

Amendment Number 14 (16)
Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/ Developmental Disability Tailored Plan

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

Background:

The purpose of this Amendment is to make clarifications, technical corrections and updates related to the following Sections:

- I. Section III. Definitions, Contract Term, General Terms and Conditions, Other Provisions and Protections;
- II. Section V. Scope of Services;
- III. Section VII. Attachments; and
- IV. Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

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

209. **Tailored Care Management Payments:** Per member per month 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.

b. **Section III.A. Definitions is revised to add the following:**

280. **Children and Families Specialty Plan (CFSP):** A statewide capitated Prepaid Health Plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of Chapter 108D, including the requirements pertaining to the Children and Families (CAF) specialty plan, but excluding the requirements only pertaining to BH I/DD Tailored Plans.

281. **Risk-bearing Subcontractor:** Assumes financial risk from the upstream health plan by agreeing to share in costs and outcomes under a subcontract agreement.

c. **Section III. B. Acronyms is revised to add the following:**

266. CFSP: Children and Families Specialty Plan

d. **Section III. D. General Terms and Conditions, 11. CONTRACT ADMINISTRATORS, For the Department, is revised and restated in its entirety as follows:**

- a. Contract Administrator for all contractual issues listed herein:

Name & Title	Kimberley Kilpatrick Associate Director, Managed Care Contracting
Address Physical Address	1915 Health Services Way Raleigh, NC 27607
Address Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-410-5526
Email Address	Kimberley.Kilpatrick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

- b. Contract Administrator regarding day to day activities arising under Contract *Section V. A: Unified or Section V. B. Medicaid:*

Name & Title	Kelsi A. Knick Deputy Director of BH I/DD Tailored Plans
Physical Address	1915 Health Services Way Raleigh, NC 27607
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

- c. Contract Administrator regarding day to day activities arising under Contract *Section V. C: State-funded Services:*

Name & Title	Brad Looper DMH/DD/SUS Managed Care Operations Liaison
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mail Service Center Address	3001 Mail Service Center Raleigh, NC 27601
Telephone Number	919-268-5928
Email Address	Brad.looper@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

- d. Department's Federal, State and the Department Compliance Coordinator for all security matters:

Name & Title	Pyreddy Reddy, DHHS CISO
Address 1	1915 Health Services Way Raleigh, NC 27607
Telephone Number	919-855-3090
Email Address	Pyreddy.Reddy@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

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

Name & Title	John Thompson Chief Compliance Officer
Physical Address	1915 Health Services Way Raleigh, NC 27607
Mailing Address	2501 Mail Service Center Raleigh, NC 27699-2501
Telephone Number	919-527-7701
Email Address	John.e.thompson@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

II. Modifications to Section V. Scope of Services

Specific subsections are modified as stated herein.

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

(f) Reserved;

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

(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.

c. *Section V. A. Unified, 1. Administration and Management, 6. Competitive Integrated Employment for Individuals with I/DD, i.* is revised and restated in its entirety as follows:

i. The BH I/DD Tailored Plan shall participate in the Department’s ongoing efforts to improve and enhance opportunities for individuals with I/DD to engage in competitive integrated employment. The BH I/DD Tailored Plan shall:

(i) Coordinate and oversee employment services and supports for Members/Recipients with I/DD interested in pursuing competitive integrated employment who are receiving ADVP Services or the Day Components of ICF-IID In Lieu of Services which are provided in a setting licensed as an ADVP as described in *Section V. Scope of Services, B. Medicaid, 3. Care Management, iii. Care Coordination and Care Transitions for All Members, (vii)(e)*.

(ii) The BH I/DD Tailored Plan shall ensure Competitive Integrated Employment (CIE) services and supports are provided for Members as described in *Section V.B.3.iii.(vii)(e)*.

(a) The BH I/DD Tailored Plan shall hire and utilize at least one Competitive Integrated Employment (CIE) Coordinator to link and monitor services, and to explore, obtain, and maintain employment in a competitive and integrated setting as described in *Section VII. Sixth Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*.

(1) The CIE Coordinator may provide support to Member Care Managers when CIE goals are not met as specified in the person-centered plan.

- (2) The CIE Coordinator shall perform the duties and responsibilities as described in *Section VII. Sixth Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services.*
- (iii) Conduct coordination of employment services with the goal of facilitating the Member/Recipient in exploring, obtaining and maintaining employment in a competitive and integrated setting.
 - (iv) Work cooperatively with the Department, community providers, and Member/Recipients and their families, to implement the Department’s CIE I/DD Strategic Plan. The CIE I/DD Strategic Plan will be developed with input from key stakeholders including the BH I/DD Tailored Plan, community providers, and Members/ Recipients and their families.
 - (v) Complete the CIE Data Collection Tool provided by the Department, as described in *Section VII. Seventh Revised and Restated Attachment J. Table 1* and submit it to the Department’s CIE I/DD lead within thirty (30) Calendar Days after the last day of each calendar quarter, and work cooperatively with the Department to explain or clarify any data submitted in the CIE Data Collection Tool upon the Department’s request.
 - (vi) Participate in the MCO CIE Stakeholder Advisory Group for CIE in accordance with the schedule established by the Department.
 - (vii) Participate in other ad hoc activities that promote inclusive employment, which may include without limitation, one-on-one meetings between the Department and the BH I/DD Tailored Plan, targeted quality improvement activities, or other activities as determined by the Department, upon request and reasonable prior notice by the Department.

d. **Section V. B. Medicaid, 2. Benefits, Section V.B.2. Third Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans is revised, renamed, and restated in its entirety as follows:**

Section V.B.2. Fourth Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans, BH I/DD Tailored Plans, and CFSP		
BH, TBI and I/DD Services Covered by SPs, and BH I/DD TPs, and the CFSP	BH, I/DD and TBI Services Covered by BH I/DD TPs and the CFSP	BH, I/DD and TBI Services Covered Exclusively by BH I/DD TPs
<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Inpatient Behavioral Health services • Outpatient Behavioral Health emergency room services • Outpatient Behavioral Health services provided by direct-enrolled providers • Peer Supports Services • Partial hospitalization • Mobile crisis management • Facility-based crisis services for children and adolescents • Professional treatment services in facility- based crisis program • Outpatient opioid treatment • Ambulatory Withdrawal Management without Extended On-Site Monitoring (Ambulatory detox) • Ambulatory Withdrawal Management 	<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • Residential treatment facility services • Child and adolescent day treatment services • Intensive in-home services • Multi-systemic therapy services • Psychiatric residential treatment facilities (PRTFs) • Assertive community treatment (ACT) • Community support team (CST) • Psychosocial rehabilitation • Clinically managed low-intensity residential treatment* • Clinically managed population-specific high intensity residential program* • Clinically managed residential treatment services (Substance 	<p>State Plan BH and I/DD Services</p> <ul style="list-style-type: none"> • 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

<ul style="list-style-type: none"> with Extended On-Site Monitoring Research-based Behavioral Health Treatment for Autism Spectrum Disorder (ASD) Diagnostic assessment Clinically managed residential withdrawal management services Medically monitored inpatient withdrawal management services (Non-hospital medical detoxification) Early and periodic screening, diagnostic, and treatment (EPSDT) services Substance abuse intensive outpatient program (SAIOP) Substance abuse comprehensive outpatient treatment program (SACOT) 	<ul style="list-style-type: none"> abuse non-medical community residential treatment) Medically monitored intensive inpatient services (Substance abuse medically monitored residential treatment) 1915(i) Option services Supported Employment for IDD and TBI/ Individual Placement and Support (IPS) Services Individual and Transitional Support (ITS) Services Respite Services Community Living and Supports (CLS) Services Community Transition Services 	
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* Coverage effective upon the effective date of the CMS approved State Plan Amendment.

e. Section V. B. Medicaid, 2. Benefits, Section V.B.2. Second Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services is renamed, revised, and restated in its entirety as follows:

Section V.B.2. Third Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
1	Outpatient services	
2.1	Intensive outpatient services	Substance use intensive outpatient program
2.5	Partial hospitalization services	Substance use comprehensive outpatient treatment
3.1	Clinically Managed Low-Intensity Residential Treatment Services	Clinically Managed Low-Intensity Residential Treatment Services
3.3	Clinically managed population-specific high-intensity residential services	Clinically managed population-specific high-intensity residential services
3.5	Clinically managed high-intensity residential services	Clinically managed residential services (substance abuse non-medical community residential treatment)
3.7	Medically monitored intensive inpatient services	Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)
4	Medically managed intensive inpatient services	Medically managed intensive inpatient service (Inpatient BH services)

Section V.B.2. Third Revised and Restated Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
Reserved		
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory withdrawal management, without extended on-site monitoring (ambulatory detoxification)
2-WM	Ambulatory withdrawal management with extended on-site monitoring	Ambulatory withdrawal management, with extended on-site monitoring
3.2WM	Clinically managed residential withdrawal management	Clinically managed residential withdrawal management services (social setting detoxification)
3.7-WM	Medically monitored inpatient withdrawal management	Medically monitored inpatient withdrawal management services (non-hospital medical detoxification)
4-WM	Medically managed intensive inpatient withdrawal management	Medically managed intensive inpatient withdrawal management services (Inpatient BH services)

f. Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Medicaid, (k), (3) is revised and restated in its entirety as follows:

(3) Vaccines provided for children enrolled in Medicaid shall go through the VFC, when the VFC program includes the vaccine, unless an exception is made by the Department.

g. Section V. B. Medicaid, 2. Benefits, ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members is revised to add the following:

(xxiv) The BH I/DD Tailored Plan shall submit CMS-416 data, based off the prior federal fiscal year, to the Department each year before June 1st. The BH I/DD Tailored Plan shall also submit quarterly CMS-416 data to the Department no later than the 15th day of the month following the end of the previous quarter.

h. Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (iv) Pharmacy Utilization Management, (d), (7) is revised and restated in its entirety as follows:

(7) The BH I/DD Tailored Plan shall reimburse the pharmacy for dispensing the emergency supply of medication, including dispensing fee and ingredient cost, for each fill.

i. Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (vi) Pharmacy Benefits Manager, (e) is revised and restated in its entirety as follows:

(e) The BH I/DD Tailored Plan shall provide a liaison with whom the Department will communicate directly. The BH I/DD Tailored Plan 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.

- j. **Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (vii) Pharmacy Program, (a), (1) Drug Utilization Review, vii.** is revised and restated in its entirety as follows:
- 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 thirty (30) Calendar Days of receipt of the Department's request.
- k. **Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (a) Dispensing Fees, (2)** is revised and restated in its entirety as follows:
- (2) The BH I/DD Tailored Plan shall reimburse a dispensing fee for covered outpatient drugs defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).
- l. **Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (a) Dispensing Fees, (6)** is revised and restated in its entirety as follows:
- (6) For 340B Hemophilia and Non-340B Hemophilia drugs, the dispensing fee is paid based on the number of units dispensed, utilizing a multiplier at \$0.04 per unit for Hemophilia Treatment Center (HTC) pharmacies and \$0.025 per unit for all other Non-Hemophilia Treatment Center pharmacies.
- m. **Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (1)** is revised and restated in its entirety as follows:
- (1) The BH I/DD Tailored Plan shall reimburse pharmacies' ingredient costs at the same rate at the NC Medicaid Direct rate, per the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1).
- n. **Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (6) Ingredient Costs for Non-340B, ii., b)** is revised and restated in its entirety as follows:
- b) Under the State Plan, the dispensing fee for blood clotting factor products used to treat hemophilia is paid based on the quantity of units dispensed. The per unit professional dispensing fee is \$0.04/unit for hemophilia treatment center (HTC) pharmacies, as defined in the State Plan. The per unit professional dispensing fee is \$0.025/unit for all other non-hemophilia treatment center pharmacies.
- o. **Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (ii), (4)** is revised and restated in its entirety as follows:
- (4) Each year, the Department will divide the amount of Tailored Care Management that was delivered 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: thirty percent (30%);
 - ii. Contract Year 2: forty-five percent (45%);
 - iii. Contract Year 3: fifty-five percent (55%); and
 - iv. Contract Year 4: fifty-five percent (55%).

- p. Section V. B. Medicaid, 3. Care Management, vi. Care Management Policy, (ii), (v) is revised and restated in its entirety as follows:**
- (v) Process for overseeing AMH+ practices or CMAs 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.
 - (2) Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ or CMA 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+ or CMA, 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) Reserved.
 - (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).
- q. Section V. B. Medicaid, 3. Care Management, vi. Care Management Policy, (ii) is revised to add the following:**
- (bb) Describe how, if a certified AMH+ or CMA contracted by the BH I/DD Tailored Plan to provide Tailored Care Management terminates its contract with a CIN or Other Partner, the BH I/DD Tailored Plan will facilitate the transition to a new CIN or data partner(s) in a manner that will minimize disruptions to Member receipt of care management.
- r. Section V. B. Medicaid, 3. Care Management, ix. Prevention and Population Health Programs, (iii) Opioid Misuse Prevention and Treatment Program, (b) Opioid Misuse Prevention and Treatment Program, (1), vii. is revised and restated in its entirety as follows:**
- 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 *Section VII. Seventh Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards, No. 8 Location-Based Services (Behavioral Health)* for Substance Abuse Comprehensive Outpatient Treatment(adult), Substance Abuse Intensive Outpatient Program (adults and children), and Opioid Outpatient Treatment Program (OTP) (adult).
- s. Section V. B. Medicaid, 3. Care Management, xiii. Additional Care Coordination Functions for Members Obtaining 1915(i) Services, (ii) is and restated in its entirety as follows:**
- (ii) For all members obtaining 1915(i) services, regardless of whether they engage in Tailored Care Management, the BH I/DD Tailored Plan shall ensure that care coordination includes:
 - (a) Conducting the independent assessment using a Department-designated tool to determine need for specific 1915(i) services. The BH I/DD Tailored Plan shall comply with any additional guidance released by the Department on the Department-designated tool to conduct the independent assessment.
 - (b) Guiding the development and submission of the Care Plan/ISP, based on assessed need and living arrangements:
 - (1) If applicable, the BH I/DD Tailored Plan shall ensure that the member’s care manager convenes a person-centered planning meeting and completes the Care Plan/ISP in line

with federal requirements 42 C.F.R. § 441.725. This is done after the member is administered the independent assessment using a Department-designated tool for initial plans of care. For individuals receiving 1915(i) services, the annual Care Plan/ISPs are due during the Member's month of birth.

- (2) If applicable, the BH I/DD Tailored Plan shall ensure that the member's AMH+ practice or CMA reviews and submits the Care Plan/ISP to the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall review Care Plan/ISP for compliance with 1915(i) SPA requirements, medical necessity, and the member's health and safety needs.
 - (4) For 1915(i) services requiring prior authorization review, the BH I/DD Tailored Plan shall approve or deny the Care Plan/ISP within fourteen (14) Calendar Days of receiving a complete the Care Plan/ISP.
 - (5) In the case where services are immediately needed, the BH I/DD Tailored Plan shall complete an interim care plan/interim ISP within fourteen (14) Calendar Days of the Member's 1915(i) eligibility determination, so that services may be approved. Notwithstanding the existence of an interim care plan/interim ISP, the full, initial Care Plan/ISP must be completed no later than forty-five (45) Calendar Days following the determination of eligibility for 1915(i) services. Immediately needed 1915(i) services may include, but are not limited to, 1915(i) services that a member needs in order to:
 - i. Facilitate timely discharge from an inpatient setting or to prevent inappropriate placement in an inpatient or other restrictive setting;
 - ii. Prevent imminent placement outside the person's current living arrangement;
 - iii. Address severe co-occurring behavioral health and/or psychiatric conditions that place the person or others at significant risk of harm; or
 - iv. Prevent imminent loss of competitive integrated employment or an offer of such employment.
 - (6) The BH I/DD Tailored Plan shall ensure that 1915(i) services begin within forty-five (45) Calendar Days of Care Plan/ISP approval.
- (c) Completing the independent assessment using a Department-designated tool prior to the development of the Care Plan/ISP and updating the independent assessment at least annually or as significant changes occur with the Member as required by 42 C.F.R. § 441.720(b).
- (1) The BH I/DD Tailored Plan update the independent assessment using a Department-designated tool by no later than thirty (30) days before expiration of the Member's eligibility for 1915(i) services to prevent gaps in services.
 - (2) The BH I/DD Tailored Plan shall ensure a new Care Plan/ISP is developed and signed by the Member/LRP (if applicable) at least annually. Prior to the Member/LRP (if applicable) signing the Care Plan/ISP, the annual independent assessment and determination of eligibility for 1915(i) services must be completed.
- (d) Explaining the service authorization process.
- (e) Assisting the member/LRP (if applicable) in choosing a qualified provider to implement each service in the Care Plan/ISP, including providing a list of available providers and arranging provider interviews.
- (f) Monitoring Care Plan/ISP goals at a minimum frequency based on the target date assigned to each goal.
- (g) Maintaining close contact with the member/LRP (if applicable), providers and other members of the Care Plan/ISP team, noting any recommended revisions needed to ensure that changes are noted and updates are effectuated in a timely manner.
- (h) Promoting the delivery of services and supports in the most integrated setting that is clinically appropriate for the member as required by 42 C.F.R. § 441.710(a)(1)(i).
- (i) Reserved.

- (j) Providing timely notification to BH I/DD Tailored Plan utilization management of updates to eligibility for 1915(i) services and timely processing of updates to the Care Plan/ISP.
- (k) Monitoring at least quarterly to ensure that any restrictive interventions (including protective devices used for behavioral support) are written into the Care Plan/ISP and the Positive Behavior Support Plan (if applicable).
- (l) Monitoring of service delivery to verify that:
 - (1) At least one (1) 1915(i) service is utilized at a frequency determined by the Department in the 1915(i) SPA as required by 42 C.F.R. § 441.710(c).
 - (2) Services are furnished in accordance with the Care Plan/ISP.
 - (3) Member is offered a choice of 1915(i) service providers.
 - (4) Member has access to services and supports that meet the member's needs.
 - (5) Issues of health, safety and wellbeing (rights restrictions, abuse/neglect/ exploitation, backup staffing) and non-1915(i) service needs (medical care) are addressed and documented as appropriate.
 - (6) 1915(i) services utilized do not exceed authorization.
 - (7) Member is satisfied with the services being rendered.

- t. **Section V. B. Medicaid, 4. Providers, i. Provider Network, (iii) Availability of Services (42 C.F.R. § 438.206), (b), (3) is revised and restated in its entirety as follows:**
 - (3) Ensuring that no incentive is given to providers, monetary or otherwise, for withholding, reducing, or limiting medically necessary services.

- u. **Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (u) is revised and restated in its entirety as follows:**
 - (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 High Risk Pregnant Women, to the extent that each LHD chooses to provide these services.

- v. **Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (f) Provider Disenrollment and Termination, (3) BH I/DD Tailored Plan Provider Termination, i. is revised and restated in its entirety as follows:**
 - 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. Termination by the BH I/DD Tailored Plan is not an "adverse determination" as that term is defined in NCGS § 108C-2(1). BH I/DD Tailored Plan termination or suspension of all or part of a Provider contract, or denial of a Provider's participation in the BH I/DD Tailored Plan, does not constitute a Provider's termination, disenrollment, suspension, or denial from the Medicaid Program by the Department.

- w. **Section V. B. Medicaid, 4. Providers, v. Provider Payments, (ix) Local Health Departments (LHD) Payments, (b) is revised and restated in its entirety as follows:**
 - (b) Reserved.

- x. **Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xxix) ICF/IDD Provider Payments, (b) is revised and restated as follows with no revisions to subsections (1)-(2):**
 - (b) Effective July 1, 2025, the BH I/DD Tailored Plan shall increase reimbursement rates paid to ICFs appearing on the Department's ICF-IID fee schedule posted to the Department's Fee Schedule and Covered Codes website by a uniform dollar amount prescribed by the Department for services furnished by revenue codes in the rate book on or after July 1, 2025 and during the rating period

of July 1, 2025 through June 30, 2026. The BH I/DD Tailored Plan shall apply the uniform dollar increase to ICF/ IDD provider reimbursement rates consistent with the timeline requirements of *Section V.B.6.i.(iv)*. For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the PIHP shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)*.

y. Section V. B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio is revised and restated to add the following:

- (x) Medical Loss Ratio Reporting for Risk-Bearing BH I/DD Tailored Plan Subcontractors
 - (a) Starting January 1, 2026, the BH I/DD Tailored Plan shall require any Risk-bearing Subcontractor, as defined by the Department, to calculate and report the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8(b). The first MLR reporting year for Subcontractors will be January 1, 2026 through June 30, 2026 and aligned with the BH I/DD Tailored Plan's rating period thereafter.
 - (1) The BH I/DD Tailored Plan shall require Risk-bearing Subcontractors to calculate and report MLR consistent with the Department's requirements in 42 C.F.R. § 438.8(d) and 42 C.F.R. § 438.8(k) on an aggregate basis combining experience for Medicaid Expansion Eligible Members and non-Medicaid Expansion populations.
 - (2) The Subcontractor shall apply a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3) using the CMS published credibility factors.
 - (3) The BH I/DD Tailored Plan's Subcontractor's report shall be submitted to the BH I/DD Tailored Plan within one hundred eighty (180) Calendar Days of the end of the MLR reporting year.
 - (4) The BH I/DD Tailored Plan may require that all classification of activities that improve health care quality, including contributions to health-related resources and initiatives that advance public health and Health Equity be submitted to the BH I/DD Tailored Plan for review and approval, but only the activities that the BH I/DD Tailored Plan requests to include in the BH I/DD Tailored Plan's MLR calculations must be submitted to the Department.
 - (5) The BH I/DD Tailored Plan shall report the outcome of the Subcontractor's MLR calculations in the MLR templates and associated instructions to be provided by the Department.

z. Section V. C. State-funded Services, 1. Recipients, a. Eligibility for State-funded BH, I/DD, and TBI Services, xii. Waiting List for State-funded Services, e) is revised and restated in its entirety as follows:

- e) The BH I/DD Tailored Plan shall provide interim services as defined by 42 C.F.R. § 96.121 and 42 C.F.R. § 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 Use Prevention Treatment and Recovery Services Block Grant (SUPTRS).

aa. Section V. C. State-funded Services, 1. Recipients, b., Recipient Engagement, vii. Communications with Recipient and Potential Recipients, d), 2. is revised and restated in its entirety as follows:

- 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 Recipient explicitly requests that emails are not encrypted and signs a waiver acknowledging the risk of unencryption;

bb. Section V. C. State-funded Services, 2. Services, a., Section V.C.2. Third Revised and Restated Table 1: State-funded BH, I/DD and TBI Services is revised and restated in its entirety as follows:

Section V.C.2 Fourth Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	Core Services	Non-Core Services
All-Disability	<ol style="list-style-type: none"> 1. Diagnostic assessment²² 2. Facility based crisis for adults^{23*} 3. Inpatient BH services* 4. Mobile crisis management* 5. Outpatient services²⁴ 	<ol style="list-style-type: none"> 1. BH urgent care* 2. Facility based crisis for children and adolescents*
Adult Mental Health	<ol style="list-style-type: none"> 1. Assertive community treatment (ACT) 2. Assertive engagement²⁵ 3. Reserved. ²⁶ 4. Community support team (CST) 5. Peer Support Services²⁷ 6. Psychosocial rehabilitation 7. Mental health recovery residential services²⁸ 8. Individual placement and support (IPS)-supported employment ²⁹ 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management 	<ol style="list-style-type: none"> 1. Partial hospitalization
Child Mental Health	<ol style="list-style-type: none"> 1. Reserved.³⁰ 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement 	<ol style="list-style-type: none"> 1. Mental health day treatment
I/DD and TBI	<ol style="list-style-type: none"> 1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment³¹ 6. Respite 7. Adult Day Vocational Programs (ADVP) 8. I/DD and TBI Care Management³² 	<ol style="list-style-type: none"> 1. TBI long term residential rehabilitation services
Substance Use Disorder - Adult	<ol style="list-style-type: none"> 1. Ambulatory Withdrawal Management without Extended Onsite Monitoring and Ambulatory Withdrawal Management with Extended Onsite Monitoring * 2. Assertive engagement 3. Reserved. 4. Clinically managed population specific high intensity residential services³³ 5. Opioid Treatment Program Services 6. Medically Monitored Inpatient Withdrawal Management Services* 	<ol style="list-style-type: none"> 1. Clinically managed residential withdrawal services *

* Crisis Services as defined as Section V.C.4.iv.a.

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) service

	<ol style="list-style-type: none"> 7. Peer supports³⁴ 8. Substance use residential services and supports³⁵ 9. Clinically managed low-intensity residential treatment services 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Medically monitored intensive inpatient services (Substance abuse medically monitored community residential treatment) 13. Clinically managed residential services (Substance abuse non-medical community residential treatment) 14. Individual placement and support (IPS) supported employment 15. Community Support Team 16. BH Comprehensive Case Management 17. Medically monitored intensive inpatient services³⁵ 18. Clinically managed high-intensity residential services – Pregnant & Parenting³⁵ 19. Clinically managed high-intensity residential services³⁵ 	
Substance Use Disorder - Child	<ol style="list-style-type: none"> 1. Multi-systemic therapy (MST) 2. SAIOF 3. Substance use residential services and supports 4. Reserved. 5. Assertive Engagement 6. Clinically managed medium-intensity residential services – Adolescent³⁵ 	<ol style="list-style-type: none"> 1. Intensive in-home 2. Day Treatment Child and Adolescent 3. Respite

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 Reserved.

²⁷ Peer supports include individual and group services.

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

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

³⁰ Reserved.

³¹ I/DD and TBI care management will 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.

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.

- cc. **Section V. C. State-funded Services, 2. Services, a., Section V.C.2. Table 2: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to State-funded SUB Services** is revised and restated in its entirety as follows:

First Revised and Restated 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
3.1	Clinically managed low intensity residential services	Clinically managed low-intensity residential treatment 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

- dd. **Section V. C. State-funded Services, 2. Services, a. State-funded BH, I/DD and TBI Services, vii. Utilization Management, b) Person-Centered Planning, 2.** is revised and restated in its entirety as follows:

2. 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 Recipients 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.

- ee. **Section V. C. State-funded Services, 3. Care Management and Prevention, h. Relocation of Recipients Following Emergency Residential Care Facility Closures, iii. Emergency Closures of Adult Care Homes, b)** is revised and restated in its entirety as follows:
- 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 Recipients reside.
- ff. **Section V. C. State-funded Services, 3. Care Management and Prevention, i. Justice Involved Programs, i. Department of Adult Corrections (DAC) Priority Re-entry, a)** is revised and restated in its entirety as follows:
- a) To support individuals with SMI the BH I/DD Tailored Plans shall support the DAC Priority Re-entry program. The BH I/DD Tailored Plan shall employ care coordinators and peer support specialists to be responsible for the care coordination of the individuals on the High Priority Re-entry List provided monthly by the DAC. The BH I/DD Tailored Plan shall link individuals on the High Priority Re-entry List to community behavioral providers, physical health providers, and other prison transition supports. Telehealth appointments are to be initiated and scheduled only if requested by the prison.
- gg. **Section V. C. State-funded Services, 4. Providers, a. Provider Network iii. Availability of Services, b)** is revised and restated in its entirety as follows:
- b) The BH/IDD Tailored Plan shall ensure that no incentive is given to providers, monetary or otherwise, for withholding, reducing, or limiting medically necessary services.
- hh. **Section V. C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, v., a) QAPI Plan, 10., ii.-iii.** is revised and restated in its entirety as follows:
- ii. The BH I/DD Tailored Plan's actions/initiative taken based on Member Advisory Committee and Consumer and Family Advisory Committee feedback in alignment with improvement and appropriateness of care provided to Recipients;
- iii. Mechanisms to review Recipient satisfaction and feedback on the Recipient experience with BH I/DD Tailored Plan responsiveness to Recipient issues/comments/concerns;
- ii. **Section V. C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, iv. Quality Measures, c)** is revised and restated in its entirety as follows:
- c) Reserved.
- jj. **Section V. C. State-funded Services, 5. Quality, a. Quality Management and Quality Improvement, vii. Measurement of Outcomes, b)** is revised and restated in its entirety as follows:
- 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 Recipients 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.
- kk. **Section V. C. State-funded Services, 6. Claims Management, b. BH I/DD Tailored Plan Submission of Claims, iv.** is revised and restated in its entirety as follows:
- iv. For services paid for pursuant to UCR-funded methodology, the BH I/DD Tailored Plan shall enroll Recipients into the appropriate benefit plan and report service units to NC Tracks.

- II. *Section V. C. State-funded Services, 7. Financial Requirements, i. Financial Viability, ii., a)* is revised and restated in its entirety as follows:
- a) Reserved.

III. **Modifications to Section VII. Attachments**

Specific Attachments are modified or added as stated herein.

- a. *Fifth Revised and Restated Attachment A. BH I/DD Tailored Plan Organizational Roles and Positions for Medicaid and State-funded Services* is revised and restated in its entirety as *Sixth Revised and Restated Attachment A. BH I/DD Tailored Plan Organizational Roles and Positions for Medicaid and State-funded Services* and attached to this Amendment.
- b. *Fourth Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies* is revised and restated in its entirety as *Fifth Revised and Restated Attachment B. Summary of Medicaid Covered Services & Clinical Coverage Policies* and attached to this Amendment.
- c. *Fourth Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics* is revised and restated in its entirety as *Fifth Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics* and attached to this Amendment.
- d. *Fourth Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards* is revised and restated in its entirety as *Fifth Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards* and attached to this Amendment.
- e. *Fifth Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* is revised and restated in its entirety as *Sixth Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* and attached to this Amendment.
- f. *Sixth Revised and Restated Attachment J. Reporting Requirements* is revised and restated in its entirety as *Seventh Revised and Restated Attachment J. Reporting Requirements* and attached to this Amendment.
- g. *Third Revised and Restated Attachment M. Policies, 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* is revised and restated in its entirety as *Fourth Revised and Restated Attachment M. Policies, 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and attached to this Amendment.
- h. *Third Revised and Restated Attachment M. Policies, 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients* is revised and restated in its entirety as *Fourth Revised and Restated Attachment M. Policies, 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients* and attached to this Amendment.
- i. *Third/Fourth Revised and Restated Attachment M. Policies, 13. Approved <TP NAME> In Lieu of Services* is revised and restated in its entirety as *Fourth/Fifth Revised and Restated Attachment M. Policies, 13. Approved <TP NAME> In Lieu of Services* and attached to this Amendment.

- j. *Fourth Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* is revised and restated in its entirety as *Fifth Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages* and attached to this Amendment.
- k. *Attachment W. Business Associate Agreement* is incorporated into the Contract and attached to this Amendment.

IV. **Section VIII. Second Revised and Restated Attachment Q. Application Response and Completed Attachments, Section VIII. 12. First Revised and Restated Business Associate Agreement** is revised and restated as **Section VIII. 12. Reserved.**

V. **Effective Date**

This Amendment is effective January 1, 2026, unless otherwise explicitly stated herein, subject to approval by CMS.

VI. **Other Requirements**

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

Execution:

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

Department of Health and Human Services, Division of Health Benefits

 Melanie Bush, Deputy Secretary
 NC Medicaid

Date: _____

BH I/DD Tailored Plan Name

 BH I/DD Tailored Plan **Authorized Signature**

Date: _____

Sixth 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. Sixth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	<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 Individual Support Plans 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 hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD or a TBI must have one (1) of the following minimum qualifications: <ul style="list-style-type: none"> ○ A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; OR ○ A master's degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR ○ A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or

Section VII. Sixth 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>care coordination to complex individuals with I/DD or TBI.</p> <ul style="list-style-type: none"> • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, BH I/DD Tailored Plan and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the enrollee’s care manager. • The Department will grant a one-time staff exception (‘grandfathering’) for specified BH I/DD Tailored Plan staff that: <ul style="list-style-type: none"> ○ Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan Contract Award (July 26, 2021). ○ This exception is based on the staff enrollee possession the required number of years of experience, but not the required degree, degree type or licensure type.
<p>3. State-funded BH Care Management Coordinator</p>	<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 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.</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.
<p>4. Care Managers for North Carolina Medicaid Managed</p>	<p>For Medicaid, these individuals shall be responsible for providing integrated whole-</p>	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements.

Section VII. Sixth 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
Care Program and State-funded Services	<p>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"> • Care Managers must meet North Carolina’s definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department’s February 2022 waiver of experience requirement for Qualified Professionals. • For care managers serving enrollees with LTSS needs: <ul style="list-style-type: none"> ○ Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. ○ This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).	<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 at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
7. Reserved.		
8. Full-Time Peer Support Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members and recipients with BH diagnoses residing in a state psychiatric hospital or an ACH.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements. • Must have NC Certified Peer Support Specialist Program Certification within six (6) months of position start date.

Section VII. Sixth 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
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. • 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> .	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements. • Must: <ul style="list-style-type: none"> a. Be a Master’s level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or licensed as a RN plus one (1) year of relevant experience working directly with individuals with SMI; or b. Have one (1) year prior relevant and direct experience providing diversion services under TCL.
11. System of Care Family Partner(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan’s core System of Care functions.	<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 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

Section VII. Sixth 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>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. A Master’s degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or b. A Bachelor’s degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or c. A Bachelor’s-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
<p>14. Member and Recipient Appeal Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>This individual manages and adjudicates member and recipient appeals in a timely manner.</p>	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements.
<p>15. Member and Recipient Complaint and Grievance Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>This individual manages and adjudicates member and recipient complaints and grievances in a timely manner.</p>	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements.
<p>16. Full-Time Member and Recipient Complaint and Grievance Staff for North Carolina Medicaid Managed</p>	<p>These individuals work to resolve member and recipient complaints and grievances in accordance with state and federal laws and this Contract.</p>	<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

Section VII. Sixth 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
Care Program and State-funded Services		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.
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	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.

Section VII. Sixth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
Managed Care Program and State-funded Services		<ul style="list-style-type: none"> Pharmacists shall be registered, with current NC Pharmacist license.
24. Full-Time I/DD and TBI Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	<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 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3.
25. PBM Liaison for the North Carolina Medicaid Managed Care Program	If the BH I/DD Tailored Plan partners with a third-party PBM, this individual serves as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	N/A
26. Tribal Provider Contracting Specialist (If applicable) for the North Carolina Medicaid Managed Care Program	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements.
27. Reserved.		
28. Liaison between the Department and the North Carolina Attorney General’s MID for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the NC Attorney General’s Medicaid Investigation Division.	<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, or have at least three (3) years of relevant experience
31. Liaison to the Division of Social Services for the North	This individual serves as the primary liaison with the Division of Social Services,	<ul style="list-style-type: none"> Must meet North Carolina Residency requirements.

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
Carolina Medicaid Managed Care Program and State-funded 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.	
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.
33. Olmstead Manager	Provide coordination across BH I/DD Tailored Plan program areas to assist the BH I/DD Tailored Plan in putting in place an array of policies, procedures or practices that support the ADA/Olmstead integration mandate within the BH I/DD Tailored Plan and its provider network.	<ul style="list-style-type: none"> • Must meet North Carolina Residency requirements. • Must hold: <ul style="list-style-type: none"> a. A Bachelor’s degree in an area specific to the program from an appropriately accredited institution and three years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience; or b. Master’s degree in an area specific to the program from an appropriately accredited institution and two years of experience in the area of assignment, including one year in a supervisory or consultative capacity; or an equivalent combination of education and experience.
34. Housing Development Coordinator	<p>The Housing Development Coordinator’s job responsibilities shall include but not be limited to the following:</p> <ol style="list-style-type: none"> 1. Map existing permanent supportive housing (PSH), PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process. Utilize the map and other information sources to develop plans to target new stock development or access to untapped existing stock within the BH I/DD Tailored Plan Region. 2. Engage public housing authorities (PHAs), Continuums of Care (COCs), and Balance 	<ul style="list-style-type: none"> • Must hold a Bachelor’s degree with a least two (2) years of experience working with individuals and the housing systems serving people with SMI/SPMI obtaining and maintaining PSH. This position shall apply these skills to the development of permanent supportive housing within the BH I/DD Tailored Plan Region aligned with TCL.

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>of State (BoS) with the BH I/DD Tailored Plan, NCHFA, grant, and other housing resources to develop housing stock and access throughout the BH I/DD Tailored Plan Region.</p> <ol style="list-style-type: none"> 3. Develop regional housing databases for the BH I/DD Tailored Plan’s Region connecting public stock with private housing options for TCL staff. 4. Utilize public notices of newly initiated housing developments, assertively engage private developers linking them with BH I/DD Tailored Plan, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and rehabilitation in exchange for access agreements for individuals with disabilities. 5. Technically assist existing TCL staff and TCL provider engagement with their improved access of computerized housing availability systems, giving priority to, and more effectively offering and getting access for, TCL individuals to Targeted Key Housing. 6. Specify the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams. 7. Ad hoc participation in Local Barriers Committee to address housing barriers and participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations. 8. In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices. In collaboration with DAAS, improve timely 	

Section VII. Sixth 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>communication between DHHS Regional Housing Coordinators, landlords and TCL service providers.</p> <p>9. Work within the BH I/DD Tailored Plan and with external housing providers to develop Enhanced Bridge Housing, TCL priority to BH I/DD Tailored Plan or Public Housing Authority-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches.</p>	
<p>35. TCL Quality Assurance (QA) Specialist</p>	<p>This position manages TCL Quality Assurance Performance Improvement (QAPI) activities. The TCL Quality Assurance Specialist job responsibilities shall include but not limited to the following:</p> <ol style="list-style-type: none"> 1. Serve as the organization’s TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives. 2. Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of life survey administration, and Root Cause Analyses (RCAs). 3. Develop and implement procedures including member outcomes monitoring to ensure the quality of mental health and employment services and that the frequency and intensity of services are sufficient to help individuals achieve increased independence and community integration, housing stability, and reduced institutional contacts and incidents of harm. Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits. 	<ul style="list-style-type: none"> • Must hold a Bachelor’s degree with a least two (2) years of experience in QA, preferably in a behavioral or medical managed care environment.

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>4. Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues.</p> <p>5. Provide support for Local Barriers Committee to identify, aggregate, and report barriers to member community integration and transitions to and maintenance of supportive community housing.</p> <p>6. Develop and strengthen processes as needed to ensure compliance with and timeliness of required provider reporting, member assessments and surveys, and other data submissions, including incidents of harm reporting via the DHHS IRIS system or its replacement, service outcomes assessments via NC-TOPPS, TCL Quality of Life surveys, and other required data submissions and reporting tools Provide support as needed for TCL team members to develop and implement data collection tools and procedures to ensure all program requirements are met; to support tracking, monitoring, and reporting; and to evaluate and ensure the quality of TCL services and functions.</p>	

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
36. TCL Data Analyst	<p>This position provides data support for TCL Quality Assurance Performance Improvement (QAPI) activities and required reporting and manages and carries out procedures to ensure TCL data accuracy.</p> <p>The TCL Data Analyst’s responsibilities shall include but are not limited to the following:</p> <ol style="list-style-type: none"> 1. Serve as the organization’s TCL data quality point of contact for DHHS; 2. Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; 3. Regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVE, internal client data management systems, NCTracks extracts provided by the Department); 4. Identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy; 5. Collect and aggregate data for required TCL reporting; 6. Conduct ongoing monitoring to ensure timely Quality of Life survey administration; and 7. Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and evaluation of the effectiveness of QAPI activities and initiatives. 	<ul style="list-style-type: none"> • Must hold a Bachelor’s degree with a least two (2) years of experience in data management and analysis, preferably in a behavioral or medical managed care environment.
37. Supported Employment Specialist	<p>This individual’s job responsibilities shall include but not be limited to the following:</p> <ol style="list-style-type: none"> 1. As the BH I/DD Tailored Plan’s point of contact, engage in statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE; 	<ul style="list-style-type: none"> • Must hold a Bachelor’s degree and have at least two (2) years of experience working with adults with SMI/SPMI. Preference for experience obtaining competitive employment for adults with SMI/SPMI (preferably utilizing Individual Placement and Supports (IPS), Vocational

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<ol style="list-style-type: none"> 2. Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE; 3. Provide direct technical assistance to sustain existing IPS providers by working within the BH I/DD Tailored Plan to implement a stable NC CORE payment model standardized by the Department; 4. Review all provider’s current IPS Fidelity Reviews, technically assist with recommended improvements, develop plans of correction for long-standing provider fidelity issues, and when required by reviewers assist during IPS Fidelity Reviews; 5. Facilitate, technically support, record provider feedback, and invite trainers to in-network IPS Collaboratives that include ACT Employment Specialists, and Peer-run Entities involved in IPS support; 6. Ensure and improve providers’ NC CORE linkage to Vocational Rehabilitation (VR) offices throughout the BH I/DD Tailored Plan’s Region, attend key statewide VR meetings, invite VR offices into IPS collaboratives, and assertively engage VR regional leadership to problem-solve and improve NC CORE service to TCL members; 7. Facilitate the expansion of benefits counseling within network providers, improve VR benefits counseling linkage, and when possible, improve relationships with Social Security Administration offices and IPS providers. Furthermore, serve as the point of contact with the Department for meetings involving the statewide benefits counseling electronic system; 8. Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional BH I/DD Tailored Plan departments; 	<p>Rehabilitation, or other research-based employment model).</p>

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>9. Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve;</p> <p>10. Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships; and</p> <p>11. As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models.</p>	
38. Outreach Diversion Specialist	<p>North Carolina Certified Peer Support Specialist with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships. This position applies these skills to Transitions to Community Living for individuals being considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP).</p> <p>The Outreach Diversion Specialist's job responsibilities shall include but not be limited to the following:</p> <ul style="list-style-type: none"> • Educating the member (and their family, as appropriate) on the choice to the remain in the community); • Providing referrals and linkages to available individualized community-based supports and services; 	<ul style="list-style-type: none"> • Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS) within six (6) months of position start date

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<ul style="list-style-type: none"> Developing a Community Integration Plan for those who choose to remain in the community; and Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps taken to address concerns and objections to the admission. 	
39. BH I/DD Tailored Plan Transition Coordinator	<p>This individual shall be solely responsible for performing the following tasks for TCL members, which cannot be delegated to the Tailored Care Manager:</p> <ul style="list-style-type: none"> (a) Convene a transition team; (b) Schedule and convene transition planning / personal care plan meetings; (c) Facilitate discussion of a crisis plan, disaster plan, and emergency plan; (d) Ensure housing and financial support needs of the TCL member are addressed; (e) Ensure health and safety monitoring needs of the TCL member are addressed; and (f) Plan for and facilitate check-ins between the final transition planning meeting and move-in of the TCL member at the community-based supportive housing. 	<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. <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 Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI. Must meet North Carolina Residency requirements.
40. Housing Supervisor	<p>Role involves but is not limited to the following:</p> <ul style="list-style-type: none"> Creating, editing, and implementing existing or new housing policy; 	<p>Five or more years of full time experience working in the field of developing, managing, and/or coordinating access to affordable housing, including without limitation: (1) professional experience in successfully</p>

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<ul style="list-style-type: none"> Integrating the housing team into the Plan’s TCL efforts and process to develop, fund, and maintain access to supportive housing for TCL members; and Closely work with the TCL quality assurance staff to provide data reported internally and externally on the Plan’s catchment-wide housing strategy, development, access, TCL member tenure, and other housing related issues. 	<p>operating a Housing First Model as it applies to people with disabilities transitioning into their chosen community; (2) at least one year as a lead or supervisor of employees in an affordable housing program.</p> <p>*Any existing staff employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a housing supervisor position shall be grandfathered and shall not be required to meet the qualifications set forth above.</p>
41. TCL Program Manager	<p>Role involves but is not limited to the following:</p> <ul style="list-style-type: none"> Facilitate cross-functional teams that create and implement recovery oriented, person-centered care plans; Create and implement Housing First, Employment First, Integrated Care, Recovery-Oriented Care, and Social Drivers of Health policies and procedures; Cross-functionally integrate TCL transition efforts across all BH I/DD Tailored Plan departments, and supervise the elevation of transition barriers to the Plan’s Local Barriers Committee; and Closely work with the TCL quality assurance staff to provide TCL data reported internally and externally. 	<ul style="list-style-type: none"> Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management <p>*Any existing staff currently employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above</p>
42. Barriers and Training Coordinator	<p>Role involves but is not limited to the following:</p> <ul style="list-style-type: none"> Coordinate and help ensure staff completion of all trainings required by the Department pursuant to the Contract for BH I/DD Tailored Plan and PIHP staff and network providers serving or supporting TCL members; Develop, coordinate and help ensure staff completion of any additional TCL in-person and virtual trainings which may be required or requested by the Department for BH I/DD Tailored Plan and PIHP staff and network providers serving or 	<ul style="list-style-type: none"> Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>supporting TCL members or the PIHP’s TCL efforts;</p> <ul style="list-style-type: none"> • Coordinate and facilitate BH I/DD Tailored Plan / PIHP’s monthly Local Barriers Committee meetings, and track and facilitate any potential barrier issues and questions to be addressed by the BH I/DD Tailored Plan / PIHP and its Local Barriers Committee; • Develop the agenda for Local Barriers Committee meetings, and be responsible for maintaining and forwarding to the Department the minutes of each Local Barriers Committee meeting and the Local Barriers Committee tracker within 14 calendar days after each meeting; • Work collaboratively with Local Barriers Committee members, BH I/DD Tailored Plan / PIHP staff, and network providers to help ensure timely identification and reporting of local barriers; exploration of potential resolutions and mitigation steps for local barriers; and identification of potential barrier patterns, root causes, and any quality improvements needed to mitigate risk and help improve TCL outcomes; • Ensure the Department is notified of any urgent barriers and work collaboratively with the Department to address all unresolved local barriers; • Participate in ad hoc barriers intervention meetings scheduled by the Department; and • Facilitate the identification and tracking of barriers leading to housing separations for TCL members and where applicable, participate in the BH I/TT Tailored Plan / PIHP’s root cause analysis process for deaths or level 3 incidents involving TCL members. 	<ul style="list-style-type: none"> • *Any existing staff currently employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a transition program manager position shall be grandfathered and shall not be required to meet the qualifications set forth above

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
43. Department of Adult Corrections (DAC) Priority Re-Entry Care Coordinator	This individual is responsible for the care coordination for Recipients on the High Priority Re-entry list.	<ul style="list-style-type: none"> • Qualified Professional with at least one year experience with the forensic population. • Must meet North Carolina Residency requirements
44. Department of Adult Corrections (DAC) Priority Re-Entry Peer Support Specialist	<ul style="list-style-type: none"> • This individual is responsible for collaborating with BH I/DD Tailored Plan staff and physical and behavioral health providers to identify complex care needs and clinical service linkage needs. • Facilitate and accompany Member/Recipient on visits to health services, wraparound services (e.g., housing, transportation, employment, food assistance), and probation/parole. <p>Educate Member/Recipient about services covered under the North Carolina State Plan for Medical Assistance, Medicaid 1915(b)(c) waiver, or the State-funded Service array.</p>	<ul style="list-style-type: none"> • Peer certified with at least one year forensic experience or lived experience with justice involvement. • Must meet North Carolina Residency requirements
45. Juvenile Justice Behavioral Health (JJBH) Liaison	<ul style="list-style-type: none"> • This individual is responsible for serving as the care coordinator for justice involved youth and families as well as coordinating with JJBH partnerships. • Work with JJBH local teams to develop processes and an annual Plan of Work that will address needs, challenges and goals. Consult with Department Juvenile Justice • Lead and external technical assistance support as needed. • Establish partnerships and build relationships with DJJ staff, court officials, local treatment providers, community organizations, juvenile detention centers, etc. to enhance youth access to and utilization of behavioral health services. • Work with internal and external stakeholders to ensure JJBH domains and System of Care are integrated into all JJBH processes. 	<ul style="list-style-type: none"> • Bachelor’s degree required; master’s degree preferred. • Minimum of 5 years of experience working with youth with juvenile justice involvement, mental health, substance use, and/or intellectual/developmental disability population. • Must have working knowledge of the juvenile justice system and System of Care • Must meet North Carolina Residency requirements

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Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<ul style="list-style-type: none"> • Host/facilitate regular JJBH local team meetings. • Meet regularly with Department Juvenile Justice Lead. Prepare updates on local team status. • Monitor local team and juvenile detention center funding allocation and utilization. 	
46. Treatment Accountability for Safer Communities (TASC) Manager	<ul style="list-style-type: none"> • This individual is responsible for overseeing TASC contracts to monitor performance of the programs and coordinate with TASC Directors and Department leads. 	<ul style="list-style-type: none"> • Qualified Professional with experience with the forensic population. • Must meet North Carolina Residency requirements
47. Competitive Integrated Employment (CIE) Coordinators	<ul style="list-style-type: none"> • Facilitate CIE outcomes for Recipients by promoting services that support individuals and families with I/DD in achieving CIE. • Educate Recipients about informed choice and employment opportunities. • Provide technical assistance on conducting Department recommended employment assessments. • Assist Recipients in applying for all additional services needed to achieve and maintain CIE, including but not limited to financial supports, housing, transportation benefits, and other services. • Monitor Recipient progress through each phase of the process. 5. Conduct outreach to community stakeholders including family and caregivers, advocates, service providers and persons with lived experience. 	<ul style="list-style-type: none"> • Qualified Professional as defined in 10A NCAC 27G.0104

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

Fifth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies documents the list of Clinical Coverage Policies the Department maintains currently for its NC Medicaid Direct program for Medicaid benefits that will be covered by the BH I/DD Tailored Plans. Full details on the policies are available at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>.

North Carolina's Medicaid State Plan is available here: <https://medicaid.ncdhhs.gov/document/state-plan-under-title-xix-social-security-act-medical-assistance-program>. The Department reserves the right to update the clinical coverage policies for covered benefits.

Section VII. Fifth Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	KEY REFERENCES
Allergies	NC Clinical Coverage Policy 1N-1, Allergy Testing NC Clinical Coverage Policy 1N-2, Allergy Immunotherapy
Ambulance Services	42 C.F.R. § 410.40 NC State Plan Att. 3.1- A.1, Page 18 NC Clinical Coverage Policy 15
Anesthesia	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; App. 8 to Att. 3.1-A, Pages 1-4; NC Clinical Coverage Policy 1L-1, Anesthesia Services NC Clinical Coverage Policy 1L-2, Moderate (Conscious) Sedation, AKA Procedural Sedation and Analgesia (PSA)
Audiology Therapy	North Carolina Medicaid State Plan, Att., 3.1-A.1, Page 7c.15 NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	SSA, Title XIX, Section 1905(g)

	<p>42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11</p> <p>NC Clinical Coverage Policy 1-F, Chiropractic Services</p>
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 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>
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>
Durable medical equipment (DME)	<p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 3</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> <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>
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 Clinical Coverage Policy 1E-7, Family Planning Services</p>
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 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> <p>NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics</p>
Freestanding birth center services (when licensed or otherwise recognized by the State)	<p>SSA, Title XIX, Section 1905(a)(28)</p> <p>North Carolina Medicaid State Plan Att. 3.1-A, Page 11</p>
Gynecology	<p>North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a)</p> <p>NC Clinical Coverage Policy 1E-1, Hysterectomy</p> <p>NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions</p>
Hearing Aids	<p>North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1</p> <p>NC Clinical Coverage Policy 7, Hearing Aid Services</p>
HIV case management services	<p>Supplement 1 to Attachment 3.1-A, Part G Page 1</p> <p>North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management</p>
Home health services	<p>SSA, Title XIX, Section 1905(a)(7)</p> <p>42 C.F.R. §440.70</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.I, Pages 13, 13a-13a.4</p> <p>NC Clinical Coverage Policy 3A</p>
Home infusion therapy	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3</p> <p>NC Clinical Coverage Policy 3H-1, Home Infusion Therapy</p>
Hospice services	<p>SSA, Title XIX, Section 1905(a)(18)</p> <p>42 C.F.R. §418</p> <p>North Carolina Medicaid State Plan 3.1-A, Page 7</p> <p>NC Clinical Coverage Policy 3D, Hospice Services</p>
ICF-IID services	<p>42 C.F.R. 440.150</p> <p>8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities</p>
Innovations waiver services	<p>8P: North Carolina Innovations (*Innovations waiver enrollees only)</p>
Inpatient hospital services	<p>SSA, Title XIX, Section 1905(a)(1)</p> <p>42 C.F.R. §440.10</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 1</p> <p>North Carolina Medicaid State Plan, Att. 3.1-E</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>

<p>Inpatient psychiatric services for individuals under age 21</p>	<p>SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services</p>
<p>Inpatient substance use services</p>	<p>NC Clinical Coverage Policy 8B, Inpatient BH Services: Medically managed intensive inpatient withdrawal management services Medically managed intensive inpatient services</p>
<p>Inpatient and Outpatient BH services</p>	<p>North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Intensive-In-Home Services Multisystemic Therapy Psychosocial Rehabilitation Child and Adolescent Day Treatment Partial Hospitalization Professional Treatment Services in a Facility Based Crisis Program NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-6: Community Support Team (CST) NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification) NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-9: Opioid Treatment Program (OTP) NC Clinical Coverage Policy 8A-10: Clinically Managed Residential Withdrawal Services (social setting detoxification)* NC Clinical Coverage Policy 8A-11: Medically Monitored Inpatient Withdrawal Management Services (non-hospital medical detoxification) NC Clinical Coverage Policy 8A-12: Substance Abuse Intensive Outpatient Program* NC Clinical Coverage Policy 8A-13: Substance Abuse Comprehensive Outpatient Treatment Program* 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</p>

	<p>NC Clinical Coverage Policy 8D-3: Clinically Managed Low-Intensity Residential Treatment Services*</p> <p>NC Clinical Coverage Policy 8D-4: Clinically Managed Population-Specific High Intensity Residential Program*</p> <p>NC Clinical Coverage Policy 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) [£]</p> <p>NC Clinical Coverage Policy 8D-6: Medically Monitored Intensive Inpatient Services (Substance Abuse Medically Monitored Community Residential Treatment)[£]</p> <p>NC Clinical Coverage Policy 8B: Inpatient BH Services</p> <p>NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers</p> <p>NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders</p> <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> <p>NC Clinical Coverage Policy 8J: Children’s Developmental Service Agencies (CDSAs)</p> <p>NC Clinical Coverage Policy 8L - Mental Health/Substance Abuse Targeted Case Management</p> <p>* Clinical coverage policy is being promulgated with effective date January 1, 2026.</p>
<p>Laboratory and X-ray services</p>	<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 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-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring</p> <p>NC Clinical Coverage Policy 1S-9, Genetic Testing for Diagnosis and Treatment</p> <p>NC Clinical Coverage Policy 1S-10, Genetic Testing for Carrier and Prenatal</p> <p>NC Clinical Coverage Policy 1S-11, Genetic Testing - Gene Expression</p> <p>NC Clinical Coverage Policy 1S-12, Genetic Testing - Next Generation Sequencing (NGS)</p> <p>NC Clinical Coverage Policy 1S-13, Cell and Gene Therapies</p> <p>NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures</p>

[£] Clinical coverage policy is being promulgated with effective date January 1, 2026.

[£] Clinical coverage policy is being promulgated with effective date January 1, 2026.

	<p>NC Clinical Coverage Policy 1K-2, Bone Mass Measurement</p> <p>NC Clinical Coverage Policy 1K-6, Radiation Oncology</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>
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-D, Page 1-4</p> <p>Non-Emergency Medical Transportation Managed Care Policy</p>
Nursing facility services	<p>SSA, Title XIX, Section 1905(a)(4)(A)</p> <p>42 C.F.R. §440.40</p> <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 Management Program</p>
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, 13e</p> <p>NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p>
Ophthalmological Services	<p>NC Clinical Coverage Policy 1T-1, General Ophthalmological Services</p> <p>NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services</p>
Optometry services	<p>SSA, Title XIX, Section 1905(a)(12)</p> <p>42 C.F.R. § 441.30</p> <p>NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a</p> <p>G.S. § 108A-70.21(b)(2)</p>

	NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient hospital services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS) in In-Home Settings NC Clinical Coverage Policy 3L-1, State Plan Personal Care Services (PCS) in Congregate Settings
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the- Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies
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.1, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation

	<p>NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services</p> <p>NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy</p> <p>NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair)</p> <p>NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy</p> <p>NC Clinical Coverage Policy 1A-12, Breast Surgeries</p> <p>NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy</p> <p>NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia</p> <p>NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity</p> <p>NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum</p> <p>NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy</p> <p>NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies</p> <p>NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services</p> <p>NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm</p> <p>NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision</p> <p>NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services</p> <p>NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education</p> <p>NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation</p> <p>NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation</p> <p>NC Clinical Coverage Policy 1A-27, Electrodiagnostic Studies</p> <p>NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP)</p> <p>NC Clinical Coverage Policy 1A-30, Spinal Surgeries</p> <p>NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy</p> <p>NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing</p> <p>NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures</p> <p>NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services</p> <p>NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA)</p> <p>NC Clinical Coverage Policy 1A-38, Special Services: After Hours</p> <p>NC Clinical Coverage Policy 1A-39, Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials</p> <p>NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation</p> <p>NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilatation</p> <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	SSA, Title XIX, Section 1905(a)(5)

	<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>
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 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> <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 of the Contract</i></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>
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> <p>NC Clinical Coverage Policy 5B, Orthotics and Prosthetics</p>
Reconstructive Surgery	<p>NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery</p> <p>NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery</p> <p>NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision</p> <p>NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty</p>
Respiratory care services	<p>SSA, Title XIX, Section 1905(a)(20)</p> <p>SSA, Title XIX, Section 102(e)(9)(A)</p>

	<p>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</p> <p>NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies</p> <p>NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services</p>
Rural health clinic services (RHC)	<p>SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411</p> <p>42 C.F.R. § 405.2463</p> <p>42 C.F.R. § 440.20</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1</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>
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, 13e</p> <p>NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies</p>
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>
Tobacco cessation counseling for pregnant women	<p>SSA, Title XIX, Section 1905(a)(4)(D)</p> <p>North Carolina Medicaid State Plan, Att. 3.1-A, Page 2</p>
Transplants and Related Services	<p>North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9</p> <p>NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL)</p> <p>NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia</p> <p>NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia</p> <p>NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias</p> <p>NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors</p> <p>NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma</p> <p>NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation 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> <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> <p>NC Clinical Coverage Policy 11B-9, Thymus Tissue Implantation</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>
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>
1915(i) Option Services	<p>NC Clinical Coverage Policy 8H-1: Supported Employment for IDD and TBI</p> <p>NC Clinical Coverage Policy 8H-2: Individual Placement and Support (IPS)</p> <p>NC Clinical Coverage Policy 8H-3: Individual and Transitional Support (ITS)</p> <p>NC Clinical Coverage Policy 8H-4: Respite</p> <p>NC Clinical Coverage Policy 8H-5: Community Living and Supports (CLS)</p> <p>NC Clinical Coverage Policy 8H-6: Community Transition</p>

Fifth Revised and Restated Attachment E. BH I/DD Tailored Plan Quality Metrics

1. BH I/DD Tailored Plan Quality Metrics for Medicaid

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual that will be provided no later than six (6) months prior to BH I/DD Tailored Plans launch, or when the Department releases the data required for such reports, whichever is later.

Updates to BH I/DD Tailored Plan Quality Metrics

- a. The Department will review and update the quality measures annually in January and reflect any updates in the NC Medicaid Managed Care Technical Specifications document posted on the NC DHHS Quality Management and Improvement website, as necessary, to align with the annual January update.
- b. The BH I/DD Tailored Plan shall begin to track the updated measures when posted annually in January.
- c. The BH I/DD Tailored Plan shall not be required to report on the updated measures posted in January until the end of the subsequent Contract Year following the annual posting to the NC DHHS Quality Management and Improvement website in accordance with *Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the BH I/DD Tailored Plan would report the results in June 2024).
- d. An asterisk (*) indicates that the measure is calculated by the Department.

The BH I/DD Tailored Plan will also be required to report the Innovations and TBI waiver measures listed in *Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measurers* and *Section VII. Fifth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with BH I/DD Tailored Plans around these performance measures. The BH I/DD Tailored Plan will also be required to report the 1915(i) measures listed in *Section VII. Fifth Revised and Restated Attachment E.1. Table 7: 1915 (i) Performance Measurers*. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may engage with BH I/DD Tailored Plans around these performance measures.

An asterisk (*) indicates that the measure is calculated by the Department.

Section VII. Fourth Revised and Restated Attachment E.1. Table 1: Survey Measures and General Measures: Pediatric

Ref #	CBE #	Measure Name	Steward
This entire table is reserved.			

Section VII. Fifth Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures

Ref #	NQF/CBE #	Measure Name	Steward
1.	Reserved		
2.	0032	Cervical Cancer Screening (CCS-E)	NCQA
3.	0033	Chlamydia Screening (CHL)	NCQA
4.	0059/ 0575	Glycemic Status Assessment for Patients with Diabetes (GSD) ^ù	NCQA
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
6.	Reserved		
7.	0018	Controlling High Blood Pressure (CBP) ^ù	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
9.	Reserved.		
10.	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA
11.	Reserved		
12.	1768	Plan All-Cause Readmissions (PCR)[Observed versus expected ratio]*	NCQA
13.	0418/0418e	Screening for Depression and Follow-Up Plan (CDF)	CMS
14.	Reserved		
15.	Reserved		
16.	NA	Rate of Screening for Health-Related Resource Needs (HRRN)*	NCDHHS
17.	Reserved		
18.	NA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
19.	Reserved		
20.	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA
21.	0034	Colorectal Cancer Screening (COL-E)	NCQA
22.	Reserved.		
23.	1516	Child and Adolescent Well-Care Visits (WCV)	NCQA

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

Section VII. Fifth Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures

Ref #	NQF/CBE #	Measure Name	Steward
24.	0038	Childhood Immunization Status (Combination 10) (CIS-E)	NCQA
25.	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA
26.	1407	Immunizations for Adolescents (Combination 2) (IMA-E)	NCQA
27.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA
28.	1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
29.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
30.	NA	Low Birth Weight* ⁶⁴	NCDHHS
31.	NA 1517	Prenatal and Postpartum Care (PPC) ⁶⁶	NCQA
32.	NA	Rate of Screening for Pregnancy Risk* ⁶⁷	NCDHHS
33.	3620	Adult Immunization Status (AIS-E)	NCQA
34.	Reserved		
35.	2372	Breast Cancer Screening (BCS-E)	NCQA
36.	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA
37.	3620	Adult Immunization Status (AIS-E)	NCQA
38.	N/A	Adults' Access to Preventive/Ambulatory Health Services (AAP)	NCQA
39.	0272/ 0275/ 0277/ 0283	Avoidable Adult Utilization:* <ul style="list-style-type: none"> • <i>PQI 01: Diabetes Short-term Complication Admission Rate</i> • <i>PQI 05: COPD or Asthma in Older Adults Admission Rate</i> • <i>PQI 08: Heart Failure Admission Rate</i> • <i>PQI 15: Asthma in Younger Adults Admission Rate</i> 	AHRQ
40.	0728/ N/A	Avoidable Pediatric Utilization: * <ul style="list-style-type: none"> • <i>PDI 14: Asthma Admission Rate</i> • <i>PDI 15: Diabetes Short-term Complications Admission Rate</i> 	AHRQ
41.	N/A	Blood Pressure Control for Patients with Diabetes*	NCQA
42.	0038	Childhood Immunization Status (Combination 7) (CIS-E)	NCQA
43.	2903/ 2904	<i>Contraceptive Care: All Women (CCW) *</i>	US Office of Population Affairs

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

Section VII. Fifth Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures

Ref #	NQF/CBE #	Measure Name	Steward
44.	2902	<i>Contraceptive Care: Postpartum (CCP) *</i>	US Office of Population Affairs
45.	2607	<i>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI) *</i>	NCQA
46.	1448	<i>Developmental Screening in the First Three Years of Life (DEV) *</i>	OHSU
47.	N/A	<i>EPSDT Screening Ratio *</i>	NCDHHS
48.	N/A	<i>Eye Exam for Patients with Diabetes (EED)</i>	NCQA
49.	3488	<i>Follow-Up After Emergency Department Visit for Substance Use (FUA) *</i>	NCQA
50.	N/A	<i>Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)</i>	NCQA
51.	0004	<i>Initiation and Engagement of Substance Use Disorder Treatment (IET)</i>	NCQA
52.	N/A	<i>Lead Screening in Children (LSC) *</i>	NCQA
53.	N/A	<i>Managed LTSS Admissions to a Facility From the Community (MLTSS 6) *</i>	CMS
54.	N/A	<i>Managed LTSS Minimizing Facility length of Stay (MLTSS 7) *</i>	CMS
55.	N/A	<i>Managed LTSS Successful Transition After Long-Term Facility Stay (MLTSS 8) *</i>	CMS
56.	2517	<i>Oral Evaluation, Dental Services (OEV) *</i>	DQA (ADA)
57.	N/A	<i>Prenatal Depression Screening and Follow-Up (PND-E) *</i>	NCQA
58.	3484	<i>Prenatal Immunization Status (PRS-E) *</i>	NCQA
59.	N/A	<i>Statin Therapy for Patients with Cardiovascular Disease (SPC) *</i>	NCQA
60.	2528/3700/3701	<i>Topical Fluoride for Children (TFL) *</i>	DQA (ADA)
61.	2940	<i>Use of Opioids at High Dosage in Persons Without Cancer (OHD) *</i>	PQA
62.	2950	<i>Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) *</i>	PQA
63.	3400	<i>Use of Pharmacotherapy for Opioid Use Disorder (OUD)*</i>	CMS
64.	0024	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) *</i>	NCQA

Section VII. Fourth Revised and Restated Attachment E.1. Table 3: Survey Measures and General Measures: Maternal

Ref #	NQF #	Measure Name	Steward	Frequency	Submission
This entire table is reserved.					

Section VII. Fourth Revised and Restated Attachment E.1. Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction

Ref #	NQF #	Measure Name	Steward
1.	0006	CAHPS Survey	AHRQ

Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
1.	Number and percent of new waiver enrollees who have a Level of Care evaluation prior to receipt of services.	NC DHHS	Annually Fiscal Year	November 1
2.	Number and percent of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Per Waiver Performance measure number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services. Numerator: Number of new C waiver participants who received an initial LOC evaluation.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Number and percent of annual Level of Care evaluations for Innovations Waiver enrollees which were appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
5.	Number and percent of New Level of Care evaluations appropriately completed using waiver approved processes and instrument.	NC DHHS	Annually Fiscal Year	November 1
6.	Reserved.			
7.	Number and percent of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to BH I/DD Tailored Plan monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
8.	Number and percent of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
9.	Number and percent of 1915 (c) waiver providers with a plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Number and percent of monitored non-licensed, and non-certified providers, who have been found to be out of compliance and have plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Number and percent of monitored non-licensed and non-certified providers that are compliant with Innovations Waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Number and percent of monitored providers agencies wherein all staff completed all mandated training training for 1915 (c) Waiver.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Number and percent of beneficiaries reporting that their Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Number and percent of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
16.	Number and percent of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1
17.	Number and percent of individuals whose annual Individual Support Plan was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
18.	Number and percent of Innovations waiver participants whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager to address their changing needs.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
19.	Number and percent of Innovations waiver participants whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
20.	Reserved.			
21.	Number and percent of new 1915(c) waiver beneficiaries receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
22.	Number and percent of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Number and percent of Innovations waiver beneficiaries reporting their Tailored Care Manager helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Number and percent of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percent of deaths where required BH I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November
26.	Number and percent of actions taken to protect the beneficiary from additional harm, where indicated as a percent of all actions where protective actions were indicated.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27.	Number and percent of beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Number and percent of Innovations waiver beneficiaries not requiring medical treatment or hospitalization due to medication errors.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
29.	Number and percent of incidents that were not critical involving Innovations Waiver enrollees referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Number and percent of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Annually Fiscal Year	November 1
32.	Number and percent of level 2 or 3 incidents where BH I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
33.	Number and Percent of level 2 and 3 incidents reported within required state policy timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Reserved.			
35.	Number and Percent of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Number and Percent of restrictive interventions (both restraint and seclusion) that did not result in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
37.	The number and percent of claims that are coded and paid in accordance with the reimbursement methodology specified in the approved waiver for services rendered.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
38.	Reserved.			
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			
43.	Number and percent of Innovations Waiver enrollees who are receiving services as specified in the Individual Support Plan.	NCDHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
44.	Number and percent of Innovations Waiver Members ages 21 and older who had a primary care or preventative care visit during the Innovations Waiver year.	NCDHHS	Annually Fiscal Year	November 1
45.	Number and percent of Innovations Waiver Members under the age of 21 who had a primary care or preventative care visit during the Innovations waiver year.	NC DHHS	Annually Fiscal Year	November 1
46.	Reserved.			
47.	Number and percent of capitation payments to the BH I/DD Tailored Plans that are made in accordance with the CMS approved actuarially sound rate methodology.	NC DHHS	Quarterly 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
48.	Number and percent of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields.	NC DHHS	Quarterly 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. Fifth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
1.	Number and percent of new TBI Waiver enrollees who have a Level of Care evaluation prior to receipt of services	NC DHHS	May 1 – April 30	September 1
2.	Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
3.	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
4.	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	May 1 – April 30	September 1
5.	Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
6.	Proportion of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
7.	Proportion of providers reviewed according to BH I/DD Tailored Plan monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards	NC DHHS	May 1 – April 30	September 1
8.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	May 1 – April 30	September 1
9.	Proportion of monitored non-licensed, non-certified providers that successfully implemented an approved corrective action plan	NC DHHS	May 1 – April 30	September 1
10.	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	May 1 – April 30	September 1
11.	Proportion of PCPs that are completed in accordance with State Medicaid Agency’s requirements	NC DHHS	May 1 – April 30	September 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

12.	Proportion of Individual Support Plans that address identified health and safety risk factors	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	May 1 – April 30	September 1
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency’s requirements	NC DHHS	May 1 – April 30	September 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	May 1 – April 30	September 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	a. May 1 – October 31 b. November 1 – April 30	a. March 1 b. September 1
17.	Proportion of new waiver beneficiaries receiving services according to their Individual Support Plan within 45 days of Individual Support Plan approval	NC DHHS	May 1 – April 30	September 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. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	May 1 – April 30	September 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	May 1 – April 30	September 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	May 1 – April 30	September 1
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

23.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required.	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
24.	Number and Percentage of deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
25.	Percentage of medication errors resulting in medical treatment	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
26.	Percentage of beneficiaries who received appropriate medication	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
27.	Percentage of level 2 and 3 incidents reported within required time frames	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 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. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 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. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
30.	Percentage of restrictive interventions resulting in medical treatment	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures

31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
32.	Percent of restrictive interventions used by a trained staff member.	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
33.	Percent of restrictive interventions that are documented according to state policy.	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
34.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	NC DHHS	Quarterly a. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 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. May 1 – July 31 b. August 1 – October 31 c. November 1 – January 31 d. February 1 – April 30	a. December 1 b. March 1 c. June 1 d. September 1
36.	The proportion of claims paid by the PIHP for NC TBI waiver services that have been authorized in the service plan	NC DHHS	May 1 – April 30	September 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
1.	Number and percent of new BH I/DD Tailored Plan members who have an independent evaluation prior to receipt of services	NC DHHS	Annually Fiscal Year	November 1
2.	Number of BH I/DD Tailored Plan members who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
3.	Number of BH I/DD Tailored Plan members with SMI/SED who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
4.	Reserved.			
5.	Number of BH I/DD Tailored Plan members with I/DD who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
6.	Number of BH I/DD Tailored Plan members with TBI who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
7.	Number of BH I/DD Tailored Plan members on the Innovations waitlist who received an independent evaluation during the fiscal year	NC DHHS	Annually Fiscal Year	November 1
8.	Proportion of independent re-evaluations completed at least annually for BH I/DD Tailored Plan members using 1915(i) services	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 1
9.	Proportion of new independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Fifth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
14.	Proportion of 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
18.	Reserved.			
19.	Percentage of beneficiaries reporting that their Care Plan/ISP Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
20.	Reserved.			
21.	Proportion of Care Plans/ISPs Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
22.	Reserved.			
23.	Reserved.			
24.	Reserved.			
25.	Reserved.			
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP Individual Support Plan within 45 days of ISP Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
27.	Reserved.			

Section VII. Fifth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
28.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Reserved.			
32.	Reserved.			
33.	Reserved.			
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly 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.	Percentage of BH I/DD Tailored Plan Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly 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.	Reserved.			
38.	Reserved.			
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly 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. Fifth Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures

Ref #	Measure Name	Steward	Measurement Period	Date of Submission
41.	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
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
44.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly 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
45.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly 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
46.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly 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

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

The BH I/DD Tailored Plan will be expected to calculate and report on those measures that require claims or encounter data or clinical data, as described in a technical specifications manual and on the reporting template. When the Department provides calculated measure data, the BH I/DD Tailored Plan will be responsible for reviewing the results and using the information to inform quality improvement activities. 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 regarding performance improvement.

<i>Section VII. Fifth Revised and Restated Attachment E.2. Table 2: Survey Measures and General Measure for State-funded Services</i>				
Ref #	Measure	Steward	Measurement Period	Report Due
1.	Initiation of Services (mental health & SUD)	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
2.	Engagement in Services (mental health & SUD)	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
3.	Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment & Substance use disorder treatment	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
4.	State Psychiatric Hospital Readmissions within thirty (30) Calendar Days and one hundred eighty (180) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15

5.	ADATC Readmissions within thirty (30) Calendar Days and one hundred eighty (180) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
6.	Community MH Inpatient Readmissions within thirty (30) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
7.	Community SUD Inpatient Readmission within thirty (30) Calendar Days	NC DHHS	Quarterly July – September October – December January – March April – June	February 15 May 15 August 15 November 15
8.	Follow-up after discharge from community hospitals, state psychiatric hospitals, and Facility Based Crisis services for mental health treatment	NC DHHS	Quarterly July – September October – December January – March April – June	February 15 May 15 August 15 November 15
9.	Follow-up after discharge from community hospitals, state psychiatric hospitals, state ADATC's and Detox/Facility Based Crisis Services for substance use disorder treatment	NC DHHS	Quarterly July – September October – December January – March April – June	February 15 May 15 August 15 November 15

3. BH I/DD Tailored Plan Combined Quality Metrics for Medicaid and State-funded Services

The measures below that are not in the first release of the Technical Specifications may be calculated by The Department. The quality measures will be reviewed and updated annually. The Department will monitor other measures that are not included in the tables below and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance measures.

Section VII. Fourth Revised and Restated Attachment E.2. Table 3: Combined Survey Measures and General Measures for Medicaid and State-funded Services

Ref #	Measure	Steward	Measurement Period	Report Due
1.	Net Increase in Members Served in TCL Supportive Housing	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
2.	Members Served in TCL Supportive Housing	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15
3.	TCL Supportive Housing Retention	NC DHHS	Quarterly July – September October – December January – March April - June	February 15 May 15 August 15 November 15

Section VII. Fourth Attachment E.2. Table 4: BH I/DD Tailored Plan Combined Quality Metrics for Medicaid and State-funded Services

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

Fifth Revised and Restated Attachment F. BH I/DD Tailored Plan Network Adequacy Standards

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

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

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

The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all Members have timely access to all covered health care services, BH I/DD Tailored Plans shall ensure its Network meets, at a minimum, the following time/distance standards as measured from the Member's residence for adult and pediatric providers separately through geo-access mapping conducted at least annually. Certain service types are not subject to separate adult and pediatric provider standards. These service types are marked with a (*) and include: hospitals, pharmacies, occupational, physical, or speech therapists, LTSS, and nursing facilities.

For purposes of network adequacy standards for physical health providers/services, except as otherwise noted, adult services are those provided to a Member who is 21 years of age or older and pediatric (child/children) services are those provided to a Member who is less than 21 years of age.

For purposes of network adequacy standards for SUD and mental health treatment providers, except as otherwise noted, adult services are those provided to a Member who is 18 years of age or older and pediatric/adolescent (child/children) services are those provided to a Member who is less than 18 years of age.

The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time/distance standards found in Distance Standards for BH service types in Section VII. Fifth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid and Section VII. Fifth Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid.

Section VII. Fifth 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	<p>≥ 2 Providers of each outpatient Behavioral Health service within 30 minutes or 30 miles of residence for at least 95% of Members</p> <ul style="list-style-type: none"> • <i>Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):</i> Not subject to standard 	<p>≥ 2 Providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of Members</p> <ul style="list-style-type: none"> • <i>Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):</i> Not subject to standard
8.	Location-Based Services	<ul style="list-style-type: none"> • <i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program Services:</i> ≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of Members <ul style="list-style-type: none"> ○ <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard 	<ul style="list-style-type: none"> • <i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Opioid Treatment Program Services:</i> ≥ 2 Providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members. • <i>Child and Adolescent Day Treatment Services:</i> Not subject to standard

¹ Nurse Practitioners and Physician Assistants may be included to satisfy Primary Care access requirements.

² Measured for members who are female and age 14 or older. Certified Nurse Midwives may be included to satisfy OB/GYN access requirements.

Section VII. Fifth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid

Reference Number	Service Type	Urban Standard	Rural Standard
9.	Crisis Services	<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>Medically Monitored Inpatient Withdrawal Management Services:(non-hospital medical detoxification)</i> ≥ 2 Providers within each BH I/DD Tailored Plan Region • <i>Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification), Ambulatory Withdrawal Management with Extended On-Site Monitoring, Clinically Managed Residential Withdrawal services (social setting detoxification), Mobile Crisis Management:</i> ≥ 2 Providers of each crisis service within each BH I/DD Tailored Plan Region 	
10.	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11.	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12.	Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
13.	All State Plan LTSS (except nursing facilities and 1915(i) services)*	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	
14.	Nursing Facilities*	≥ 1 nursing facility accepting new patients in every county.	
15.	Residential Treatment Services	<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>Medically Monitored Intensive Inpatient Services (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>Clinically Managed Residential Services (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>Adolescent:</i> Contract with all designated CASPs statewide ○ <i>Pregnant and Parenting:</i> Contract with all designated CASPs statewide 	

Section VII. Fifth 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
		<ul style="list-style-type: none"> • <i>Clinically Managed Population-Specific High-Intensity Residential Program</i>: contract with all designated CASPs • <i>Clinically Managed Low-Intensity Residential Treatment Services</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 (Refer to 10A NCAC 27G.5600E)³ ○ <i>Adolescent</i>: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600) • <i>Psychiatric Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID</i>: Not subject to standard • <i>Medically monitored intensive inpatient services</i> 	
16.	1915(c) HCBS Waiver Services: NC Innovations	<ul style="list-style-type: none"> • <i>Community Living & Support, 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 participating counties only)	<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. • <i>Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports</i>: ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • <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</i>: N/A. 	
18.	Employment and Housing Services	<ul style="list-style-type: none"> • <i>Individual Placement and Supports (IPS) – Supported Employment (Adult MH)</i>: Eligible individuals shall have the choice of at least two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. 	

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

Section VII. Fifth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	Service Type	Urban Standard	Rural Standard
19.	1915(i) Services	<ul style="list-style-type: none"> • <i>Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD):</i> ≥ 2 providers of each 1915(i) service within each BH I/DD Tailored Plan Region • <i>In-Home Respite:</i> ≥ 2 providers within 45 minutes of the member’s residence. 	

Section VII. Fifth 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) • Diagnostic Assessment • 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 • Opioid Treatment Program Service-(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 Withdrawal Management without Extended On-Site Monitoring (Ambulatory detoxification) • Ambulatory Withdrawal Management with Extended On-Site Monitoring • <i>Clinically Managed Withdrawal services (social setting detoxification)</i> • <i>Medically Monitored Withdrawal Management services (Non-hospital medical detoxification) (adult)</i> • Mobile Crisis Management
4.	Inpatient BH Services	<ul style="list-style-type: none"> • Inpatient Hospital – Adult • Acute care hospitals with adult inpatient psychiatric beds • Medically Managed Intensive Inpatient Withdrawal Management (Acute care hospitals with adult inpatient substance use beds) • Medically Managed Intensive Inpatient services (Acute care hospitals with adult inpatient substance use beds)

Section VII. Fifth 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
		Inpatient Hospital – Adolescent/Children <ul style="list-style-type: none"> • Acute care hospitals with adolescent inpatient psychiatric beds • Medically managed intensive inpatient Service (Acute care hospitals with adolescent inpatient substance use beds) • Acute care hospitals with child inpatient psychiatric beds
5.	Partial Hospitalization	<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 • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment) • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services • 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 (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports Services • Diagnostic Assessment
8.	1915(c) HCBS Waiver Services: NC Innovations	<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. Fifth 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
10.	Employment and Housing Services	<ul style="list-style-type: none"> • Individual Placement and Support-Supported Employment (Adult MH)
11.	1915(i) Services	<ul style="list-style-type: none"> • Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

BH I/DD Tailored Plan is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service:

Section VII. Fifth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
Primary Care			
1	Preventive Care Service – adult, 21 years of age and older	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears	Within thirty (30) Calendar Days
1a	Preventive Care Services – child, birth through 20 years of age		Within fourteen (14) Calendar Days for Members less than six (6) months of age Within thirty (30) Calendar Days for members six (6) months of age and older.
2	After-Hours Access – Emergent and Urgent	Care requested after normal business office hours.	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
3	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within twenty-four (24) hours
4	Routine/Check-up without Symptoms	Non-symptomatic visits for routine health check-up.	Within thirty (30) Calendar Days
Prenatal Care			
5	Initial Appointment – 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	Within twenty-four (24) hours

Section VII. Fifth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
		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.	
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. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</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. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Emergency Services available immediately available twenty-four (24) hours a day, 7 days a week.
11	Emergency Services for Mental Health	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Immediately available twenty-four (24) hours a day, 7 days a week.
12	Emergency Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Immediately available twenty-four (24) hours a day, 7 days a week.
13	Urgent Care Services for Mental Health	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for</i>	Within twenty-four (24) hours

Section VII. Fifth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	Visit Type	Description	Standard
		<i>Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	
14	Urgent Care Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within twenty-four (24) hours
15	Routine Services for Mental Health	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within fourteen (14) Calendar Days
16	Routine Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within forty-eight (48) hours

The BH I/DD Tailored Plan is required to use the following provider types as “specialty care” providers for purposes of *Section VII. Fifth Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time or Distance Standards for Medicaid* and *Section VII. Fifth Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid* as found in this attachment.

Section VII. Fourth Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	Service Type
1.	Allergy/Immunology
2.	Anesthesiology
3.	Cardiology
4.	Dermatology
5.	Endocrinology

Section VII. Fourth Revised and Restated Attachment F.1. Table 4: Specialty Care Providers for Medicaid	
Reference Number	Service Type
6.	ENT/Otolaryngology
7.	Gastroenterology
8.	General Surgery
9.	Gynecology
10.	Infectious Disease
11.	Hematology
12.	Nephrology
13.	Neurology
14.	Oncology
15.	Ophthalmology
16.	Optometry
17.	Orthopedic Surgery
18.	Pain Management (Board Certified)
19.	Psychiatry
20.	Pulmonology
21.	Radiology
22.	Rheumatology
23.	Urology

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

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

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

The Department will issue updated analysis of urban and rural counties defined by the North Carolina Rural Economic Development Center based on the most recently available U.S. Census population data.

In order to ensure that all members have timely access to all covered health care services, BH I/DD Tailored 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. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients* for service types marked with a (^). The BH I/DD Tailored Plan is required to use the definitions of service categories for BH time or distance standards found in distance standards for BH service types in *Section VII. Fifth 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. Fifth 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	<p>≥ 2 providers of each outpatient Behavioral Health service within 30 minutes or 30 miles of residence for at least 95% of recipients⁴</p> <p><i>Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i></p>	<p>≥ 2 providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of recipients</p> <p><i>Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD): Not subject to standard</i></p>
2.	Location-Based Services [^]	<p><i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Opioid Treatment Program Services: ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients</i></p> <p><i>Child and Adolescent Day Treatment Services: Not subject to standard</i></p>	<p><i>Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Opioid Treatment Program Services: ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients</i></p> <p><i>Child and Adolescent Day Treatment Services: Not subject to standard</i></p>
3.	Crisis Services [^]	<ul style="list-style-type: none"> • <i>Facility based crisis for adults: The greater of:</i> <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>Medically monitored inpatient withdrawal management (Non-hospital Medical Detoxification): ≥ 2 providers within each BH I/DD Tailored Plan Region</i> • <i>Ambulatory Withdrawal Management without Extended Onsite Monitoring Services (Ambulatory Detoxification) & Ambulatory withdrawal management with extended onsite monitoring: ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region</i> 	
4.	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5.	Reserved		

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

Section VII. Fifth 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
6.	Community/ Mobile Services [^]	Assertive Community Treatment, Community Support Team, Peer Supports (Individual & Group), Transition Management Service, Intensive In-home, BH Comprehensive Case Management, Multi-Systemic Therapy: Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
		<i>Assertive Engagement: 2 providers of each outpatient BH service within 30 minutes or 30 miles of residence for at least 95% of recipients⁵</i>	<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>
7.	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>Clinically Managed Low-Intensity Residential Treatment Services:</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 (Refer to 10A NCAC 27G.5600E)⁶ ○ <i>Adolescent:</i> Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600) • <i>Medically monitored intensive inpatient services (Substance Abuse Medically Monitored Community Residential Treatment):</i> Access to ≥1 licensed provider • <i>Clinically managed residential services (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>Pregnant and Parenting:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region ○ <i>Adolescents:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region • <i>Substance Use Residential Supports & Mental Health Recovery Residential Services:</i> Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region 	
8.	Employment and Housing Services	<ul style="list-style-type: none"> • <i>Residential Supports, Supported Living Periodic, Respite:</i> Eligible individuals shall have the choice of at least 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • <i>Individual Placement and Support-Supported Employment (Adult MH & Adult SUD):</i> 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>Day Supports. Community Living Support, Supported Employment, Adult Day Vocational Programs (ADVP):</i> 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • <i>Clinically Managed Population-specific High Intensity Residential Programs:</i> To be determined 	

⁵ The Department defines recipients for the purposes of network adequacy as those who received State-funded Services in the previous year.

⁶ BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to clinically managed low-intensity residential treatment services.

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

Section VII. Fifth Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	Service Type	Classification	Disability Group				
			I/DD or TBI	Adult MH	Child MH	Adult SUD	Child SUD
1.	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
2.	Location-Based Services [^]	Psychosocial Rehabilitation		Y			
		Substance Abuse Comprehensive Outpatient				Y	
		Substance Abuse Intensive Outpatient Program				Y	Y
		Opioid Treatment Program Service				Y	
3.	Crisis Services [^]	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Medically Monitored Inpatient Withdrawal Management Services (Non-hospital Medical Detoxification)				Y	
		Ambulatory Withdrawal Management without Extended Onsite Monitoring Services (<i>Ambulatory Detoxification</i>) & <i>Ambulatory withdrawal management with extended on-site</i>				Y	
4.	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y	Y
5.	Reserved						

Section VII. Fifth 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
6.	Residential Treatment Services	Clinically Managed Low-Intensity Residential Treatment Services				Y	
		Substance Abuse Medically Monitored Residential Treatment				Y	
		Clinically managed residential services (Substance Abuse Non-Medical Community Residential Treatment)				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			
		Clinically managed high intensity residential services – Pregnant & Parenting				Y	
		Clinically managed medium-intensity residential services - Adolescents					Y
		Clinically Managed High-intensity Residential Services –				Y	
		Medically monitored intensive inpatient services				Y	
7.	Community/ Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	
		Transition Management Service		Y			
		Reserved.					
		Intensive In-home			Y		Y

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

BH I/DD Tailored Plan is additionally required to meet the following appointment wait-time standards for adult and pediatric providers separately, which vary by the type of service.

Section VII. Fifth 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. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within two (2) hours
2.	Facility-Based Crisis Management	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for</i>	Immediately available twenty-four (24) hours

Section VII. Fifth Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	Visit Type	Description	Standard
	Services (FBC for Adult, Non-Hospital Medical Detox)	<i>Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	a day, three hundred sixty-five (365) days a year.
3.	Emergency Services for Mental Health	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Immediately available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.
4.	Emergency Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</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. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within twenty-four (24) hours
6.	Urgent Care Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within twenty-four (24) hours
7.	Routine Services for Mental Health	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within fourteen (14) Calendar Days
8.	Routine Services for SUDs	Refer to <i>Section VII. Fourth Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients</i>	Within forty-eight (48) hours

Sixth Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts

1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid

The BH I/DD Tailored Plan shall develop and implement contracts with providers to meet the requirements of the Contract. The BH I/DD Tailored Plan's provider contracts shall, at a minimum, comply with the terms of the Contract, state and federal law, and include required standard contracts clauses.

1. Contracts between the BH I/DD Tailored Plan and providers, must, at a minimum, include provisions addressing the following:

- a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
- b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
 - i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section II.A.* of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.
- c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the state includes an extension option.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination. The contract may include a no-cause termination clause.
- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 1. Transition of administrative duties and records; and
 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and the timeframe

within which the provider must notify the Department of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

- i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.
- ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 1. During the provider credentialing transition period, no less frequently than every five (5) years.
 2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. **Liability Insurance:** The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost, and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.
- h. **Member Billing:** The contract must address the following:
 - i. That the provider shall not bill any member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the member requests to receive the service; and
 - ii. Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- i. **Provider Accessibility:** The contract must address provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
 - i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to NC Medicaid Direct, if the provider serves only Medicaid beneficiaries;
 - ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and
 - iii. Have a "no-reject policy" for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A provider's competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the provider.
- j. **Eligibility Verification:** The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the BH I/DD Tailored Plan, before rendering health care services.
- k. **Medical Records:** The contract must address provider requirements regarding patients' records, in accordance with 42 C.F.R. § 438.208(b)(5). The contract must require that providers:
 - i. Maintain confidentiality of member medical records and personal information and other health records as required by law;
 - ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
 - iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

- l. Member Appeals and Grievances: The contract must address the provider's obligation to cooperate with the member in regard to member appeals and grievance procedures.
- m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
- n. Provider Network: The contract must include a provider network provision that ensures that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
- o. Provider Payment: The contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider agrees to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in the BH I/DD Tailored Plan's web-based billing process.
- p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.
- q. Utilization Management (UM): The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- r. Quality Management: The contract must address the provider's participation in the compliance process and the Network Continuous Quality Improvement process.
- s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
- t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Grievance and Appeals as found in *Section V.B.4.v. Provider Grievances and Appeals*.
- u. Assignment: Provisions on assignment of the contract must include that:
 - i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
- v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- w. Interpreting and Translation Services: The contract must have provisions that indicate:
 - i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
 - ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.

- iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- x. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
- y. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.
- z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy.
- aa. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- bb. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organization. The BH I/DD Tailored Plan shall include in Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. If a Provider is not complying with applicable critical incident and/or death reporting requirements or the BH I/DD Tailored Plan identifies trends in incident reporting, the BH I/DD Tailored Plan shall utilize remedial measures available under the contract with the Provider, including but not limited to provider monitoring and corrective actions, to remedy the noncompliance and minimize occurrence of preventable incidents.
- dd. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in Section V.B.4.iv. Provider Payments of the BH I/DD Tailored Plan Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the BH I/DD Tailored Plan shall reimburse providers no less than one hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Section VII. Third Revised and Restated Attachment H. Addendum for Indian Health Care*

Providers includes the information required by this provision or to contracts when the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement. When a BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

- ee. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH/IDD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile or mail. Clinical documentation includes, but is not limited to, Certificates of Medical Necessity (CMNs), invoices, discharge summaries and operative reports, sterilization consent forms and child medical exam checklists. The mutually agreed upon solution for electronic claim attachments must at a minimum allow providers to submit claim attachments electronically at the time of claim submission through an online portal and standard ASC X12 HIPAA transaction (275 claim attachment format or attachment indication in an 837 with the automated ability to link the separately received attachment to the claim and process the claim).
- ff. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) Business Days of concluding the authorized outpatient procedure.
- gg. Physician Advisor Use in Claims Dispute: The contract must indicate that the BH I/DD Tailored Plan shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.
- hh. Miscellaneous Provisions - The contract shall include provisions which address the following:
 - i. If the BH I/DD Tailored Plan determines that services, supplies, or other items are covered and Medically Necessary, the BH I/DD Tailored Plan shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the insured or the Provider of the service, supply, or other item.
 - ii. When the BH I/DD Tailored Plan offers to contract with a Provider, the BH I/DD Tailored Plan shall make available its schedule of fees, if any associated with the top 30 services or procedures most commonly billed by the class of Provider, with the exception of Value-Based Fees, which would not be included until Contract Year 2.
 - iii. Notice contact provisions - The contract shall address the following:
 - a. All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.
 - b. Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five (5) Business Days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic

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

- iv. Contract Amendments - The contract shall address the following:
 - a. BH I/DD Tailored Plan shall send any proposed contract amendment to the notice contact of a health care provider. The proposed amendment shall be dated, labeled "Amendment," signed by the BH I/DD Tailored Plan, and include an effective date for the proposed amendment.
 - b. A health care provider receiving a proposed amendment shall be given at least sixty (60) Calendar Days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within sixty (60) Calendar Days.
 - c. If a health care provider objects to a proposed amendment, then the proposed amendment is not effective and the BH I/DD Tailored Plan shall be entitled to terminate the contract upon sixty (60) Calendar Days written notice to the health care provider.
 - d. A health care provider and the BH I/DD Tailored Plan may negotiate contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts.
- v. Policies and Procedures: The contract shall address the following:
 - a. BH I/DD Tailored Plan's policies and procedures applicable to contracted health care providers shall be incorporated into the BH I/DD Tailored Plan's Provider Manual or posted to the BH I/DD Tailored Plan's website.
 - b. The policies and procedures of the BH I/DD Tailored Plan shall not conflict with or override any term of a contract, including contract fee schedules.
- vi. Provider Manual: The BH I/DD Tailored Plan shall include Department-developed standard terms and conditions included in the Tailored Care Management (TCM) Provider Manual Addendum: Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs in its contracts with Designated Pilot Care Management Entities.

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

- a. AMH Provider Manual
- b. *Section VII. Third Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid Members*
- c. *Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid Members*
- d. *Section VII. First Revised and Restated Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid 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 [BH I/DD Tailored Plan's] contract with NC DHHS could result in

liability for money damages, including civil or criminal penalties and sanctions under state and/or federal law.

b. Hold Member Harmless

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

c. Liability

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

d. Non-discrimination Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to Provider Records

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

- i. The United States Department of Health and Human Services or its designee;
- ii. The Comptroller General of the United States or its designee;
- iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid Managed Care program personnel, or its designee
- iv. The Office of Inspector General
- v. North Carolina Department of Justice Medicaid Investigations Division
- vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
- vii. The North Carolina Office of State Auditor, or its designee
- viii. A state or federal law enforcement agency.
- ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

2. The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the BH I/DD Tailored Plan and/or NC Department of Health and Human Services.
 3. Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.
- g. G.S. 58-3-225, Prompt claim payments under health benefit plans.
1. Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, BH I/DD Tailored Plan shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:
 2. The [Provider] shall submit all claims to the [BH I/DD Tailored Plan] for processing and payments within three-hundred-sixty-five (365) Calendar Days from the date of covered service and, in the case of health care provider facility claims, within three-hundred-sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. When a Member is retroactively enrolled, [the BH I/DD Tailored Plan] shall not limit the time in which claims may be submitted by the [Provider] to fewer than three hundred sixty-five (365) Calendar Days from the date of enrollment for health care provider, health care provider facility, or pharmacy point of sale claims. However, the [Provider's] failure to submit a claim within this timeframe will not invalidate or reduce any claim if it was not reasonably possible for the [Provider] to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.
 - i. For Medical claims (including behavioral health):
 1. The [BH I/DD Tailored Plan] shall within eighteen (18) Calendar Days of receiving a Medical Claim notify the [Provider] whether the claim is clean or pend the claim and request from the [Provider] all additional information needed to process the claim. The [BH I/DD Tailored Plan] shall have the capability to request additional information via 277 Health Care Claim Request for Additional Information EDI transaction, via electronic means (including through a portal or email), and via mail. The [BH I/DD Tailored Plan] shall implement the capability for EDI 277 and electronic method (portal or email) no later than BH I/DD Tailored Plan Launch if approved by the Department. If an extension is needed, the [BH I/DD Tailored Plan] may submit a request to the Department's Contract Administrator including the proposed implementation timeline and an explanation of how provider abrasion will be minimized during the extended implementation period.
 2. The [BH I/DD Tailored Plan] shall pay or deny a clean medical claim within thirty (30) Calendar Days of receipt of the clean claim.
 3. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
 - ii. For Pharmacy Claims:
 1. The [BH I/DD Tailored Plan] shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
 2. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.

- iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the [BH I/DD Tailored Plan] shall deny the claim per § 58-3-225 (d).
 - iv. The [BH I/DD Tailored Plan] shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).
 - v. If the [BH I/DD Tailored Plan] fails to pay a clean claim in full pursuant to this provision, the [BH I/DD Tailored Plan] shall pay the [Provider] interest. Late Payments will bear interest on the portion of the claim payment that is late at the annual rate of eighteen (18) percent beginning on the first day following the date that the claim should have been paid or was underpaid.
 - vi. . The BH I/DD Tailored Plan shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. 58-3-225(k).
 - vii. The [BH I/DD Tailored Plan] shall pay the interest from subsections (v) and (vi) as provided in that subsection and shall not require the [Provider] to requests the interest or the liquidated damages.
 - viii. For purposes of claims payment, the [BH I/DD Tailored Plan] shall be deemed to have paid the claim as of the Date of Payment, and the [BH I/DD Tailored Plan] shall be deemed to have denied the claim as of the date the remittance advice is sent to the [Provider]. The [BH I/DD Tailored Plan] defines Date of Payment as either the date of Electronic Funds Transfer (EFT) to the [Provider] or the date a paper check is mailed to the [Provider].
- h. Contract Effective Date.
- 1. The contract shall at a minimum include the following in relation to the effective date of the contract.
 - 2. The effective date of any [Provider] added under this [Agreement] shall be the later of the effective date of this [AGREEMENT] or the date by which the [Provider's] enrollment as a Medicaid enrolled provider is effective within NC Tracks or successor NC Medicaid provider enrollment system(s).
- i. Tobacco-free Policy.
- 1. Providers who may Elect to Implement a Tobacco-Free Policy
Contracts with retail pharmacies, properties where no direct clinical services are provided, non-emergency medical transport, alternative family living settings, or manufacturing sites that employ adults who receive group day services, are not required to develop or maintain a tobacco-free policy. However, nothing herein shall prohibit these categories of providers from implementing a partial or full tobacco-free policy
 - 2. Reserved.
 - 3. Providers subject to Partial Tobacco-Free Policy
Starting January 1, 2027, Contracts with facilities that are owned or controlled by the provider and which provide ICF-IID services or IDD residential services that are subject to the Home and Community Based Services (HCBS) final rule shall at a minimum include the following in relation to the implementation of a tobacco-free policy. In these settings, the following policies shall be required:
[Provider] shall develop and implement a tobacco-free policy that includes at a minimum the following requirements:
 - (1) *Use of tobacco products is prohibited indoors when the building or home in which the [Provider] operates is under the Provider's control as owner or lessee.*
 - (2) *For Outdoor areas of the property under, [PROVIDER's] control as owner or lessee shall:*
 - i. *Ensure access to common outdoor space(s) free from exposure to tobacco use; and*
 - ii. *Prohibit staff/employees from using tobacco products anywhere on property.*

4. Contracts with Intermediate care facilities for adults with intellectual disabilities (ICF-IID) and adult I/DD residential services that are subject to the Home and Community Based Services (HCBS) final rule; adult care homes; family care homes; residential hospices; skilled nursing facilities; and long term nursing facilities that are subject to the partial tobacco-free policy requirement shall retain the option to implement a one hundred percent (100%) tobacco-free campus policy for the safety of clients and staff.
5. Providers subject to Full Tobacco-Free Policy
Starting January 1, 2027, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.
[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 products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on [Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.
- j. Contracts between the BH I/DD Tailored Plan and Providers must include the following definitions:
 1. “Amendment” – Any change to the terms of a contract, including terms incorporated by reference, that modifies the fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order or by the BH I/DD Tailored Plan Contract is not an amendment.
 2. Contract” – A written agreement between an insurer and a Medicaid-enrolled provider for the provision of health care services by the provider on an in-network basis.
 3. “Health care provider” – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-funded Services

The BH I/DD Tailored Plan shall develop and implement contracts with providers to meet the requirements of the Contract. The BH I/DD Tailored Plan’s provider contracts shall, at a minimum, comply with the terms of the Contract, state law, and include required standard contracts clauses.

1. **Contracts between the BH I/DD Tailored Plan and Providers, must, at a minimum, include provisions addressing the following:**
 - a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices that constitute the entire contract between the parties.
 - b. Definitions: The contract must define technical State-funded Services terms used in the contract, and if those definitions are referenced in other documents distributed to providers and recipients, ensure that definitions are consistent.
 - i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section III.A.* of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.

- c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the state includes an extension option.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a network contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division.
- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 - 1. Transition of administrative duties and records; and
 - 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's network participation requirements as outlined in the State's Credentialing and Re-credentialing Policy and to notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
 - i. The provider's obligations to be an enrolled State-funded Services provider, and the grounds for termination if the provider does not maintain enrollment.
 - ii. The provider's obligations to complete reenrollment/re-credentialing before contract renewal and in accordance with the following:
 - 1. During the provider credentialing transition period, no less frequently than every five (5) years.
 - 2. During provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the Department.
- g. Liability Insurance: The contract must address the provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the BH I/DD Tailored Plan, and at the provider's sole cost and to notify the BH I/DD Tailored Plan of subsequent changes in status of professional liability insurance on a timely basis.
- h. Recipient Billing: The contract must address the following that the provider shall not bill any State-funded Services recipient for covered services. This provision shall not prohibit a provider and recipient from agreeing to continue non-covered services at the recipient's own expense, as long as the provider has notified the recipient in advance that the BH I/DD Tailored Plan may not cover or continue to cover specific services and the recipient requests to receive the service.
- i. Provider Accessibility: The contract must address Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the BH I/DD Tailored Plan's standards for provider accessibility. The contract must address how the provider will:
 - i. Offer hours of operation that are no less than the hours of operation offered to commercial enrollees;
 - ii. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, including holidays, when medically necessary; and

- iii. Have a “no-reject policy” for referrals within capacity and parameters of their competencies. Providers shall agree to accept all referrals meeting criteria for services they provide when there is available capacity. A Provider’s competency to meet individual referral needs will be negotiated between the BH I/DD Tailored Plan and the Provider.
- j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility before rendering health care services and reporting of eligibility information to the BH I/DD Tailored Plan.
- k. Medical Records: The contract must require that providers:
 - i. Maintain confidentiality of recipient medical records and personal information and other health records as required by law;
 - ii. Maintain adequate medical and other health records according to industry and BH I/DD Tailored Plan standards; and
 - iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.
- l. Recipient Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the recipient in regard to recipient appeals and grievance procedures.
- m. Provider Network: The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
- n. Provider Network: The contract must include a provider network provision that ensures that LGBTQ recipients who obtain covered services are not subject to treatment or bias that does not affirm their orientation.
- o. Provider Payment: The Contract must include a provider payment provision that describes the methodology to be used as a basis for payment to the provider. However, the agreement shall not include a rate methodology that provides for an automatic increase in rates. This provision shall be consistent with the Reimbursement Policy required under G.S. 58-3-227(a)(5). Provider must be able to send 837 HIPAA compliant transactions and to receive 835 Remittances or to participate in BH I/DD Tailored Plan’s web-based billing process.
- p. Data to the Provider: The contract must address the BH I/DD Tailored Plan’s obligations to provide data and information to the provider, such as:
 - i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - ii. Information on benefit exclusions; administrative and UM requirements; credential verification programs; quality assessment programs; and provider sanction policies.
 - iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.
- q. Utilization Management: The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- r. Quality Management: The contract must address the provider’s participation in the compliance process and the Network Continuous Quality Improvement process.
- s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.

- t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Complaint and Appeals as found in *Section V.C.4.e. Provider Grievances and Appeals*.
- u. Assignment: Provisions on assignment of the contract must include that:
 - i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
 - ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
- v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
- w. Interpreting and Translation Services: The contract must have provisions that indicate:
 - i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
 - ii. The provider must ensure the provider's staff is trained to appropriately communicate with recipients with various types of hearing loss.
 - iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- x. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- y. Chapter 58 requirements: The contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- z. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. The BH I/DD Tailored Plan shall include in Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. If a Provider is not complying with applicable critical incident and/or death reporting requirements or the BH I/DD Tailored Plan identifies trends in incident reporting, the BH I/DD Tailored Plan shall utilize remedial measures available under the contract with the Provider, including but not limited to provider monitoring and corrective actions, to remedy the noncompliance and to minimize occurrence of preventable incidents.
- aa. Providers Subject to Other Payment Directives: For all contracts with providers subject to specific payment provisions as found in *Section V.C.4.iv. Provider Payments*, a provision that indicates the terms and conditions of each applicable payment methodology/requirement.
- bb. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.

- cc. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.
- dd. Physician Advisor Use in Claims Dispute: The contract must indicate that the BH I/DD Tailored Plan shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.
- ee. Facility Based Crisis (FBC) Providers: For all contracts with a facility-based crisis or Behavioral Health Urgent Care (BHUC) Provider, the contract must include provisions requiring the provider to:
 - i. Enroll and participate in the Department's bed registry system.
 - ii. Participate in local Crisis Community Collaboratives to facilitate crisis service access, coordinate with local stakeholders to develop regional community crisis plans, and address local crisis service barriers.
 - iii. Educate the community and other local providers about their crisis services.
 - iv. Accept individuals with mental health, substance use disorder, I/DD and or TBI, regardless of payor status or county of residence.
 - v. Submit information the BH I/DD Tailored Plan needs to complete the Crisis Facility Utilization Report and Crisis Service Funding Report as defined in *Section VII. Seventh Revised and Restated Attachment J: Reporting Requirements*.

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

- a. Compliance with state laws
The [Provider] understands and agrees that it is subject to all state laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's State-funded Services contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state funds. The [Provider] understands and agrees that any violation by a provider of a state law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under Federal or state law.
- b. Hold Recipient Harmless
The [Provider] agrees to hold the recipient harmless for charges for any covered service. The [Provider] agrees not to bill a recipient for medically necessary services covered by the Company so long as the recipient is eligible for coverage.
- c. Liability
The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors.

Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].

d. Non-discrimination: Equitable Treatment of Recipients:

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

e. Access to provider records

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

- i. NC DHHS, its State-funded Services personnel, or its designee;
- ii. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
- iii. The North Carolina Office of State Auditor, or its designee;
- iv. A state law enforcement agency; and
- v. Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

g. Provider ownership disclosure

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

Seventh Revised and Restated Attachment J. Reporting Requirements

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

In addition, the BH I/DD Tailored Plan shall submit select reports that apply to only Medicaid, as identified in *Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid*, *Seventh Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid*, and *Seventh 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 *Seventh Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements State-funded Services*.

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

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Administration & Management		
1. Operating Report	Annual report of each entity identified under the BH I/DD Tailored Plan Operating Report, providing evidence of BH I/DD Tailored Plan oversight activities and entity performance (i.e. metrics, CAPs, sanctions).	Annually
B. Members and Recipients		
1. Member and Recipient Services Quality Assurance Report	Quarterly report of survey results which measures member and recipient ability to access needed services, ease of use of telephone, webinar services, convenience, help function effectiveness and recommendations for engagement/education approach adjustments based on survey results.	Quarterly
2. Member and Recipient Marketing and Educational Activities Report	Quarterly summary of member and recipient marketing and educational activities, including number/type of events hosted, event locations and number of members and recipients reached.	Quarterly
3. Member and Recipient Appeals and Grievances Report	Quarterly report on the appeals and grievances received and processed by the BH I/DD Tailored Plan including the total number of appeal and grievance requests filed with the BH I/DD Tailored Plan, the basis for each appeal or grievance, the status of pending requests, and the disposition of any requests that have been resolved.	Quarterly
4. Monthly CWCN	Monthly report containing the names and Medicaid ID numbers, and all data fields as outlined in the approved DHHS CWCN data template of members identified as CWCN per the BH I/DD Tailored Plan's Region.	Monthly
5. Reserved.		
6. Enrollment Summary Report	Monthly summary report highlighting key member and recipient enrollment activities, consistent with 42 C.F.R. § 438.66(c)(1) - (2) and including number and rate of enrollment and disenrollment by Medicaid or NC Health Choice eligibility category, number of welcome packets and ID cards sent, and time to distribute welcome packets and ID cards.	Monthly
7. Innovations / TBI Waiver Slot and Waiting List Report	Monthly report on the status of the use of waiver slots and reserved capacity, and list of members on the Registry of Unmet Need (waiting list).	Monthly

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)

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

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)

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

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
11. CIE Data Collection Tool	Report generated by completion of the CIE Data Collection Tool provided by the Department, regarding individuals receiving Adult Developmental Vocational Program (ADVP) services or any In-Lieu of Services (ILOS) inclusive of activities that promote engagement in competitive integrated employment (CIE) or in meaningful day activities supporting competitive integrated employment. This report includes without limitation and as applicable the following information regarding the individuals: involvement in post-secondary education, employment assessments, career planning, Supported Employment, Informed Choice Decision Making, engagement in CIE, and the Member's hire date. For members engaged in CIE, the following data is also included: wages earned, and average hours worked per week.	Quarterly
12. TBI Screening Report	Quarterly report on call center screenings that identify recipients with potential TBI and their access to mental health, SUD, I/DD, or other services.	Quarterly
13. Crisis Facility Utilization Report	Report of encounter and demographic information for individuals who are utilizing services at FBCs and BHUCs.	Monthly
14. Crisis Service Funding Report	Report on funding and expenditures for BHUC and FBC crisis services performed in a BH I/DD Tailored Plan catchment area.	Annually
C. Community Inclusion		
1. Daily Reporting on Community Integration Services and Supports	Daily report of information on community integration services (e.g., housing, in-reach and transition, diversion, Assertive Community Treatment (ACT), CST, supported employment, and other services) for members SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Transition to Community Living Database (TCLD), or other systems determined by the State.	Daily
2. Daily Reporting on Supportive Housing Rental Subsidies and Leases	Daily reporting of rental subsidy information for, including but not limited to, individuals with SMI residing in or at-risk of entry into State psychiatric hospitals or adult care homes, using the Community Living Integration and Verification (CLIVE) system.	Daily

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)

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

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
Appointment Wait Times Report		
5. Timely Access Behavioral Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for behavioral health within specified timeframes by category. Submit with Timely Access Behavioral Health Provider Appointment Wait Times Report.	Annually
6. Provider Grievances and Appeals Report	Monthly report of all provider appeals and grievances and provider grievance and appeal statistics, including number/type of appeals, appeal outcomes, and average time to resolution. 42 C.F.R. § 438.66(c)(3).	Monthly
7. Behavioral Health Services Providers Report	Data template to report contracted provider network for Behavioral Health Services. The frequency of this report is monthly until Go-Live and then quarterly thereafter.	Monthly until Tailored Plan launch; Quarterly thereafter
8. Reserved.		
9. NEMT Provider Contracting Report	Non emergency provider contracting report at a detailed and summary level from the BH I/DD Tailored Plans.	Third Friday of Each Month
<i>E. Quality and Value</i>		
1. Reserved.		
2. PIP Progress Report	Quarterly PIP update on activities outlined in the PIP.	Quarterly
<i>F. Stakeholder Engagement</i>		
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
<i>G. Program Administration</i>		
1. Service Line Report**	Monthly service line utilization and statistics compared to SLAs, including wait time and abandonment rate by Service Line.	Monthly
2. Service Line Issue Summary Report**	This quarterly report will identify the reasons for calls received by all service lines and the dispositions of those calls. This report applies to all calls received.	Quarterly
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
5. BH SFS Waitlist / Rate of Institutionalization Report	Quarterly report capturing metrics of individuals being placed on waitlists, including type of services requested, reason for removal from waitlist, and dates of requesting and receiving services.	Quarterly
6. Reserved.		
H. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the BH I/DD Tailored Plan, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by members and recipients, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries Report	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment	Quarterly

Section VII. Seventh Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
	<p>amount(s). Instructions are included on how to respond to the REOMB.</p> <p>The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.</p>	

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

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Members		
1. Reserved.		
2. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
3. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)

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

¹ Ad-Hoc deliverable, including all data elements and format, will be requested no less than ten (10) Calendar Days in advance or mutually agreed upon timeframe.

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
10. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
11. Reserved.		
12. Reserved.		
13. UM and Clinical Coverage Report	The BH I/DD Tailored Plan shall provide analysis of their compliance with attestation upon request	Ad-Hoc ²
14. Ongoing Transitions of Care Status Report	Monthly reporting identifying and reconciling data for members who are transitioning to and from the BH I/DD Tailored Plan on an ongoing basis.	Monthly
15. Reserved.		
16. Reserved.		
17. Innovations Waiver Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrated compliance with 1915(c) waiver assurances.	Quarterly
18. TBI Performance Measures Report	Quarterly/semi-annual/annual Performance Measures are required to demonstrate compliance with 1915(c) waiver assurances.	Quarterly
19. 1915(i) Performance Measures Report	This report is to demonstrate ongoing compliance with annual/semi-annual/quarterly 1915(i) state plan performance measures.	Quarterly
20. 1915 Service Authorization Report	Authorized and billed 1915(i), 1915(c), 1915(b)(3) services for community living supports, community networking, supported employment, and supported living.	Quarterly
21. 1915(i) Transition Report	This report tracks the status of individuals transitioning to 1915(i) including assessment completion, assessment submission, and transition to 1915(i) services.	Monthly
22. EVV Key Metrics Report	Reporting of EVV program data/information	Monthly
23. NC Select Drug Report	Report on Members requesting drugs on the NC Select Drug List, the status of PA requests, status of paid claims, time to complete PA reviews, and single case provider agreements.	Quarterly
C. Care Management		
1. CMHRP Corrective Action Plan Report	Quarterly Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.	Quarterly

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

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
2. Care Needs Screening Report	Quarterly report of member screening results, including Healthy Opportunity & Care Needs Screening of members who have opted out of Tailored Care Management or who are ineligible for Tailored Care Management due to receipt of a duplicative service.	Quarterly
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. Reserved.		
5. TCM Provider Contracting and Integration Report	Monthly TCM Provider contracting and integration status report.	Monthly
6. Nursing Facility Transitions Report	Quarterly report listing BH I/DD Tailored Plan members discharged from a nursing facility and to where they were discharged.	Quarterly
7. Reserved.		
8. Reserved.		
9. Data Elements for Enhanced Validation (DEEV) Report	Monthly report. BH I/DD Tailored Plans will leverage the template to support post-production monitoring for Tailored Care Management (TCM).	Monthly
10. PCP Operational Monitoring Report	Monthly report of PCP assignment, changes, and panel limits.	Monthly
D. Reserved.		
1. Reserved		
E. Providers		
1. Reserved.		
2. Reserved.		
3. Timely Access Physical Health Provider Appointment Wait Times Report	Annual report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category.	Annually
4. Timely Access Physical Health Provider Appointment Wait Times Narrative Report	Annual narrative report demonstrating percentage of providers offering appointment wait times for physical health within specified timeframes by category. Submit with Timely Access Physical Health Provider Appointment Wait Times Report.	Annually
5. Reserved.		
6. Reserved.		
7. Reserved.		

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
8. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
9. Reserved.		
10. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. BH I/DD Tailored Plans will include records of members where no payment was received from the State or payment received differed from the amount expected. BH I/DD Tailored Plans will only include member records with discrepancies on this report to the State. The BH I/DD Tailored Plan Capitation Reconciliation Report will be submitted on a monthly cadence. BH I/DD Tailored Plans will indicate expected values and values observed on ASC x12 834 monthly file for members.	Monthly
11. Reserved.		
12. Reserved .		
F. Quality and Value		
1. Annual Quality Measures Report	Annual BH I/DD Tailored Plan performance on quality measures.	Annually
G. Stakeholder Engagement		
1. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served,	Annually
H. Financial Requirements		
1. Financial Reporting Template	Financial Reporting Template is an excel template with 30+ pages. Portions of it are due annually while others are submitted monthly. It includes income statements, profitability disclosures, Medical Loss Ratio calculations and a few others. Audited Financial Statements submitted as part of this reporting packet must comply with 42 CFR 438.3(m).	Monthly
2. Reserved.		
3. Reserved.		
4. Claims Monitoring Report	This report provides a summary of the claims that have been received and processed by the BH I/DD Tailored Plan during the reporting period based on the Statuses and Claim Types defined within the report template.	Monthly

Section VII. Seventh Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
5. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the BH I/DD Tailored Plan template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
6. Emergency Department (ED) and DSS Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department, DSS Office, hotel or similar temporary setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the ED over thirty (30) consecutive hours or within one (1) Business Day of notification of DSS boarding, document escalation to appropriate parties including but not limited to BH I/DD Tailored Plan Clinical Director or designee.	Weekly
7. Service Associated Request Report	Tailored Plan decision regarding the service requested on the Request to Move: Provider Form.	Monthly
8. TPL Recovery Match Report	Report detailing those claims upon which the BH I/DD Tailored Plan has been unable to effectuate third party liability (TPL) recovery within one (1) year of the date of service.	Monthly
9. Payer Initiated Claim Adjustment Report	Ad hoc report required in the event the State deems necessary or a provider escalates grievance related to BH I/DD Tailored Plan claim adjustment processing. The BH I/DD Tailored Plan must complete required information within the report for the Department to validate appropriate claim adjustment was complete.	Ad hoc

Section VII. Sixth Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Members		
1. Clearinghouse Daily Uploads Extract	Daily extract of each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan to a member. In accordance with the Notice of Adverse Benefit Determination Clearinghouse Upload Instruction Policy.	Daily
B. Benefits and Care Management		
1. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly

2. Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual member, service type, determination date, and approval status.	Weekly
3. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly
4. Reserved.		

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

Section VII. Seventh Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services (Effective May 1, 2026)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
A. Eligibility		
1. Reserved.		
B. Care Management and Prevention		
1. TBI Services Quarterly Expenditures Report*	Quarterly report on administration of State-funded TBI programming expenditures and associated services.	Quarterly
2. Reserved.		
3. Substance Abuse/Juvenile Justice Initiative Quarterly Report*	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
4. Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a	Quarterly

Section VII. Seventh Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
	Qualified Professional in Substance Abuse (QPSA).	
5. TBI Annual Report	The annual report consists of a combination of both quantitative and qualitative information, which provides a more holistic understanding of service usage, trends and network adequacy for the TBI population within North Carolina’s publicly funded service system.	Annually
6. Department of Adult Corrections (DAC) Priority Re-Entry Outcomes	BH I/DD Tailored Plan shall provide the Department with a report detailing DAC Priority Re-entry to include outcomes data for the DAC Priority Reentry individuals.	Monthly
C. Quality and Value		
1. Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems	Quarterly

Section VII. Seventh Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services (Effective May 1, 2026)

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
	caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.	
D. Financial Requirements		
1. Financial Status Report	Monthly report containing expenditure categories, allocation letter number, current period expenditures, approved budget, previously reported expenditures, YTD expenditures, and un-expended balance. This report will contain Federal Non-UCR and State Special Categorical expenditures. The Department may request additional submissions of information pertaining to use of these funds on an ad hoc basis.	Monthly
2. Reserved.		
3. Substance Use Prevention Treatment, and Recovery Services Block Grant (SUPTRS) Narrative Compliance Report	Bi-annual narrative report on compliance with target and outcome prevention activities, as well as practices and measures for priority populations, as detailed in 45 C.F.R. Part 96.	Bi-Annual
4. Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR expenditures. This report will contain a certification portion attesting that all information included is accurate.	Monthly

* State-Funded Services-only report should include information related to all SFS recipients, including those who are enrolled in the Tailored Plan program, Medicaid Direct PIHP program, or a SFS program alone.

** Report should include data that represents the activities of both the BH/IDD Tailored Plan contract and the Medicaid Direct PIHP Contract.

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

Section VII. Sixth Revised and Restated Attachment J. Table 8: TCL Reporting Requirements (Effective July 1, 2025)		
BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due last day of the month for the prior month, or the first Business Day following the last day of the month if the last day falls on a weekend or holiday.
2. TCL Annual Service Capacity Report	Capacity analysis for ACT, CST, TMS, Crisis Services and IPS. Includes identification of barriers and projects/steps implemented to remove barriers	Annually Fiscal Year 2025

**Section VII. Sixth Revised and Restated Attachment J. Table 8: TCL Reporting Requirements
(Effective July 1, 2025)**

BH I/DD Tailored Plan Report Name	BH I/DD Tailored Plan Report Description	Frequency
3. TCL Housing Performance Plan Measures Reporting Template	Report tracking TCL Housing Performance Plan Measures. This report indicates measures for each PHIP per quarter based on their reported Tier 1, Tier 2 Expectations, results provided by the BH I/DD Tailored Plan and the Department's verified results.	Quarterly
4. TCL IPS Population and Utilization Report	Report on IPS TCL population and utilization of the service, includes updates on IPS cohorts (as part of ACT and standalone IPS)	Quarterly
5. TCL IPS Strategic Plan Progress Report	Report on TCL Strategic Plan progress, includes data required as part of the Department approved IPS Strategic Plan (as part of ACT and standalone IPS)	Quarterly
6. TCL ACT and IPS Report	Monthly report to monitor the total number of individuals receiving ACT, In-reach, and transition supports; the number of individuals receiving IPS services, including those served by fidelity teams, and the total that are in the priority population; information on the individuals receiving fidelity IPS services, including In/At-Risk checklist and identification of new IPS or ACT teams	Monthly

Attachment M. POLICIES

Fourth Revised and Restated Attachment M. 1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy

a. Background

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

b. Scope

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

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

- a. In accordance with Section 4.(5). of Session Law 2015-245, as amended,¹ the Department will conduct regular data reviews to identify beneficiaries who meet one or more of the following criteria for enrollment in a BH I/DD Tailored Plan:
 - b. Beneficiaries being served by the Innovations waiver;²
 - c. Beneficiaries being served by the TBI waiver;³
 - d. Beneficiaries being served by Transitions to Community Living (TCL);
 - e. Beneficiaries on the waiting list for the Innovations waiver;
 - f. Beneficiaries on the waiting list for the TBI waiver;
 - g. Beneficiaries who have used a Medicaid service that will only be available through a BH I/DD Tailored Plan as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
 - h. Beneficiaries who have used a BH, I/DD, or TBI service funded with state, local, federal or other non-Medicaid funds as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations*;
 - i. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina;

¹ Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

² All Medicaid beneficiaries who are enrolled in the Innovations waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.

³ All Medicaid beneficiaries who are enrolled in the TBI waiver, regardless of excluded or delayed status (e.g., dual eligible, HIPP or medically needy), must enroll in a BH I/DD Tailored Plan to receive waiver services.

- 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*;
- k. Beneficiaries who have a qualifying mental health diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;^{4,5}
- l. Beneficiaries who have a qualifying SUD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations* who used a Medicaid-covered enhanced BH service during the lookback period;⁶
- m. Beneficiaries who have had two (2) or more psychiatric hospitalizations or readmissions within eighteen (18) months;
- n. Beneficiaries who have had an admission to a State psychiatric hospital or alcohol and drug abuse treatment center (ADATC), including, but not limited to, individuals who have had one or more involuntary treatment episode(s) in a State-owned facility;
- o. Beneficiaries who have had two (2) or more visits to the emergency department for a psychiatric problem within eighteen (18) months; and
- p. Beneficiaries who have had two (2) or more episodes using BH crisis services within eighteen (18) months.
- q. The Department will employ the processes described below to identify existing Medicaid beneficiaries as eligible for a BH I/DD Tailored Plan.
- r. In the period prior to Standard Plan launch:
 - i. The Department will conduct data reviews to identify beneficiaries meeting BH I/DD Tailored Plan data-based eligibility criteria using dates of service to be determined by the Department.
 - ii. Beneficiaries identified by the Department as meeting the BH I/DD Tailored Plan eligibility criteria based on available data or through the request to enroll in a BH I/DD Tailored Plan process will remain in their delivery system at Standard Plan launch.
- s. In the period between Standard Plan and BH I/DD Tailored Plan launch:
 - i. The Department will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet BH I/DD Tailored Plan data-based eligibility criteria.
 - ii. The Department will send beneficiaries identified as BH I/DD Tailored Plan eligible a notice informing them of their BH I/DD Tailored Plan eligibility and auto-enroll them in NC Medicaid Direct/the LME/MCO in their Region.

⁴ The list of Medicaid-covered enhanced BH services can be found in NC Medicaid Clinical Coverage Policy 8-A.

⁵ Beneficiaries who meet the following criteria for SMI or SED are determined BH I/DD Tailored Plan eligible: (1) beneficiaries under 18 years of age with a claim or encounter with a date of service since the lookback period that includes a schizophrenia or schizoaffective disorder, regardless of service utilization; (2) beneficiaries with a claim/encounter demonstrating use of electroconvulsive therapy since January 1, 2018, regardless of diagnosis; and (3) beneficiaries who have used clozapine or long acting injectable anti-psychotics since January 1, 2018, regardless of diagnosis.

⁶ The list of Medicaid-covered enhanced BH services can be found in NC Medicaid Clinical Coverage Policy 8-A.

- t. Beneficiaries who are not identified and auto-enrolled through the Department's data review will have the option to request to enroll in NC Medicaid Direct/LME/MCO by submitting a request for to the Department for review.
- u. Prior to BH I/DD Tailored Plan launch, the Department will reassess BH I/DD Tailored Plan eligibility for beneficiaries who were previously identified as meeting the BH I/DD Tailored Plan eligibility criteria who receive Medicaid services through NC Medicaid Direct/LME/MCOs based on a more recent lookback period.
- v. Beneficiaries who no longer meet the BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in Standard Plans at BH I/DD Tailored Plan launch unless they are excluded from Standard Plan enrollment, in which case, they will be auto-enrolled in NC Medicaid Direct.
- w. The Department will send beneficiaries who continue to meet the BH I/DD Tailored Plan eligibility criteria based on data reviews or the request to enroll in a BH I/DD Tailored Plan process at the point of the reassessment a notice indicating that they will be enrolled in a BH I/DD Tailored Plan and can elect to enroll in a Standard Plan at any point during the coverage year unless they are excluded from Standard Plans, in which case they can enroll in NC Medicaid Direct at any point during the coverage year.
- x. The Department will transmit BH I/DD Tailored Plan assignment to the BH I/DD Tailored Plan through an 834 eligibility file.
- y. If a beneficiary selects a Standard Plan prior to the scheduled transition date to BH I/DD Tailored Plans, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit Standard Plan selection to the Standard Plan through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary chooses to enroll in a Standard Plan, the beneficiary will not have access to services only covered by BH I/DD Tailored Plans (unless the beneficiary is under age 21 and the service is covered through EPSDT).
- z. If the beneficiary is excluded from Standard Plan enrollment and elects to enroll in NC Medicaid Direct prior to the scheduled transition to BH I/DD Tailored Plans, the Enrollment Broker will transmit the NC Medicaid Direct selection to the Department through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary who is excluded from Standard Plan enrollment chooses to enroll in NC Medicaid, the beneficiary will not have access to non-State Plan services only covered by BH I/DD Tailored Plans (e.g., waiver services, in lieu of services, and value-added services).
- aa. For a beneficiary who is eligible for a BH I/DD Tailored Plan and is either auto-enrolled to a BH I/DD Tailored Plan or selects a Standard Plan, coverage by the BH I/DD Tailored Plan or Standard Plan begins on the first day of BH I/DD Tailored Plan launch.
- bb. Period after BH I/DD Tailored Plan implementation (ongoing enrollment)
- cc. Standard Plan members
 - i. The Department will regularly review encounter, claims and other relevant and available data to identify Standard Plan members who newly meet BH I/DD Tailored Plan data-based eligibility criteria.
 - ii. The Department will send a notice to Standard Plan members identified as eligible for a BH I/DD Tailored Plan.
 - iii. Beneficiaries enrolled in a Standard Plan who are identified by the Department's data review as meeting BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in a BH I/DD Tailored Plan the

first of the month following identification, unless the member calls prior to the end of the month to request to continue enrollment in the Standard Plan. Beneficiaries who are auto-enrolled in the BH I/DD Tailored Plan will have the option to re-enroll in a Standard Plan.

- iv. Beneficiaries who are not identified through the Department's data review will have the option to request a review for BH I/DD Tailored Plan enrollment as described below. In cases where the Department approves a beneficiary's request, the beneficiary will be enrolled in a BH I/DD Tailored Plan on the first day of the following month.

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

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

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

- a. The Department will allow a beneficiary who is enrolled in a Standard Plan, the Children and Families Specialty 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 Move to a BH I/DD Tailored Plan: Beneficiary Form
 - ii. Request to Move to a BH I/DD Tailored Plan: Provider Form
 - iii. Reserved.

- d. In cases where a beneficiary uses the Request to Move to BH I/DD Tailored Plan: Beneficiary Form, the beneficiary (or guardian/legally responsible person) submits a form that indicates whether the beneficiary meets at least one of the eligibility criteria for a BH I/DD Tailored Plan as outlined in Section 4.(5) of Session Law 2015-245, as amended.⁷

- e. The beneficiary's care manager may assist the beneficiary to complete the form. If the care manager assists the beneficiary to complete the form, the care manager must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.

- f. The beneficiary must provide either documentation of their needs or contact information for their provider with permission for the Enrollment Broker to contact the provider.

⁷ Section 4.(5) of Session Law 2015-245, as amended by Session Law 2018-48.

- g. The beneficiary (or authorized representative⁸) must sign the form providing permission for the Enrollment Broker 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 Move to BH I/DD Tailored Plan: Provider Form
 - i. In cases where a beneficiary uses the Request to Move to 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.
 - ii. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
 - iii. The beneficiary (or authorized representative) must also sign the form providing permission for the Enrollment Broker to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.
 - iv. The beneficiary or authorized representative or provider transmits the completed form.
 - v. The Enrollment Broker will review the request within twenty-four (24) hours of receipt for a services associated request.
 - vi. The Enrollment Broker's Clinical team will review the form for non-associated requests and determine whether the beneficiary is eligible for a BH I/DD Tailored Plan according to the following timeframes:
 - (a) Request to Move to BH I/DD Tailored Plan: Beneficiary Form will be reviewed in eight (8) Calendar Days
 - (b) Request to Move to BH I/DD Tailored Plan: Provider Form will be reviewed in five (5) Calendar Days
- i. The Enrollment Broker will transmit the beneficiary's transfer to a BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the transfer, unless there is a service need as outlined in the next section.
- j. Request for a Beneficiary Enrolled in a Standard Plan or the CFSP Needing a Service Only Available in the BH I/DD Tailored Plans
 - i. Beneficiaries enrolled in Standard Plans or the CFSP 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.
 - ii. The provider must submit the service authorization request and the Request to Move to BH I/DD Tailored Plan: Provider Form to the Department on behalf of the Standard Plan member.
 - iii. The Standard Plan member or legal guardian must sign the Request to Move to 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.
- k. The Enrollment Broker will review and enroll the Standard Plan/ CFSP member in a BH I/DD Tailored Plan effective within one (1) business day retroactive to the date of the request.⁹

⁸ Authorized representative refers to the beneficiary's legal guardian.

⁹ For Standard Plan or CFSP 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.

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-enrolled 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-enrolled 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-enrollment 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 beneficiaries, 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 choice period.
- 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 notified as part of the annual choice period. Beneficiaries who do not meet one of the criteria above and are excluded from Standard Plan enrollment will be enrolled in NC Medicaid Direct.

g. Medicaid Eligibility Redeterminations

- a. At a member's annual Medicaid renewal, if a member is redetermined eligible for Medicaid, continues to be eligible for a BH I/DD Tailored Plan, and has not elected to enroll in a Standard Plan, the Department will auto-enroll 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 Catchment Area.

- b. If the member's eligibility has moved to a county that is part of a different BH I/DD Tailored Plan Catchment Area, the Department will auto-enroll 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. Once a year, during the annual ninety (90) day choice period, the member will be notified of the health plan enrollment choices. They may select a Standard Plan or CFSP if he or she is eligible. If the member selects a Standard Plan or CFSP, if eligible, the Enrollment Broker will transmit the Standard Plan or CFSP, as applicable, selection to the Department. The Department will transmit the Standard Plan/ CFSP selection to the Standard Plan/ CFSP through an 834 eligibility file. Coverage of the member by the Standard Plan/ CFSP will begin on the first day of the next month in which the member selected the Standard Plan/ CFSP.
- 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 Move to BH I/DD Tailored Plan.
- f. If a member is determined to no longer be eligible for Medicaid, the member will be notified and disenrolled from the BH I/DD Tailored Plan by the Department.

h. Special Enrollment Cases

Exempt populations

- a. Exempt populations as defined in Section V.B.1.i.(iii)(a) that are BH I/DD Tailored Plan eligible will be able to enroll in BH I/DD Tailored Plans.
- b. The Enrollment Broker will provide choice counseling to exempt populations and support BH I/DD Tailored Plan, Standard Plan, NC Medicaid Direct, EBCI Tribal Option (as applicable), and PCP selection throughout the beneficiary's eligibility year.
- c. If a beneficiary in an exempt population selects a BH I/DD Tailored Plan, the Enrollment Broker will transmit the BH I/DD Tailored Plan selection to the Department. The Department will transmit BH I/DD Tailored Plan selection to the BH I/DD Tailored Plan through an 834 eligibility file.
- d. If a beneficiary in an exempt population elects to move from a BH I/DD Tailored Plan to a Standard Plan or other delivery system (such as NC Medicaid Direct or EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan or delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan or delivery system.¹⁰
- e. Beneficiaries who are eligible for the EBCI Tribal Option will be permitted to transfer to the EBCI Tribal Option from any delivery system during the annual ninety (90) day choice period and at any point during the year,
- f. Deemed newborns

¹⁰ There may be instances (e.g., an urgent medical need), as determined by the Department and based on the beneficiary's needs, in which enrollment in the new PHP or the new delivery system may become effective sooner, including mid-month.

- i. The Department shall enroll deemed newborns in a Standard Plan or Tribal Option (as eligible) regardless of the mother's enrollment in a BH I/DD Tailored Plan. To enroll in a BH I/DD Tailored Plan the beneficiary must meet Tailored Plan eligibility criteria.

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

- a. Member disenrollment from the BH I/DD Tailored Plan may occur pursuant to specific criteria described in this Policy, which may include complete disenrollment from Medicaid Managed Care or disenrolling from a BH I/DD Tailored Plan to a Standard Plan.
- b. Member requested disenrollment
 - i. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the BH I/DD Tailored Plan to the Enrollment Broker by phone, mail, or electronically.
 - ii. A member who is not excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to a Standard Plan or the EBCI Tribal Option (if applicable) any time during the coverage year.¹¹
 - iii. A member who is excluded from Standard Plan enrollment may request disenrollment from a BH I/DD Tailored Plan and transfer to NC Medicaid Direct any time during the coverage year.
 - iv. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
 - v. At the time of the disenrollment request, choice counseling and informed consent for the member or his or her representative will be required from the Enrollment Broker.
 - vi. The Enrollment Broker will process disenrollment requests in accordance with the following:
 - 1. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver, or Transitions to Community Living Program. The Enrollment Broker will inform the member they must leave the waiver or program to disenroll.
 - 2. The Enrollment Broker will notify the Department of its decision by the next business day following receipt of the request.
- c. Notice of disenrollment determination
 - i. The Department will notify the member or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
 - ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.¹²
- d. Expedited review of member initiated requests for disenrollment
 - i. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the BH I/DD Tailored Plan could

¹¹ Members enrolled in the Innovations or TBI waivers must disenroll from their respective waiver before they can disenroll from a BH I/DD Tailored Plan.

¹² 42 C.F.R. § 438.56(e).

- jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
- ii. The Enrollment Broker will process requests for expedited review in accordance with the following:
 - (a) The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
 - (b) The Department will evaluate and decide whether to approve or deny the request.
 - iii. The Department will notify the member, or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.
- e. Disenrollment required by the Department
1. The Department may disenroll a member from Medicaid Managed Care for any of the following reasons:
 - (a) Loss of eligibility
 1. If the Department determines that a member is no longer eligible for Medicaid, the member will be notified by the Department and the member will be disenrolled from the BH I/DD Tailored Plan. The disenrollment effective date will be the last date of the member's Medicaid eligibility.
 2. If a member is disenrolled from a BH I/DD Tailored Plan solely because the member loses his or her eligibility for Medicaid for a period of two (2) months or less, the member will automatically be reenrolled in the BH I/DD Tailored Plan upon reenrollment in Medicaid.¹³
 - (b) Change in Medicaid eligibility category
 1. If the Department determines that a member is no longer eligible for Medicaid Managed Care because they become part of an excluded or temporarily excluded population as described in *Section V.B.1.i.(iii)(c)* the member will be notified by the Department and the Department will disenroll the member from the BH I/DD Tailored Plan and enroll them in NC Medicaid Direct. The disenrollment effective date will be the date when the member's change in eligibility category was effective.
 - (c) Nursing facility long-term stays
 1. A member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from the BH I/DD Tailored Plan on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.¹⁴
 2. The BH I/DD Tailored Plan shall utilize the Department-developed standardized process for monitoring length of stay for members in nursing facilities to ensure members receive appropriate levels of care and to report to the Department members who need to be disenrolled due to stays that exceed ninety (90) calendar days.
- f. To monitor and report a member's length of stay in a nursing facility the BH I/DD Tailored Plan must use the following process:

¹³ 42 C.F.R. § 438.56(g).

¹⁴ Session Law 2015-245, as amended by Session Law 2018-49.

- i. Within thirty (30) days of admission to a nursing facility, the BH I/DD Tailored Plan will assess a member's health care needs and estimate the potential length of stay. If the member requires a stay for longer than ninety (90) calendar days, the BH I/DD Tailored Plan must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.
 - ii. The BH I/DD Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.
 - iii. The Department will send the BH I/DD Tailored Plan and the member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the member's disenrollment from the BH I/DD Tailored Plan.
 - iv. The BH I/DD Tailored Plan must notify the Department with an attestation of any member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.
- g. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.
- h. **Neuro-Medical Centers and Veterans Homes**
- i. A beneficiary, otherwise eligible for enrollment in the BH I/DD Tailored Plan, residing in a state-owned Neuro-Medical Center or a DMVA-operated Veterans Home when the Department implements the BH I/DD Tailored Plan is excluded and will receive care in these facilities through NC Medicaid Direct.
 - ii. A member determined eligible for and transferred for treatment in a state-owned Neuro-Medical Center or DMVA-operated Veterans Home after implementation of BH I/DD Tailored Plans will be disenrolled from the BH I/DD Tailored Plan by the Department.
 - iii. The Neuro-Medical Center or Veterans Home will submit the member's information, including date of admission, to the Department within fourteen (14) calendar days of admission.
 - iv. The Department will notify the member and the BH I/DD Tailored Plan of the disenrollment and the disenrollment effective date.
 - v. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.
 - vi. In accordance with 42 C.F.R. § 438.56(f), members, or an authorized representative, may appeal disenrollment determinations made by the Enrollment Broker or the Department through an appeals process defined by the Department.
- j. **BH I/DD Tailored Plan and Managed Care Enrollment Policy Changes**
- The Department reserves the right to amend this Policy based on an increase or decrease in covered populations in Medicaid Managed Care, changes in North Carolina or federal law or regulation, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes. The Department shall provide written notice to each BH I/DD Tailored Plan of such change no later than sixty (60) days prior to the effective date of such change, unless shorter notice period is required by a federal or state law or regulatory change, with the Parties executing a Contract Amendment to incorporate such modifications.

Fourth Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients

a. Background

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

b. Behavioral Health Services Definitions

1. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.
2. Adult Facility-Based Crisis Services: a state-funded crisis service for the purpose of network adequacy standards.
3. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.
4. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.
5. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.
6. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.
7. Clinically managed residential withdrawal services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.
8. Medically monitored inpatient withdrawal management services (non-hospital medical detoxification): a crisis service for the purpose of network adequacy standards.
9. Clinically Managed Low-Intensity Residential Treatment Services: a Medicaid service for the purpose of network adequacy standards.
10. Clinically Managed Population Specific High-Intensity Residential Program: a Medicaid service for the purpose of network adequacy standards.
11. Clinically Managed Residential Services: a Medicaid service for the purpose of network adequacy standards.
12. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
13. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
14. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4): inpatient BH services for the purpose of network adequacy standards.

15. Medically managed intensive inpatient withdrawal management services (Acute Care Hospitals with Adult Inpatient Substance Use Beds ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standards.
16. Hospitals with Adult Inpatient Substance Use Beds (ASAM Level 4 and ASAM Level 4WM): inpatient BH services for the purpose of network adequacy standards.
17. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
18. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
19. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
20. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
21. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
22. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
23. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.
24. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, and primarily delivered in-person with the individual and in locations outside the agency's facility for the purposes of the BH appointment wait-time standards.
25. Emergency services for mental health: Services to treat a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention for the purpose of BH appointment wait-time standards.
26. Urgent Care for Mental Health:
 - a) Services to treat a condition in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, shall progress to the need for emergent services/care for appointment wait-time standards.
 - b) Services to treat a condition in which a person has potential to become actively suicidal or homicidal without immediate intervention for the purposes of the BH appointment wait-time standards.
27. Routine Services for Mental Health: Services to treat a person who describes signs and symptoms resulting in clinically significant distress or impaired functioning, which has impacted the person's ability to participate in daily living or markedly decreased person's quality of life for the purposes of the BH appointment wait-time standards.
28. Emergency Services for SUDs: Services to treat a life-threatening condition in which the person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm

to others, and/or is unable to adequately care for self without supervision due to the effects of chronic substance use; includes crisis intervention for the purpose of BH appointment wait-time standards.

29. Urgent care for SUD:

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

30. Routine Services for SUD: Services to treat a person who describes signs and symptoms consequent to substance use resulting in a level of impairment which can likely be diagnosed as a SUD according to the current version of the Diagnostic and Statistical Manual for the purposes of the BH appointment wait-time standards.

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

Fourth/Fifth Revised and Restated Revised and Restated Attachment M. 13. Approved <TP NAME> In Lieu of Services

In Lieu of Services are alternative services or settings that are substituted for services or settings covered under the Medicaid State Plans or otherwise covered by this Contract but have been determined by the Department to be medically appropriate, cost-effective substitutes for the State Plan services included within this Contract.

The BH I/DD Tailored Plan may cover for Members, services or settings that are in lieu of services or settings covered under the State Plans as follows:

1. The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute based on documentation provided to the Department by the BH I/DD Tailored Plan demonstrating such cost effectiveness and clinical effectiveness;
2. The BH I/DD Tailored Plan shall ensure that Members are provided the rights outlined in *Section V.B.2.i.(vii)* In Lieu of Services for all approved In Lieu of Services;
3. The approved In Lieu of Services are authorized and identified in this Contract and will be offered to Members at the option of the BH I/DD Tailored Plan; and
4. The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the capitation rates that represent the covered State Plan services, unless a federal or State statute or regulation explicitly requires otherwise.

In the event In Lieu of Services do not meet cost neutrality, excess expenses will be excluded from the rate development process. In accordance with *Section V.B.2. Benefits*, the following In Lieu of Services have been approved by the Department:

Fourth Revised and Restated Attachment L. 7. Approved Alliance Health In Lieu of Services					
Service Name	Definition of ILOS	Covered Medicaid State plan service or setting for which each ILOS is a substitute	Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.	Specific coding for each ILOS to be used on claims and encounter data	Effective Date
Child Assertive Community Treatment	Child Focused Assertive Community Treatment (Child ACTT) is a team-based multi-disciplinary approach to serve children in their homes, kinship placements, DSS foster homes, or may begin during transition from a more restrictive residential setting.	Psychiatric Residential Treatment Facility (PRTF) Level III Group Home	Eligible population includes youth with a primary mental health diagnosis. High risk for out of home residential treatment due to history of multiple hospitalizations, multiple placements in residential treatment Symptoms at a severity level where PRTF or other intensive residential treatment The duration of service is up to twenty-eight (28) weeks maximum and provided per week.	H0040 U5 HA	07/01/2024
Long Term Community Supports (LTCS)	Long Term Community Supports (LTCS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process, choose to access active treatment to assist them with skills to live as independently as possible in the community.	Individuals with Intellectual Disabilities (ICF)	Eligible population includes individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. Medicaid eligible: Age 22 or older and meet ICF-IID eligibility criteria	T2016 U5 U1- Level 1 T2016 U5 U2 -Level 2 T2016 U5 U3 -Level 3 T2016 U5 U4 -Level 4 T2016 U5 U6 -Level 5	07/01/2024
In Home Therapy Services:	Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or multisystem involvement.	Intensive In-Home Services (IIHS)	Eligible population is for children and adolescents ages 3-20 years of age in need of individual and family therapy services, parenting, and coping skills practice in their environment, as well as some coordination of care due to complex psychosocial situations and/or multisystem involvement. The duration of service is one (1) unit per week, with length of service one hundred eighty (180) days	H2022 HE U5 H2022 TS U5	07/01/2024

<p>Family Centered Treatment (FCT)</p>	<p>Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. Designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities, FCT treats the youth and his/her family through individualized therapeutic interventions.</p>	<p>Residential Level II Family Type (TFC) Psychiatric Residential Treatment Facility (PRTF)</p>	<p>Eligible population involves a step down from a higher level of care, DSS involvement in the last year, Juvenile Justice involvement in the last 6 months, behavioral health Emergency Room visit and/or hospitalization in the last 6 months, multiple school suspensions within the past year, and crisis intervention in the last 6 months.</p> <p>FCT treats the youth and his/her family through individualized therapeutic interventions. Decrease in crisis episodes and inpatient stays. FCT provides an alternative to out-of-home placements or, when it is in the youth's best interest to be placed out of the home, to minimize the length of stay and reduce the risk of readmission.</p> <p>The duration of service is six (6) months</p>	<p>H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4</p>	<p>07/01/2024</p>
<p>Transitional Youth Services (TYS)</p>	<p>The Transitional Youth Services Program is a home and community-based Outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently.</p> <p>The interventions focus on rehabilitating member strengths and skills as well as linking the member to available resources to assist him/her in relearning a sense of accountability for his/her own behavior.</p>	<p>Residential Level II Family Type (TFC) Level III Residential Facility Services</p>	<p>Eligible population is Members who are leaving the foster care or juvenile justice systems, or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood.</p> <p>The duration of service is one unit for 9-12 months length of service.</p>	<p>H2022 U5</p>	<p>07/01/2024</p>
<p>Behavioral Health Crisis Assessment and Intervention (BHCAI)</p>	<p>BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting.</p> <p>Members experiencing a behavioral health crisis meeting Emergent or Urgent Triage Standards. BHCAI-Per Event-Per Diem (2-23 hours). Rapid Response-Per Diem (14 days or less).</p>	<p>Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)</p>	<p>Eligible population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.</p>	<p>T2016 U5 or T2016 U6</p>	<p>07/01/2024</p>

<p>Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)</p>	<p>This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders.</p>	<p>Emergency Depts Inpatient Psychiatric Hospitalization</p>	<p>Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.</p>	<p>RC 0160</p>	<p>07/01/2024</p>
<p>High Fidelity Wraparound</p>	<p>High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated, integrated, family-driven care DocuSign Envelope ID: 1C2730A0-0635-487A-88F6-DC0BC6D74C71 #30-2022-007-DHB-1 Amendment 1 Page 141 of 148 to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW. The HFW process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.</p>	<p>Residential Level II Family Type (TFC) Residential Treatment Services Level II Group Home</p>	<p>Eligible population Children, youth, and young adults with Serious Emotional Disturbance (SED) that have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and substance use problems, Involved in (or history of) multiple child-serving. Systems (e.g., child welfare, juvenile justice). The duration of service is 9-12 months</p>	<p>H0032 - U5</p>	<p>07/01/2024</p>

<p>Short Term Residential Stabilization</p>	<p>Residential Supports provides individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the person's life skills, provide the supervision needed, maximize their self-sufficiency, increase self-determination and ensure the person's opportunity to have full membership in his/her community. Residential Supports includes learning new skills, practice and/or improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source. Residential Supports are provided to individuals who live in a community residential setting that meets the home and community-based characteristics. Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed using the PIHP AFL checklist for health and</p>	<p>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Facility Based Crisis</p>	<p>Eligible population includes individuals in need of and receiving comprehensive and intensive habilitative supports– aggressive, consistent implementation of a program of specialized and generic habilitative training. Medicaid eligible Age 21 or older Meet ICF-IID eligibility criteria and/or the definition of developmental disability.</p> <p>The duration of service is 30 days for initial authorization and for concurrent is every 30 days. Services maximum is 180 days.</p>	<p>T2016 TF U5</p>	<p>07/01/2024</p>
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	<p>safety related issues. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports.</p>				
<p>Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis (Residential Services – Complex Needs)</p>	<p>Residential Services – Complex Needs is a short-term residential treatment service focused on members with primary intellectual disabilities/developmental disabilities (ID/DD) with co-occurring mental health diagnoses or significant behavioral characteristics.</p>	<p>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)</p> <p>Psychiatric Residential Treatment Facility (PRTF)</p>	<p>Eligible population includes Individuals with Complex Needs are the ages of 5 and under 21, with a developmental and/or intellectual disability and a mental health disorder diagnosis who are Medicaid eligible and at risk of not being able to return to or maintain placement in a community with I/DD diagnosis and meet the ICF/IDD level of care consistent with the Innovations Wavier. The individual also has co-occurring MH diagnosis or significant behavioral challenges for which services and supports require significant experience and expertise in dual diagnosis.</p>	<p>H0018 HA</p>	<p>07/01/2024</p>

Fourth Revised and Restated Attachment L. 7. Approved **Partners Health Management** In Lieu of Services

Service Name	Definition of ILOS	Covered Medicaid State plan service or setting for which each ILOS is a substitute	Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.	Specific coding for each ILOS to be used on claims and encounter data	Effective Date
Long Term Community Supports (LTCS)	<p>Long Term Community Supports (LTCS) consist of a broad range of residential and day services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active treatment to assist them with skills to live as independently as possible in the community. LTCS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD). ICF-IID is an all-inclusive service that includes residential and also supports the members' meaningful day activities. Our LTCS service is broken down into 5 levels which delineate the services provided at each level. Each level of our LTCS service supports staffing to create a person-centered meaningful day for the member.</p>	Individuals Community and Residential (ICF-IDD)	Eligible population includes Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; age 22 and over. Available only for individuals in need of and receiving active treatment – aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services.	T2016 U5 U1- Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5	07/01/2024
Rapid Response	<p>Rapid Response Homes are licensed therapeutic foster homes with a North Carolina Licensed Child Placing Agency or licensed alternative family living (AFL) homes that provides emergency treatment, structure, stabilization, and supervision to children and youth who are experiencing a behavioral health crisis and who have Medicaid originating from the designated LME/MCO catchment area. This emergency service is intended to support family stability, prevent abuse and neglect,</p>	Emergency Department- Family Based Crisis (ED/FBC) Psychiatric Residential Treatment Facility (PRTF)	Target population includes members aged 5-20 with Child MH/SU, including individuals with MH/SU and I/DD, not functionally eligible for the NC Innovations Waiver program but are in crisis due to their condition and presenting symptoms. Youth are presenting in crisis, however, do not meet the imminent danger to self or others threshold and can be diverted short term while a sound long term plan is formulated and executed. Crisis is characterized as serious conflict in current environment, adding to emotional dysregulation, requiring removal to allow de-escalation and reevaluation/assessment and further development of the crisis plan as needed.	S9484 U5 (low) S9484 HK U5 (high)	07/01/2024

	provide short term treatment, and prevent or minimize the need for out-of-home placements.				
In Home Therapy Services	In Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions to be provided in the home setting for individuals with complex clinical needs that traditional outpatient cannot adequately address in a time limited fashion. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the needs and prevent future incidents.	Intensive In-Home (IIHS)	Target population includes children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. Duration of Service is 1 unit a week, 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5	07/01/2024
Behavioral Health Urgent Care (BHUC)	Behavioral Health Urgent Care (BHUC) A designated intervention/treatment location, known as a Behavioral Health Urgent Care (BHUC) that is an alternative to any community hospital Emergency Department where consumers with urgent primary behavioral health needs will receive triage and referral.	Emergency Department Visit Inpatient Psychiatric Hospital Admission	Target Population includes members age 4 and older experiencing a behavioral health crisis. Includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards. The duration of service is per 1 unit per event (2 hours per episode)	T2016 U5	07/01/2024
Child Focused Assertive Community Treatment (Child ACT)	Child Focused Assertive Community Treatment (Child ACT) is a team-based multi-disciplinary approach to serve children in their community-based home setting. This includes homes, kinship placements, Department of Social Services (DSS) foster homes, or may begin during transition from a Therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED).	PRTF Level III Group Home	Child ACT meets the needs of youth who are at high risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment and Have a history of multiple psychiatric hospitalizations or History of one or more long term (greater than 30 calendar days) psychiatric hospitalization(s) at a state facility or Have a history of multiple episodes of Residential Treatment Services and/or Psychiatric Residential Treatment Facility (PRTF) services. The duration of service is 24 units or 6 months	H0040 U5 HA	07/01/2024

Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders	Inpatient Psychiatric Hospitalization	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	07/01/2024
Rapid Care Services Children and Adults with Mental Illness and/or Substance use disorders	Rapid Care Services allow time for extended assessment which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.	Emergency Department Visit Inpatient Psychiatric Hospitalization	Emergency Department Visit Inpatient Psychiatric Hospitalization Target population includes members ages 3 and older and provides an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses. Rapid Care Services may be provided to members in crisis who need short-term intensive evaluation, which can include a multi-disciplinary team of individuals such as clinicians, psychiatrists, nurses, and peer support specialists. The member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation AND the individual's medical needs are stable and appropriate for this level of care. Duration of Service 1 unit per day-Maximus length of service is 23 hours.	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High	07/01/2024
Family Centered Treatment (FCT)	Family Centered Treatment (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services.	Intensive In-Home Residential Treatment Level III	Target population includes members ages 3-20 with mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is monthly maximum of 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	07/01/2024
Residential Services-Complex Need	Residential Services – Complex Needs is a short-term residential treatment service focused on treatment of member with cooccurring	Psychiatric Residential Treatment Facility (PRTF)	Target population includes children and adults, ages 5 through 21 with either: Primary mental health (MH) diagnosis and I/DD diagnosis or borderline intellectual	H0018 HA	07/01/2024

	conditions and complex presentation. The members being served through Residential Services – Complex Needs will benefit most from a multi-disciplinary approach with staff who are trained to treat I/DD, mental health and severe behaviors.	Inpatient Psychiatric Hospitalization	functioning with traits that inhibit optimal functioning OR Primary I/DD diagnosis with co-occurring MH diagnosis.		
Individual Rehabilitation , Coordination, & Support Services	The purpose of this service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the individual’s living, learning, social, and work environments. IRCS is a skill building service, not a form of psychotherapy or counseling. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary’s skills develop. Services are based on medical necessity, person-centered, shall be directly related to the beneficiary’s diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the individual’s Person-Centered Plan. This service was developed in response to COVID-19 state of emergency and intended to be used only during a state of emergency, natural disaster, or situation where member is unable to attend PSR on site due to personal extenuating circumstances.	Psychosocial Rehabilitation	Target population includes ages 18 and older for individual has receiving a comprehensive clinical assessment and has been diagnosed with a serious and persistent mental illness (SPMI), which includes one of the following diagnoses: Bipolar Disorder, Major Depression, a diagnosis within the spectrum of psychotic disorders, and/or Substance use disorder (SUD). Duration of service is 1-unit per week, 52 weeks.	H2017 U5	07/01/2024
High Fidelity Wraparound (HFW)	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health,	Psychiatric Residential Treatment Facility (PRTF) Residential Level III Placement	Target population includes Youth with a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability AND Based on the current comprehensive clinical assessment including the use of the CALOCUS or CANS, functional impairment is	H0032 - U5	07/01/2024

	physical health, child welfare, juvenile/criminal justice, and education), experience serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in PRTFs or other institutional settings, and/or are aging out of Department of Social Services (DSS) care.		demonstrated to indicate this level of service. Duration of Service is 12-18 months		
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-up to age 21) with behavioral health diagnoses of mental health and/or substance use disorders in reestablishing the knowledge and skills necessary to live independently. Transitional Youth Services staff assist and support the member in identifying goals and addressing barriers to independence. This process considers all systems affecting the member, including family, school/work, peers, individual needs, and the community. All services are delivered in the member's natural environment to increase the likelihood of sustaining the progress made during the intervention. The aim of the program is to give members the skills and resources to resolve and prevent future problems in areas like housing, employment, parenting, or involvement with the court or social services. The interventions focus on member strengths and skills, as well as linking the member to available resources. Transitional Youth Services' staff work closely with families and community members to help ensure the member is safe, engaging in	Residential Level II Family Type (TFC) Intensive In-Home Services (IIHS)	Target population includes members ages 16-21 are eligible for this service when there is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference manual), Must demonstrate a deficit in at least one independent living skill or essential life component. Duration of service is 1-unit= 1 month or according to the Benefit Plan. 9 months-12 months	H2022 U5	07/01/2024

	<p>positive peer activities, learning the life skills needed to support themselves, and working or pursuing education. The assigned Transitional Youth Services Staff will work closely with the probation officer, courts, family, and any other involved formal and informal resources to ensure collaboration around the goals of services, interventions being provided, and discharge recommendations.</p>				
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Fourth Fifth Revised and Restated Attachment L. 7. Approved Trillium Health Resources In Lieu of Services

Service Name	Definition of ILOS	Covered Medicaid State plan service or setting for which each ILOS is a substitute	Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.	Specific coding for each ILOS to be used on claims and encounter data	Effective Date
Behavioral Health Crisis Assessment and Intervention (BH-CAI)	A designated service that is designed to provide triage, crisis risk assessment, evaluation, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital Emergency Department.	Emergency Departments	Target population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. (Per Event) 1-Per Person/This service is designed to be completed during regular and extended business hours of Tier III settings up of at least 12 hours; and up to 23 hours, 59 minutes in Tier IV settings.	T2016 U5 or T2016 U6	07/01/2024
Family Centered Treatment (FCT)	Family Centered Treatment is a researched, viable alternative to residential placements, hospitalization, correctional facility placement and other community-based services. A distinctive aspect of FCT is that it has been developed as a result of frontline Qualified Professionals' effective practice. Family Centered Treatment® (FCT) is a comprehensive evidence-based model of intensive in-home treatment for at risk children and adolescents and their families. FCT is intended to promote permanency goals. FCT treats the youth and his/her family through individualized therapeutic interventions.	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)	Target Population include a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability; and there are significant family functioning issues that have been assessed and indicated that the beneficiary would benefit from family systems work (to include access to service issues and social determinants such as food and housing insecurity. Duration of Service is 6-months	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	07/01/2024
Community Living Facilities and Support (CLFS)	Community Living Facilities and Supports (CLFS) consist of a broad range of services for adults with developmental disabilities who, through the Person Center Plan (PCP) process, choose to access active treatment to assist them	Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)-Community & Institutional	Target Population includes for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and integrated health services. •Medicaid eligible	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 –	07/01/2024

	<p>with skills to live as independently as possible in the community. CLFS is an innovative, community-based, comprehensive service for adults with intellectual and/or developmental disabilities. CLFS for individuals with Intellectual disability is an alternative definition in lieu of ICF-IID under the Medicaid 1915 b benefit. This service enables Trillium to provide comprehensive and individualized active treatment services to adults to maintain and promote their functional status and independence. This is also an alternative to home and community-based services waivers for individuals that potentially meet the ICF/ID level of care.</p>		<p>•Meet NC GS 122c definition for Developmental Disability</p>	<p>Level 4 T2016 U5 U6 – Level 5</p>	
<p>High Fidelity Wrap-around (HFW)</p>	<p>High Fidelity Wraparound (HFW) is an intensive, teambased, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, child welfare, juvenile/criminal justice, special education), who are experiencing serious emotional or behavioral difficulties, have dual diagnosis (MH and/or SUD, and IDD) with complex needs, and are at risk of placement in therapeutic residential settings, or other institutional settings, or have experienced multiple crisis events. Typically, this would be for youth with primary mental health diagnosis with co-occurring substance use disorder or an individual</p>	<p>Level II Group Setting & Program Level II Family Setting & Program</p>	<p>Target Population includes children, youth, and young adults with Serious Emotional Disturbance (SED) and have multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and/or substance use problems. Duration of service is 12 months:</p>	<p>H0032 - U5</p>	<p>07/01/2024</p>

	with co-occurring intellectual or developmental disabilities in the mild-moderate range. High Fidelity Wraparound is also utilized in a pro-active manner to serve those high-risk youth that are involved with multiple agencies.				
Family Navigator	<p>Family Navigators can assist members and families to navigate these challenging times and to understand the changes in systems through lived experience. NC already offers this for adults who experience Mental Health and Substance use disorders using a Peer support model. Family Navigator is the equivalent for Medicaid beneficiaries who experience IDD or TBI. Family Navigator is a way of working with children, adolescents and/or adults with an IDD or TBI diagnosis and who are experiencing challenges navigating the systems that can provide support for the health and well-being of this population. Family Navigator is a critical element of the habilitation model as it allows flexibility to meet member's particular needs in their own environment or current location (i.e. home, hospitals, jail, shelters, streets, etc.) using a variety of methods. It is designed as a short-term outreach and engagement service targeted to populations or specific member circumstances that prevent the individual from fully participating in needed care for intellectual or developmental disability or traumatic brain injury.</p>	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	<p>Targeted Population includes ages 3-64 for members diagnosed with intellectual/developmental disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems.</p> <p>Service is designed to meet the needs of the member. Maximum per month is 40 units (15 minutes) per month</p>	T2041 U5	07/01/2024

<p>Acute and Subacute Services Provided in an Institute for Mental Disease</p>	<p>This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members age 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD.</p> <p>Providers must follow the requirements for inpatient level of care outlined in the Division of Medical Assistance (DMA) Clinical Coverage Policy (CCP) 8-B, Inpatient Behavioral Health Services.</p>	<p>Emergency Department Inpatient Stay</p>	<p>Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.</p>	<p>0160</p>	<p>07/01/2024</p>
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Fourth Revised and Restated Attachment L. 7. Approved Vaya Health In Lieu of Services

Service Name	Definition of ILOS	Covered Medicaid State plan service or setting for which each ILOS is a substitute	Clinically oriented definition(s) for target population(s) for each ILOS for which the State has determined each ILOS to be a medically appropriate and cost-effective substitute.	Specific coding for each ILOS to be used on claims and encounter data	Effective Date
Acute and Subacute Services Provided in an Institute for Mental Disease (IMD)	This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR 435.1010 for acute and subacute inpatient psychiatric or substance use disorders. Delivery of service is provided by nursing and medical professionals under the supervision of a psychiatrist. Members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD.	Inpatient hospitalization Facility Based Crisis	Target Population includes members ages 21 to 64 with any DSM-5, or any subsequent editions of this reference material, diagnosis and one of the following: Impaired reality testing (e.g., delusions, hallucinations), disordered behavior, potential danger to self or others, concomitant severe medical illness or substance use disorder, and/or severely impaired social, familial, occupational, or developmental functioning.	RC 0160	07/01/2024
Outpatient Plus	Outpatient Plus ("OPT Plus") is a combination of best practice outpatient therapy services, monitoring, support, and management of care interventions to be provided for individuals of any age with complex clinical needs that basic outpatient therapy cannot adequately address.	Intensive In-Home Community Support Team	Target Population includes member has a mental health or SUD diagnosis (as defined by the DSM-5 or any subsequent editions of this reference material); Member does not have service restrictions due to their NC Medicaid program eligibility category that would make them ineligible for this service. Duration of service is one unit equals one hour of service- 412 units with length of service 180 days.	H2021 U5	07/01/2024
Critical Time Intervention Termination effective date: 03/31/2025	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical	Community Support Assertive Community Treatment Team Emergency Department visits Inpatient Psychiatric Admission	Target Population includes individuals discharge from psychiatric inpatient settings, release from correctional settings, transition out of foster care settings into adult services, transition from homelessness in housing	H0032 U5 HK	04/01/2023-03/31/2025

	transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition, CTI defines a critical transition as occurring within no more than 45 days from the start of service.				
Behavioral Health Crisis Risk Assessment and Intervention (BHCAI)	A designated service that is designed to provide triage, crisis risk assessment, and intervention within a Behavioral Health Urgent Care (BHUC) setting. A BHUC setting is an alternative, but not a replacement, to a community hospital emergency department (ED). Individuals receiving this service have primary behavioral health needs and an urgency determination of urgent or emergent. Individuals receiving this service will be evaluated, stabilized, and/or referred to the most appropriate level of care.	Emergency Department Inpatient Hospital	Targeted Population served is all Mental Health or SUD, and co-occurring BH/IDD population. Ages 4 and older beneficiaries experiencing a behavioral health crisis meeting Emergent or Urgent triage standards for members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. Members experiencing a behavioral health crisis meeting emergent or urgent triage standards. One unit per event-4-6 hours. One per crisis episode. If two visits occur within 30-90 days, the LME/MCO must be notified of the rapid recidivism.	T2016 U5 or T2016 U6	07/01/2024
Family Centered Treatment	Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary	Residential Level II Program Type Residential Level III (1-4 beds)	Target Population includes Children and adolescents (ages 3-21) who have an MH/SUD diagnosis (some with co-occurring IDD) and are at risk of out of home placement or have previously been unsuccessful in residential treatment, or currently in residential treatment where discharge has been delayed due to identified need for family systems treatment. Duration of service is 6-months:	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	07/01/2024

	<p>care physicians. FCT includes the provision of crisis services. FCT is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.</p>				
<p>Residential Services – Complex Needs Termination effective 11/30/2025</p>	<p>This short-term residential treatment service focuses on members with primary diagnoses of intellectual/developmental disabilities (I/DD) with co-occurring mental health (MH) diagnoses or significant behavioral challenges. The members being served would benefit most from a multi-disciplinary approach with staff that are trained to treat I/DD, MH, and severe behaviors.</p>	<p>Psychiatric Residential Treatment Facility (PRTF) Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)</p>	<p>Target Population includes children and adults with dual diagnoses (I/DD and MH) who have high-level behavioral needs, have experienced multiple placements, and have difficulty functioning in community settings. This service is provided in a small group home or alternative family living setting with very structured supports. Families are actively engaged in the treatment program and coached on strategies and interventions that could be replicated in non-residential treatment settings, such as the member’s own home or family home. Duration of service is billed one per day/180 units with length of service 6-months.</p>	<p>H0018 HA</p>	<p>07/01/2024-11/30/2025</p>
<p>Rapid Care Services</p>	<p>Rapid Care Services allow time for extended assessment, which may involve a clinical interview; assessment by clinicians, nurse, and/or psychiatric staff; various screening tools, with the ability to observe the member over a longer period of time to determine if symptoms increase or decrease; response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.</p>	<p>Emergency Department Inpatient Hospital</p>	<p>Targeted Population includes mental health and/or substance use disorder(s), the member presents with a behavioral health crisis that is likely to significantly reduce in acuity after crisis de-escalation, therapeutic intervention, and observation. Duration of service is billed as one unit = one event per day and will utilize a two-tiered billing system based on the amount of time spent at the site as outlined below. If a member receives less than 1.5 hours of intervention, the applicable outpatient, psychiatric, or other CPT codes would be utilized. This level of care is generally used for a duration of 23 hours or less, with optimal utilization between four to six hours per event. Rapid Care Services may be provided up to 23 hours per episode and will be performed in a facility that operates 24/7/365 days a year</p>	<p>S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High</p>	<p>07/01/2024</p>

	This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).		under psychiatric supervision. This facility must be able to accept individuals who are currently under involuntary petition for first evaluations.		
High Fidelity Wraparound	High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, holistic, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g., mental health, child welfare, juvenile/criminal justice, special education), experience serious emotional or behavioral difficulties, are at risk of placement in a Psychiatric Residential Treatment Facility (PRTF) or other institutional settings, or are aging out of Department of Social Services (DSS) care.	Residential Level II	Target Population includes youth with a mental health or substance use disorder diagnosis, youth requires coordination between two or more service agencies, including medical or non-medical providers; and youth has current or past history within the last six months of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior. Duration of service is 36-48 units per member/12 months; maximum of 18 months.	H0032U5	07/01/2024
In-Home Therapy Services	In-Home Therapy Services (IHTS) consist of evidence-based therapy services and coordination of care interventions provided in the home for individuals with complex clinical needs that outpatient therapy alone cannot adequately address in a time-limited fashion.	Intensive In-Home	Target Population includes a mental health (MH) and/or substance use (SU) diagnosis, symptoms and behaviors at home, school, or in other community settings, due to the member's MH and/or SU disorder, are moderate to severe in nature and require intensive, coordinated clinical interventions; evidence of problems in at least two major life domains that are significantly affecting the member's behavioral health needs. Duration of service is one unit per week with a minimum of two hours combined therapy and coordination of care- 24 units with length of service 6-months.	H2022 HE U5 H2022 TS U5	07/01/2024

Enhanced Crisis Response (ECR)	Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery. For youth in the emergency department (ED) or in a non-therapeutic home who are at risk of admission to the ED, the practitioner will respond as soon as possible but no longer than two hours from receipt of the referral. For other referrals, response will be on the same day or by the end of the following day.	Emergency Department Inpatient Hospitalization	<p>Target Population includes members ages 3-21 with mental health (MH) diagnoses, co-occurring MH and intellectual/ developmental disability (I/DD) diagnoses, and/or co-occurring MH and substance use disorder (SUD) diagnoses, OR potential diagnoses of the above based on current symptoms/behavioral health needs.</p> <p>This service targets youth abandoned in the ED who are also at risk of intervention from DSS. The expected outcome is that the ECR provider quickly engages the guardian(s), creates a crisis plan, and links the member to services to support the guardian's ability to allow the youth to return home. The service also includes youth in DSS custody (in a DSS foster home or DSS shelter) who are at risk of presenting to the ED as a measure to assist with maintaining the youth in the community. Additionally, the intent of this service is to work with youth who remain inpatient due to difficulty with discharge planning.</p> <p>Enhanced Crisis Response (ECR) operates under the philosophy that children thrive when they can safely remain in or be reunified with the home of their own family and/or a safe permanent alternative. The program will utilize fully licensed practitioners who provide an immediate comprehensive clinical assessment (when necessary), along with corresponding 24/7 service delivery.</p>	H2011 U5 U1 weekly unit	07/01/2024
Long-Term Community Supports (LTCS)	Long-Term Community Supports (LTCS) is a community-based comprehensive service for adults (age 22 and older) with intellectual/ developmental disabilities (I/DD) that provides individualized services and supports to a person who would otherwise be institutionalized in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)	<p>Target Population includes members 22 of age or older, meet ICF/IID level of care and/or the definition of developmental disability specified in NCGS § 122C-3(12a). Reside in an ICF/IID (when used for transition from an ICF/IID into a home or community-based setting) or is at risk of being placed in an ICF/IID, and be able to maintain health, safety, and well-being in the community with LTCS and other services and supports delivered in the home or community.</p>	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3	07/01/2024

Child- Focused Assertive Community Treatment	Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multidisciplinary approach to serve children in their residential setting. This includes homes, kinship placements, and Department of Social Services (DSS) foster homes, or the service may begin during transition from a therapeutic residential setting. Child ACT uses a community-based team approach to meet the needs of youth with Serious Emotional Disturbance (SED). The team members providing the direct interventions to the child and family may vary based on the needs of the individual. The team will have daily meetings to prioritize activities, share information, and discuss individual members. The team will be available to respond 24/7 for crisis de-escalation and assessment, inclusive of availability by phone within 15 minutes and face-to-face within one to two hours.	Psychiatric Residential Treatment Facility (PRTF)	Target Population includes at risk for out-of-home residential treatment due to a Mental Health (MH) or Substance Use (SU) diagnosis, or are preparing to step down from Residential Treatment Services and/or Psychiatric Residential Treatment. Duration of service is 1-Unit per week-24 Units-6 months.	H0040 U5 HA	07/01/2024
Transitional Youth Services	The Transitional Youth Services Program is a home and community-based outpatient intervention that supports transition-age members (ages 16-21) with behavioral health diagnoses in reestablishing the knowledge and skills necessary to live independently.	Level II Family Type, Therapeutic Foster Care Residential Level II Program Type Residential Level III	Target Population includes members who are leaving the foster care or juvenile justice systems or who otherwise find themselves in this life stage without the developmentally appropriate and necessary skills and supports to successfully transition to adulthood. Duration of service is billed one unit per month/The service is expected to achieve outcomes within six to 12 months (six-12 units of service). Additional units may be authorized in exceptional cases as medical necessity dictates. Transitional Youth Services Specialists work closely with families and community members to help ensure the member is safe, engaging in positive peer activities, learning	H2022 U5	07/01/2024

			the life skills needed to support themselves, and working or pursuing education.		
Assertive Community Treatment Step Down (ACT SD) Termination effective date 12/31/2025	ACT SD service supports beneficiaries whose symptom severity no longer merits the intensity of ACT interventions but cannot be adequately addressed with Outpatient Therapy alone. ACT SD is a community based, person-centered and recovery focused service designed to assist the beneficiary in maintaining stable functioning and wellness while providing support for continued recovery.	Assertive Community Treatment (ACT)	Target Population includes beneficiaries with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six months	H0040 U5	07/01/2024-12/31/2025
First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) *New ILOS* Effective 07/01/2025	First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member’s or beneficiary’s first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration.	Assertive Community Treatment (ACT)	Target Population includes members must have NC Medicaid or NC Health Choice based on residence in a county located within Vaya’s region and be enrolled in Vaya’s Behavioral Health and I/DD Tailored Plan or NC Medicaid Direct PIHP; The member must between the ages 15-30 years old, currently experiencing first-episode/onset of psychosis. Duration of Service is one event (or per diem) defined as a 15-minute, face-to-face contact, lasting a minimum of eight minutes. Target Population includes members ages 15-30 years old, currently experiencing first-episode/onset of psychosis and has significant functional impairment with performing the range of routine tasks required for age-appropriate functioning in the community.	H0040 HK U5	07/01/2025

	<p>First-Episode Psychosis – Assertive Community Treatment (FEP-ACT) is a team-based, comprehensive approach to treating symptoms of a member’s or beneficiary’s first episode of psychosis. FEP-ACT is based on a multi-element treatment approach to FEP called Coordinated Specialty Care (CSC) that has been validated through extensive research and broadly implemented across the nation. A member who is appropriate for FEP-ACT benefits most from receiving services from a single provider and is at risk of hospitalization, homelessness, substance use, victimization, or incarceration.</p>				
<p>Dual Diagnosis Capable (DDC) ACT *New ILOS* Effective 07/01/2025</p>	<p>Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD</p>	<p>SAIOP Facility-Based Crisis</p>	<p>Target Population include ages 18 and older with a primary SUD diagnosis and a co-occurring MH diagnosis. A member who is appropriate for this service needs assertive engagement to develop treatment motivation. The member does not benefit from receiving services across multiple, disconnected providers, and may be at greater risk of hospitalization, relapse, and/or incarceration.</p>	<p>H0040 HH U5</p>	<p>07/01/2025</p>

<p>services with MH services. It helps people address both disorders at the same time—through the same service organization by the same team of treatment providers.</p> <p>Dual Diagnosis-Capable Assertive Community Treatment (DDC-ACT) is a team-based, multidisciplinary approach to providing comprehensive, strengths-based, and person-centered services to individuals with primary substance use disorder (SUD) needs and co-occurring mental illness who have challenges living independently in the community. The Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice endorsed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Integrated treatment improves quality of life for people with co-occurring severe mental health (MH) and substance use disorders by combining SUD services with MH services. It helps people address both disorders at the same time—through the same service organization by the same team of treatment providers.</p>				
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Fifth Revised and Restated Attachment P. Performance Metrics, Service Level Agreements (SLAs) and Liquidated Damages

It is agreed by the Parties that no performance metric or SLA will be determined as unmet and no liquidated damages will be assessed or punitive action taken against Contractor where the fault of such purported non-compliance is significantly, materially or predominantly caused by a third-party, including by the Department. A subcontractor of the Contractor is not a third-party.

Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective May 1, 2026)		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
A. Administration and Management		
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	\$2,500 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in <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 contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in <i>Section III.D.46 SUBCONTRACTORS.</i>	Up to \$25,000 per occurrence
6.	Failure to open a Medicaid help center case or to confirm or request that DSS open a Rapid Response Team case as described in Sections <i>V.A.8.i.(i)</i> or <i>V.A.8.ii.(i)</i> of the Contract within one (1) Business Day of the BH I/DD Tailored Plan receiving a notification described in <i>Sections V.A.8.i.</i> or <i>V.A.8.ii.</i> of the Contract.	\$500 per Member per Calendar Day
7.	Failure to develop a <i>Rapid Response Plan</i> and attach the Rapid Response Plan to the Member's Medicaid help center or Rapid Response Team case within seven (7) Business Days of the BH I/DD Tailored Plan receiving notification described in <i>Sections V.A.8.i.(i)</i> or <i>V.A.8.ii.(i)</i> of the Contract.	\$500 per Member per Calendar Day
8.	Failure to update a Member's <i>Rapid Response Plan</i> and attach the updated <i>Rapid Response Plan</i> to the Member's open Medicaid help center or Rapid Response Team case within seven (7) Calendar Days	\$500 per Member per Calendar Day

**Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid
(Effective May 1, 2026)**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
	from the last Rapid Response Plan update on a Member for whom the PIHP received notification described in <i>Sections V.A.8.i. or V.A.8.ii.</i> of the Contract and who is staying in the Emergency Department, DSS Office, hotel, or similar placement while awaiting placement in a clinically appropriate setting for medically necessary services.	
B. Members		
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in <i>Section V.B.1.iv. Marketing.</i>	\$2,500 per occurrence
2.	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
3.	Reserved.	
4.	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
5.	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
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	\$2,500 per occurrence
7.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in <i>Section V.B.1.vi. Member Grievances and Appeals.</i>	The value of the reduced or terminated services as determined by Department for the timeframe specified by the Department. AND \$500 per Calendar Day for each day the BH I/DD Tailored Plan fails to provide continuation or restoration as required by Department.
8.	Failure to attend mediations and hearings as scheduled as specified in <i>Section V.B.1.vi. Member Grievances and Appeals.</i>	\$500 for each mediation or hearing that BH I/DD Tailored Plan fails to attend as required
9.	Failure to comply with Transition of Care requirements as specified <i>Section V.B.1.ii. Transition of Care.</i>	\$50 per Calendar Day, per Member AND

**Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid
(Effective May 1, 2026)**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
		The value of the services the BH I/DD Tailored Plan failed to cover during the applicable transition of care period, as determined by the Department.
10.	Failure to respond to Department communications regarding: (1) expedited State Fair Hearing requests, including failure to upload any documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal, within nine (9) Work Hours of the timestamp on the Department’s communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal within the requirements in <i>Section III.D. 38. <u>RESPONSE TO STATE INQUIRIES AND REQUEST FOR INFORMATION.</u></i>	\$250 per occurrence.
C. Benefits		
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	\$2,500 per occurrence per Member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified <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
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified <i>Section V.B.4.i. Provider Network.</i>	\$500 per occurrence
4.	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
5.	Failure to timely update drug ingredient cost reimbursement rates as required by <i>Section V.B.2.iii. Pharmacy Benefits.</i>	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$1,250 per Calendar Day per occurrence
6.	Failure to ensure that a member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified <i>Section V.B.2.iv. Non-Emergency Transportation.</i>	\$250 per occurrence per Member
7.	Failure to comply with driver requirements as defined in the Department’s NEMT Policy.	\$750 per occurrence per driver
8.	Failure to comply with the assessment and scheduling requirements as defined in the Department’s NEMT Policy.	\$125 per occurrence per Member

Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective May 1, 2026)		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
9.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	\$750 per calendar day per vehicle
10.	Reserved.	
D. Care Management		
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by <i>Section V.B.3.ii. Tailored Care Management.</i>	\$125 per Calendar Day
2.	Reserved.	
3.	Reserved.	
4.	Reserved.	
5.	Failure to notify the Department within fourteen (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
6.	Failure to meet annual requirements established by the Department for the percentage of Members who are assigned to a Provider-based Care Management as set forth in <i>Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management.</i> (Effective July 1, 2024).	Up to \$50,000 per percentage below the requirement each calendar year
7.	Failure to comply with federal conflict-free case management requirements for members enrolled in the Innovations or TBI waiver	\$250 per occurrence per Member
8.	Failure to timely notify the Department of a notice of underperformance sent to an LHD or the termination of a contract with an LHD.	\$250 per Calendar Day
9.	Failure to implement and maintain an Opioid Misuse Prevention and Treatment Program and Member Lock-In Program as <i>described in Section V.B.3.i. Prevention and Population Health Programs.</i>	Beginning at BH I/DD Tailored Plan Launch: \$1,000 per occurrence for Opioid Misuse and Prevention and Treatment Program Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$1,000 per occurrence for Member Lock-in Program
10.	<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 ninety-five percent (95%) 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. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid
(Effective May 1, 2026)**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
11.	<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
12.	Failure to timely document and honor a Member's request to opt out or opt back in to Tailored Care Management where the Member has submitted a Tailored Care Management Opt-out Form to the BH I/DD Tailored Plan as described in <i>Section V.B.3.ii.(iv)(b)(1)-(2) of the Contract.</i>	\$500 per occurrence per Member
13.	Failure to timely process the Member's choice of Tailored Care Management as described in the Tailored Care Management Auto Assignment Requirements Document and <i>Section V.B.3.ii.(v)(i) of the Contract.</i>	\$500 per occurrence per Member
14.	Failure to comply with minimum Transitional Care Management requirements for Members engaged in Tailored Care Management as described in <i>Section V.B.3.ii Tailored Care Management of the Contract.</i>	\$125 per occurrence per Member
15.	Failure to comply with minimum care coordination requirements for Members with a Behavioral Health transitional care need as described in <i>Section V.B.3 Care Management of the Contract.</i>	\$125 per occurrence per Member
E. Providers		
1.	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
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan's provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the affected Members within the timeframes required by <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
3.	Reserved.	
4.	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
5.	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
6.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	\$125 per Calendar Day

Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective May 1, 2026)		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
7.	Reserved.	
8.	Failure to remove Providers that are not actively enrolled in NC Medicaid from the BH I/DD Tailored Plan PHP Network File within one (1) Business Day as specified in <i>Section V.B.4. Provider Network Management</i> .	\$50 per provider per Business Day.
9.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in <i>Section V.D.K.5. Technical Specifications</i> .	\$500 per occurrence
F. Quality and Value		
1.	Failure to submit all required 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
2.	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
3.	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
4.	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> .
G. Claims and Encounter Management		
1.	Failure to timely submit monthly encounter data set certification.	\$500 per Calendar Day
H. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$1,000 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per Calendar Day
3.	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. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$1,000 per Calendar Day

**Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid
(Effective May 1, 2026)**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
4.	Failure to timely and accurately submit financial reports in accordance with <i>Section VII. Seventh 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
I. Compliance		
1.	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 Department determines BH I/DD Tailored Plan is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in <i>Section V.K.1. Compliance Program</i> and <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per Calendar Day
3.	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. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$125 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$1,250 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan's own conduct, a provider, or a member.	\$125 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in <i>Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services</i> and <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$1,000 per Calendar Day
7.	Failure by the BH I/DD Tailored Plan, as determined by the Department, to ensure the privacy, security, and confidentiality of any data and/or electronic or hardcopy documents that contain Member Protected Health Information (PHI), in accordance with the standards of the DHHS privacy and security policies, state regulations, and/or federal regulations including: the Privacy Rule at 45 C.F.R. Parts 160 and 164, the Security Rule at 45 C.F.R. Parts 160, 162 and 164, and the applicable provisions of HIPAA and HITECH that results in a breach of a member PHI.	\$250 per Member per occurrence AND if the Department deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the BH I/DD Tailored Plan's failure to comply with the terms of this Contract, the BH I/DD Tailored Plan shall also be liable for all costs associated with the provision of such monitoring and/or safeguard services.

**Section VII. Fifth Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid
(Effective May 1, 2026)**

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
J. Technical Specifications		
1.	Reserved.	
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	\$250 per occurrence
3.	Failure by the BH I/DD Tailored Plan to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	\$250 per Member per occurrence, not to exceed \$5,000,000
K. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	\$250 per Calendar Day
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	\$500 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	\$250 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain any other plan or program required under the Contract for which a specific liquidated damage amount is not set forth above (e.g. drug utilization review program).	\$ 10,000 per occurrence per plan or program
5.	Failure to provide a timely CAP or comply with a CAP as required by the Department.	\$250 per Calendar Day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved CAP
6.	Engaging in gross customer abuse of Members by Contractor service line agents as prohibited by <i>Section V.A.2.(xxiv) Gross Customer Abuse</i> .	\$1,000 per occurrence
7.	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 Department.
8.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	\$250 per occurrence.

Section VII. Fifth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective May 1, 2026)

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
A. Administration and Management		
1.	Failure to comply with conflict of interest requirements described in <i>Section III.D.15. <u>DISCLOSURE OF CONFLICTS OF INTERESTS</u></i> and <i>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. <u>DISCLOSURE OF CONFLICTS OF INTERESTS</u></i> and <i>Section III.D.16. <u>DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION.</u></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 <u>DISCLOSURE OF OWNERSHIP.</u></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. <u>SUBCONTRACTORS.</u></i>	Up to \$12,500 per occurrence
B. Providers		
1.	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
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan’s provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the affected recipients within the timeframes required by <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
3.	Reserved.	
4.	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
5.	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
6.	Failure to timely submit a PIHP Network Data File that meets the Department’s specifications.	\$125 per Calendar Day

Section VII. Fifth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective May 1, 2026)

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
7.	Reserved.	
C. Claims Management		
1.	Reserved.	
D. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per Calendar Day
2.	Failure to timely and accurately submit monthly financial reports in accordance with <i>Section VII. Seventh 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
E. Compliance		
1.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	\$625 per incident for failure to fully cooperate during an investigation
2.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan’s own conduct, a provider, or a recipient.	\$125 per Calendar Day
3.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in <i>Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services</i> and <i>Section VII. Seventh Revised and Restated Attachment J. Reporting Requirements</i> .	\$500 per Calendar Day
F. Technical Specifications		
1.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member’s PHI.	\$125 per recipient per occurrence
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of recipient PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	\$125 per recipient per occurrence

Section VII. Fifth Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective May 1, 2026)		
No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
3.	Failure by the BH I/DD Tailored Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	\$125 per recipient per occurrence, not to exceed \$2,500,000
G. Directives and Deliverables		
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	\$125 per Calendar Day that Department determines BH I/DD Tailored Plan is not in compliance
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	\$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	\$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	\$5,000 per occurrence per plan or program
5.	Failure to provide a timely and acceptable corrective action plan or comply with a CAP as required by the Department.	\$125 per Calendar Day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved corrective action

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

Section VII. Fifth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective May 1, 2026)					
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	\$2,500 per service line per month
2.	Call Response Time/Call Answer Timeliness – Member and	The BH I/DD Tailored Plan shall answer at least eighty-five percent (85%) of	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total	Monthly	\$5,000 per month

**Section VII. Fifth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services
(Effective May 1, 2026)**

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
	Recipient Service Line	calls within thirty (30) seconds.	number of calls received by the service line during the measurement period.		
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	\$5,000 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	\$5,000 per month
5.	Call Wait/Hold Times – Behavioral Health Crisis Line	The BH I/DD Tailored Plan shall answer at least ninety-eight percent (98%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$7,500 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	\$7,500 per month

**Section VII. Fifth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services
(Effective May 1, 2026)**

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
7.	Call Response Time/Call Answer Timeliness – Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$2,500 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	\$2,500 per month
9.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$2,500 per month
10.	Provider Welcome Packet Timeliness	The BH I/DD Tailored Plan shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in Section V.B.4. <i>iii Provider Relations and Engagement.</i>	The number of Provider Welcome Packet sent by the BH I/DD Tailored Plan within the required timeframe divided by the total number of new providers who have executed a contract with the BH I/DD Tailored Plan during the measurement period	Quarterly	97.99% - 95%: \$2,500 per quarter 94.99% - 80%: \$3,750 per quarter 79.99% or less: \$5,000 per quarter
11.	Member Welcome Packet Timeliness – Separate Mailing for Welcome Letter and Member Handbook	The BH I/DD Tailored Plan shall meet or exceed ninety-nine percent (99%) of welcome letters and Member handbooks (mailed separately from identification	The number of welcome letters and Member handbooks (mailed separately from identification cards) mailed by the BH I/DD Tailored Plan within the required timeframe divided by the total number of new	Monthly	98.99% - 95%: \$2,500 per month 94.99% - 80%: \$3,750 per month

**Section VII. Fifth Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services
(Effective May 1, 2026)**

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
	<i>Applies if the BH I/DD Tailored Plan utilizes separate mailings to send components of the Welcome Packet</i>	cards) mailed within the timeframes specified in V.B.1.iii. <i>Member Engagement.</i>	Members enrolled in the BH I/DD Tailored Plan during the measurement period.		79.99% or less: \$5,000 per month
12.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet <i>Applies if the BH I/DD Tailored Plan utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)</i>	The BH I/DD Tailored Plan shall meet or exceed ninety-nine percent (99%) of Member Welcome Packets (single mailing of entire welcome packet) mailed within the timeframes specified in V.B.1.iii. <i>Member Engagement.</i>	The number of Member Welcome Packets (single mailing of entire welcome packet) mailed by the BH I/DD Tailored Plan within the required timeframe divided by the total number of new Members enrolled in the BH I/DD Tailored Plan during the measurement period.	Monthly	98.99% - 95%: \$2,500 per month 94.99% - 80%: \$3,750 per month 79.99% or less: \$5,000 per month
13.	Non-Emergency Medical Transportation – Approved Trips	The BH I/DD Tailored Plan shall complete ninety-nine and one-half percent (99.5%) of all approved NEMT trips.	The number of NEMT trips approved by the BH I/DD Tailored Plan minus the number of NEMT trips missed due to Provider No-Show or No Provider Vehicle Available (NPVA), as those terms are defined in the BCM011-T-TP operational report, divided by the total number of NEMT trips approved by the BH I/DD Tailored Plan. <i>NEMT trips for hospital discharges will not be included in determining compliance with this SLA.</i>	Monthly	99.25%-99.49% = \$7,500 per month 99.01%-99.24% = \$10,000 per month 99% or less = \$12,500 per month

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

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)					
No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
A. Enrollment and Disenrollment					
1.	Member Enrollment Processing	The BH I/DD Tailored Plan shall process one hundred percent (100%) of standard eligibility files within twenty-four (24) hours of receipt.	The percentage of eligibility files ingested and applied by the BH I/DD Tailored Plan to its system to trigger enrollment and disenrollment processes.	Daily	\$500 per twenty-four (24) hour period Note: Effective one (1) month prior to BH I/DD Tailored Plan launch
B. Member Grievances and Appeals					
1.	Member Appeals Resolution - Standard	The BH I/DD Tailored Plan shall resolve at least ninety-eight percent (98%) of BH I/DD Tailored Plan internal appeals within the specified timeframes for standard appeals.	The number of internal appeals with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	96.00% - 97.99% = \$2,500 per month 95.99% or less = \$5,000 per month
2.	Member Appeals Resolution - Expedited	The BH I/DD Tailored Plan shall resolve ninety-nine and one-half percent (99.5%) of internal appeals within the specified timeframes for expedited appeals.	The number of internal appeals with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the appeal divided by the total number of internal appeals filed during the measurement period.	Monthly	99.01% - 99.49% = \$3,750 per month 99.00% or less = \$5,000 per month

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
3.	Member Grievance Resolution	The BH I/DD Tailored Plan shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	96.00% - 97.99% = \$1,750 per month 95.99% or less = \$2,500 per month
C. Pharmacy Benefits					
1.	Adherence to the Preferred Drug List	The BH I/DD Tailored Plan shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	\$50,000 per quarter
D. Care Management					
1.	Contracting with AMH+ and CMAs	The BH I/DD Tailored Plan shall contract with one hundred percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in <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 and willing AMH+ practices and CMAs.	Monthly	\$25,000 per month
E. In-Reach and Diversion					
1.	Reserved.				

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
F. Service Lines					
1.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds of being queued to an agent and abandoned within thirty (30) seconds of being queued to an agent divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
2.	Call Wait/Hold Times - Nurse Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
3.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation.	Monthly	\$5,000 per month
4.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$5,000 per month

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
5.	Call Wait/Hold Times - Pharmacy Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$5,000 per month
6.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$5,000 per month
7.	Call Response Time/Call Answer Timeliness - NEMT Member Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
8.	Call Wait/Hold Times - NEMT Member Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
9.	Call Abandonment Rate – NEMT Member Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	\$5,000 per month
10	Call Response Time/Call Answer Timeliness - NEMT Provider Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
11	Call Wait/Hold Times - NEMT Provider Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	\$5,000 per month
12	Call Abandonment Rate – NEMT Provider Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	\$5,000 per month
13	Reserved.				

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
14	Encounter Data Timeliness – Medical	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of medical encounters within thirty (30) Calendar Days after payment whether paid or denied.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Monthly	\$25 per encounter per Calendar Day
15	Encounter Data Timeliness – Pharmacy	The BH I/DD Tailored Plan shall submit ninety-eight percent (98%) of pharmacy encounters within seven (7) Calendar Days after payment whether paid or denied. For purposes of this standard, pharmacy encounters only include 837-P encounters that contain at least one (1) line with an NDC, 837-I encounters with bill type 13x that contain at least one (1) line with an NDC, and NCPDP encounters.	The number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.	Weekly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$100 per claim per Calendar Day

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
16	Encounter Data Accuracy – Medical	The BH I/DD Tailored Plan shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for Medical claims. For purposes of this standard, medical encounters include 837-P encounters and 837 I-encounters.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Monthly	\$12,500 per month
17	Encounter Data Accuracy – Pharmacy	The BH I/DD Tailored Plan shall meet or exceed a ninety-eight percent (98%) approval acceptance rate for pharmacy claims. For purposes of this standard, pharmacy encounters only include NCPDP encounters.	A paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.	Weekly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$25,000 per week

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
18	Encounter Data Reconciliation— Medical	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days. For purposes of this standard, medical encounters only include 837-P encounters and 837-I encounters.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.	Monthly	\$5,000 per month

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
19	Encounter Data Reconciliation— Pharmacy	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: \$5,000 per month
G. Website Functionality					
	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

Section VII. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
2.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	\$2,500 per month
3.	Timely response to electronic inquiries	The BH I/DD Tailored Plan shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) Business Days of receipt.	Electronic 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. Fifth Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective May 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
4.	Access to Primary/ Preventive Care for Individuals under NC Innovations waiver	Ninety percent (90%) of Innovations waiver beneficiaries will have a primary care or preventative health service	The percentage of Medicaid enrollees continuously enrolled for the 12-month contract period under the 1915(c) NC Innovations waiver (ages 3 and older) who received at least one service under the NC Innovations waiver during the measurement period who also received a primary care or preventative health service. For Innovations Waiver beneficiaries three (3) to six (6) years of age and twenty (20) years of age and older, the person received a primary care or preventative health service during the measurement period. For Innovations Waiver beneficiaries seven (7) to nineteen (19) years of age, the person received a primary care or preventative health service during the previous two measurement periods.	Annually	\$50,000 per year

Section VII. Fifth Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services (Effective January 1, 2026)

No.	Measure	Performance Standard	Definition	Measurement Period	Liquidated Damage
1.	Reserved.				
2.	Reserved.				

Section VII. Fourth Revised and Restated Attachment P.

Table 6: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot)

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
1.	Reserved.	
2.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.	\$250 per Calendar Day that the Department determines the BH I/DD Tailored Plan is not in compliance
3.	Failure to authorize or deny Pilot services for Members within the Department’s required authorization timeframes.	\$250 per Calendar Day
4.	Failure to pay Pilot invoices to HSOs within the Department’s required payment timeframes.	\$250 per Calendar Day per HSO
5.	<p>Failure to comply with the following provisions enumerated in <i>Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards</i> of to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs:</p> <ul style="list-style-type: none"> • Ensure that BH I/DD Tailored Plan workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data; • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials; and • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment. 	\$250 per occurrence

Attachment W. Business Associate Agreement

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“Agreement”) is made between North Carolina Department of Health and Human Services, Division of Health Benefits (“DHB” and “Covered Entity”) and **TP NAME** (“Business Associate”) (collectively the “Parties”).

1. BACKGROUND

- a. Covered Entity and Business Associate are Parties to an agreement entitled Contract #30-2020-052-DHB-# Behavioral Health I/DD Tailored Plan **TP NAME** (“Contract”), 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 Agreement as an attachment 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” or “ePHI” 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. “Person” shall have the same meaning as the term “person” in 45 C.F.R. § 160.103 and shall include a human being that is born alive, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.
- e. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164.
- f. “Protected Health Information” or “PHI” shall have the same meaning as the term “Protected Health Information” in 45 C.F.R. § 160.103, limited to the information compiled, created, or received by Business Associate from or on behalf of Covered Entity.
- g. “Required By Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
- h. “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.

- i. "Security Rule" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subpart C.
- j. 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 PHI 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. Part 164 with respect to ePHI, to prevent use or disclosure of the ePHI 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 PHI by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to comply with all applicable requirements of the Security Rule (45 C.F.R. Part 164, Subparts A and C) with respect to electronic protected health information.
- e. Business Associate shall implement physical, administrative and technical safeguards that reasonably protect the confidentiality, integrity and availability of any ePHI that it creates, receives, maintains or transmits on behalf of the NC DHHS.
- f. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410.
- g. 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 PHI on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- h. Business Associate agrees to make available PHI as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- i. Business Associate agrees to make available PHI for amendment and incorporate any amendment(s) to PHI in accordance with 45 C.F.R. § 164.526.
- j. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of PHI 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.
- k. Business Associate agrees to make available the information required to provide an accounting of disclosures of PHI 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 PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:

- 1) Would not violate the Privacy Rule if done by Covered Entity; or
 - 2) 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 PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
- 1) The disclosures are Required By Law; and
 - 2) 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 PHI 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 shall not use or disclose PHI 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:
- 1) 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;
 - 2) Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
 - 3) If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.
- c. **Effect of Termination.**
- 1) Except as provided in paragraph (2) 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 PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
 - 2) In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

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. In the event that 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.

IN WITNESS WHEREOF, Business Associate agrees to and executes this Agreement as of the Effective Date of the Contract.

TP NAME

TP POC
POC Title

Date

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS

Melanie Bush
Deputy Secretary, NC Medicaid

Date