applicant has included the following documents with this completed Certification of Financial Condition.
1. Audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant (CPA for the two most recent fiscal years, including at a minimum balance sheet, income statement, and cash flow statement for each year. Must provide the contact information for the CPA/audit firm.
 2. The current Month End Balance Sheet and Year-to-Date Income Statement at the time of proposal submission.
 3. The most recent corporate tax filing OR independent audit report. If submitting the independent audit report, must include contact information for the audit firm.
- The Applicant is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.
- The Applicant has included a brief statement outlining and describing its financial stability.
- The Applicant has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.
- The Applicant is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.
- The Applicant acknowledges that this is a continuing certification, and the Applicant shall notify the Department

If any one or more of the foregoing boxes is NOT checked, the Applicant shall explain the reason in the space below:

The Applicant is encouraged to explain any negative financial information in its financial statement below and are encouraged to provide documentation supporting those explanations:

By completing this Certification of Financial Condition and Legal Action Summary, the Applicant affirms the ability to financially support implementation and on-going costs associated with this Contract, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the Applicant.

Signature

Date

Printed Name

Title

The remainder of this page is intentionally left blank.

8. Disclosure of Litigation and Criminal Conviction

The Applicant must provide information regarding litigation and criminal conviction in response to the RFA by completing this Form.

1. The Applicant shall disclose, if it, or any of its subcontractors, or their officers, directors, or key personnel who may provide Services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception.
2. The Applicant shall disclose if it, or its any of its subcontractors, are the subject of any current litigation or investigations of noncompliance under federal or state law.
3. The Applicant shall disclose any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its subcontractors during the three (3) years preceding its offer that involve (1) Services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Applicant or subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Applicant or subcontractor.
4. In the event the Applicant, an officer of the Applicant, or an owner of a twenty-five percent (25%) or greater share of the Applicant, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Applicant's business integrity, such Applicant shall be prohibited from entering into a contract for goods or Services with any department, institution, or agency of the State.
5. The Applicant shall disclose any legal action that could adversely affect the Applicant's financial conditions or ability to meet the requirements any Contract resulting from the RFA.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements set forth in RFA *Section III.D.15. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition*, and the resulting obligations should a Contract be awarded to the Applicant.

9. Disclosure of Conflicts of Interest

Applicant must provide conflict of interest information by completing this form in its response to the RFA.

Applicant shall:

- Disclose any relationship to any business or associate with whom the Applicant is currently doing business that creates or may give the appearance of conflict of interest related to this RFA and any Contract that may be awarded to Applicant because of the RFA.

- Disclose any Board member, Director or staff member, known by the Applicant to have a conflict of interest or potential conflict of interest related to this RFA and any Contract that may be awarded to Applicant because of the RFA.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements regarding conflicts of interest set forth in *RFA Section III.D.15. Disclosure of Conflicts of Interest*, and the resulting obligations should a Contract be awarded to the Applicant.

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10. Disclosure of Ownership Interest

Applicant must provide information regarding ownership and control as described in 42 C.F.R. § 455.104 by completing this Attachment.

Applicant shall provide, for the Applicant, the following information:

1. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Applicant, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Applicant's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Applicant if that interest equals at least 5% of the value of the Applicant's assets, is an officer or director of a Applicant organized as a corporation, or is a partner in a Applicant organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. § C.F.R 455.100-104);
2. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Applicant, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Applicant's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Applicant if that interest equals at least 5% of the value of the Applicant's assets, is an officer or director of a Applicant organized as a corporation, or is a partner in a Applicant organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. § 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
3. Whether the person (individual or corporation) with an ownership or control interest in the Applicant is related to another person with ownership or control interest in the Applicant as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Applicant has a 5% or more interest is related to another person with ownership or control interest in the Applicant as a spouse, parent, child, or sibling
4. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity, as defined in 42 C.F.R. § 455.101 in which an owner of the Applicant has an ownership or control interest; and
5. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section D, Paragraph 15, Staffing Requirements) of the Applicant as defined in 42 C.F.R. § 455.101.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements set forth in RFA Section

11. Subcontractor Identification

The Applicant must identify and provide the information below for all subcontractors that will be used in meeting Contract requirements should a contract be awarded to Applicant.

Legal Name of Contractor and name used for business (if different) and FEIN	Term of Contract between Applicant and Subcontractor	Description of Services Provided by Subcontractor as it relates to RFA Requirements	Estimated Value of the Contract	Is the Subcontractor HUB certified as provided in G.S. 143-128.4?

By signing the RFA, Applicant:

1. Certifies that the information provided in this Response to *Section VIII.11. Subcontractor Identification* is true to the best of its information and belief;
2. Acknowledges the requirements set forth in *RFA Section III.C.46. Subcontractors*, requiring Department approval of any subcontractors used in the performance of any Contract awarded as a result of the RFA; and
3. Attests that it understands, pursuant to NCGS §58-56-26, that, in the event of Contract award, Applicant is solely responsible to provide competent administration of its claims duties.

12. Business Associate Agreement

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUSINESS ASSOCIATE AGREEMENT

This Agreement is made between the North Carolina Department of Health and Human Services (“Covered Entity”) and _____ (“Business Associate”) (collectively the “Parties”).

(1) BACKGROUND

- a. Covered Entity and Business Associate are parties to a Contract entitled BH I/DD Tailored Plan, whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
- b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the “Department”) that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
- c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a “business associate” within the meaning of the HIPAA Privacy Rule.
- d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

(2) DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

- a. “Electronic Protected Health Information” shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103.
- b. “HIPAA” means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
- c. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
- d. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. § Part 160 and Part 164.
- e. “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- f. “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
- g. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.
- h. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

(3) OBLIGATIONS OF BUSINESS ASSOCIATE

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.
- b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
- e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
- h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(4) PERMITTED USES AND DISCLOSURES

- a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
 - i. would not violate the Privacy Rule if done by Covered Entity; or
 - ii. would not violate the minimum necessary policies and procedures of the Covered Entity.
- b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
 - i. The disclosures are Required by Law; or
 - ii. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
- d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

(5) TERM AND TERMINATION

- a. Term. This Agreement shall be effective as of the effective date of the Contract and shall terminate when the Contract terminates.
- b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
 - i. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

- ii. Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
 - iii. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.
- c. Effect of Termination.
- i. Except as provided in paragraph ii. of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - ii. If Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(6) GENERAL TERMS AND CONDITIONS

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. If a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.
- d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

Signature of Authorized Representative

Name of Entity

Name and Title

DATE

13. Reserved.

14. First Revised and Restated State Certifications

State Certifications

Contractor Certifications Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
G.S. 133-32: http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32
Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): https://digital.ncdcr.gov/digital/collection/p16062coll5/id/11940
G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

Certifications

- (1) Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009), the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.
(2) Pursuant to G.S. 143-48.5 and G.S. 143-133.3, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system.
(3) Pursuant to G.S. 143-59.1(b), the undersigned hereby certifies that the Contractor named below is not an 'ineligible Contractor' as set forth in G.S. 143-59.1(a) because:
(a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); and
(b) [check one of the following boxes]
[] Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a 'tax haven country' as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; or
[] The Contractor or one of its affiliates has incorporated or reincorporated in a 'tax haven country' as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 but the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.
(4) Pursuant to G.S. 143-59.2(b), the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.
(5) Pursuant to G.S. 143B-139.6C, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C. and that a violation of that statute shall void the Agreement.
(6) The undersigned hereby certifies further that:
(a) He or she is a duly authorized representative of the Contractor named below;
(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
(c) He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1 and -59.2 shall be guilty of a Class I felony.

Contractor's Name: Click or tap here to enter text.

Contractor's Authorized Agent: Signature Date

Printed Name: Click or tap here to enter text. Title: Click or tap here to enter text.

15. First Revised and Restated Federal Certifications

The undersigned states that:

- 1. He or she is the duly authorized representative of the Contractor named below;
- 2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:
 - a. The Certification Regarding Nondiscrimination;
 - b. The Certification Regarding Drug-Free Workplace Requirements;
 - c. The Certification Regarding Environmental Tobacco Smoke;
 - d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - e. The Certification Regarding Lobbying;
- 3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;
- 4. [Check the applicable statement]

He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

OR

He or she **has not completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

- 5. The Contractor shall require its subcontractors to whom such certifications and disclosures apply, if any, to make the same certifications and disclosure.

Signature

Click or tap here to enter text.

Title

Click or tap here to enter text.

Contractor Name

Date

[This Certification Must be Signed by the Same Individual Who Signed the Proposal Execution Page]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Contractor certifies that it will provide a drug-free workplace by:
 - a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - b. Establishing a drug-free awareness program to inform employees about:
 - i. The dangers of drug abuse in the workplace;
 - ii. The Contractor’s policy of maintaining a drug-free workplace;
 - iii. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - i. Abide by the terms of the statement; and
 - ii. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - e. Notifying the Department within ten days after receiving notice under subparagraph (d)(ii) from an employee or otherwise receiving actual notice of such conviction;
 - f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(ii), with respect to any employee who is so convicted:
 - i. Taking appropriate personnel action against such an employee, up to and including termination; or
 - ii. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
 - g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional

pages if necessary):

Address:

Street:	Click or tap here to enter text.
City, State, Zip Code:	Click or tap here to enter text.

Address:

Street:	Click or tap here to enter text.
City, State, Zip Code:	Click or tap here to enter text.

Contractor will inform the Department of any additional sites for performance of work under this agreement.

3. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier

**Covered Transactions
Instructions**

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 22 CFR 513.100. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies**, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all subrecipients shall certify and disclose accordingly.
4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

VI. Disclosure Of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the

initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract

grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP- DE-90-001."

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Disclosure Of Lobbying Activities
(Approved by OMB 0344-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

<p>1. Type of Federal Action:</p> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<p>2. Status of Federal Action:</p> <input type="checkbox"/> a. Bid/offer/application <input type="checkbox"/> b. Initial Award <input type="checkbox"/> c. Post-Award	<p>3. Report Type:</p> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ Quarter _____ Date Of Last Report: _____
<p>4. Name and Address of Reporting Entity:</p> <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier (if known) _____ Congressional District (if known) _____		<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> Congressional District (if known) _____
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description:</p> CFDA Number (if applicable) _____	
<p>8. Federal Action Number (if known)</p>	<p>9. Award Amount (if known) \$</p>	
<p>10. a. Name and Address of Lobbying Entity <i>(if individual, last name, first name, MI):</i></p> <p align="center"><i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i></p>	<p>b. Individuals Performing Services <i>(including address if different from No. 10a.) (last name, first name, MI):</i></p> <p align="center"><i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i></p>	
<p>11. Amount of Payment <i>(check all that apply):</i></p> \$ _____ <input type="checkbox"/> actual <input type="checkbox"/> planned	<p>13. Type of Payment <i>(check all that apply):</i></p> <input type="checkbox"/> a. retainer <input type="checkbox"/> b. one-time fee <input type="checkbox"/> c. commission <input type="checkbox"/> d. contingent fee <input type="checkbox"/> e. deferred <input type="checkbox"/> f. other; specify: _____	
<p>12. Form of Payment <i>(check all that apply):</i></p> <input type="checkbox"/> a. cash <input type="checkbox"/> b. In-kind; specify: Nature _____ Value _____		
<p>14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11 <i>(attach Continuation Sheet(s) SF-LLL-A, if necessary):</i></p>		
<p>15. Continuation Sheet(s) SF-LLL-A attached: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>		Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____
<p>Federal Use Only</p>		<p>Authorized for Local Reproduction Standard Form - LLL</p>

16. Request for Proposed Modifications to the Terms and Conditions

As provided in Section II.C.3, Applicant may submit proposed modifications to the terms and conditions of the RFA for consideration by the Department. The proposed modifications do not alter the terms and conditions of the RFA and have no force or effect on the RFA or any contract unless accepted by the Department and incorporated through a BAFO, negotiation document, addenda to the RFA or amendment to the Contract.

The Department at its sole discretion may consider any proposed modifications submitted in this Attachment.

The Applicant must check the appropriate box to indicate whether it is proposing modifications to the terms and conditions of the RFP:

The Applicant DOES NOT propose modifications.

OR

The Applicant DOES propose modifications as provided in the following table.

	RFA Citation	Redline of Proposed Modification
	(i.e., section & page number)	(i.e., include text as published in RFA and strikethrough words, phrases or sentences proposed to be deleted and underline words, phases, or sentences proposed to be added)
1.		
2.		

17. Supplemental Evaluation Questions for Empty Region(s)

In the event of an Empty Region, the Department will notify eligible Applicants about the opportunity to respond to the Supplemental Evaluation Questions. When making such notification, the Department will identify the Empty Region(s) for which the Department will accept responses to the Supplemental Evaluation Questions. These Supplemental Evaluation Questions are to be completed only upon request by the Department. Applicants who wish to be considered for the award of an Empty Region must submit responses within the time specified by the Department at the time of notification.

In responding to the Supplemental Evaluation Questions below, Applicants should be specific in describing any existing capabilities or community relationships they may have in the Empty Region(s).

Supplemental Evaluation Question	
1.	<p>The Applicant shall describe its approach to meeting and maintaining the capital and other financial requirements, described in the <i>Section V. B. 7. Financial Requirements</i> and <i>Section V. C. 7. Financial Requirements</i>, should it be awarded any Empty Region(s). The response shall include:</p> <ul style="list-style-type: none"> • Amounts of available capital by source expected at the time of BH I/DD Tailored Plan launch; and • Amounts of available capital by source expected 12 months following BH I/DD Tailored Plan launch; and • Amounts of available capital by source expected 24 months following BH I/DD Tailored Plan launch.
List all Entities that <i>may</i> perform core functions or proposed experiences related to this response.	
Response – Region 1	
Response – Region 2	

Response – Region 3
Response – Region 4
Response – Region 5
Response – Region 6

Response – Region 7

Supplemental Evaluation Question

2.	<p>The Applicant shall describe its strategy for developing a provider network in each Empty Region for which it would like to be considered, consistent with the requirements outlined in <i>Section V.E.1. Provider Network</i> and in a way that minimizes disruption for members. The response shall detail any differences from the approach described in response to <i>Question 13 in Section VIII. Attachment Q. Application Response and Completed Attachments</i> on provider network development strategies, and shall include:</p> <ul style="list-style-type: none"> a. Description of any business or community relationships the Applicant may be able to leverage to develop a provider network in the Empty Region prior to BH I/DD Tailored Plan launch; b. Description of other strategic approaches that will be used to develop and maintain a provider network to ensure network adequacy standards and highest quality care in the Empty Region, inclusive of strategies for physical health, behavioral health, pharmacy, I/DD and TBI service providers, as well as networks for both Medicaid and State-Funded systems; c. Description of any unique characteristics of the population in the Empty Region (noting any differences within the region), including any unique health or health resource needs, challenges, and gaps, and a description of how the Applicant will address these needs and mitigate any challenges; and d. Description of strategies to recruit and support providers, including hospitals, in traditionally underserved areas of the Empty Region.
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List all Entities that <i>may</i> perform core functions or proposed experiences related to this response.

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Response – Region 1

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Response – Region 2

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Response – Region 3
Response – Region 4
Response – Region 5
Response – Region 6
Response – Region 7

Supplemental Evaluation Question	
3.	<p>The Applicant shall:</p> <ul style="list-style-type: none"> a. Describe its ability to manage community-based efforts which are focused on health promotion, prevention, and collaboration, including those described in <i>Section V.A.4. Stakeholder Engagement and Community Partnerships</i> and <i>Section V.C.3.g Diversion from Institutional Settings</i>, in the Empty Region; b. Describe any pre-existing relationships the Applicant may be able to leverage in managing community-based efforts, which are focused on health promotion, prevention and collaboration; c. Describe its approach to building capacity to manage community-based efforts, which are focused on health promotion, prevention, and collaboration in the Empty Region. d. Describe any proposed physical facilities or local presence of the Applicant in the Empty Region and the types of roles/functions that would be staffed there. <p>The response shall include approaches to:</p> <ul style="list-style-type: none"> a. Crisis/involuntary commitment (IVC) (including managing local area crisis plans, maintaining continual crisis response systems and facilitating local/regional crisis collaboratives), as described in <i>Section V.A.4.e. Community Crisis Services Plan for Medicaid and State-funded Services</i>;

- b. Disaster Response (including participating in community disaster planning and supporting the provision of medical, behavioral health, I/DD, LTSS, TBI, and pharmacy services to impacted communities);
- c. Community collaboratives, as described in *Section V.A.4.b. Engagement with Community and County Organizations for Medicaid and State-Funded Services*, (including leading or participating in county- or stakeholder- led collaboratives focused on children’s system of care).

List all Entities that *may* perform core functions or proposed experiences related to this response.

Response – Region 1

Response – Region 2

Response – Region 3

Response – Region 4

Response – Region 5

Response – Region 6

Response – Region 7

Supplemental Evaluation Question

4.	<p>The Applicant shall describe 1) its existing administrative and operational capacity to accept an expanded service area; 2) any past experience with building administrative and operational capacity in a new service area; and 3) a proposed approach to building administrative and operational capacity to accommodate an expanded service area, if awarded. The response shall include approaches to:</p> <ul style="list-style-type: none"> a. Provider Network Expansion; b. Staffing; c. Facilities; d. Information Technology; e. Member Services; f. Provider Services; and g. Claims and Utilization Management.
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List all Entities that <i>may</i> perform core functions or proposed experiences related to this response.

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Response

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