Amendment Number 5(7)

Contract #30-2020-052-DHB-#

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

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

Purpose:
The purpose of this Amendment is to modify existing requirements and incorporate new requirements to the Contract in 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 VI. Contract Performance; and
- **IV.** Section VII. Attachments.

The Parties agree as follows:

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

Specific subsections are modified as stated herein.

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

1. **1115 Demonstration Waiver**: North Carolina's amended 1115 demonstration waiver to the federal Centers for Medicare & Medicaid Services (CMS). The waiver is the legal authority for the specific items of the Medicaid Managed Care transformation that require CMS waiver approval (waiver #11-W00313/4).

64. **Cross Area Service Program (CASP):** DMH/DD/SUS designated specialty service program that is funded by the DMH/DD/SUS through federal and/or State funds to provide targeted services to an identified population segment (e.g., pregnant women, families, etc.). A CASP is designated by the DMH/DD/SUS as a result of a critical federal grant initiative or a priority state service initiative.

67. **Date of Payment**: The point in time following the Claim Adjudication Date when reimbursement is generated for services. This is either the date of Electronic Funds Transfer (EFT) or the date a paper check is mailed.

85. **Exclusion Lists:** Lists the BH I/DD Tailored Plan must check to determine the exclusion status of the BH I/DD Tailored Plan, or its subcontractors, as well as any person with ownership or controlling interest, or any agent or managing employee of the BH I/DD Tailored Plan, and lists the Department must check to determine the exclusion status of providers, to ensure that the BH I/DD Tailored Plan does not pay federal funds to Excluded Persons or entities, including:
    a. State Excluded Provider List;
    b. U.S. Department of Health and Human Services, Office of Inspector General's (HHS OIG) List of Excluded Individuals/Entities (LEIE);
    c. The System of Award Management (SAM);
    d. The Social Security Administration Death Master File (SSADMF);
    e. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
    f. Office of Foreign Assets Control (OFAC).

91. **Grantee:** The State government entity (i.e., DHHS, DMH/DD/SUS) to which a federal grant is awarded, and which is responsible and accountable for the use of the funds provided and for the performance of the grant-supported project or activity.

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

200. **State-Fund Balance:** Comprised of any state-funds allocated by DMH/DD/SUS that were not expended in prior fiscal years.

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

242. **ACT Fidelity Review:** The comprehensive evaluation of each Assertive Community Treatment (ACT) provider conducted periodically by the entity designated by the Department, based upon the Tool for Measurement of ACT (TMACT) which is used to assess how well a provider is performing in critical elements of ACT and to identify any areas where improvement is needed.
243. **Acute Care Hospital:** Has the same meaning as Acute Care Hospital as defined in NCGS § 108A-145.3(1).
244. **Adult Developmental Vocational Program**: A day/night service which provides organized developmental activities for individuals with intellectual/developmental disabilities to prepare the individual to live and work as independently as possible. The activities and services of ADVP are designed to adhere to the principles of normalization and community integration.
245. **Assertive Community Treatment (ACT):** Services provided in accordance with Medicaid Clinical Coverage Policy 8A-1 *Assertive Community Treatment (ACT) Program* or State-Funded Assertive Community Treatment.
246. **Community Support Team (CST):** Services provided in accordance with Medicaid Clinical Coverage Policy 8A-6 NC Medicaid Community Support Team (CST) or State-Funded Community Support Team services.
247. **Competitive Integrated Employment:** Work that is performed on a full-time or part-time basis (including self-employment) and for which a Member/ Recipient: (a) is compensated at a rate that is not less than applicable minimum wage for the place of employment; (b) is eligible for the level of benefits provided to other employees; (c) interacts with other persons who are not individuals with disabilities to the same extent that individuals who do not have disabilities interact with this person; and (d) has opportunities for advancement that are similar to those available to other employees who are not individuals with disabilities as defined in 34 C.F.R §361.5(c)(9).
248. **Competitive Integrated Employment Intellectual/ Developmental Disabilities (CIE I/DD) Strategic Plan:** The Department's plan for further development and implementation of enhanced CIE services and supports for Members/ Recipients with I/DD.
249. **Competitive Integrated Employment (CIE) Data Collection Tool:** The Competitive Integrated Employment Data Collection Tool developed by the Department for purposes of gathering information regarding individuals with intellectual or developmental disabilities receiving 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.
250. **Comprehensive Case Management:** A 24/7 service for adults with either a primary mental health (MH) or primary substance use (SU) disorder, or co-occurring MH/SU/IDD TBI diagnosis, in addition to other designated eligibility criteria, that would benefit from time-limited case management assistance to access necessary behavioral health, physical health, health-related, and social services.
251. **Critical Access Hospital:** Has the same meaning as Critical Access Hospital as defined in 42 C.F.R. § 400.202.
252. **Day Components of ICF-IID in Lieu of Service in ADVP Setting:** The day components of any ICF-IID In Lieu of Service which have been developed and implemented by the BH I/DD Tailored Plan that are provided in an ADVP setting.
253. **Individual Placement and Support (IPS):** Supported Employment services provided in accordance with the IPS fidelity model within Medicaid Clinical Care Policy 8H-2 *1915(i) Individual Placement & Support (IPS) for Mental*

Health and Substance Use or Amended State-Funded Individual Placement & Support (IPS) for Adult Mental Health/Adult Substance Use (AMA/ASA).

254. **IPS Fidelity Review:** The comprehensive evaluation of each Individual Placement and Support (IPS) Supported Employment Services provider by the entity designated by the Department, based upon the IPS fidelity tool which is used to assess how well a provider is performing in critical elements of IPS and to identify any areas where improvement is needed.
255. **Lease up**: When an individual signs a lease for a property of that individual's choosing and has all rights and responsibilities of tenancy that individuals without disabilities have.
256. **Local Barriers Committee:** Team of experts from across the North Carolina Department of Health and Human Services (NC DHHS) that convenes monthly to review challenges to community integration for people with serious mental illness, with intent to resolve issues immediately. Ad hoc Department and BH I/DD Tailored Plan participants will be added as needed to resolve issues.
257. **Healthy Opportunities Pilot Duplicative Service**: A service is considered duplicative if it provides the same service or activity to a single individual that is available to that individual through a Medicaid/other service, (including In Lieu of Services (ILOS), Value-Added Services (VAS), 1915(i) services, and 1915(c) waiver services), State-Funded Services, or any other approved Medicaid authority outside of the 1115 demonstration, or other available federal/state/local publicly funded services.
258. **In-Reach/Transitions to Community Tool:** The tool approved by the Department that documents the TCL members' transition preferences, choices, and goals recorded by the TCL in-reach specialist and given to the transition team as a basis for transition and person-centered planning.
259. **Medicaid Expansion:** As defined in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended, which extends Medicaid eligibility to adults under age 65 (including parents and adults without dependent children) with incomes below one hundred thirty-three percent (133%) of the federal poverty level.
260. **Medicaid Expansion Eligible Members:** NC Medicaid beneficiaries enrolled in Medicaid based on meeting requirements for Medicaid Expansion eligibility category.
261. **MCO Stakeholder Advisory Group for CIE:** The stakeholder advisory group for competitive integrated employment opportunities for individuals with I/DD that includes representatives from each BH I/DD Tailored Plan, which is facilitated by the Department.
262. **RN/OT Evaluator Team:** The BH I/DD Tailored Plan's Registered Nurses and Occupational Therapists, or Certified Occupational Therapist Assistants providing physical health and functional assessments for individuals and transition planning assistance to individuals in TCL with complex medical conditions and/or significant functional deficits.
263. **Specialized Services:** Services as defined in 42 CFR 483.120.
264. **State Barriers Committee:** Convenes monthly as required and outlined in the DOJ Settlement Agreement (SA) meets to solve systemic barriers elevated to the Department. The committee consists of cross-functional DHHS departmental subject matter experts, associated state experts outside the Department, and external stakeholders connected to the implementation of TCL in North Carolina.
265. **System Security Plan (SSP)**: Serves as an overview of the security requirements for the system and its components by describing the security controls in place, or planned, for meetings those requirements, the rationale for security categorization, how individual controls are implemented within specific environments, and situational system usage restrictions. Additional information regarding the System Security Plan is located at https://policies.ncdhhs.gov/wp-content/uploads/DHHS-Security-Manual-v01_03-2023.pdf. The term Security Compliance Plan (SCP) may be used interchangeably with System Security Plan (SSP).
266. **TCL Designated Tailored Care Management Provider:** Advanced Medical Home Plus (AMH+) practice or Care Management Agency (CMA) that provides Tailored Care Management for TCL participants in accordance with the Department's Tailored Care Management requirements for TCL participants. Each TCL Designated Tailored Care Management Provider must be designated by the Department and endorsed by the BH I/DD Tailored Plan in the region the AMH+ or CMA seeks to serve.

267. **TCL Housing Pilot:** The supportive housing pilot conducted by the Department in collaboration with participating BH I/DD Tailored Plans which will focus on streamlining the process for accessing and utilizing targeted housing units, allowing the BH I/DD Tailored Plans to develop and foster relationships directly with property managers.

268. **TCL Implementation Plan:** The final Implementation Plan developed by the Department and provided to the Independent Reviewer and United States Department of Justice pursuant to the Fifth Modification of the Settlement Agreement, which identifies how the State will meet the metrics and timelines for its implementation of each of the Settlement Agreement's requirements.

c. *Section III. B. Abbreviations and Acronyms.* The following defined acronym is revised and restated in its entirety as identified herein:

59. DMH/DD/SUS: Division of Mental Health, Developmental Disabilities and Substance Use Services

d. *Section III. B. Abbreviations and Acronyms* is revised to add the following:

243. ACT: Assertive Community Treatment
244. ADVP: Adult Developmental Vocational Program
245. CCP: Continuing Care Plan
246. CIE: Competitive Integrated Employment
247. CLS: Community Living Supports
248. CST: Community Support Team
249. DCW: Direct Care Worker
250. HASP: Healthcare Access and Stabilization Program
251. IPS: Individual Placement & Support
252. IR/TCL: In-Reach Transitions to Community Living
253. SPMI: Severe and Persistent Mental Illness
254. TAC: Technical Assistance Collaborative
255. UNC: University of North Carolina

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

1. The Contract Term will be from July 26, 2021, through June 30, 2028, and shall include an implementation period and Contract Years 1 through 4 as follows:

Contract Period	July 26, 2021 through June 30, 2028
Implementation Period	July 26, 2021 through June 30, 2024
Contract Year 1	July 1, 2024 through June 30, 2025
Contract Year 2	July 1, 2025 through June 30, 2026
Contract Year 3	July 1, 2026 through June 30, 2027
Contract Year 4	July 1, 2027 through June 30, 2028

f. *Section III. D. General Terms and Conditions, 1: <u>ACCESS TO PERSONS AND RECORDS:</u>* is revised and restated in its entirety as follows:

1. <u>ACCESS TO PERSONS AND RECORDS</u>:

a. Pursuant to N.C. Gen. Stat. §§ 147-64.7 and 143-49(9), the Department, the State Auditor, appropriate state or federal officials, and their respective authorized employees or agents shall have access to persons and premises, or such other locations where duties under the Contract are being performed, and are authorized to inspect, monitor, or otherwise evaluate all books, records, data, information, and accounts of the Contractor, their Subcontractor(s), other persons directed by the Contractor, or Contractor's parent or affiliated companies as far as they relate to transactions under the Contract, performance of the Contract, or to costs charged to the Contract. The Contractor shall retain any such books, records, data, information, and accounts in accordance with **<u>Paragraph</u>**

37. RECORDS RETENTION of this Section III.D. of this Contract. Changes or additional audit, retention or reporting requirements may be imposed by federal or state law and/or regulation, and the Contractor must adhere to such changes or additions.

b. The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with N.C. Gen. Stat. § 147-64.7. Nothing in this Section is intended to limit or restrict the State Auditor's rights.

c. The financial auditors of the Department shall also have full access to all of Contractor's financial records and other information determined by the Department to be necessary for the Department's substantiation of the monthly payment(s). These audit rights are in addition to any audit rights any federal agency may have regarding the use of federally allocated funds.

d. The following entities may audit the records of this Contract during and after the term of the Contract to verify accounts and data affecting fees or performance:
   i. The State Auditor;
   ii. The internal auditors of the affected department~~,~~ or agency, to the extent authorized by law; and
   iii. he Joint Legislative Commission on Governmental Operations (Commission) and Commission Staff, as defined in NCGS § 120-72(3), whose primary responsibility is to provide professional or administrative services to the Commission.

e. Nothing in this section is intended to limit or restrict the State Auditor's rights.

f. This term shall survive termination or expiration of the Contract.

g. ***Section III. D. General Terms and Conditions, 10: <u>COMPLIANCE WITH LAWS:</u>*** **is revised and restated to add the following:**

f. Certifications and Representations
   i. Contractor shall certify annually pursuant to 2 C.F.R. § 200.209 Certifications and Representations that it is in compliance with federal certification and representation requirements regarding Nondiscrimination, Drug-Free Workplace Requirements, Environmental Tobacco Smoke, Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions and Lobbying.
   ii. Contractor shall certify annually that is in compliance with state certification requirements regarding Verification of Employee Work Authorization, Ineligibility, Prior Convictions and Prior Employment.

h. ***Section III. D. General Terms and Conditions, 11: <u>CONTRACT ADMINISTRATORS:</u> For the Department, Contract Administrator regarding day to day activities herein*** **is revised to indicate the two (2) Contract Administrators for day to day activities as follows:**

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	820 S. Boylan Avenue McBryde Building Raleigh, NC 27603
Mail Service Center Address	1950 Mail Service Center Raleigh, NC 27699-1950
Telephone Number	919-527-7031
Email Address	kelsi.knick@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

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

Name & Title	Kelly Crosbie Director, Division of Mental Health, Developmental Disabilities, and Substance Use Services

Physical Address	695 Palmer Drive Anderson Building Raleigh, NC 27601
Mail Service Center Address	3001 Mail Service Center Raleigh, NC 27601
Telephone Number	984-239-0657
Email Address	kelly.crosbie@dhhs.nc.gov Medicaid.Contractadministrator@dhhs.nc.gov

i. ***Section III. D. General Terms and Conditions, 18. ENTIRE AGREEMENT AND ORDER OF PRECEDENCE:*** **is revised and restated in its entirety as follows:**

18. **ENTIRE AGREEMENT AND ORDER OF PRECEDENCE.** This Contract consists of the following documents incorporated herein by reference:
    a. Any amendments, business requirements, or implementation plans, executed by the Parties, in reverse chronological order; and any Contractor policies, plans, processes, procedures, strategy documents, work plans, or work flows that require Department approval and have been approved, in reverse chronological order;
    b. Executed Contract;
    c. Negotiation Document #1;
    d. Written clarifications, in reverse chronological order;
    e. Addenda to the RFA, in reverse chronological order;
    f. The RFA in its entirety; and
    g. Applicant's application.

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

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

d. **Tailored Care Management Payments**: The Department will make payments to the Contractor to support Tailored Care Management. The Contractor will make the following payments to certified AMH+ practices and Care Management Agencies for Tailored Care Management in accordance with *Section V.B.4.v. Provider Payments*:
    i. Tailored Care Management payment per member per month in which the AMH+ or CMA performed Tailored Care Management. Payment will be at a fixed rate and acuity-tiered. It will not be placed at risk.

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

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

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

l. ***Section III. D. General Terms and Conditions, 34. <u>PAYMENT AND REIMBURSEMENT:</u> f. Healthy Opportunities Pilot Program, i., h.* is revised and restated in its entirety as follows:**

h. The Contractor shall return unused Pilot funds to the Department at the Department's request to reconcile the Contractor's actual Pilot spending against Pilot payments received from the Department and is required to return all unused Pilot funds to the Department at the end of the Pilot program in accordance with the Department's Healthy Opportunities Pilot Payment Protocol: Tailored Plans/ PIHPs.

m. ***Section III. D. General Terms and Conditions, 34. <u>PAYMENT AND REIMBURSEMENT:</u> g. Monthly Single Stream Fund Base Allocation* is revised and restated in its entirety as follows:**

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

n. ***Section III. D. General Terms and Conditions, 34. <u>PAYMENT AND REIMBURSEMENT:</u> m. Tailored Care Management Capacity Building Performance Incentive Program Payments, i., a.-f.* is revised and restated in its entirety as follows:**

a. Incentive payments will be separate from and in addition to the capitation payments and non-risk payments made to the Contractor under this Contract and will be specifically identified as the "performance incentive payment" in any distribution to the Contractor.
b. The incentive payment is not premium revenue and will not be considered as such for purposes of calculating the Contractor's Medical Loss Ratio.
c. In no event will payments exceed five percent (5%) of total capitation revenue that the Contractor receives during the Contract Year.
d. Eligibility to participate in the Performance Incentive Program is not linked to whether the Contractor is a public or private entity or whether the Contractor has provided an intergovernmental transfer to the Department.
e. Payments are for performance on a quarterly basis under the Contract Year in which the performance incentive arrangement is applied.
f. The program will not be renewed automatically, but the Department may include the program in subsequent Contract Years. The Department will notify the Contractor ninety (90) Calendar Days prior to the distribution of additional funds if the program will be in effect for that Contract Year.

o. ***Section III. D. General Terms and Conditions, 37. <u>RECORDS RETENTION:</u> a.* is revised and restated in its entirety as follows:**

a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer or shorter period is required by federal or State law or policy. Federal record retention standards are located in 45 C.F.R. § 74.53. The State policy is mandated by the State Archives of North Carolina and is located here: https://archives.ncdcr.gov/government.

p. ***Section III. D. General Terms and Conditions, 50. <u>WAIVER:</u>* is revised and restated in its entirety as follows**:

50. **<u>WAIVER:</u>** The failure to enforce or the waiver by the State of any right or of breach or default on one occasion or instance shall not constitute the waiver of such right, breach or default on any subsequent occasion or instance. The Department reserves the right to waive any of the requirements in this Contract by providing written notice of such waiver to Contractor. In order to constitute a waiver, said waiver must be entitled "Waiver of Contract Requirements," list the specific requirement(s) being waived, the timeframe for such waiver, and be signed and dated by the Deputy Secretary for the Division of Health Benefits. For avoidance of doubt or dispute, there shall be no tacit, de facto, verbal, informal, or written waivers signed by anyone other than the Deputy Secretary of the Division of Health Benefits. Without such explicit written and signed "Waiver of Contract Requirements" document, the waiver is not effective.

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, (i)*** **is revised and restated in its entirety as follows:**

(i) In the State of North Carolina, the Department is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance and the single state authority for the SAMHSA Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant. The Division of Health Benefits (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) program. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the Medicaid program. The Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS) is designated with the administration of State-funded mental health, developmental disability, TBI and substance use services.

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

(n) Managed Care Clinical Supplemental Guidance;
(o) Notice of Adverse Benefit Determination Clearinghouse Upload Instructions;
(p) Notice of Adverse Benefit Determination Guide;
(q) Healthy Opportunities Pilot Care Management Protocol: Tailored Plans/PIHPs;
(r) Healthy Opportunities Pilot Payment Protocol: Tailored Plans/PIHPs;
(s) Healthy Opportunities Pilot Transitions of Care Protocol: Tailored Plans/PIHPs;
(t) Tailored Care Management Auto Assignment Requirements Document;
(u) TCL Housing Guidelines;
(v) TCL QAPI Guidance;
(w) Comprehensive Case Management;
(x) Department's TCL Implementation Plan;
(y) Tailored Care Management (TCM) Provider Manual Addendum: Healthy Opportunities Pilot Standard Terms & Conditions for AMH+s/CMAs;
(z) Tailored Care Management Provider Manual;
(aa) Encounter Data Submission Guide;
(bb) Encounter Data Submission Companion Guides - 837I and 837;
(cc) DMH/DD/SUS Records Management and Documentation Manual;
(dd) DMH/DD/SUS State-funded Enhanced Mental Health and Substance Abuse Services Manual;
(ee) DMH/DD/SUS Service Definitions;
(ff) Person-Centered Planning Instruction Manual;
(gg) DMH/DD/SUS policies;
(hh) NCMT AMH/PCP AA Requirements Document; and
(ii) NC Medicaid Managed Care Billing Guidance to Health Plans.

c. ***Section V. A. Unified, 1. Administration and Management, ix. Staffing and Facilities for Medicaid and State-funded Services, (vi) Key BH I/DD Tailored Plan Personnel, (e)*** **is revised and restated in its entirety as follows:**

(e) Key Personnel include the following as identified in *Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements*:

Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements			
Role		**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program and State- funded Services	Individual who has clear authority over the general administration and day-to-day business activities of this Contract. Duties and Responsibilities include but are not limited to: • Appoint, supervise, and terminate area authority staff • Administer area authority services • Develop the budget of the area authority for review by the area board • Provide information and advice to the board of county commissioners through county manager • Serve as the liaison between the area authority and the department	• Must meet North Carolina residency requirements under this Contract • Must hold a Master's degree from an accredited college or university in business, healthcare administration, public health, finance, law, medicine or a related field that is deemed acceptable by the area board • Must have management experience
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State- funded Services	Individual responsible for accounting and finance operations, including financial audit activities.	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years' of progressive accounting experience, of which three (3) years are supervisory
3.	Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State- funded Services	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training.	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree from an accredited college or university • Minimum of seven (7) years' experience in a managed care organization

Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements			
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
4.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.	• Must meet North Carolina residency requirements under this Contract • Must be a primary care physician or psychiatrist, fully licensed to practice in NC and in good standing. • Minimum of five (5) years of experience in a health clinical setting and five (5) years' experience in managed care • If a primary care physician, clinical experience with child/adolescent and adult populations is preferred. If individual does not have experience with all populations, direct medical staff reports must have experience. • If a psychiatrist, clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience)
5.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and manages all fraud, waste, and abuse and compliance activities.	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree from an accredited college or university
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected.	• Must meet North Carolina residency requirements under this Contract • Must hold a Bachelor's degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years' experience in health care

Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements			
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
7.	Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances. Individual reports to the CMO.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred
8.	Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and the peer review functions of related member appeals. Individual reports to the CMO.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT)
9.	Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for providers services and provider relations, including all network development and management issues. Individual reports to the COO.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of combined network operations, provider relations, and management experience

10.	Deputy Chief Medical Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for activities as assigned by the CMO including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for supporting CMO in ensuring an integrated approach	• Must meet North Carolina residency requirements under this Contract
			• Minimum of five (5) years' experience in a health clinical setting and two (2) years' experience in managed care
			• If the CMO is a psychiatrist, then the DCMO must meet the following requirements:
			  ○ Must be a primary care physician fully licensed to practice in NC and in good standing.
			  ○ Minimum of five (5) years clinical experience and two (2) years'

	Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements		
	Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs. Individual reports to the CMO.	experience in managed care ○ Clinical experience with child/adolescent and adult populations is preferred. If individual does not have child/adolescent and adult populations experience, direct medical staff reports must have experience with these populations. • If the CMO is a primary care physician, then the DCMO must meet the following requirements: ○ Must be a psychiatrist fully licensed to practice in NC and in good standing ○ Minimum of five (5) years' experience in a BH and/or I/DD clinical setting and two (2) years' experience in managed care ○ Clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, at least one direct medical staff report must have experience)
11.	I/DD and TBI Clinical Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI benefits with physical health and BH benefits. Individual reports to the CMO.	• Must meet North Carolina residency requirements under this Contract • Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI • Minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in I/DD care

Section V.A.1. Third Revised and Restated Table 1. Key Personnel Requirements			
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
12.	Director of Population Health and Care Management of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for providing oversight and leadership of all prevention/population health, care management and care coordination programs, including oversight of care management provided by AMH+, State-funded case management providers, and care management agencies and care management delivered by Local Health Departments. Individual reports to the CMO.	• Must meet North Carolina residency requirements under this Contract • Minimum of five (5) years of demonstrated care management/population health experience in a healthcare organization serving Medicaid beneficiaries, including experience with BH and I/DD populations • North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT)
13.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the BH I/DD Tailored Plan pharmacy benefits and services. Individual reports to the CMO.	• Must meet North Carolina residency requirements under this Contract • Must be a North Carolina- registered pharmacist with a current NC pharmacist license • Minimum of three (3) working years of Medicaid pharmacy benefits management experience

d. ***Section V. A. Unified, 1. Administration and Management, ix. Staffing and Facilities for Medicaid and State-funded Services, (xiii) Organization Roles and Positions, (c) Fraud, Waste, and Abuse Staffing, (1)*** **is revised and restated in its entirety as follows:**

(1) The BH I/DD Tailored Plan shall establish a single point of contact to serve as a liaison with the Department, including DHB and DMH/DD/SUS program integrity staff, and Medical Investigation Division (MID) and to facilitate timely response to Department requests for information, including claims data. This individual may be the same person who serves as the liaison for the PIHP.

e. ***Section V. A. Unified, 1. Administration and Management, ix. Staffing and Facilities for Medicaid and State-funded Services, (xiv) Physical Presence in North Carolina, (e)*** **is to add the following:**

(30) Waiver Contract Manager;
(31) Olmstead Manager.;
(32) Housing Development Coordinator;
(33) TCL Quality Assurance (QA) Specialist;
(34) TCL Data Analyst;
(35) Supported Employment Specialist;
(36) Outreach Diversion Specialist;
(37) Diversion Specialist; and
(38) BH I/DD Tailored Plan Transition Coordinator.

f. ***Section V. A. Unified, 2. Program Operations*** **is revised to add the following:**

vii. Provider Network Management and Provider Contracting

(i) The BH I/DD Tailored Plan shall contract with all Cross-Area Service Programs (CASPs) located throughout the State. A listing of the current CASPs is distributed annually with the state-funded Continuation Allocation letter. The BH I/DD Tailored Plan shall use the plan's approved standard contract for all providers who are CASPs.

g. ***Section V. A. Unified, 3. Compliance, ii. Program Integrity (PI) for Medicaid and State-funded Services, (iii), (a), (2)-(3)*** **is revised and restated in its entirety as follows:**

(2) The BH I/DD Tailored Plan shall disclose to the Department within thirty (30) Calendar Days of BH I/DD Tailored Plan's knowledge of any disciplinary actions or exclusions that have not been communicated on the Provider Enrollment File as a Termination to the BH I/DD Tailored Plan imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.

(3) The BH I/DD Tailored Plan shall check, at the time of contracting and at least every month thereafter, the exclusion status of any agents, managing employees, or persons with an ownership or controlling interest in the BH I/DD Tailored Plan or any of its delegated entities~~,~~ or subcontractors against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal or state funds to Excluded Person(s) or entities. The BH I/DD Tailored Plan shall not be controlled by a sanctioned individual. 42 C.F.R. 438.602(d) and 42 C.F.R. § 438.808(a).

h. ***Section V. A. Unified, 3. Compliance, ii. Program Integrity (PI) for Medicaid and State-funded Services, (iii), (j) Post-Payment Clinical and Administrative Reviews for State-Funded Services, (1)*** **is revised and restated in its entirety as follows:**

(1) The BH I/DD Tailored Plan shall conduct post-payment reviews of State-funded Services to monitor whether services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SUS Records Management and Documentation Manual; the DMH/DD/SUS State-funded Enhanced Mental Health and Substance Abuse Services Manual and the DMH/DD/SUS Service Definitions; the Person-Centered Planning Instruction Manual; DMH/DD/SUS policies; and the NC General Statutes, as applicable.

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

(iii) Investigation Coordination

(a) The BH I/DD Tailored Plan shall refer all allegations of fraud for Medicaid and State-funded Services, including instances involving the BH I/DD Tailored Plan's own conduct, to the Department using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) Calendar Days of making the determination.

(b) Once an allegation of fraud has been referred to the Department, until further written notice by the Department, the BH I/DD Tailored Plan shall not take any further action including the following:

(1) Contacting the subject of the investigation about any matters related to the investigation;

(2) Continuing the investigation into the matter;

(3) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or

(4) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

(c) The BH I/DD Tailored Plan shall cooperate with all appropriate State and federal agencies, including MID, the DMH/DD/SUS Financial Audit and Program Integrity teams and/or federal OIG, in investigating fraud and abuse.

(d) The BH I/DD Tailored Plan shall provide data or information requested by the Department including the DMH/DD/SUS Financial Audit and Program Integrity teams or MID, as relevant, in the standardized format within five (5) Calendar Days of receiving the request.

(e) The BH I/DD Tailored Plan shall cooperate with the Department, including the DMH/DD/SUS Financial Audit and Program Integrity teams and MID, as relevant, to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.

(f) If the BH I/DD Tailored Plan is directed to complete the investigation into potential instances of fraud, then the BH I/DD Tailored Plan shall report to the Department, including the DMH/DD/SUS Financial Audit and Program Integrity teams and MID, as relevant, in a specified format, its finding within ten (10) Calendar Days of the conclusion of the investigation.

(g) The BH I/DD Tailored Plan shall report new information related to a previously referred potential instance of fraud where PI, the DMH/DD/SUS Financial Audit and Program Integrity teams and MID did not intervene in the investigation to the Department. The BH I/DD Tailored Plan shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) Calendar Days of receiving or identifying the new information.

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

(i) Action by the BH I/DD Tailored Plan shall not preclude the Department, including the DMH/DD/SUS Financial Audit and Program Integrity teams or MID from conducting an audit or accepting a self-disclosure from a provider even if the BH I/DD Tailored Plan has conducted an audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.

(j) The BH I/DD Tailored Plan must participate in:

   (1) Monthly calls with the Department regarding fraud, waste, and abuse;

   (2) Quarterly in-person or virtual meetings with the Department, including the DMH/DD/SUS Financial Audit and Program Integrity teams and MID regarding fraud and abuse; and

   (3) Ad hoc calls or meetings as requested by the Department, including the DMH/DD/SUS Financial Audit and Program Integrity teams and MID.

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

j. ***Section V. A. Unified, 3. Compliance, iv. Third Party Liability (TPL) for Medicaid, (ix) Identification of Other Forms of Insurance*** **is revised to add the following:**

(i) The BH I/DD Tailored Plan shall ensure providers have the capability to verify other insurance information through the BH I/DD Tailored Plan's provider portal and Real-Time Eligibility Electronic Data Interchange (EDI) transactions 270/271. The BH I/DD Tailored Plan shall provide an operational timeline to the Department for review and approval on how the BH I/DD Tailored Plan will meet the requirements of this section by BH I/DD Tailored Plan Launch.

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

(xiii) Bypass Third Party Liability Rules

   (a) No later than BH I/DD Tailored Plan Launch, the BH I/DD Tailored Plan shall adjudicate claims as the primary payer and bypass Third Party Liability edits for Medicaid covered services that commercial insurance does not typically cover based on criteria in the Managed Care Billing Guide (Section 3.27 Other Insurance and Third-Party Liability Bypass Guidance Document).

(xiv) To support the insurance come-behind billing effort and protect the BH I/DD Tailored Plan's recovery rights on billed claims, the BH I/DD Tailored Plan shall submit to the Department a listing of the claims previously billed to insurance carriers or recovered by other means. This listing is referred to as a match-off file. After the initial match-off file is delivered, the subsequent frequency will be monthly. The BH I/DD Tailored Plan shall deliver the initial match-off file to reflect the claims billed to insurance carriers or recovered during the period of July 1, 2024 through September 30, 2024 to the Department by no later than October 15, 2024. The monthly match-off files shall be delivered by the fifteenth (15th) day of each month and include the claims billed or recovered in the previous calendar month.

(a) To support the match-off process, the match-off file should contain the following required data elements:
   (1) DHB Recognized Medicaid Identification number;
   (2) From Date of Service;
   (3) To Date of Service;
   (4) Charge Amount;
   (5) Paid Amount;
   (6) Paid Date;
   (7) Date Billed to Carrier or Claim Recouped from Provider; and
   (8) Deposit date of recovery or date claim recouped from Provider.

(b) If the BH I/DD Tailored Plan does not provide a match-off file or delivers the file to the Department after the due date described in this section, any resulting refunds requested by carriers will be refunded to the carrier by the BH I/DD Tailored Plan.

l. ***Section V. A. Unified, 3. Compliance, vi. Medicaid Service Recipient Explanation of Medical Benefit (REOMB) for Medicaid*** **is revised to add the following:**

(x) The BH I/DD Tailored Plan shall submit a REOMB report quarterly, or upon request, to the Department.

m. ***Section V. A. Unified, 4. Stakeholder Engagement and Community Partnerships, iv., (vii) Outreach and Education, (e)*** **is revised and restated in its entirety as follows:**

(e) Reserved.

n. ***Section V. A. Unified, 4. Stakeholder Engagement and Community Partnerships, vi., c.*** **is revised and restated in its entirety as follows:**

c. Reserved.

o. ***Section V. A. Unified*** **is revised to add the following:**

5. Transitions to Community Living
   i. TCL Program Implementation
      (i) The BH I/DD Tailored Plan shall make available and implement all services and supports for Members/Recipients who are TCL members or TCL-eligible with the goal that individuals with disabilities have a right under the Rehabilitation Act, Americans with Disabilities Act, and the US Supreme Court decision in Olmstead v LC (1999), to receive community-based services that meet their needs in the most integrated setting possible. The BH I/DD Tailored Plan shall ensure the availability and provision of services and supports for the TCL population it serves in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.
      (ii) To meet the terms of the Settlement Agreement, BH I/DD Tailored Plan staff will continue to perform the TCL functions of in-reach, diversion, transition and complex care for TCL participants. BH I/DD Tailored Plan TCL staff will work exclusively with TCL members or TCL-eligible individuals.
      (iii) The BH I/DD Tailored Plan shall assign members eligible for TCL in-reach specialist, transition coordinator, registered nurse/occupational therapist evaluator team, and diversion specialist.
      (iv) The BH I/DD Tailored Plan's RN/OT Evaluator Team shall provide physical health and functional assessments and transition planning assistance primarily for TCL members transitioning from Adult Care Homes (ACHs), and to the extent capacity allows, to TCL members transitioning from other settings, with complex medical and/or functional conditions that significantly impede the transition of the member into the community (severity is determined by the BH I/DD Tailored Plan screening process). The RN/OT Evaluator Team shall complete all of the following:
         (a) Within thirty (30) Calendar Days after referral of the TCL member to the RN/OT Evaluator Team, perform an in-person, initial physical health and functional assessment of the TCL member, review the member's

records and collateral information available from other sources, and develop recommendations for services and supports needed to support the member in community-based housing. When the TCL member resides in another BH I/DD Tailored Plan's region, the "home and host" process described in the below subsection (v) shall apply.

(b) Within thirty (30) calendar days after the RN/OT Evaluator Team's initial assessment of the TCL member, provide the member's behavioral health services provider maintaining the member's Person-Centered Plan a copy of the physical health and functional assessment and the RN/OT Evaluator Team's recommendations for services and supports needed to support the member in community-based housing in the next transition team meeting;

(c) The RN/OT Evaluator Team or qualified BH I/DD Tailored Plan staff working with them will perform a housing walkthrough to assess the TCL member's need for physical and functional health accommodations in the member's chosen housing to further inform and implement the RN/OT Evaluator Team's assessment recommendations. This walkthrough shall be done before transition, except to the extent when that is not possible due to housing occupancy restrictions, the walkthrough will be performed within three (3) Business Days after the member's transition.

(d) Within seven (7) calendar days after the RN/OT Evaluator Team 's walkthrough of the member's community-based housing, consult face-to-face (preferably in person, or using Telehealth instead) with the TCL member and the TCL member's behavioral health service providers to include the medical, self-care, functional skill development recommendations and reasonable accommodations recommendations pertaining to the TCL member's housing in the member's person-centered plan; and present any recommended specialty care services to the TCL member and to their attending ordering provider. If the ordering provider and the TCL member approve the recommendation, the ordering provider will make the appropriate referral.

(e) During the ninety (90) days post-transition period, verify that the TCL member's chosen physical health, behavioral health and specialty services are effective, and shall reassess as needed to make additional recommendations.

(v) The Home and Host RN/OT Evaluator Team Process is based upon the guidance regarding In-Reach and Transitioning Individuals Between LME-MCOs set forth on the Department's TCL website. If the member resides in a county which is not their county of Medicaid eligibility, the home BH I/DD Tailored Plan may contact the host or BH I/DD Tailored Plan defined at the county in which the member resides. After the home BH I/DD Tailored Plan receives member-signed releases of information to exchange information, the host BH I/DD Tailored Plan's RN/OT Evaluator Team would complete and share the assessment with the home BH I/DD Tailored Plan's RN/OT Evaluator Team. The home TCL Transition Coordinator and Transition Team would incorporate the host RN/OT Evaluator Team assessment recommendations into the transition plan and Person-Centered Plan and follow existing In-Reach and Transitioning Individuals between LME-MCOs guidance for additional RN/OT Evaluator Team responsibilities.

ii. Tailored Care Management for TCL Members

(i) Tailored Care Management for TCL members provided by TCL Designated Tailored Care Management Providers and BH I/DD Tailored Plan care managers shall incorporate all care coordination activities in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.

(ii) Tailored Care Management for TCL members shall be performed by and be the responsibility of the BH I/DD Tailored Plan as the assigned care manager, unless the TCL member elects to obtain Tailored Care Management from a TCL Designated Tailored Care Management Provider.

(iii) TCL members and TCL-eligible individuals shall be assigned to Tailored Care Management based at the BH I/DD Tailored Plan unless the member elects to obtain Tailored Care Management from a TCL Designated Tailored Care Management Provider in accordance with the provisions of this Section and *Section V.B.3*. The BH I/DD Tailored Plan shall ensure that TCL members and TCL-eligible individuals are afforded a choice of Tailored Care Management provider.

(iv) Where applicable, the BH I/DD Tailored Plan may allow an individual to continue receiving Tailored Care Management from their current provider where the provider is a TCL Designated Tailored Care Management Provider. BH I/DD Tailored Plan TCL staff shall work cooperatively with TCL Designated Tailored Care Management providers and BH I/DD Tailored Plan care managers to ensure that all care management and coordination needs of the TCL member or TCL-eligible individual are effectively addressed. The BH I/DD Tailored Plan shall ensure that all TCL functions are fulfilled for TCL members and TCL-eligible individuals who elect to receive Tailored Care Management from a TCL Designated Tailored Care Management Provider.

(v) For TCL members who are receiving a duplicative TCM service, who opt out of Tailored Care Management, or who fail to engage in Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for performing care coordination in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.

(vi) The BH I/DD Tailored Plan shall utilize the TCL-specific care management policy and TCL designation requirements developed by the Department to evaluate providers seeking to become a TCL Designated Tailored Care Management provider. The Department has selected NCQA as the organization responsible for certification of TCL Designated Tailored Care Management Providers.

(vii) The BH I/DD Tailored Plan shall work cooperatively with NCQA and the Department to support qualified AMH+/CMA providers seeking to be designated by the Department to serve TCL members and TCL-eligible individuals in accordance with the TCL-specific Tailored Care Management requirements and process established by the Department. The BH I/DD Tailored Plan shall establish and implement criteria for evaluation of qualified AMH+ practices and CMAs in accordance with the process developed by the Department and written guidance issued by the Department Tailored Care Management Provider Manual. The BH I/DD Tailored Plan shall establish and implement one set of criteria for LME/MCO operations, including, without limitation, the BH I/DD Tailored Plan and Prepaid Inpatient Health Plan contracts.

(viii) The BH I/DD Tailored Plan shall submit to the Department a letter of support for those providers that have demonstrated experience effectively providing services to TCL members and TCL-eligible individuals and working effectively with TCL staff. BH I/DD Tailored Plans may work with Tailored Care Management providers by mutual agreement to prepare for NCQA pre-designation auditing. The letter shall include the BH I/DD Tailored Plan's attestation that the provider meets the TCL designation requirements established by the Department and the support requirements established by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall submit one letter of support for the LME/MCO operations, including without limitation, the Prepaid Inpatient Health Plan contract. The BH I/DD Tailored Plan shall work cooperatively with the Department to ensure that all TCL Designated Tailored Care Management providers serving its members provide Tailored Care Management functions in accordance with the requirements of this Contract.

(ix) The BH I/DD Tailored Plan shall notify the Department within five (5) Business Days after discovery if it learns that any TCL Designated Tailored Care Management Provider fails to continue meet the criteria established by the Department and the BH I/DD Tailored Plan.

   (a) Upon notification to the Department of any TCL Designated Tailored Care Management Provider failing to continue to meet the TCL Designated Tailored Care Management criteria established by the Department, if the Department determines that rescinding the provider's designation as a TCL Designated Tailored Care Management provider is appropriate, the Department will issue the provider and the BH I/DD Tailored Plan written notice of its decision. The BH I/DD Tailored Plan shall reassign any TCL Members receiving TCL Tailored Care Management services from the provider who has lost their designation as a TCL Designated Tailored Care Management Provider and shall provide the Member notice of the reassignment within fourteen (14) Calendar Days after receipt of notice of the rescinded TCL designation from the Department.

   (b) In the event the BH I/DD Tailored Plan seeks to take action as permitted under its contract with the TCL Designated Tailored Care Management Provider for failure to meet criteria for designation as a TCL Tailored Care Management provider or failure to perform as required under the provider contract, the BH I/DD Tailored Plan shall notify the provider and issue appeal rights consistent with the provider contract.

(x) The BH I/DD Tailored Plan's TCL staff shall share the member's person-centered plan with the member's Tailored Care Management care manager.

(xi) The BH I/DD Tailored Plan shall develop and implement an expedited process in order to receive and respond to inquiries from a plan based care manager, AMH+, or CMA delivering Tailored Care Management to the TCL member.

(a) For urgent situations affecting the TCL member's health, safety, and housing security, as determined in the BH I/DD Tailored Plan's discretion, the BH I/DD Tailored Plan shall respond to inquiries within twenty-four (24) hours of receiving them.

(b) For non-urgent situations, the BH I/DD Tailored Plan shall respond to inquiries within three (3) Business Days of receiving them.

(xii) The BH I/DD Tailored Plan's TCL staff shall participate in any member care team meetings to which the BH I/DD Tailored Plan's TCL staff have been invited by the Tailored Care Management care manager.

(xiii) The BH I/DD Tailored Plan shall ensure that the BH I/DD Tailored Plan's TCL staff receive training on coordinating care with Tailored Care Management care managers.

(xiv) The BH I/DD Tailored Plan shall include as part of the BH I/DD Tailored Plan's Care Management Policy, submitted to the Department for review and approval, a new component of the BH I/DD Tailored Plan's Care Management Policy that incorporates policies and procedures for delivering Tailored Care Management to TCL members to address all of the following:

(a) TCL members and TCL-eligible individuals are afforded a choice of Tailored Care Management provider.

(b) How BH I/DD Tailored Plan TCL staff will work cooperatively and coordinate with the TCL members' Tailored Care Management providers to ensure that all care management and care coordination needs of the TCL member or TCL-eligible individual are effectively addressed.

(c) Criteria for the BH I/DD Tailored Plan's evaluation and endorsement of qualified AMH+ practices and CMAs through a letter of support for TCL designation in accordance with the process developed by the Department and written guidance issued by the Department, as described in *Section V.A.5.ii.(vii).* and *Section V.A.5.ii.(viii)*.

(d) How the BH I/DD Tailored Plan will monitor services provided by TCL Designated Tailored Care Management providers to confirm criteria established by the Department and the BH I/DD Tailored Plan as described in *Section V.A.5.ii.(xi)* are met.

(e) Expedited process by which the BH I/DD Tailored Plan will receive and respond to inquiries from a TCL member's Tailored Care Management provider in accordance with the timelines specified in this Contract.

(f) How BH I/DD Tailored Plan's TCL staff will work collaboratively with each TCL member's Tailored Care Management provider to:

(1) Share the TCL member's person-centered plan with the TCL member's Tailored Care Management care manager,

(2) Ensure the TCL member's Tailored Care Management care manager participates in TCL member care team meetings,

(3) Complete training on coordinating care with each TCL member's Tailored Care Management provider, and;

(4) Coordinate the provision of Tailored Care Management to the TCL member.

(g) BH I/DD Tailored Plan's approach to providing technical assistance to AMH+ practices and CMAs, including those designated to provide Tailored Care Management to TCL members.

iii. The BH I/DD Tailored Plan shall review, and to the extent necessary, provide technical assistance regarding each Tailored Care Management providers' policies and procedures for serving TCL members. Housing

(i) Development and Improvement of Housing Opportunities.

(a) The BH I/DD Tailored Plan shall develop and implement strategies for accomplishing housing objectives and milestones for the TCL population in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan including the annual housing expectations as set for in *Section*

VII. Attachment U. Annual Housing Expectations. These housing objectives and milestones shall include without limitation:

(1) Reducing homelessness;
(2) Diverting individuals from institutional settings;
(3) Increasing the number of individuals entering supportive housing;
(4) Sustaining supportive housing and decreasing housing separations;
(5) Promoting independence for members with disabilities;
(6) Improving members' health;
(7) Helping members explore and obtain supported employment;
(8) Helping members sustain supported employment; and
(9) Increasing landlord engagement to increase the number of housing units available for members.

(b) The BH I/DD Tailored Plan shall improve the capacity and performance of service providers to sustain supportive housing and improve housing retention rates in accordance with TCL Housing Guidelines issued by the Department and with the Department's TCL Implementation Plan.

(c) The BH I/DD Tailored Plan shall notify the Department of a housing separation that involves a Level 3 Incident as defined by 10A NCAC 27G .0602 or death of a TCL member within twenty-four (24) hours after the BH I/DD Tailored Plan's discovery of the Level 3 Incident or death. The BH I/DD Tailored Plan shall conduct a root cause analysis for housing separations that involve a Level 3 Incident or death of a TCL member and report the findings of the root cause analysis to the Department within five (5) Business Days or other timeframe specified by the Department. The BH I/DD Tailored Plan shall develop and implement any plan for performance improvement that may be required by the Department following any such housing separation within the timeframe specified by the Department. Any such performance improvement plan to be developed and implemented by the BH I/DD Tailored Plan shall include without limitation, mitigation of any compliance and risk issues identified by the BH I/DD Tailored Plan or the Department.

(d) Upon execution of this Amendment, the BH I/DD Tailored Plan shall oversee the housing inspections in accordance with the annual Housing Quality Standards (HQS) or National Standard for the Physical Inspection of Real Estate (NSPIRE) which must be timely conducted by a third-party HQS/NSPIRE certified housing inspector to ensure that each permanent supportive housing unit is safe, fully functional, and sanitary.

  (1) For quality control purposes, the Housing Collaborative will conduct inspection reviews of no less than five (5) of each BH I/DD Tailored Plan's permanent supportive housing units each month by the BH I/DD Tailored Plan's inspectors, at the Department's expense. Quality Assurance inspections will be completed within sixty (60) Calendar Days of the original inspection and may include just a paper review of previous inspection report if no citations were noted. BH I/DD Tailored Plans will be notified of units for Quality Assurance inspection prior to an inspector visiting the property and findings will be shared with BH I/DD Tailored Plan prior to communicating with the property. If inspections completed by the Housing Collaborative identify any noncompliant properties, the BH I/DD Tailored Plan will have the opportunity to demonstrate that the issues causing the HQS/NSPIRE inspection to fail occurred after completion of the most recent timely inspection by the BH I/DD Tailored Plan.

(e) The BH I/DD Tailored Plan may request written approval from the Department to utilize HQS/NSPIRE certified housing inspectors employed directly by the BH I/DD Tailored Plan, subject to the Department's review of information presented by the BH I/DD Tailored Plan, and in accordance with the following:

  (1) The BH I/DD Tailored Plan shall ensure timely completion of no less than ninety percent (90%) of housing inspections in accordance with the Department's TCL Housing Guidelines. If, at any time, more than ten percent (10%) of the BH I/DD Tailored Plan's required housing inspections are untimely, BH I/DD Tailored Plan shall retain third-party certified housing inspectors to the extent needed to complete all pending and overdue inspections within thirty (30) Calendar Days.
  (2) If the Department determines that the BH I/DD Tailored Plan has not sufficiently demonstrated that the cause of HQS/NSPIRE inspection failure occurred after timely inspection by the BH I/DD Tailored

Plan, the BH I/DD Tailored Plan will be required to contract with the Housing Collaborative at BH I/DD Tailored Plan's expense, for re-inspection of any units that failed HQS inspection and retain a third-party certified inspector to verify no less than two percent (2%) of HQS/NSPIRE inspections conducted by the BH I/DD Tailored Plan-employed HQS/NSPIRE-certified inspectors during the past six (6) months.

(3) The Department may rescind its approval of the BH I/DD Tailored Plan's use of BH I/DD Tailored Plan-employed HQS/NSPIRE-certified inspectors if the Housing Collaborative inspections find that fifteen percent (15%) or more of the housing inspections performed by the BH I/DD Tailored Plan's HQS/NSPIRE-certified inspectors do not meet passing inspection standards; if the BH I/DD Tailored Plan has failed to complete at least ninety percent (90%) of the housing inspections in a timely manner; or if the BH I/DD Tailored Plan fails to materially comply with any other requirements of this Section regarding inspection of permanent supported housing.

(4) As a condition of its approval, the Department may require that a third-party certified housing inspector verify a percentage of inspections conducted by the BH I/DD Tailored Plan's HQS/NSPIRE housing inspectors were conducted in accordance with Department TCL Housing Guidelines.

(f) The BH I/DD Tailored Plan shall develop and implement a regional enhanced bridge housing program that provides transitional housing for TCL members, including without limitation individuals transitioning from State Psychiatric Hospitals and Adult Care Homes. BH I/DD Tailored Plan shall operate its regional bridge housing program in accordance with the Department's TCL Housing Guidelines, the Settlement Agreement, and the TCL Implementation Plan. The BH I/DD Tailored Plan shall submit a monthly TCL Housing Entry and Exit Report through PCDU detailing the utilization of the regional enhanced bridge housing program. Through its regional enhanced bridge housing program, the BH I/DD Tailored Plan shall monitor and incorporate requirements into provider contracts for regional enhanced bridge housing to complete the following functions for TCL members:

(1) Physical health and functional assessment to the extent needed in accordance with the TCL Housing Guidelines,

(2) Ensure furnishing of skill building services prior to transitioning to the community, and

(3) Ensure delivery of services to support the TCL member's person-centered goals that include access to housing, services, employment, and other community integration efforts.

(g) The BH I/DD Tailored Plan shall provide In-Reach, transition and housing services to achieve the benchmarks established in the Department's TCL Housing Performance Plan. The BH I/DD Tailored Plan shall submit to the Department data to demonstrate the BH I/DD Tailored Plan's compliance with the TCL Housing Performance Plan Measures within twenty (20) Calendar Days after the last day of each quarter.

(h) If the BH I/DD Tailored Plan fails to meet the performance measures under the Department's TCL Housing Performance Plan, the Department reserves the right to impose any and all remedies available under *Section VI.* of the Contract.

(ii) Housing Slots

(a) The BH I/DD Tailored Plan shall provide supportive housing slots for TCL members to live in settings that meet the following criteria:

(1) They are permanent housing with Tenancy Rights;

(2) They include tenancy support services that enable members to attain and maintain integrated, affordable housing. Tenancy support services offered to members living in supportive housing are flexible and are available as needed and desired, but are not mandated as a condition of tenancy;

(3) They enable members with disabilities to interact with individuals without disabilities to the fullest extent possible;

(4) They do not limit a member's ability to access community activities at times, frequencies and with persons of their choosing;

(5) They are scattered site housing, where no more than twenty percent (20%) of the units in any development are occupied by individuals with a disability known to the State, except as set forth below:

a) Up to two hundred fifty (250) Housing Slots may be in disability-neutral developments, that have up to sixteen (16) units, where more than twenty percent (20%) of the units are occupied by individuals with a disability known to the State; and
b) They afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities.

(iii) In-Reach

(a) The BH I/DD Tailored Plan shall ensure that preferences, recovery strategies, and goals documented in the In-Reach Transitions to Community Living (IR/TCL) tool are clearly documented in each TCL member's transition plan, which is the member's community services person-centered plan. For TCL members in a state psychiatric hospital (SPH), that information is required to be included in the member's SPH Continuing Care Plan (CCP).

(b) TCL In-Reach and Diversion functions may not be delegated by BH I/DD Tailored Plan or its TCL In-Reach or Diversion staff to any entity providing care management for the member.

(c) During In-Reach, the TCL In-Reach Specialist shall offer the TCL member (and where applicable, their guardian) opportunities to meet with other individuals with similar disabilities who:

(1) Have transitioned into community-based permanent supportive housing through TCL,
(2) Are competitively employed and/or receiving adult education or training, and
(3) Are receiving services within the community, and integrated and active in their community and/or family.

(d) Prior to disclosing the identity, disability status, diagnosis, and/or contact information of an individual with similar disabilities to a TCL member, the PIHP's TCL In-Reach Specialist shall obtain and document the individual with similar disabilities' consent for disclosure to the TCL member.

(e) If the TCL member (and where applicable, their guardian) chooses to meet with these transitioned individuals, the In-Reach Specialist shall facilitate and attend such face-to-face meetings "(preferably in person, or if not reasonably feasible, using Telehealth). The visit shall be performed in-person, and/or in the community based, or using Telehealth upon the TCL member's preference.

(iv) Transition

(a) The BH I/DD Tailored Plan shall convene, as frequently as needed, the transition teams supporting TCL members to effectively prepare a comprehensive discharge and transition plan for each TCL member. Transition team meetings shall occur in person and face-to-face with the TCL member.

(b) The BH I/DD Tailored Plan shall require the following to participate in meetings of transition teams supporting TCL members: (a) the TCL Transition Coordinator; (b) the Provider(s) that are or will be serving the TCL member; (c) where applicable, the member's care manager delivering tailored care management; and (d) in the case of transitions from state psychiatric facilities, the member's Social Worker.

(c) BH I/DD Tailored Plan transition team meetings supporting TCL members shall be led by the member and facilitated by the transition coordinator.

(d) BH I/DD Tailored Plan transition teams supporting TCL members shall complete the following responsibilities: (a) identify and specify services, service providers, and community activities and supports required to meet the member's needs as part of the member's transition plan; and (b) establish tasks and timelines for transition team members to facilitate development of a comprehensive and timely discharge and transition plan.

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

specialists, transition coordinators, diversion specialist, and their supervisors and associated BH I/DD Tailored Plan staff.

(f) The BH I/DD Tailored Plan shall address and resolve internally any obstacles to a TCL member's discharge and transition to community-based supportive housing. The BH I/DD Tailored Plan shall resolve any barriers internally or refer any unresolved barriers to the Local Barriers Committee and for systemic barriers, the State Barriers Committee.

(g) The BH I/DD Tailored Plan shall include all of the following personnel as standing members in local transition teams, also known as Local Barriers Committee: (a) TCL leadership, (b) cross-functional representatives, (c) local Ombudsman, (d) DHHS TCL staff, and (e) ad hoc members such as individuals, providers, and other stakeholders.

(h) BH I/DD Tailored Plan Local Barriers Committee shall accomplish all of the following:

(1) Meet at least monthly, and more often if needed to support the needs of TCL members;

(2) Maintain an agenda that includes standing items, including without limitation, adult care home barriers, State barriers committee elevations, and Department state barriers committee updates; and

(3) Keep minutes of each meeting and provide the Department with a copy of the Local Barriers Committee's meeting minutes for each month within seven (7) Business Days after the last day of the month.

(i) The BH I/DD Tailored Plan shall ensure that no more than ninety (90) Calendar Days after a TCL member transitions into supportive housing, the TCL Transition Coordinator convenes the member's transition team to assess and identify the member's ongoing needs and the transition team roles and responsibilities for meeting those needs.

(j) The BH I/DD Tailored Plan Local Barriers Committee shall complete and submit to the Department its quarterly local barriers tracker or other Local Barriers Committee activity logs requested by the Department.

(v) Training Requirements for Staff and Providers

(a) The BH I/DD Tailored Plan shall ensure that all of its staff (including without limitation In-Reach staff, Transition Coordinators, Diversion, and Tailored Care Management staff) and providers (including without limitation CST and ACT providers, and TCL Designated Tailored Care Management Providers) who support TCL members shall complete the following annual training curricula developed by the Department and made available by the Department free of charge on a virtual platform:

(1) Series of on-line housing training modules developed by TAC/UNC that addresses service gaps identified in the coaching/mentoring of CST providers, tenancy rights, reasonable accommodations;

(2) Permanent Supportive Housing Refresher training; and

(3) DHHS-approved Person Centered Planning Training.

(b) The BH I/DD Tailored Plan shall develop and implement a barriers training curriculum specific to their region and the population they serve regarding local and state barriers identification, referrals, and solution processes in accordance with written guidance provided by the Department, including a template curriculum, and the Department's TCL Implementation Plan. The BH I/DD Tailored Plan will submit the proposed training curriculum to the Department for approval within ninety (90) Calendar Days after the Department issues written guidance regarding the identification, referral, and resolution of local and state barriers for the TCL population. The BH I/DD Tailored Plan shall ensure that all staff (including without limitation In-Reach staff, Transition Coordinators, Diversion, and Tailored Care Management staff) and providers (including without limitation CST and ACT providers and TCL Designated Tailored Care Management Providers) who support TCL members complete this barriers training annually.

(vi) TCL Staffing Level

(a) To fulfill its responsibilities to serve and support TCL members and TCL-eligible individuals, the BH I/DD Tailored Plan shall maintain the TCL staffing level needed to effectively serve the TCL members and TCL-eligible individuals in its Region in accordance with the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.

(b) The BH I/DD Tailored Plan shall maintain a TCL team comprised of the following key TCL positions needed to effectively serve BH I/DD Tailored Plan's TCL members and TCL-eligible individuals:
   (1) Transition Coordinator and Transition Coordinator Supervisor;
   (2) In-Reach Specialist and In-Reach Supervisor;
   (3) Outreach Diversion Specialist;
   (4) Housing Development Coordinator;
   (5) Housing Supervisor;
   (6) Quality Assurance Specialist;
   (7) Data Analyst;
   (8) TCL Program Manager;
   (9) Supported Employment Specialist; and
   (10) Barriers and Training Coordinator.

(vii) Housing Pilot

(a) BH I/DD Tailored Plans participating in the Department's TCL Housing Pilot will work cooperatively with the Department to streamline the process for accessing and utilizing targeted housing units for TCL members, allowing the BH I/DD Tailored Plan to develop and foster relationships directly with property managers. BH I/DD Tailored Plan shall perform all of the following key responsibilities as part of the TCL Housing Pilot:
   (1) Recruit, onboard, train and supervise the dedicated team of Housing Specialists who are assigned to the TCL Housing Pilot to improve access to Targeted/Key units in new Low-Income Housing Tax Credit-financed properties, and to effectively coordinate pre-tenancy and tenancy sustaining services offered by in reach staff, peer support services and case management staff.
   (2) Participate to the development of a standard process map as well as TCL Housing Pilot policies and procedures for initial lease up activities of the targeted units consistent with the In-Reach/ Transition and Diversion Manual.
   (3) Participate to the development of evaluation criteria/outcomes used to measure the success of the TCL Housing Pilot through working with North Carolina Housing Finance Agency (NCHFA) and the Technical Assistance Collaborative (TAC) to develop a means to collect and report to the Department on lease up increases and period of time to lease up throughout the pilot.
   (4) Support Housing Specialists to evaluate data on lease up increases and time to lease up gathered during the pilot to conduct periodic process improvements.
   (5) The BH I/DD Tailored Plan's TCL Housing Pilot staff shall actively participate in pilot planning and implementation meetings scheduled by the Department to be held no less frequently than monthly. BH I/DD Tailored Plan's TCL Housing Pilot Staff shall participate in training with key parties including without limitation, the Department, NCHFA, and the Technical Assistance Collaborative (TAC), as well as the BH I/DD Tailored Plan's dedicated Housing Specialists, as needed and as determined by the Department.
   (6) Collaborate with the Department's consultant, the TAC, in evaluation and discussion of lessons learned to assess efforts and improve processes after the initial lease up process is complete with a property.
   (7) Meet with property development managers within one hundred (100) Calendar Days prior to property availability once property data sheets are available (i.e., one hundred twenty (120) Calendar Days prior to property availability) to build relationships and understand the property's application processes.
   (8) Refer directly and assist TCL members in executing a lease and conduct move-in tenancy management activities as needed, such as furnishing unit and setting up utilities, in order to fill available targeted housing units once a certificate of occupancy is provided.
   (9) Work cooperatively with the Department's Division of Aging and Adult Services to complete and process waivers when needed for referred TCL members.

(viii) TCL Staff Expansion for Implementation Plan

(a) BH I/DD Tailored Plan shall complete its responsibilities to serve TCL members and TCL-eligible individuals in accordance with the Settlement Agreement, the Department's TCL Implementation Plan, and the

Department's TCL Housing Pilot (for participating BH I/DD Tailored Plan's). The Department has identified key TCL staff positions that are required by each BH I/DD Tailored Plan to serve TCL members and TCL-eligible individuals (collectively, "TCL Staff Expansion"). The Department shall notify each BH I/DD Tailored Plan of its TCL Staff Expansion and the corresponding amount of TCL Staff Expansion Funding, as defined in the following paragraph.

(b) The Department shall provide additional funds to the BH I/DD Tailored Plan through the BH I/DD Tailored Plan's PMPM for the sole purpose of helping to fund the additional expenses that will be incurred by the BH I/DD Tailored Plan to hire and retain qualified individuals to fill the TCL Staff Expansion positions. BH I/DD Tailored Plan shall use the TCL Staff Expansion Funding exclusively for the purpose of recruiting, hiring and retaining qualified individuals to fill the TCL Staff Expansion positions. To the extent needed to maintain an appropriate TCL staffing level to effectively serve TCL members and TCL-eligible individuals, the BH I/DD Tailored Plan shall utilize funds available to it, including funds other than the TCL Staff Expansion Funding, for the purpose of hiring and retaining additional TCL staff beyond the specific positions funded by the TCL Staff Expansion Funding.

(c) BH I/DD Tailored Plan shall take all steps necessary to develop and implement expedited recruitment, hiring and onboarding of qualified individuals to fill any open TCL Staff Expansion positions funded by the TCL Staff Expansion Funding. The BH I/DD Tailored Plan shall leverage the experience and expertise of its existing TCL staff to support the hiring and onboarding of qualified individuals to fill the TCL Staff Expansion positions. BH I/DD Tailored Plan shall make best efforts to complete the hiring and onboarding for any open TCL Staff Expansion positions as expeditiously as possible and in any event within one hundred twenty (120) Calendar Days after the position becomes open.

(ix) Department Monitoring of TCL Staff Expansion.

(a) To ensure the appropriate utilization of the Department's funding contribution toward each BH I/DD Tailored Plan's TCL Staff Expansion, the Department will monitor the BH I/DD Tailored Plan's recruiting, hiring, and onboarding practices for the TCL Staff Expansion positions to ensure the following:

(1) BH I/DD Tailored Plan's job description aligns with the responsibilities for each type of position set forth in this Contract;

(2) New hiring salaries are competitively set using the TCL Staff Expansion Funding to reclassify current TCL positions, equitably blend and maintain new and current staff positions at all TCL staff levels;

(3) The BH I/DD Tailored Plan's expedited interview, hiring, BH I/DD Tailored Plan onboarding, and TCL training ramp up meet the timelines established in this Contract;

(4) The BH I/DD Tailored Plan deploys TCL Staff Expansion positions; and

(5) The BH I/DD Tailored Plan continues to employ qualified individuals in the TCL Staff Expansion positions.

(b) The BH I/DD Tailored Plan shall submit to the Department one quarterly report shared across and inclusive of other LME/MCO operations, including without limitation, the PIHP, regarding the status of its recruitment, hiring and onboarding of individuals for the TCL Staff Expansion positions within fifteen (15) Calendar Days after the last day of each calendar quarter. For any BH I/DD Tailored Plan that fails to comply with the timeline or other contractual requirements governing the TCL Staff Expansion, the Department may in its discretion perform onsite TCL Expansion Staff reviews to provide technical assistance and ongoing monitoring regarding the BH I/DD Tailored Plan's progress with recruiting, hiring and onboarding individuals for the TCL Staff Expansion positions, and the BH I/DD Tailored Plan's contract compliance with the terms of this Contract governing the TCL Staff Expansion.

iv. Behavioral Health Services

(i) Access to Array and Intensity of Behavioral Health Services

(a) The BH I/DD Tailored Plan shall submit an annual TCL Service Capacity Report to the Department on an annual basis in July 2025, in accordance with templates issued by the Department.

(b) The BH I/DD Tailored Plan shall provide access to the array and intensity of services and support necessary to enable TCL members, with or without a housing slot, to successfully transition to and live in the

community in accordance with the TCL Implementation Plan, Settlement Agreement, and any guidance issued by the Department regarding Behavioral Health Services for TCL members, which will be assessed based on the TCL Annual Service Capacity Report.

(1) The TCL member must be fully informed of their rights and opportunities to transition into community-based permanent supportive housing, employment/education, behavioral, medical, function skill and other services, and community integration activities in the community of their choice;

(2) The member completes an Informed Decision-Making Tool (IDM) with the BH I/DD Tailored Plan; and

(3) For fidelity reviews completed on or after July 20, 2024, the BH I/DD Tailored Plan shall require Providers scoring in the low fidelity range (3.0-3.4 for ACT, below 100 for IPS) to receive coaching and TA from the Department's vendor. Within thirty (30) Calendar Days of the final debrief, providers scoring in the low fidelity range will contact the Department's vendor to begin coaching and TA. Coaching and TA will last a minimum of six (6) months. The scope of the training and coaching assignment will be determined by the Department's vendor in consultation with the Department based on an assessment of areas of improvement and recommendations detailed in the final fidelity report. The BH I/DD Tailored Plan will be notified of any providers who do not initiate required coaching and TA or any providers who do not complete required coaching and TA.

(ii) Assertive Engagement

(a) The BH I/DD Tailored Plan Tailored Plan shall monitor community service providers and update provider contracts as needed to ensure assertive engagement is provided for TCL members or TCL-eligible individuals, and that assertive engagement services provided include all of the following:

(1) Engage regularly and build rapport with TCL members or TCL-eligible individuals in the facility;

(2) Serve as standing and tasked members of transition teams supporting TCL members or TCL-eligible individuals;

(3) Complete assigned transition tasks before, during and after the TCL member's or TCL-eligible individual's transition; and

(4) Be available to directly assist the TCL member or TCL-eligible individual in pre-transition community visitation.

(b) The BH I/DD Tailored Plan shall utilize funding provided by the Department to expand assertive engagement for the purpose of ensuring and improving access to assertive engagement for TCL members, including without limitation, to increase rates and/or improve payment models, and to improve the availability and provision of intensive services for TCL members in facilities.

(c) The BH I/DD Tailored Plan shall establish and implement provider contractual requirements for assertive engagement that are consistent with the Department's guidance regarding assertive engagement, and the requirements of the Settlement Agreement and the Department's TCL Implementation Plan.

v. IPS Services

(i) Prioritized IPS for TCL Members

(a) The BH I/DD Tailored Plan shall improve the capacity and performance of service providers to engage TCL members regarding IPS and to improve employment outcomes for TCL members in accordance with TCL Supported Employment Guidance issued by the Department and with the Department's TCL Implementation Plan.

(b) The BH I/DD Tailored Plan shall prioritize TCL members to receive IPS and that TCL members who make an informed choice to pursue competitive integrated employment are referred to the BH I/DD Tailored Plan for a 1915(i) assessment, complete the 1915(i) assessment, have included IPS in the TCL member's Care Plan/ ISP, and upon approval of 1915(i) eligibility as determined by the Department, are referred to an IPS provider.

(1) The BH I/DD Tailored Plan shall educate TCL members regarding IPS and the benefits of employment on recovery leveraging the behavioral health supports the member is currently receiving. Evidence based IPS for TCL members includes without limitation, assistance in preparing for, identifying, and maintaining competitive integrated employment.

(ii) Implementation of Standardized North Carolina Collaborative for Ongoing Recovery through Employment (NC CORE) Model

(a) The BH I/DD Tailored Plan shall implement the NC CORE Model for IPS provided to TCL members in accordance with guidance issued by the Department and with the Department's TCL Implementation Plan.

(b) The BH I/DD Tailored Plan shall oversee its provider network to ensure that the delivery of IPS services under the NC CORE Model enables providers to engage TCL members, enroll them in services, provide integrated services, assist them in preparing for employment or education, identify job opportunities consistent with individuals' choices, and assist individuals to obtain and maintain employment and receive follow-up services following employment as needed.

(c) The BH I/DD Tailored Plan shall provide technical assistance to all providers on the effective implementation of the NC CORE milestone payment model for IPS services provided to TCL members. The requirements of subsection *V.A.5.iv.(i)(a)-(b)* shall not apply to TCL members receiving ACT.

(iii) Improved IPS and ACT Supported Employment Services

(a) The BH I/DD Tailored Plan shall monitor its provider network to ensure that TCL members receiving ACT who elect to receive supported employment are provided supported employment by the vocational specialist on the ACT team.

(1) The BH I/DD Tailored Plan shall develop and maintain IPS and ACT provider capacity that is adequate to serve TCL members in the essential area of supported employment.

(2) The BH I/DD Tailored Plan shall improve the quality and outcome of IPS Services in accordance with the IPS Strategic Plan approved by the Department and progress will be reviewed with the BH I/DD Tailored Plan in bi-monthly calls starting February 2025.

(3) To improve IPS and ACT supported employment services, the BH I/DD Tailored Plan shall:

a) Review each service provider's current IPS Fidelity Review, or ACT Fidelity Review (as applicable) upon receipt of the final fidelity report from the Department and provide technical assistance to providers to address recommended improvements. The BH I/DD Tailored Plan shall develop plans of correction for long-standing provider fidelity issues and monitor the provider's progress in subsequent fidelity reviews.

b) Submit required monthly TCL IPS Population and Utilization Reports to the Department, including data required as part of the Department approved IPS Strategic Plan.

c) Submit required quarterly TCL IPS Strategic Plan Progress Reports to the Department, including data required as part of the Department approved IPS Strategic Plan.

d) 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.

e) Improve IPS providers' linkage to Vocational Rehabilitation (VR) offices throughout 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.

f) Facilitate the expansion of benefits counseling by network providers, improve VR benefits counseling linkage for TCL members, when applicable, and facilitate improved relationships between local Social Security Administration offices and IPS providers.

(iv) Integrated Supported Employment and Behavioral Health Services for TCL Members

(a) The BH I/DD Tailored Plan shall include provisions in its IPS Supported Employment Service provider contracts and shall monitor its providers to ensure that TCL members receive IPS Supported Employment Services from a provider who also offers integrated behavioral health services in accordance with TCL Supported Employment Guidance issued by the Department and with the Department's TCL Implementation Plan, including job preparation, job identification, and job retention.

(b) The BH I/DD Tailored Plan shall inform all TCL members of IPS through face-to-face visits, Telehealth, phone calls, or written materials provided to member. The BH I/DD Tailored Plan shall engage with each member

to consider IPS services and refer any TCL members who make an informed decision for a 1915(i) assessment to be referred and receive IPS services. The BH I/DD Tailored Plan shall engage the TCL member utilizing strategies provided in accordance with TCL Supported Employment Guidance issued by the Department and with the Department's TCL Implementation Plan.

(c) The BH I/DD Tailored Plan shall ensure that all TCL members receiving ACT services are educated on and offered supported employment services integrated with other behavioral health services provided through ACT.

(d) The BH I/DD Tailored Plan shall inform all TCL members receiving ACT services of supported employment embedded in the ACT services, to enable them to make an informed decision to be connected to the Supported Employment Services.

vi. Quality Assurance and Performance Improvement

(i) The BH I/DD Tailored Plan shall include the following additional elements in its QAPI Plan to support its current and future TCL members un accordance with TCL QAPI Guidance issued by the Department:

(a) Processes to monitor, assess, ensure and improve the quality and sufficiency of services and supports provided to populations in or at risk of entrance into institutional or adult care home settings, as referenced in the TCL Settlement Agreement, including TCL member outcomes monitoring. The TCL QAPI plan will address service aspects including and not limited to the following:

(1) Person-Centered Plans adhere to the Department issued Person-Centered Planning Guidance document and training;

(2) Services are individualized, evidence based, and recovery focused as outlined in the TCL Implementation Plan;

(3) Services and supports strengthen the individual's integration into community living;

(4) Services and supports mitigate housing separations;

(5) Expansion of evidenced based peer support (examples include Wellness Recovery Action Plan (WRAP) and Wellness Management Recovery (WMR)), focused on individuals in the current and future TCL target population; and

(6) Crisis planning and response services adhere to Person Centered Planning Guidance Document and Template.

(7) Contract providers meet the four (4) core requirements of the Settlement Agreement:

i. Providing services that are recovery focused and evidence based;

ii. Providing services that are flexible to meet the individualized needs of the individual;

iii. Providing services that help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and

iv. Providing services that increase and strengthen the individual's network of community and natural supports, as well as their use of such supports.

(b) Processes to monitor, assess, ensure and improve the delivery, quality and effectiveness, and outcomes of contracted In-Reach, discharge and transition planning, pre-screening and diversion functions for populations in or at risk of entrance into institutional or adult care home settings.

(ii) In accordance with TCL QAPI guidance issued by the Department, the BH I/DD Tailored Plan shall integrate TCL QAPI Plan elements into its overall QAPI and QMIP by September 2, 2024. Beginning with the report due August 14, 2024, the BH I/DD Tailored Plan shall submit to the Department within forty-five (45) Calendar Days following the end of each quarter a TCL QAPI Progress Report regarding implementation of the TCL component of its QAPI Plan in accordance with TCL QAPI Guidance issued by the Department.

6. Competitive Integrated Employment for Individuals with I/DD

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) 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.

(iii) 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.

(iv) Complete the CIE Data Collection Tool provided by the Department, as described in *Section VII. Third 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.

(v) Participate in the MCO CIE Stakeholder Advisory Group for CIE in accordance with the schedule established by the Department.

(vi) 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.

ii. CIE Terms Used in This Section

(i) As used in this *Section V. Scope of Services. A. Unified. 6. Competitive Integrated Employment for Individuals with IDD. i. (i)*, "Competitive Integrated Employment" is work that is performed on a full-time or part-time basis (including self-employment) and for which a Member/Recipient: (a) is compensated at a rate that is not less than applicable minimum wage for the place of employment; (b) is eligible for the level of benefits provided to other employees; (c) is at a location where the Member/ Recipient interacts with other persons who are not individuals with disabilities to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with these persons; and (d) present opportunities for advancement that are similar to those for other employees who are not individuals with disabilities, as defined in 34 C.F.R §361.5(c)(9).

7. Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements:

i. Upon notification by the Department, the BH I/DD Tailored Plan shall coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120, for Members admitted to nursing facilities and coordinate transition back to the community if or when the Member no longer meets medical necessity criteria for skilled nursing.

ii. The BH I/DD Tailored Plan shall arrange for the provision of Specialized Services identified by the PASRR process for Members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this Contract as listed in *Section V.C.2.a.iv.*

(i) The BH I/DD Tailored Plan shall confirm clinically appropriate State Specialized Services are documented in the nursing facility's plan of care for the Member and shall coordinate with the nursing facility and other providers, as relevant, to ensure linkage to Specialized Services.

8. Clinically Appropriate Placement of Minors

i. Within one (1) Business Day, or as soon as reasonably feasible thereafter, of the BH I/DD Tailored Plan's receipt of written notification that a Member/Recipient under eighteen (18) years of age remains in the Emergency Department ready for discharge and in need of Medicaid State Plan enhanced behavioral health services that include, if in applicable benefit plan and meets medical necessity criteria, residential placement in a licensed facility (i.e., residential treatment, and/or PRTF service) upon discharge from the Emergency Department, the BH I/DD Tailored Plan shall demonstrate best efforts to arrange for the Member/Recipient to receive such services in an appropriate placement with the approval of the Member/Recipient's guardian or legally responsible person (LRP). The BH I/DD Tailored Plan shall report to the Department weekly on all such Members/Recipients through the BCM-

073-M Report. To the extent the Department requires additional information on any individual Member/Recipient listed on the BCM-073-M Report, the Department shall notify the BH I/DD Tailored Plan through the PCDU.

ii. (i) A Member/Recipient's need for such services shall be determined through a Comprehensive Clinical Assessment (CCA) or similar evaluation. To the extent that the Emergency Department, guardian, LRP, contracted provider, or external TCM provider or other person/entity does not permit the BH I/DD Tailored Plan and its contracted providers to have prompt and timely access to the Member/Recipient to conduct and complete a full, timely and valid CCA or similar evaluation, the BH I/DD Tailored Plan shall notify the Department's Rapid Response Team (RRT), which will collaborate with the BH I/DD Tailored Plan and other persons and entities to ensure a CCA or similar evaluation is timely completed. any Member/ Recipient under eighteen (18) years of age who is taken into physical DSS custody and requires Medicaid State Plan enhanced behavioral health services that include residential placement in a licensed facility (i.e., residential treatment and/or PRTF service). The BH/IDD Tailored Plan shall demonstrate best efforts to arrange for the Member/Recipient to be appropriately placed within twenty-four (24) hours, or as soon a reasonably feasible thereafter, of the BH I/DD Tailored Plan's receipt of notification from DSS that the Member/ Recipient is in DSS physical custody and the BH/IDD Tailored Plan determines requires such services are medically necessary. The BH I/DD Tailored Plan shall demonstrate best efforts to avoid such a Member/ Recipient being boarded overnight in a DSS office, hotel, or similar placement. Automatic referral to a hospital emergency department for services does not satisfy this requirement. The BH I/DD Tailored Plan shall report to the Department weekly on all such Members/Recipients through the BCM-073-M Report. To the extent the Department requires additional information on any individual Member/Recipient listed on the BCM-073-M Report, the Department shall notify the BH I/DD Tailored Plan through the PCDU.

(i) Nothing in this Section requires the BH/IDD Tailored Plan to arrange for placement outside the recommended level of care in the Member/Recipient's CCA, or outside of services available in the applicable State-funded or Medicaid benefit plan, or where there is no availability of placement in the BH I/DD Tailored Plan network, including facilities operated by DSOHF. In the event that the parent, legal guardian or legal custodian of a Member/Recipient under eighteen (18) years of age identified in this section rejects or refuses admission to appropriate placement identified by the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall make best efforts to identify a mutually agreeable placement within the recommended level of care, but shall, in no case later than twenty-four (24) hours of receiving the parent's, legal guardian's, or legal custodian's rejection of appropriate placement identified by the BH I/DD Tailored Plan, demonstrate best efforts to arrange for placement for the Member/ Recipient in an appropriate setting for receipt of medically necessary Medicaid State Plan enhanced behavioral health services that include residential placement in a licensed facility, subject to the parents', legal guardian's, or legal custodian's consent.

p. ***Section V. B. Medicaid, 1. Members, i. Eligibility and Enrollment for BH I/DD Tailored Plans, (v) Medicaid managed Care Enrollment and Disenrollment, (a) BH I/DD Tailored Plan Roles and Responsibilities*, *(5)* is revised and restated in its entirety as follows:**

(5) The BH I/DD Tailored Plan shall ensure automatic reenrollment of a Member who is disenrolled solely because they lose North Carolina Medicaid eligibility for period of two (2) months or less. 42 C.F.R. § 438.56(g). From September 27, 2022 through seventeen (17) months after the end of the COVID-19 Public Health Emergency on October 11, 2024, the BH I/DD Tailored Plan shall ensure automatic reenrollment of a Member who is disenrolled solely because they lose North Carolina Medicaid eligibility for a period of ninety (90) Calendar Days as allowed under the Department's CMS approved waiver of Automatic Reenrollment into Medicaid Managed Care Plans as defined in section 1902(e)(14)(A) of the Social Security Act.

q. ***Section V. B. Medicaid, 1. Member, ii. Transition of Care, (i) Ongoing Requirements, (d), (5)* is revised and restated in its entirety as follows:**

(5) In instances in which a Member transitions into a BH I/DD Tailored Plan from NC Medicaid Direct, a Standard Plan, another BH I/DD Tailored Plan, another type of plan established by the Department or another type of health insurance

coverage, and the Member is in an ongoing course of treatment or has an Ongoing Special Condition, the BH I/DD Tailored Plan shall permit the Member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g), and as otherwise required by the Contract. A Member's I/DD, mental health diagnosis, substance use disorder or TBI shall be considered a special condition under N.C. Gen. Stat § 58-67-88(a)(1). In lieu of the transitional period established in N.C. Gen. Stat. § 58-67-88(d), the BH I/DD Tailored Plan shall honor a transitional period of a minimum of ninety (90) Calendar Days for all out-of-network Providers serving a transitioning Tailored Plan Members at the time of transition, treating out-of-network Providers the same as in-network Providers regarding both reimbursement and prior authorization requirements.

r. ***Section V. B. Medicaid, 1. Members, ii. Transition of Care, (i) Ongoing Requirement, (e) Transitions of Care with Change of Providers*** **is revised and restated in its entirety as follows:**

(e) Transition of Care with Change of Providers

(1) The BH I/DD Tailored Plan shall develop policies, processes and procedures to support Members transitioning between providers when a provider is terminated from or otherwise leaves the BH I/DD Tailored Plan's network.

i. The BH I/DD Tailored Plan shall develop policies, process and procedures that include supporting Members transitioning between providers when a provider is terminated from or otherwise leaves the BH I/DD Tailored Plan's network. The Provider Transition of Care Policy shall include at a minimum, the requirements of this Section.

ii. In instances in which a provider is terminated or leaves the BH I/DD Tailored Plan's network for expiration or nonrenewal of the contract and the member is in an ongoing course of treatment or has an ongoing special condition, the BH I/DD Tailored Plan shall permit the Member to continue seeing their provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d), (e), (f), and (g).

iii. In instances in which a provider is terminated or leaves the BH I/DD Tailored Plan's network for reasons related to quality of care or Program Integrity, the BH I/DD Tailored Plan shall notify the Member in accordance with this Section's requirements and shall assist the member in transitioning to an appropriate in-network provider that can meet the member's needs. The Department shall support the BH I/DD Tailored Plan in facilitating a timely transition.

(2) Member Notification of Provider Termination

i. Within fifteen (15) Calendar Days of providing notice of termination to the provider, the BH I/DD Tailored Plan shall provide written notice of termination of a network provider to all Members who have received or are scheduled to receive services consistent with *Section VII. Fourth Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* from the terminated provider within the twelve (12) month period immediately preceding the date of notice of termination, except if a terminated provider is a primary care provider (PCP), Advanced Medical Home Plus (AMH+) or care management agency (CMA) for a member. 42 C.F.R. § 438.10(f)(1).

ii. If a terminated provider is a PCP, AMH+ or CMA for a Member, the BH I/DD Tailored Plan shall notify the Member by the later of thirty (30) Calendar Days prior to the effective date of the termination or fifteen (15) Calendar Days after the receipt or issuance of a provider termination notice of the following:

a) Procedures for selecting an alternative PCP, AMH+ or CMA.

b) That the member will be assigned to a PCP, AMH+ or CMA if they do not actively select one within thirty (30) Calendar Days.

iii. If a terminated provider is a PCP, AMH+ or CMA for a member, the BH I/DD Tailored Plan shall ensure that the member selects or is assigned to a new PCP, AMH+ or CMA within thirty (30) Calendar Days of the date of notice to the member and notify the member of the procedures for continuing to receive care from the terminated provider and the limitations of the extension.

iv. The BH I/DD Tailored Plan shall use a member notice consistent with the Department-developed model member notice for the notification required by this Section. 42 C.F.R. § 438.10(c)(4)(ii).

(3) The BH I/DD Tailored Plan shall hold the member harmless for any costs associated with the transition between providers, including copying medical records or treatment plans.

(4) The BH I/DD Tailored Plan shall establish a Provider Transition of Care Policy that is consistent with the Department's Transition of Care Policy and this Contract.

i. The Provider Transition of Care Policy shall include processes and procedures for coordinating care for members who:

a) Have an ongoing special condition as defined in N.C. Gen. Stat. § 58-67-88(a)(1);

b) Are discharged from a residential or institutional setting;

c) Are obtaining services from a provider that leaves the BH I/DD Tailored Plan's network;

d) Must select a new PCP after a provider termination; and

e) Other requirements as identified by the Department.

(5) The BH I/DD Tailored Plan shall submit the Provider Transition of Care Policy to the Department for review and approval one hundred fifty (150) Calendar Days after the Contract Award.

(6) 1115 Waiver STC Member Notification

i. During the first six (6) months following BH I/DD Tailored Plan Launch, Contractor shall provide written notification to all Members who experienced disruption in their receipt of primary care treatment because their provider was not in Contractor's network within fifteen (15) Calendar Days if Member's historical primary care provider subsequently signs a contract to enter the BH I/DD Tailored Plan's provider network. When a Member's historical primary care provider joins the BH/ IDD Tailored Plan's network, the BH/IDD Tailored Plan shall permit the Member to change their Primary Care Provider to their historical primary care provider without cause.

(f) The BH I/DD Tailored Plan shall provide encounter, provider and Member data at least monthly, or more frequently in order to support transitions of care requirements or as requested by the Department.

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

(b) The BH I/DD Tailored Plan shall implement strategies to minimize the disruption of benefits at BH I/DD Tailored Plan implementation by taking the following actions:

(1) Offer to execute a contract or single case agreement with a Member's PCP who is not in the BH I/DD Tailored Plan's network on the date when the Member is assigned a PCP prior to launch of the BH I/DD Tailored Plans Members to allow Members to keep their current primary care provider (PCP).

(2) Continue medically necessary services for Members in an ongoing course of treatment without any form of prior approval and without regard to whether such services are provided by in-network or out-of-network providers for the duration stated in the NC Medicaid Managed Care Transition of Care Policy, unless the Member or Member's legal guardian or authorized representative has opted to discontinue such services or selects an in-network provider.

(3) During the first six (6) months following BH I/DD Tailored Plan Launch, Contractor shall provide written notification to all Members who experienced disruption in their receipt of primary care treatment because their provider was not in Contractor's network within fifteen (15) Calendar Days if Member's historical primary care provider subsequently signing a contract to enter the BH I/DD Tailored Plan's provider network. When a Member's historical primary care provider joins the BH/ IDD Tailored Plan's network, the BH/IDD Tailored Plan shall permit the Member to change their Primary Care Provider to their historical primary care provider without cause.

(4) Adhere to additional prior authorization requirements identified in the Transition of Care Flexibilities provided by the Department to Contractor, including resetting the number of visits that do not require prior

authorization, continuing to honor current authorizations for ongoing benefits and complying with Department-defined protocols for streamlining prior authorization requests.

t. ***Section V. B. Medicaid, 1. Members, iii. Member Engagement, (xii) Member Welcome Packet, (b)*** **is revised and restated as follows to remove "and upon redetermination" and there are no changes to subparts (1)-(4):**

(b) The BH I/DD Tailored Plan shall include the following in the initial member Welcome Packet:

u. ***Section V. B. Medicaid, 1. Members, iii. Member Engagement, (xiii) Member Identification Cards, (b)*** **is revised and restated in its entirety as follows:**

(b) A replacement identification card shall be provided at no charge to the Member at least once every twelve (12) months, or upon request by the Member or the Member's authorized representative or upon PCP change or PCP provider data that is listed on the ID card changes (e.g. address, name, phone number).

v. ***Section V. B. Medicaid, 1. Members, iii. Member Engagement, (xiv) Member Handbook, (e), (1)*** **is revised and restated in its entirety as follows:**

(1) Covered benefits provided by the BH I/DD Tailored Plan, including:
- i. Waiver services and supports where applicable;
- ii. Care management, including how to select and change care managers or care management entities; and
- iii. Any approved In Lieu of Services and Value-Added Services.

w. ***Section V. B. Medicaid, 1. Members, iii. Member Engagement, (xiv). Member Handbook, (e), (13)*** **is revised and restated in its entirety as follows:**

(13) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100, rights related to In Lieu of Services as defined in *Section V.B.2.i.(vii)* and *Attachment M.13. Approved in Lieu of Services* of this Contract, and any other rights and responsibilities under the Contract.

x. ***Section V. B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (ii) Member Grievances and Appeals General Requirements, (i)*** **is revised and restated in its entirety as follows:**

(i) The Department shall provide such templates in a timely fashion and agrees to provide the BH I/DD Tailored Plan with ninety (90) Calendar Days' advance notice of the issuance of new templates before the templates' proposed effective date. The Department shall not issue new templates more than once a year unless required by regulatory changes. The Department shall allow the BH I/DD Tailored Plan the right to provide comment and feedback on proposed template modifications, which the Department shall consider before the templates are finalized. Except as indicated in the template, the BH I/DD Tailored Plan shall not modify Department developed template language provided for the purposes of notifying Members of grievance and appeal acknowledgements, extensions, and decisions without prior written approval from the Department.

y. ***Section V. B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (ii) Member Grievances and Appeals General Requirements*** **is revised to add the following:**

(n) The BH I/DD Tailored Plan shall apply the Member grievance, Internal Plan Appeals, and State Fair Hearing provisions outlined in this Section to any approved In Lieu of Service to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.
- (1) The offer or coverage of ILOS(s) shall in no way alter or diminish the Member's rights under 42 C.F.R. § 438 Subpart F.
- (2) Consistent with 42 C.F.R. § 438.402, a Member shall retain the right to file an appeal with regard to the denial or receipt of an ILOS.

z. ***Section V. B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (iv) Notice of Adverse Benefit Determination, (g) Internal Plan Appeals, (5)* is revised and restated in its entirety as follows:**

(5) The BH I/DD Tailored Plan shall provide members and their authorized representative, to the extent permitted by law, the member's complete case file upon request, including medical records, other documents and records, and any new or additional evidence to be considered, relied upon or generated by the BH I/DD Tailored Plan (or at the direction of the BH I/DD Tailored Plan) in connection with the Appeal. The BH I/DD Tailored Plan shall provide the information to the member free of charge and within five (5) Calendar Days from the receipt of request for standard appeals and within two (2) Calendar Days from the receipt of request for expedited appeals. 42 C.F.R. § 438.406(b)(5).

aa. ***Section V. B. Medicaid, 1. Members, vi. Member Grievances and Appeals, (ix) Appeals and Grievances Recordkeeping and Reporting, (e) Appeals and Grievance Reporting, (2)* is revised and restated in its entirety as follows:**

(2) To support the Department's monitoring efforts, the BH I/DD Tailored Plan shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:

i. Each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan;

ii. Each Notice of Resolution issued by the BH I/DD Tailored Plan~~.~~;

iii. Clearinghouse uploads should include English and the primary language of the member (if the Notice is sent in a language other than English); and

iv. Include required fields for Clearinghouse ingestion as set forth by the Notice of Adverse Benefit Determination Guide.

bb. ***Section V. B. Medicaid, 1. Members, vii. Advanced Medical Homes (AMHs) as Primary Care Providers (PCPs), (i) Advanced Medical Home Contracting, (a), (2)* is revised and restated in its entirety as follows:**

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

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

(c) The BH I/DD Tailored Plan shall, in instances in which a Member does not select a PCP at the time of enrollment, assign the Member to a PCP within twenty-four (24) hours of their enrollment in BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall allow PCPs to set limits on panel size and shall have a process for PCPs to do so. The BH I/DD Tailored Plan shall abide by the panel limits as agreed upon between the BH I/DD Tailored Plan and with the AMH/CMA and PCP.

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

(d) The BH I/DD Tailored Plan's shall use the methodology for assigning members to a PCP as defined by the Department and shared requirements for PCP Auto Assignment in PCDU: NCMT AMH/PCP AA Requirements Document for Tailored Plan.

ee. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid and NC Health Choice Services* is renamed as follows to remove the reference of NC Health Choice:**

Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid

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

Section V.B.2. Second Revised and Restated Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by Both Standard Plans and BH I/DD Tailored Plans	**BH, I/DD and TBI Services Covered Exclusively by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)**
Enhanced BH services are *italicized*	
State Plan BH and I/DD Services • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • *Partial hospitalization* • *Mobile crisis management* • *Facility-based crisis services for children and adolescents* • *Professional treatment services in facility-based crisis program* • *Outpatient opioid treatment*[3] • *Ambulatory Withdrawal Management, without Extended On-Site Monitoring* (Ambulatory Detox) • *Ambulatory Withdrawal Management, with Extended On-Site Monitoring* • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment • Clinically managed residential withdrawal services • *Medically monitored inpatient withdrawal services* • *Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization* • Early and periodic screening, diagnostic and treatment (EPSDT) services • *Substance use intensive outpatient program (SAIOP)* • *Substance use comprehensive outpatient treatment program (SACOT)*	**State Plan BH and I/DD Services** • Residential treatment facility services • *Child and adolescent day treatment services* • *Intensive in-home services* • *Multi-systemic therapy services* • Psychiatric residential treatment facilities (PRTFs) • *Assertive community treatment (ACT)* • *Community support team (CST)*[4] • *Psychosocial rehabilitation* • *Clinically managed low-intensity residential treatment** • *Clinically managed population-specific high intensity residential program** • *Clinically managed residential services* • *Medically monitored intensive inpatient services* • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) **1915(i) Option Services** • *Supported Employment for IDD and TBI/ Individual Placement and Support (IPS) Services* • *Individual and Transitional Support (ITS) Services* • *Respite Services* • *Community Living and Supports (CLS) Services* • *Community Transition Services* **Waiver Services** • Innovations waiver services • TBI waiver services

* Coverage effective upon the effective date of the CMS approved State Plan Amendment.

gg. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (iii) Covered Medicaid, (n) Institutions for mental disease (IMB) SUD Services, (2)* is revised and restated in its entirety as follows:**

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

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

(8) No later than July 1, 2024, the BH I/DD Tailored Plan shall provide a publicly available prior authorization look-up tool for physical health, mental health, substance use, I/DD and TBI services to providers to support timely prior authorization requests from providers. The prior authorization look-up tool shall include all physical health, mental health, substance use, I/DD and TBI prior authorization requirements and the tool shall be accessible without any login by a provider.

ii. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (v) Utilization Management, (e) The Clinical Practice Guidelines shall:, (6)* is revised and restated in its entirety as follows:**

(6) Reserved.

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

(7) Nursing facility stays: After an initial approval of a nursing facility stay by the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall complete the health plan portion of the DHB-2039 (PHP Notification of Nursing Facility Level of Care) form and send the form to the nursing facility via the Provider Portal, email, or other BH I/DD Tailored Plan preferred electronic means within one (1) Business Day of issuing the prior approval.

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

(2) Prior to making any changes, reduction, or removal of an ILOS, the BH I/DD Tailored Plan shall submit the Department's standardized ILOS Service Termination Form to the Department for approval. If the request to change, reduce, or remove ILOS is approved, the BH I/DD Tailored Plan shall notify all Members of the change by mail and update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

   i. The BH I/DD Tailored Plan shall notify the Department of the transition plan for current Members receiving the terminated ILOS and notify all Members of other approved service options.

ll. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vii) In Lieu of Services (ILOS), (b), (3)* is revised and restated in its entirety as follows:**

(3) If a BH I/DD Tailored Plan receives written notification from the Department that a previously approved ILOS has been determined by the Department or by CMS to no longer be medically appropriate or cost effective or if there are other compliance concerns with the ILOS requirements, including failures to protect Member rights, the BH I/DD Tailored Plan shall submit a transition plan for the ILOS for current Members receiving the terminated ILOS to the Department for review and approval within the timeframe specified by the Department in the written notification. At a minimum, the transition plan shall include the following:

   i. A transition of care plan to phase out the applicable ILOS in no longer than twelve (12) months from receipt of the notice from the Department terminating the ILOS while ensuring access to services required under the Contract with minimal disruption to care for Members.

ii. A process to notify Members of the termination of the applicable ILOS for Members that are currently receiving the ILOS, as expeditiously as required by the Member's health condition.

mm. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vii) In Lieu of Services (ILOS), (b), (6)* is revised and restated in its entirety as follows:**

(6) The BH I/DD Tailored Plan shall ensure that ILOS are provided in a manner that preserves Member rights and protections under State and federal law, including the following rights and protections related to ILOS:

i. Members shall not be required by the BH I/DD Tailored Plan to utilize an ILOS or be required to replace a Medicaid State Plan service with an ILOS. 42 C.F.R. §438.3(e)(2).

ii. The availability of an ILOS shall not be used by the BH I/DD Tailored Plan to reduce, discourage, or jeopardize access by the Member to covered Medicaid State Plan services/settings.

iii. If a Member chooses not to receive an ILOS, the Member always retains the right to receive the covered Medicaid State Plan service or setting on the same terms as would apply if an ILOS was not available.

iv. Medically appropriate Medicaid State Plan services/settings shall not be denied by the BH I/DD Tailored Plan on the basis that a Member was offered an ILOS, is receiving an ILOS, or has previously received an ILOS.

v. The Member shall be able to access the BH I/DD Tailored Plan 's grievance and appeal system described in *Section V.B.1.vi. Member Grievances and Appeals* for any ILOS offered by the BH I/DD Tailored Plan to the same extent and in the same manner as all other Medicaid State Plan services covered under the Contract.

nn. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (vii) In Lieu of Services (ILOS), (b)* is revised to add the following:**

(7) The BH I/DD Tailored Plan is required to develop and implement a consistent process to ensure that both the network Providers requesting and the BH I/DD Tailored Plan 's licensed clinical staff recommending an ILOS for a Member use professional judgment to determine and document (e.g., in the Member's care plan or medical record) that the ILOS is medically appropriate for the specific Member based on the ILOS target population descriptions outlined in *First Revised and Restated Attachment M.13. Approved In Lieu of Services.*

oo. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (viii) Value-Added Services, (c), (1)* is revised and restated as follows:**

(1) Prior to change, reduction or removal of a Value-Added Service, the BH I/DD Tailored Plan shall submit the Department's standardized Value-Added Services Termination Form to the Department for approval. Upon approval of a change, reduction or removal of a Value-Added Service, the BH I/DD Tailored Plan shall notify Members who are actively receiving the applicable Value-Added Service, as determined by the BH I/DD Tailored Plan, of the change pursuant to the requirements of 42 C.F.R. § 438.10(c)(6) and shall update all marketing and educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of change. If a change in a Value-Added Service is made for the betterment of the Value-Added Service, the BH I/DD Tailored Plan shall update their Member website to reflect this change.

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

(ix) Reserved.

qq. ***Section V. B. Medicaid, 2. Benefits, i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package, (x) Cost Sharing, (e) Exceptions for Cost Sharing* is revised to add the following:**

(4) Upon BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall not impose cost-sharing on antiretroviral medications used to treat HIV for the purpose of reducing viral load, opioid antagonist medication used to treat the

opioid use disorder, nicotine replacement therapy medications used to treat nicotine addiction and aid in smoking cessation, and medications used for opioid use disorder.

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

(i) Pursuant to Section 11405 of the Inflation Reduction Act (IRA), the BH I/DD Tailored Plan shall not apply cost sharing for approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration.

ss. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (a) Dispensing Fees, (3) – (5)* is revised and restated in its entirety as follows:**

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

(4) Reserved.

(5) Reserved.

tt. ***Section V. B. Medicaid, 2. Benefits, iii. Pharmacy Benefits, (viii) Pharmacy Reimbursement, (b) Ingredient Costs, (8), i., b), ix.* is revised and restated in its entirety as follows:**

ix. Reserved.

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

ix. Reserved.

vv. ***Section V. B. Medicaid, 2. Benefits, iv. Non-Emergency Medical Transportation, (viii)* and *Table 9: Individuals Not Eligible to Receive NEMT Services* are revised and restated in their entirety as follows:**

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

Section V.B.2. Second Revised and Restated Table 9: Individuals Not Eligible to Receive NEMT Services	
Population	**Additional Detail**
Members in a Skilled Nursing Facility	The facility is responsible for providing transportation to their patients.
Members in an ICF/IID	The facility is responsible for providing transportation to their patients as Defined in Clinical Coverage Policy
Members during an inpatient hospital stay	Transfers between facilities during an inpatient stay do not qualify for NEMT benefit.
Members during a stay in a Psychiatric Residential Treatment Facility	
Members on the Innovations Waiver as to Services for which Transportation is included as part of the Service Definition under the Innovations Waiver.	Transportation is included in the Innovations Day Supports, Respite, Community Living and Support, and Supported Employment Service Definition; Members may use NEMT for other services that do not include transportation as part of the Service Definition

Members on the TBI Waiver as to Services for which Transportation is included in the Service Definition under the TBI Waiver	Transportation is included in the TBI Waiver Service Definition for Day Supports, Cognitive Rehabilitation, Community Networking, Supported Employment, Residential Supports, Life Skills, and Supported Living; Members may use NEMT for other services that do not include transportation as part of the Service Definition

ww. *Section V. B. Medicaid, 2. Benefits* is revised to add the following:

v. To increase Member–access to 1915(i), 1915(c), and 1915(b)(3) services for community living and supports (CLS), community networking, supported employment, and supported living, BH I/DD Tailored Plans shall achieve the following service utilization rates as demonstrated through the BH I/DD Tailored Plan's submission of the 1915 Service Authorization Report:

(i) By the fiscal year ending June 30, 2025, individuals authorized to receive CLS services through Innovations Waiver or 1915(i) will utilize no less than eighty-five percent (85%) of authorized CLS Service.

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

(3) The BH I/DD Tailored Plan shall meet annual requirements set forth in *Section V.B.3.ii.(ii)(b)(4)* of this Contract for the percentage of Members actively engaged in Provider-based Tailored Care Management approaches, meaning Members assigned to Care Management Agencies (CMA) and Advanced Medical Home Plus (AMH+) providers.

i. Reserved.
ii. Reserved.
iii. Reserved.
iv. Reserved.
v. Reserved.
vi. Reserved.
vii. Reserved.
viii. The percentage shall be calculated as:
    a. Numerator: Number of members assigned to AMH+ practices or CMAs certified by the Department for Tailored Care Management.
    b. Denominator: Total number of Members assigned to a Tailored Care Management entity, including those assigned to AMH+, CMAs, and Plan-based care management.
ix. Reserved.

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

(2) Criteria for a Tailored Care Management Entity to meet Member care needs are described in this Contract and the latest version of the Tailored Care Management Auto Assignment Requirements Document. If a Member is receiving TCM services from a Tailored Care Management Entity that is unable to meet the Member's care needs as specified in the Tailored Care Management Auto Assignment Requirements Document, the BH I/DD Tailored Plan shall reassign the Member to an appropriate contracted Tailored Care Management Entity by the last day of the month in which the BH I/DD Tailored Plan becomes aware that the Tailored Care Management Entity is unable to meet the Member's care needs per the Tailored Care Management Auto Assignment Requirements Document. In the event that the BH I/DD Tailored Plan receives notification that a Provider cannot meet the Member's care needs within the last three (3) Calendar Days of the month and is unable to reassign the Member prior to the end of the month due to timing constraints, the Department expects the BH I/DD Tailored Plan to reassign the Member by the last day of the next calendar month and to engage with the Member and address their care management needs until the Member is reassigned.

zz. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (x) Ongoing Care Management, (k), (2)* is revised and restated in its entirety as follows:**

(2) The BH I/DD Tailored Plan shall use the acuity tiers to determine payment for Tailored Care Management as described in *Section V.B.4.v. Provider Payments*.

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

(3) If the member is dually diagnosed with a BH condition and I/DD or TBI, care managers must abide by the same contact requirements outlined for members with the BH Acuity tier referenced in *Section V.B.3.ii.(x) Ongoing Care Management*.

bbb. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xi) Transitional Care Management, (c), (7)* is revised and restated in its entirety as follows:**

(7) Ensure development of a written discharge plan through a person-centered planning process in which the member has a primary role and which is based on the principle of self-determination. The discharge plan will be written into the member's Care Plan/ISP and will:
   i. Identify the member's strengths, preferences, needs, and desired outcomes;
   ii. Identify the specific supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes;
   iii. Include a pharmacy plan for post-discharge facility medication handling, bridge prescriptions and prescriber, community pharmacy, and those responsible to actively support the individual in obtaining their medications post-transition;
   iv. List providers that can provide the identified supports and services that build on the member's strengths and preferences to meet the member's needs and achieve desired outcomes; and
   v. Set the date of transition as well as the timeframes for completion of all needed steps to affect the transition.

ccc. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver* is revised to add the following:**

(g) BH I/IDD Tailored Plans shall ensure that all Tailored Care Managers are properly trained to support Members new to Innovations Waiver to successfully access appropriate Home and Community Based Services.

(h) BH I/DD Tailored Plans shall provide or monitor equivalent training that AMH+ or CMA entities certified to serve Innovations Waiver Members must receive, including but not limited to training related to services and activities set forth in Clinical Coverage Policy 8P, as needed to adequately meet Innovations Waiver Member needs. Plan and provider-based Tailored care managers must all meet these training requirements.

ddd. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xiv) Staffing and Training Requirements, (f), (1), vi.* is revised and restated in its entirety to make a technical correction as follows:**

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

eee. ***Section V. B. Medicaid, 3. Care Management, ii. Tailored Care Management, (xvi) Tailored Care Management Payments, (a)* is revised and restated in its entirety to make a technical correction as follows:**

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

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

(k) The BH I/DD Tailored Plan shall not require an AMH+ practice, CMA, or CIN or Other Partner to undergo a pre-delegation audit for the purposes of NCQA accreditation, although a delegation arrangement may be entered by mutual agreement. While the Department encourages BH I/DD Tailored Plans to align oversight of Tailored Care Management with oversight of NCQA delegated functions, the BH I/DD Tailored Plan must ensure that in conducting oversight of AMH+ practices, CMAs and CINs or Other Partners that are delegates for NCQA plan-level functions, it is monitoring Tailored Care Management-specific requirements contained in this Contract and the Tailored Care Management Provider Manual published on the Tailored Care Management Webpage: https://medicaid.ncdhhs.gov/tailored-care-management.

ggg. ***Section V. B. Medicaid, 3. Care Management, v. Other Care management Programs, (ii) Local Health Departments, (a)-(b)* is revised and restated in its entirety as follows:**

(a) The BH I/DD Tailored Plan shall be required to contract with local health departments (LHDs) during a transitional period that will align with the transitional period established for Standard Plans. Accordingly, in Contract Year 1, the BH I/DD Tailored Plan shall be required to offer a right of first refusal with each LHD in its Region to provide Care Management for High Risk Pregnancy (CMHRP). In Contract Year 2, the BH I/DD Tailored Plan shall contract with each LHD in its Region(s) that the Department has determined to have met the benchmark specifications as prescribed by the Department to provide care management services to High Risk Pregnant Women, to the extent that each LHD chooses to provide these services. In Contract Year 2, the BH I/DD Tailored Plan will not be required to contract with LHDs that the Department has determined did not meet the benchmark specifications as prescribed by the Department to provide care management services to High Risk Pregnant Women. The benchmark assessment will be conducted by the Department. to assess LHD performance in providing care management services for the CMHRP populations for purposes of contracting with Tailored Plans in Contract Year 2. The benchmark specifications evaluated by the Department are available here: https://medicaid.ncdhhs.gov/cmhrp-cmarc-benchmark-specifications/download?attachment

(b) Reserved.

hhh. ***Section V. B. Medicaid, 3. Care management, vii. System of Care, (iii) System of Care Policy, (e), (5), ix.* is revised and restated in its entirety as follows:**

ix. The DMH/DD/SUS System of Care Coordinator.

iii. ***Section V. B. Medicaid, 3. Care Management, viii. In-Reach and Transition from Institutional Settings, (ii), (a), (2)* is revised and restated in its entirety as follows:**

(2) ACHs (members with SMI and I/DD);

jjj. ***Section V. B. Medicaid, 3. Care Management, xi. Relocation of Members Following Emergency Residential Care Facility Closures, (iii) Emergency closures of Adult Care Homes, (a)* is revised and restated in its entirety as follows:**

(a) The Department has developed an intra-Departmental Emergency Closures "Adult Care Home (ACH) Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions—DHSR, DAAS and DMH/DD/SUS, BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program housed within the Area Authorities on Aging.

kkk. ***Section V. B. Medicaid, 3. Care Management, xi. Relocation of Members Following Emergency Residential Care Facility Closures, (iv) Emergency Closures of Group Homes, (a)* is revised and restated in its entirety as follows:**

(a) The Department has developed an intra-Departmental Emergency Closures "Group Home Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents. The "Group Home Response Hub" is comprised of the following Divisional partners: DHSR, DMH/DD/SUS, DHB and DAAS.

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

(ii) The Department seeks a BH I/DD Tailored Plan with a robust Network to meet the medical, BH, I/DD, TBI, LTSS, and pharmacy needs of all members within its Region, including those with limited English proficiency, physical disability, BH I/DD, and/or TBI needs. The BH I/DD Tailored Plan shall demonstrate that its Network meets Department's availability, access, quality goals, and requirements and is willing to act to continuously improve its delivery of health care services to members.

mmm. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (b), (3), i, a)* is revised and restated in its entirety as follows:**

a) Any change to a standard provision required *by Section VII. Fourth Revised and Restated Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts*, is limited to those provisions outlined in Section 1. except for a change to a provision related to subsections 1.x., 1.y., 1.z., or 1.bb., which must be prior approved by the Department.

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

(f) Tobacco-free Policy

(1) Starting July 1, 2025, the BH I/DD Tailored Plan shall contract with Medicaid providers, with exceptions noted below, to implement a tobacco-free policy covering any portion of the property on which the provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy shall include a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also includes prohibition on contracted providers purchasing, accepting as donations, or distributing tobacco products to Members they serve. This tobacco-free policy requirement does not apply to: retail pharmacies; properties where no direct clinical services are provided; non-emergency medical transport; alternative family living settings; or manufacturing sites that employ adults who receive group day services; however, nothing herein shall prohibit these categories of providers from implementing a tobacco-free policy.

(2) Starting July 1, 2025, the following partial tobacco-free policy shall be required in Intermediate Care Facilities for Individuals with Intellectual Disabilities and adult I/DD residential services subject to the Home and Community Based Final Rule and in Adult Care Homes (ACH), family care homes, residential hospices, Skilled Nursing Facilities (SNFs), long term nursing facilities:

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

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

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

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

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

(3) Provider Monitoring

i. Starting July 1, 2025, the BH I/DD Tailored Plan shall monitor compliance with the tobacco-free policy requirement through their Member grievance reporting. The BH I/DD Tailored Plan shall allow Members to submit grievances related to the Provider's alleged failure to comply with the tobacco-free policy requirement. The BH I/DD Tailored Plan shall initiate technical assistance to address grievances related to exposure to tobacco use on contracted Provider property subject to the tobacco-free policy requirement by notifying the NC Division of Public Health Tobacco Prevention and Control Branch through a dedicated email address.

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

(k) The BH I/DD Tailored Plan shall monitor the Department Fee Schedule and Covered Code Portal ServiceNow website notifications and PCDU fee schedule notifications daily for changes to the NC Medicaid Direct rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Direct rates:

(1) The BH I/DD Tailored Plan shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change within the timeframes defined in *Section V.B.6.i.(iv)(d)(4)* of this Contract.

(2) The BH I/DD Tailored Plan shall implement applicable rate changes within agreed upon timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest payments to the applicable provider as defined in *Section V.B.6.i.(iv)(d).*

ppp. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (iii) Provider Contracting, (v) DSOHF Facilities, (1), ii.*** **is revised and restated in its entirety as follows:**

ii. Reserved.

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

(w) The BH I/DD Tailored Plan shall contract with all Cross-Area Service Programs (CASPs) located throughout the State. A listing of the current CASPs is distributed annually with the State-funded Continuation Allocation letter. The BH I/DD Tailored Plan shall use the Department-approved BH I/DD Tailored Plan's standard contract for all providers who are CASPs.

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

(y) For any provider subject to a rate floor as outlined in *Section V.B.4.v. Provider Payments*, a BH I/DD Tailored Plan may include a provision in the provider's contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision, with the exception of payments described in *Section V.B.4.v.(xxv)* Durable Medical Equipment; payments described in *Section V.B.2.iii.(viii)* for drugs under the Physician Administered Drug Program rate floors; and payments described in *Section V.B.4.v.(vii)* to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). A BH I/DD Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.

sss. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (ix) Network Provider System Requirements, (b)*** **is revised and restated in its entirety as follows:**

b) Unless otherwise written in the contract, the BH I/DD Tailored Plan shall load contracted providers into the claim adjudication and payment system within the following time frames to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:

(1) NC Medicaid provider attached to new contract within ten (10) Business Days after completing contract execution.

(2) NC Medicaid hospital or facility attached to a new contract within fifteen (15) Business Days after completing contract execution.
(3) Reserved.
(4) Reserved.
(5) Change in existing contract terms within fifteen (15) Business Days of the effective date after the change.

ttt. ***Section V. B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing, (f) Provider Disenrollment and Termination, (2) Termination as a Medicaid Provider by the Department, i.*** **is revised and restated in its entirety as follows:**

i. Within one (1) Business Day of receiving notification via the Provider Enrollment File (PEF) from the Department that a Provider has been terminated as a Medicaid provider, the BH I/DD Tailored Plan shall remove the provider from the BH I/DD Tailored Plan's Provider Network File (PNF) and shall end-date payment to the Provider for services furnished on or after the effective date of the Provider's termination as a Medicaid provider. In addition to end-dating payments to the Provider for services furnished on or after the effective date of the Provider's termination and removing the Provider from the BH I/DD Tailored Plan's PNF, the BH I/DD Tailored Plan shall, within fourteen (14) Calendar Days of receiving notice via the PEF that the Provider is terminated as a Medicaid provider, terminate the Provider's contract and issue a written termination notice without appeal rights to the Provider. The termination notice shall state that the effective date of the termination is the effective date of the Provider's termination as Medicaid provider. This provision applies to all providers regardless of the provider's network status.

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

(4) In accordance with 42 C.F.R. § 438.10(h)(3):
  i. The BH I/DD Tailored Plan shall update the paper directory quarterly if the BH I/DD Tailored Plan has an electronic, mobile-enabled provider directory, or monthly if they do not.
  ii. The BH I/DD Tailored Plan shall update the electronic version of the Network Directory no later than thirty (30) Calendar Days after the BH I/DD Tailored Plan receives updated Provider information from the Department and clearly identifies the date of the update.

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

(6) The Member facing Provider directory must comply with 42 C.F.R. § 438.10(h)(1). and shall include the following information, at a minimum:
  i. Provider name;
  ii. Provider demographics (first, middle, and last name, gender);
  iii. Provider DBA Name;
  iv. Reserved;
  v. Provider type (PCP, etc.);
  vi. Reserved;
  vii. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
  viii. Street address(as) of service location(s);
  ix. County(ies) of service location(s);
  x. Telephone number(s) at each location;
  xi. After hours telephone number(s) at each location;
  xii. Provider specialty by location;
  xiii. Whether provider is accepting new beneficiaries;
  xiv. Whether provider serves Medicaid beneficiaries;
  xv. Whether BH provider is serving children and adolescents;

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

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

(i) In no case shall a provider be loaded into the provider directory which cannot receive payment on the BH I/DD Tailored Plan's current payment cycle. This provision does not apply to providers suspended by the Department.

(j) The BH I/DD Tailored Plan shall provide the provider directory to the Department's designated vendor for inclusion in the Consolidated Provider Directory made available to the Enrollment Broker as described in *Section V.B.8. Technical Specifications*.

xxx. ***Section V. B. Medicaid, 4. Providers, iii. Provider Relations and Engagement, (ii) Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet, (d*****) is revised and restated in its entirety as follows:**

(d) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) Calendar Days of executing a contract with the Provider for participation within its Medicaid Managed Care Network. The Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.

yyy. ***Section V. B. Medicaid, 4. Providers, iii. Provider Relations and Engagement, (iv) Provider Manual, (b), (6)*** **is revised and restated in its entirety as follows:**

(6) To report and promptly return overpayments within sixty (60) Calendar Days of identifying the overpayment.

zzz. ***Section V. B. Medicaid, 4. Providers, i. Provider Recruitment*** **is renumbered as follows to make a technical correction with no revisions to subsections (a)-(j):**

iv. Provider Recruitment

aaaa. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (iv) Physician and Physician Extender Payments, (c)*** **is revised and restated in its entirety as follows:**

(c) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as outlined below in *Section V.B.4.v.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*

bbbb. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (v) Hospital Payments (Excluding BH Claims), (e)*** **is revised and restated in its entirety as follows:**

(e) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or East Carolina University (ECU) Health Medical Center as described in *Section V.B.4.v.(xii) Additional Directed Payments for Certain Providers* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))

cccc. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (vi) Hospital Payments for BH Claims, (a)*** **is revised and restated in its entirety as follows:**

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for Inpatient Behavioral Health services no less than one hundred percent (100%) of the Federal Fiscal Year 2024 Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) Base Per Diem rate as published in Addendum A by CMS ($895.63 effective January 1, 2024), unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement established on or after BH I/DD Tailored Plan launch.

dddd. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (vii) Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments*** **is revised and restated in its entirety as follows:**

(vii) Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments

(a) For FQHC/RHC Service claims with dates of service beginning December 1st, 2024, the BH I/DD Tailored Plan shall reimburse FQHCs and RHCs for covered services at no less than the following rates:

(1) All ancillary services (i.e. radiology, etc.) shall be based on the applicable codes included on the FQHC/RHC fee schedules.

(2) All core services shall be based on each FQHC's or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC's or RHC's respective core rate or T1015 code.

(b) For FQHC/RHC Service claims with dates of service beginning December 1, 2024, the BH I/DD Tailored Plan shall reimburse FQHCs and RHCs for covered services as follows:

(1) The BH I/DD Tailored Plan shall reimburse in network FQHCs and RHCs for Core Services visits (T1015) and Well Child visits at the respective North Carolina Medicaid Fee Schedule for FQHC and RHC Base Rates ("base reimbursement amount."). All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule and shall follow established rules as described in the Managed Care Billing Guidance to Health Plans.

(2) The BH I/DD Tailored Plan shall issue FQHCs and RHCs a supplemental wraparound payment for covered Core Service visits (T1015) and Well Child Visits, which is equal to the difference between the Provider specific Prospective Payment System (PPS)/Alternative Payment Methodology (APM) Rate from the North Carolina Medicaid PPS/APM Fee Schedule and the base reimbursement amount.

(3) The BH I/DD Tailored Plan shall identify in the payment of the claim the base reimbursement amount and the supplemental wraparound amount totaling the Provider specific PPS/APM Rate reimbursement pursuant to the Managed Care Billing Guidance to Health Plans. Following implementation of PPS/APM Rate reimbursement by BH I/DD Tailored Plan to the FQHC and RHC providers, the Department shall extract a report of paid FQHC and RHC encounters for Core Service and Well Child visits from EPS on a monthly basis and remit reimbursement to the BH I/DD Tailored Plan for the supplemental wraparound payment.

eeee. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (ix) Local Health Department (LHD) Payments, (c)*** **is revised and restated in its entirety as follows:**

(c) For Contract Years 1 and 2, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in Medicaid Fee-for-Service prior to BH I/DD Tailored Plan launch ($4.96 PMPM for all enrolled women, ages fourteen (14) to forty-four (44)).

ffff. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (g)*** **is revised and restated in its entirety as follows:**

(g) The BH I/DD Tailored Plan shall adhere to the directed payment service unit encounter requirements as described in *Section V.B.6.ii. Encounters.*

gggg. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (i)*** **is revised and restated in its entirety as follows:**

(i) For Directed Payment for Faculty Physicians Affiliated with the Teaching Hospitals for each University of North Carolina Medical School, and Hospitals Owned by UNC Health Care or East Carolina University (ECU) Health Medical Center:

(1) The Department will establish a uniform dollar increase annually at the average commercial rate for certain eligible medical professionals as defined in the Medicaid State Plan, Attachment 4.19-B, Section 5, Page 2, Subsection (c)(2).

(2) The Department will calculate the directed payment amount to the BH I/DD Tailored Plan on a quarterly basis as the difference between the rate paid to the eligible medical professionals by the BH I/DD Tailored Plan and the average commercial rate determined by the State multiplied by the actual utilization for the eligible professionals.

(3) The Department will establish an annual aggregate cap for total eligible medical professional directed payments pursuant to State Law.[211]

(4) The Department will perform an annual verification of the eligible medical professional directed payments based on BH I/DD Tailored Plan encounter data submitted to the State to assure all claims data has been properly captured and calculated for directed payments and to assure compliance with aggregate annual payment cap.

hhhh. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (j)*** **is revised and renamed as follows with no changes to subparts (1)-(3):**

(j) For Directed Payments to East Carolina University (ECU) Health Medical Center:

iiii. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)), (l) Interest and Penalties, (1)-(2)*** **is revised and restated in its entirety as follow:**

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

(2) Reserved.

jjjj. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xvii) Payments of Medical Home Fees to Advanced Medical Homes, (b), i.-ii.*** **is revised and restated in its entirety as follows:**

i. Reserved.

ii. Five dollars ($5.00) PMPM for all BH I/DDD Tailored Plan Members regardless of Age, Blind, and Disabled (ABD) status.

kkkk. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments, (xxi) Payments under Locum Tenes Arrangements, (a)*** **is revised and restated in its entirety as follows:**

(a) The BH I/DD Tailored Plan shall recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 42 C.F.R. § 455.410(b).

llll. ***Section V. B. Medicaid, 4. Providers, v. Provider Payments*** **is revised to add the following:**

(xxxiii) Electronic Visit Verification System (EVV)

(a) The BH I/DD Tailored Plan shall maintain increased reimbursement to providers subject to EVV requirements by an amount that is no less than ten percent (10%) of the reimbursement rate excluding any temporary adjustment made in response to the COVID-19 pandemic. This uniform percentage increase shall be in addition to required rate increases related to Direct Care Worker wage initiatives defined below. If a provider chooses to require or offer Direct Care Workers who are permitted to be exempt or not subject to federal EVV requirements to comply with EVV requirements, the BH IDD Tailored Plan shall not be required to pay the EVV reimbursement rate increase for such claims, and/or shall be permitted to require the provider to not submit these claims through the EVV system.

(b) This reimbursement rate increase applies to the following services:

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

(c) Codes/modifiers related to live-in caregivers are excluded from EVV and thus the directed payment described in this section is not applicable to Providers billing for codes including but not limited to the following codes/modifiers:
(1) T2012 and T2012 HQ; and
(2) T2012 GC and T2012 GC HQ.

(xxxiv) Innovations Waiver Services Direct Care Worker Wage Increases

(a) Beginning at BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse at rates no less than the amounts prescribed by the Department on the list of Innovations Waiver services for eligible Innovations Waiver Providers for eligible services and codes for which rates apply as maintained by the Department and made available to the BH I/DD Tailored Plan via the PCDU. The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements *of Section V.B.6.i.(iv)(d)4).* For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv).*
(1) Reimbursement for eligible Innovations Waiver services shall be no less than the per unit reimbursement increases communicated to the BH I/DD Tailored Plan through the PCDU and in accordance with *Section V.B.4.ii.(iii)(k)* of the Contract.

(b) The Department shall maintain and share with the BH I/DD Tailored Plan a list of Innovations services and codes that the rate increase will apply to through the DHB Fee schedule and Covered Code portal. .

(c) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to specific providers to account for any changes to Provider eligibility for enhanced reimbursement.

(d) The BH I/DD Tailored Plan shall communicate to contracted Providers that the reimbursement increase is contingent on eligibility for Innovations Direct Care Worker wage-related reimbursement increases maintained by the Department.

(xxxv) Innovations Waiver Services Direct Care Worker Rate (DCW) Increases

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse at rates no less than the amounts prescribed by the Department relative to the rates in place as of February 2020 pre-COVID plus the required HCBS DCW rate increases effective March 2022 to Innovations Waiver service Providers for designated services identified in the November 22, 2023 NC Medicaid Innovations Waiver Provider Rate Increase Provider Bulletin.

(1) The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements of *Section V.B.6.i.(iv)(d)(4)),* except that reprocessing of claims for services furnished by a Provider who completes the attestation required under Session Law 2023-134 Section 9E.15 shall occur no later than seventy-five (75) Calendar Days following contract execution or thirty (30) Calendar Days following receipt of Provider attestation, whichever is later.

(2) The BH I/DD Tailored Plan shall implement the Innovations Waiver services DCW rate consistent with Session Law 2023-134, Section 9E.15 requirements. The BH I/DD Tailored Plan shall obtain Provider attestation prior to applying the Innovations Waiver services DCW rate increases to payment for services determined by the Department to qualify for the rate increase and utilizing the Department's standard template to meet verification requirements.

(3) The BH I/DD Tailored Plan shall provide to the Department documentation collected from Providers as required by Session Law 2023-134, Section 9E.15 upon the Department's request as defined in *Section III.B.38*.

i. For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

a) Reimbursement increases for designated Innovations Waiver services shall be no less than the per unit reimbursement increases communicated to the BH I/DD Tailored Plan through the PCDU and in accordance with *Section V.B.4.ii.(iii)(k)* of the Contract.

(b) The Department shall maintain and share with the BH I/DD Tailored Plan a list of Innovations services and codes that the rate increase will apply to through the PCDU and the DHHS Website.

(c) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to Providers to account for any changes to Provider eligibility for enhanced reimbursement. The BH I/DD Tailored Plan shall not recoup overpayments made to Providers without approval of the Department.

(d) The BH I/DD Tailored Plan shall communicate to contracted Providers that the reimbursement increase is contingent on the Provider completing the Provider attestation and continuing to meet the eligibility criteria set forth in Session Law 2023-134, Section 9E.15.

(xxxvi) Payment for 1915(i) Services

(a) The BH I/DD Tailored Plan shall reimburse Providers for 1915(i) services at no less than one hundred percent (100%) of the rate paid for equivalent 1915(b)(3) services as of June 30, 2023. Equivalent 1915(b)(3) services are defined below in *Section V.B.4.v. Table 1.: 1915(b)(3) Services Transitions to 1915(i)*.

Section V. B. 4. v. Table 1.: 1915(b)(3) Services Transitioning to 1915(i)	
1915(b)(3) Services	**1915(i) Services**
In-Home Skill Building	Community Living and Support
One-time Transitional Costs	Community Transition
Individual Support	Individual and Transitional Support
Transitional Living Skills	
Intensive Recovery Supports	
Respite	Respite
Supported Employment	Supported Employment

(xxxvii) Payment for Individual Placement and Support

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers of Individual Placement and Support (IPS) services at rates no less than the rate prescribed in Clinical Coverage Policy 8H-2 and the Department Fee Schedule and Code Portal website unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative payment arrangement. For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

(xxxviii) 1915(i) Services DCW Rate Increases

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for designated 1915(i) services (as identified on the list of 1915(i) DCW services and codes to which the rates will apply posted in the PCDU) at rates no less than the amounts prescribed by the Department relative to the 1915(b)(3) rates in place as of February 2020 pre-COVID plus required HCBS DCW rate increases effective March 2022. The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements of *Section V.B.6.i.(iv)(d)(4*). For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.iv.*.

(b) The Department shall maintain and share with the BH I/DD Tailored Plan a list of 1915(i) DCW and codes that rates will apply to through the PCDU and in accordance with *Section V.B.4.ii.(iii)(3)(k)* of the Contract.

(c) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to Providers to account for any changes to Provider inclusion in enhanced reimbursement.

(d) The BH I/DD Tailored Plan shall communicate to contracted Providers that the reimbursement increase is contingent on the Department continuing to include 1915(i) services in the list of services supported by these DCW rate-related reimbursement increases.

(xxxix) Payment for Outpatient Behavioral Health Services

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for the following Outpatient Behavioral Health services at a rate no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement:

(1) Psychiatric Diagnostic Evaluation;
(2) Development/Psychological Testing and Evaluation;
(3) Therapeutic, Prophylactic, or Diagnostic Injection;
(4) Office Visit Evaluation and Monitoring Codes for Psychiatrists and Psychiatric Nurse Practitioners;
(5) Psychotherapy;
(6) Psychotherapy for Crisis;

(7) Family/Group Therapy;
(8) Electroconvulsive Therapy;
(9) Tobacco Cessation; and
(10) Screening, Brief Intervention, and Referral to Treatment.

(b) For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

(xl) Payment for Enhanced Mental Health Services

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for the following Enhanced Mental Health services at a rate no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement;

(1) Community Support Team;
(2) Assertive Community Treatment;
(3) Multi-Systemic Therapy;
(4) Intensive In-Home Services;
(5) Partial Hospitalization;
(6) Child and Adolescent Day Treatment;
(7) Psychosocial Rehabilitation;
(8) Peer Support; and
(9) Behavioral Health Long-Term or High Risk Intervention Residential.

(b) For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

(xli) Payment for Research Based Intensive Behavioral Health Treatment Services

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for Research Intensive Behavioral Health Treatment Services at a rate no less than the Department's Medicaid Fee for Service Fee Schedule rate unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement. For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d)*.

(xlii) Hospital Payments for Behavioral Health Claims

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse Providers for Inpatient Behavioral Health services no less than one hundred percent (100%) of the Federal Fiscal Year 2024 Medicare Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) Base Per Diem rate as published in Addendum A by CMS (eight hundred ninety-five dollars and sixty-three cents ($895.63)), unless the BH I/DD Tailored Plan and Provider have mutually agreed to an alternative reimbursement arrangement. For any claims that the PIHP is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

(xliii) TBI Waiver Services DCW Rate (as applicable)

(a) For dates of service on or after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall reimburse TBI providers for designated services at rates no less than the amounts prescribed by the Department relative to the rates in place as of February 2020 pre-COVID plus required HCBS DCW rate increases effective March 2022. The BH I/DD Tailored Plan shall implement the reimbursement rates consistent with the timeline requirements of *Section V.B.6.i.(iv)(d).*For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest and penalties consistent with the requirements of *Section V.B.6.i.(iv)(d).*

(b) The Department shall maintain and share with the BH I/DD Tailored Plan a list of TBI Waiver Service DCW and codes that the rate increase will apply to through the PCDU and in accordance with Section *V.B.4.ii.(iii)(3)(k)* of the Contract.

(c) The BH I/DD Tailored Plan shall have the capability to prospectively or retroactively apply reimbursement increases or decreases and recoup overpayments made to Providers to account for any changes to Provider inclusion in enhanced reimbursement.

(d) The BH I/DD Tailored Plan shall communicate to contracted Providers that the reimbursement increase is contingent on the Department continuing to include in TBI Waiver Services in the list of services supported by these DCW rate-related reimbursement increases.

(xliv) Healthcare Access and Stabilization Program (HASP)

(a) NCGS § 108A-148.1 requires the Department to submit an annual 42 C.F.R. § 438.6(c) Preprint for the Healthcare Access and Stabilization Program (HASP) for approval by CMS. Under HASP, eligible hospitals will receive payments from the BH I/DD Tailored Plan up to the average commercial rate (ACR) for all inpatient and outpatient hospital services, as specified in this Section and approved by CMS. The BH I/DD Tailored Plan shall make HASP payments as directed by the Department following approval of the HASP preprint for the applicable time period by CMS and subject to change by the Department based on direction from CMS.

(xlv) Payments to Innovation Waiver Vendors

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

(1) Community Networking;

a. Class and conference payment for attendance fees at classes and conferences is also included.

b. Payment for memberships can be covered when the beneficiary participates in an integrated class; and

c. Transportation, when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage set by the BH I/DD Tailored Plan.

(2) Home Modifications;

(3) Individual Goods and Services;

(4) Natural Supports Education;

(5) Vehicle Adaptation; and

(6) Meal Delivery Service.

(xlvi) Payment for Substance Use Disorder (SUD) Services

(a) For dates of service on or after October 1, 2024, the BH I/DD Tailored Plan shall reimburse in-network providers of substance use disorder (SUD) services at no less than one hundred percent (100%) of the Enhanced Mental Health Medicaid Fee-for-Service Fee Schedule rate, as set by the Department, unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement established on or after October 1, 2024. For any claims that the BH I/DD Tailored Plan is required to reprocess to comply with this Section, the BH I/DD Tailored Plan shall reprocess the claims and pay, as applicable, any interest consistent with the requirements of *Section V.B.6.i.(iv)(d).*

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

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

(a) The BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program, and may be required to develop additional performance improvement projects for specific focus areas and/or clinical measures as directed by the Department. The BH I/DD Tailored Plan's PIPs must be approved by the Department annually as part of the BH I/DD Tailored Plan's QAPI program. The Department may choose to narrow the number of topics available for PIPs beyond what is shown in this document.

(b) Reserved.
(c) Reserved.
(d) Reserved.
(e) The BH I/DD Tailored Plan shall conduct at least one (1) non-clinical performance improvement project on an annual basis that is related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional or ACH settings.
(f) The BH I/DD Tailored Plan shall conduct two (2) clinical performance improvement projects annually that align with the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy and must be related to one or more of the following areas:
  (1) Maternal health;
  (2) Tobacco cessation;
  (3) Diabetes prevention;
  (4) Birth outcomes;
  (5) Early childhood health and development;
  (6) Hypertension; and
  (7) Behavioral-physical health integration
(g) Reserved.
(h) The BH I/DD Tailored Plan performs below seventy-five percent (75%) for overall CMS 416 rates for EPSDT screening, the BH I/DD Tailored Plan shall submit one (1) PIP on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical PIPs annually.

nnnn. *Section V. B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (v), (b)-(c)* is revised and restated in its entirety as follows:

(b) No later than ninety (90) Calendar Days following the end date of Contract Year 1, the BH I/DD Tailored Plan shall report the initial results of its VBP Assessment conducted on VBP contracts entered or effective during Contract Year 1. The VBP Assessment may be conducted as a single assessment shared across and inclusive of activities arising under this Contract and the BH I/DD Tailored Plan's PIHP contract with the Department.
(c) No later than ninety (90) Calendar Days following the end date of each subsequent Contract Year, the BH I/DD Tailored Plan shall submit for Department review and approval Co'tractor's updated VBP Assessment on all VBP contracts entered or effective during the Contract Year. The VBP Assessment may be conducted as a single assessment shared across this Contract and the BH I/DD Tailored Plan's PIHP contract with the Department.

oooo. *Section V. B. Medicaid, 5. Quality and Value, ii. Value-Based Payments (VBP), (vi)* is revised and restated in its entirety as follows:

(vi) To ensure the BH I/DD Tailored Plan's VBP Arrangements align with the Department's strategy and goals, the BH I/DD Tailored Plan shall develop a VBP Strategy for Contract Years 1 -3, in alignment with the Department's short- and long-term goals to shift from a Fee-for-Service system to VBP model.
  (a) The VBP Strategy must be submitted to the Department within six (6) months of notice by the Department it is due.
  (b) As long as the VBP Strategy clearly states that it applies to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan may develop a single VBP Strategy shared across and inclusive of other LME/MCO operations, including, without limitation, the PIHP.
  (c) The VBP Strategy shall contain the following elements:
    (1) A narrative description addressing:
      i. The BH I/DD Tailored Plan's goals, strategies and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the BH I/DD Tailored Plan will involve BH and intellectual and developmental disability providers in its VBP arrangements.
      ii. A description of the VBP model(s) that will be pursued by the BH I/DD Tailored Plan and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for

AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers.

iii. An explanation of how the BH I/DD Tailored Plan will ensure that physical, BH, and I/DD services are integrated under its VBP arrangements.

iv. The BH I/DD Tailored Plan's plan for measurement of outcomes and results related to VBP by year.

v. The BH I/DD Tailored Plan's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes. For full Healthy Opportunities requirements, see *Section V.B.3.x. Healthy Opportunities.*

vi. A description of the BH I/DD Tailored Plan's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the BH I/DD Tailored Plan VBP programs. Specific functionalities to address include:

a) Risk adjustment;

b) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;

c) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;

d) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;

e) Reporting capabilities; and

f) Payment functions.

vii. The BH I/DD Tailored Plan's approach to address health disparities and incorporate health equity into their internal and external policies, and procedures.

(2) BH I/DD Tailored Plan's projected annual targets for VBP contracts with providers in HCP-LAN Levels 1 through 4 in a format to be determined by the Department.

(d) No later than ninety (90) Calendar Days following the end date of each Contract Year, the BH I/DD Tailored Plan shall submit to the Department for review and approval Contractor's update on all sections of the BH I/DD Tailored Plan's VBP Strategy outlined in *Section V.B.5.I.(vi)(c)* of this Contract. The VBP Strategy updates may be conducted across and inclusive of activities arising under the BH I/DD Tailored Plan Contract and the BH I/DD Tailored Plan's PIHP Contract with the Department.

pppp. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iii) Claims Processing and Reprocessing Standards*** **is revised to add the following:**

(l) No later than January 1, 2025, the BH I/DD Tailored Plan shall process crossover claims received from NC Medicaid Systems including NCTracks for Members enrolled in the Innovations Waiver or TBI Waiver program.

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

i. The BH I/DD Tailored Plan shall, within eighteen (18) Calendar Days of receiving a medical claim, notify the Provider whether the claim is clean, or pend the claim and request from the Provider all additional information needed to timely process the claim. The BH I/DD Tailored Plan shall have the capability to request additional information via x12 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 x12 277 and electronic method (portal or email) no later than the launch of the BH I/DD Tailored Plan. 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.

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

(c) Claim Submission Timeframes:

(1) For any claims with a date of service on or after BH I/DD Tailored Plan Launch:

i. Consistent with NCGS § 58-3-225(f), the BH I/DD Tailored Plan shall allow Providers to submit claims within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member by the Provider and, in the case of health care provider facility claims, within three hundred and sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365) Calendar Days. Unless otherwise agreed to by the BH I/DD Tailored Plan and the Provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the Provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Provider, later than one (1) year from the time submittal of the claim is otherwise required.

a) When a member is retroactively enrolled, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365) Calendar Days from the date of enrollment.

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

(2) Reserved.

(3) For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, the BH I/DD Tailored Plan shall allow the Provider one hundred eighty (180) Calendar Days from the primary insurer's Explanation of Benefits/ Remittance Advise date (whether the claim was paid or denied) to file the claim to the BH I/DD Tailored Plan. The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment.

ssss. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (d) Interest and Penalties, (1)-(2)* is revised and restated in its entirety as follows:**

(1) The BH I/DD Tailored Plan shall pay interest to the Provider, including, but not limited to, AMH+ practices and CMAs, on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.

(2) Reserved.

tttt. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (d) Interest and Penalties, (4)* is revised and restated in its entirety as follows:**

(4) The BH I/DD Tailored Plan shall implement fee schedule changes within forty-five (45) Calendar Days of notification from the Department or the actual date of posting on the Department's Fee Schedule and Covered Code website or PCDU.

i. The BH I/DD Tailored Plan shall reprocess all impacted claims with dates of services from the effective date of the NC Medicaid fee schedule change with correct rates and send notification of overpayments to impacted Providers within an additional thirty (30) Calendar Days of implementing fee schedule changes.

ii. This standard is only applicable for NC Medicaid rate floor programs.

iii. Failure to implement fee schedule changes within the required timeframe shall result in interest payments to the Provider as defined in this Section.

uuuu. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards, (d) Interest and Penalties*** **is revised to add the following:**

(5) All references to penalty(ies) paid to a Provider as a result of late payments to Providers are hereby stricken as of July 1, 2024.

vvvv. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (iv) Prompt Payment Standards*** **is revised to add the following:**

(f) 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.

wwww. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (v) Overpayment or Underpayment Recovery, (b)*** **is revised and restated in its entirety as follows:**

(b) In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with NCGS § 58-3-225(h), except that not less than sixty (60) Calendar Days before the BH I/DD Tailored Plan seeks to recover any overpayments or offsets any future payments from the provider, the BH I/DD Tailored Plan shall provide the written notice required under NCGS § 58-3-225(h).

xxxx. ***Section V. B. Medicaid, 6. Claims and Encounter Management, i. Claims, (viii) National Correct Coding Initiative (NCCI), (b)*** **is revised and restated in its entirety as follows:**

(b) The BH I/DD Tailored Plan shall follow NC Medicaid NCCI policies to control improper coding that may lead to inappropriate payments to providers by the BH I/DD Tailored Plan.

- (1) The Department will share the Non-public Medicaid NCCI Edit Files received from CMS with the BH I/DD Tailored Plan on a quarterly basis, when available, but no later than ten (10) Calendar Days after the files have been made available by CMS.
  - i. Reserved.
- (2) The BH I/DD Tailored Plan shall incorporate the Non-public Medicaid NCCI Edit Files into its claims payment systems for processing Medicaid claims that the PHP pays on a Fee-for-Service basis. The NCCI editing shall occur prior to current procedure code review and any other editing by the BH I/DD Tailored Plan's claims payment systems.
- (3) The BH I/DD Tailored Plan shall load the Non-public Medicaid NCCI Edit Files into its claims payment systems upon receipt of the edit files from the Department.
  - i. The edit files shall be loaded and ready for use by the BH I/DD Tailored Plan by no later than 12:00 am on the first day of the calendar quarter in which the edit files are effective.
  - ii. If the BH I/DD Tailored Plan experiences issues loading the edit files into its claims payment systems or any other issues with the edit files that prevents the BH I/DD Tailored Plan from properly loading the files into its systems, the BH I/DD Tailored Plan shall notify the Department within twenty-four (24) hours of identifying the issue.
  - iii. The BH I/DD Tailored Plan shall submit the NCCI File Certification form by the fifteenth (15th) Calendar Day of the month following the receipt of the Non-Public Medicaid NCCI Edit Files from the Department confirming the following:
    - a) The BH I/DD Tailored Plan has received and downloaded the Non-Public Medicaid NCCI Edit Files from the Department; and
    - b) The BH I/DD Tailored Plan has loaded the Non-Public Medicaid NCCI Edit Files, as provided to the BH I/DD Tailored Plan by the Department and are ready for use by the BH I/DD Tailored Plan by no later than 12:00 am on the first day of the calendar quarter in which the edit files apply.
  - iv. If the edit files are not properly loaded and ready for use by 12:00 am on the first day of the calendar quarter, the BH I/DD Tailored Plan shall reprocess any claim processed without using the Non-public Medicaid NCCI

Edits in effect for that quarter. All reprocessed claims are subject to the prompt pay standards, including interest and penalties, specified in the Contract.

v. The BH I/DD Tailored Plan shall not implement any new, revised, or deleted edits contained in the Non-public Medicaid NCCI Edit Files prior to the first day of the calendar quarter for which the edits are effective.

vi. The BH I/DD Tailored Plan shall only apply Outpatient Hospital NCCI edits to outpatient lab, drugs, and radiology claims.

yyyy. ***Section V. B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (v) Submission Standards and Frequency, (a)*** **is revised and restated as follows with revisions to subparts only as further identified within this Amendment:**

(a) The BH I/DD Tailored Plan shall submit all claims processed as encounters, as defined in this Section and in the Encounter Data Submission Guide, and each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, accuracy, and reconciliation.

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

a) Medical: for purposes of determining if the BH I/DD Tailored Plan has met the timeliness encounter submission standards, 837-P encounters that contain no lines with an NDC, 837-I encounters with bill type 13x that contain no lines with an NDC, and 837-I encounters with a bill type other than 13x will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH and AMH+ monthly medical home fees, and CMHRP and Healthy Opportunities per member per month payments.

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

a) Medical: for purposes of determining if the BH I/DD Tailored Plan has met the accuracy encounter submission standards, 837-P encounters and 837-I encounters will be counted by the Department as medical encounters. This includes encounter data for monthly medical home and care management fees, including AMH and AMH+ monthly medical home fees, and CMHRP and Healthy Opportunities per member per month payments.

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

(g) The BH I/DD Tailored Plan shall ensure that all HIPAA transactions adhere to the Department Encounter Data Submission Guide and Companion Guides - 837I, 837P and NCPDP developed by the Department or its vendor(s) to be provided at Contract Award.

(h) The BH I/DD Tailored Plan shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.

(i) The BH I/DD Tailored Plan shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Data Submission Guide and Companion Guides – 837I, 837P and NCPDP.

(j) Encounter data submissions must contain adjustments made by BH I/DD Tailored Plan due to payment errors and/or Provider adjusted claims.

(k) The BH I/DD Tailored Plan shall submit a monthly certification from the BH I/DD Tailored Plan Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.

(l) The BH I/DD Tailored Plan is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).

(m) Specifications

(1) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Data Submission Guide and Companion Guides - 837I, 837P, and NCPDP.

(2) The BH I/DD Tailored Plan shall follow the detailed process outlined in the Encounter Data Submission Guide. Encounters are defined in the two (2) groups below:

i. Medical, including ILOS, value-added services, and Healthy Opportunities pilot services. In addition, medical includes pharmacy claims billed as professional or institutional claims.

ii. Pharmacy includes outpatient pharmacy (point-of-sale) claims.

(3) The BH I/DD Tailored Plan shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.

i. The BH I/DD Tailored Plan shall have the capability to submit to the Department encounter data from:

a) Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and

b) Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.

(4) The BH I/DD Tailored Plan shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.

(5) The BH I/DD Tailored Plan, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.

(6) The BH I/DD Tailored Plan shall reference the same edit codes as the Department's system, which are defined in the Department's Encounter Data Submission Guide and Companion Guides - 837I, 837P and NCPDP.

ccccc. *Section V. B. Medicaid, 7. Financial Requirements, i. Capitation Payments, (viii)* is revised and restated in its entirety as follows:

(viii) The Department will reimburse BH I/DD Tailored Plan for additional directed payments to providers as required under *Section V.B.4.v. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The BH I/DD Tailored Plan is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The BH I/DD Tailored Plan shall provide the necessary data to support this process in a format and frequency to be defined by the Department.

ddddd. *Section V. B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio* is revised and restated in its entirety as follows:

ii. Medical Loss Ratio

(i) The Medical Loss Ratio (MLR) standards are to ensure the BH I/DD Tailored Plan is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives.

(ii) The BH I/DD Tailored Plan shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:

(a) The BH I/DD Tailored Plan shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).

(1) The CMS-defined MLR shall be reported in aggregate combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

(2) The numerator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall be defined as the sum of the BH I/DD Tailored Plan's incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).

(3) The denominator of the BH I/DD Tailored Plan's CMS-defined MLR for a MLR reporting year shall equal the BH I/DD Tailored Plan's adjusted premium revenue. The adjusted premium revenue shall be defined as the BH I/DD Tailored Plan's premium revenue minus the BH I/DD Tailored Plan's federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).

(b) The BH I/DD Tailored Plan shall calculate the Department-defined MLR experienced for all Non-Expansion populations in a MLR reporting year as the ratio of the numerator and denominator.

(1) Reserved.

(2) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:

i. The BH I/DD Tailored Plan is permitted to include expenditures made for voluntary contributions to health-related resources and initiatives that advance public health and Health Equity that align with the Department's Quality Strategy and meet the following conditions:

a) Meet standards established in the Department's Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.

b) Meet standards established in the Department's Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.

ii. The BH I/DD Tailored Plan is prohibited from including in the Department-defined MLR numerator any of the following expenditures:

a) Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

b) Payments to related providers that violate the Payment Limitations as required in the Contract.

iii. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:

a) Payments from the Department to reimburse for required additional directed or wrap payments to providers shall be subtracted from the denominator along with any associated taxes and fees.

(iii) The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:

(a) The BH I/DD Tailored Plan's classification of activities that improve health care quality, and initiatives that advance public health and Health Equity, shall be subject to Department review and approval.

(b) The BH I/DD Tailored Plan shall ensure that the following expenditures are excluded from the numerator in both the CMS-defined MLR and Department-defined MLR:

(1) Interest or penalty payments to providers for failure to meet prompt payment standards;

(2) Fines and penalties assessed by the Department or other regulatory authorities;

(3) Rebates paid to the Department if the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold for a prior year;

(4) Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of rebates paid to the Department if the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Sections V.B.7.ii.(iv)* and *V.B.7.ii.(ix)(c)* of this Contract;

(5) The BH I/DD Tailored Plan shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), PBM fees and spread pricing, marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations; and

(6) Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of remittances paid to the Department if the PIHP's risk corridor measurement resulted in a payment to the Department for a prior year, as described in *Sections V.B.7.v.(i)(j)ix.* and *V.B.7.v.(ii)(c)x*.

(c) The BH I/DD Tailored Plan shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating the CMS-defined MLR and all Non-Expansion eligibility groups for the Department-defined MLR.

(d) The BH I/DD Tailored Plan shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting year.

(e) Payments related to the Healthy Opportunities Pilot Program shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.

(f) All Tailored Care Management revenue received outside of capitation shall be excluded from the denominator of both the CMS-defined MLR and Department-defined MLR.

(g) The BH I/DD Tailored Plan shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.

(h) Care Coordination expenses included in the numerator of the MLR shall not exceed the combined expenditures for Care Coordination and Tailored Care Management less Tailored Care Management revenue received outside of capitation.

(iv) If the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold, the BH I/DD Tailored Plan shall do one of the following:

(a) Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;

(b) Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.B.3.x. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;

(c) Allocate a portion of the total obligation to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments, the remaining portion to a rebate to the Department, with amounts for each BH I/DD Tailored Plan, subject to approval by the Department.

(v) The minimum MLR threshold for the BH I/DD Tailored Plan shall be eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49.

(vi) The BH I/DD Tailored Plan must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).

(vii) The BH I/DD Tailored Plan shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the BH I/DD Tailored Plan within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the BH I/DD Tailored Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).

(viii) In any instance where Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to Department, the BH I/DD Tailored Plan shall:

(a) Re-calculate the MLR for all MLR reporting years affected by the change, and

(b) Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m); 42 C.F.R. § 438.8(k).

(ix) Minimum Medical Loss Ratio for Medicaid Expansion Eligible Member Population

(a) The BH I/DD Tailored Plan shall calculate and report a distinct aggregate Department-defined MLR for Medicaid Expansion Eligible Member population on an annual basis aligned to the rating year.

(1) The numerator, denominator and MLR calculations for the Department-defined MLR, including exclusions, will be consistent with those defined in *Section V.B.7.ii.(ii)* and *Section V.B.7.ii.(iii)(a)* and *(b)* of the Contract.

(2) The BH I/DD Tailored Plan shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member populations and non-Medicaid Expansion populations in the Department's defined MLR templates.

(3) The BH I/DD Tailored Plan shall aggregate data for Medicaid Expansion Eligible Members covered under the Contract for purposes of calculating the Department-defined MLR.

(4) The BH I/DD Tailored Plan shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 Member months in a MLR reporting year.

(5) All Tailored Care Management revenue outside of capitation shall be excluded from the denominator of both the CMS-defined MLR and Department-defined MLR.
(6) Payments related to the Healthy Opportunities Pilots shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
(7) The BH I/DD Tailored Plan shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.
(8) Care Coordination expenses included in the numerator of the MLR shall not exceed the combined expenditures for Care Coordination and Tailored Care Management less Tailored Care Management revenue outside of capitation.

(b) The CMS-defined MLR shall be reported in aggregate combined for Medicaid Expansion Eligible Member and non-Medicaid Expansion populations as defined in *Section V.B.7.ii.(ii)(a)(1)-(2)* and *Section V.B.7.ii.(iii)(a)* and *(b)* of the Contract.

(c) If the BH I/DD Tailored Plan's Department-defined MLR for Medicaid Expansion Eligible Member population is less than the minimum MLR threshold, the BH I/DD Tailored Plan shall do one of the following:
(1) Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
(2) Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in Section V.D.8. Opportunities for Health; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
(3) Contribute to initiatives that advance public health and Health Equity in alignment with the Department's Quality Strategy, subject to approval by the Department; or
(4) Allocate a portion of the total obligation to a mix of Department approved contributions to health-related resources and/or Department approved public health and Health Equity investments and the remaining portion to a rebate to the Department, with amounts for each subject to review and approval by the Department.

(d) The minimum MLR threshold in aggregate across all contracted BH I/DD Tailored Plans shall be exactly eighty-eight percent (88%) as required by Section 5.(6)c. of Session Law 2015-245, as amended by Session Law 2018-49. The minimum MLR threshold will be consistent for the Expansion population in total and the non-Expansion population in total.

(e) The BH I/DD Tailored Plan must attest to the accuracy of the calculation of the CMS-defined and Department defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports. 42 C.F.R. § 438.8(n).
(1) The BH I/DD Tailored Plan shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the BH I/DD Tailored Plan within one hundred eighty (180) Calendar Days of the end of the MLR reporting year or within thirty (30) Calendar Days of being requested by the BH I/DD Tailored Plan, whichever comes sooner to calculate and validate the accuracy of MLR reporting. 42 C.F.R. § 438.8(k)(3). In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the BH I/DD Tailored Plan shall: Re-calculate the MLR for all MLR reporting years affected by the change, and Submit a new MLR report meeting the applicable requirements. 42 C.F.R. § 438.8(m).

(f) The final minimum Medicaid Expansion MLR arrangement shall be settled after the final risk corridor determination for the Medicaid Expansion Eligible Member population.

eeeee. *Section V. B. Medicaid, 7. Financial Requirements, iv. Tailored Care Management Capacity Building Performance Incentive Program* is revised and restated in its entirety as follows:

iv. Reserved.

fffff. ***Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor*** **is revised and renamed as follows with revisions to subparts only as further identified within this Amendment:**

v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations

ggggg. ***Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations, (i), (a)-(e)*** **is revised and restated in its entirety as follows:**

(i) A risk corridor arrangement between the BH I/DD Tailored Plan and the Department will apply to share in gains and losses of the BH I/DD Tailored Plan non-Medicaid Expansion Eligible Member populations as defined in this section. The Risk Corridor payments to and recoupments from the BH I/DD Tailored Plan will be based on a comparison of the BH I/DD Tailored Plan's reported Risk Corridor Services Ratio ("Reported Services Ratio") for the Risk Corridor Measurement Period as defined in this section, to the Target Services Ratio consistent with capitation rate setting and set forth in the Tailored Plan Rate Book ("Target Services Ratio").

- (a) The Risk Corridor Measurement Period is defined as July 1, 2024 to June 30, 2025.
- (b) The risk corridor payments and recoupments will be based on a comparison of the BH I/DD Tailored Plan's Reported Services Ratio for the measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the BH I/DD Tailored Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.
- (c) The BH I/DD Tailored Plan Target Services Ratio shall be calculated using the Target Services Ratio for each rate cell documented in the BH I/DD Tailored Plan Rate Book and weighted by the BH I/DD Tailored Plan's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments and Tailored Care Management payments outside of monthly capitation).
- (d) The Reported Services Ratio numerator shall be the BH I/DD Tailored Plan's expenses for the Risk Corridor Measurement Period specific to the North Carolina Medicaid managed care programs. The numerator shall be defined as the sum of:
  - i. Incurred claims as defined in 42 C.F.R. 438.8(e)(2)(i)-438.8(e)(2)(iii) for State Plan Services, approved In-Lieu of Services, and approved Value-Added Services not including additional utilization-based directed payments, wrap payments and any non-risk COVID-19 vaccine and testing costs.
  - ii. Advanced Medical Home Fees as defined in *Section V.B.4.v. Provider Payments* including any uniform increases across all eligible providers above the defined floor and other increases with written approval from the Department.
  - iii. Performance Incentive Payments to Advanced Medical Homes as defined in *Section V.B.4.v. Provider Payments*.
  - iv. Other quality-related incentive payments to NC Medicaid providers.
  - v. Non-claims based provider stabilization payments to support provider sustainability and beneficiary access.
  - vi. Contributions to community-based health-related resources and initiatives that advance Health Equity, subject to Department review and approval.
- (e) The BH I/DD Tailored Plan is prohibited from including in the Reported Services Ratio numerator the following expenditures:
  - i. Payments to providers and Tailored Plan expenses for Tailored Care Management.
  - ii. Payments to providers for delegated Care Management.
  - iii. Advanced Medical Home Fees above the defined floor that are not uniform across all providers and have not received written approval for inclusion by the Department.
  - iv. Interest or penalty payments to providers for failure to meet prompt payment standards.
  - v. Payments to related providers that violate the Payment Limitations as required in the Contract.
  - vi. COVID-19 vaccine administration and testing costs included in any non-risk arrangement.
  - vii. Additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B) or other wrap payments, that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.

viii. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of rebates paid to the Department if the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold for a prior year as described in *Sections V.B.7.ii.(iv)* and *V.B.7.ii.(ix)(c)* of this Contract.

ix. Voluntary contributions to health-related resources or initiatives that advance Health Equity made in lieu of remittances paid to the Department if the BH I/DD Tailored Plan's risk corridor measurement resulted in a payment to the Department for a prior year as described in *Sections V.B.7.v.(i)(j)x.* and *V.B.7.v(ii)(c)x.* of this Contract.

hhhhh. *Section V. B. Medicaid, 7. Financial Requirements, v. Risk Corridor for Non-Medicaid Expansion Eligible Member Populations* is revised to add the following:

(ii) Risk Corridor for Medicaid Expansion Eligible Member Populations

(a) A distinct risk corridor arrangement between the BH I/DD Tailored Plan and the Department will apply to share in gains and losses of the BH I/DD Tailored Plan for Medicaid Expansion Eligible Member populations as defined in this Section. The risk corridor payments to and recoupments from the BH I/DD Tailored Plan will be based on a comparison of the BH I/DD Tailored Plan's Reported Services Ratio for each Risk Corridor Measurement Period as defined in this Section, to the Target Services Ratio consistent with capitation rate setting and set forth in the BH I/DD Tailored Plan Rate Book ("Target Services Ratio").

(b) Determination of payments and recoupments for Medicaid Expansion Eligible Member populations will be calculated separately from the non-Medicaid Expansion population.

i. The Risk Corridor Measurement Period for the Medicaid Expansion Eligible Member population is defined as:

1. For Period 1: July 1, 2024 to June 30, 2025.

ii. The numerator and denominator calculations for the Target Services Ratio and Reported Services Ratios, including exclusions, will be consistent with those defined in *Section V.B.7.v.(d)-(f)* of the Contract.

iii. The risk corridor payments and recoupments will be based on a comparison of BH I/DD Tailored Plan's Reported Services Ratio for each measurement period to a Target Services Ratio derived from capitation rate-setting by the Department. The Target Services Ratio will be documented in the BH I/DD Tailored Plan Rate Book by rate cell and may be revised concurrently with any amendments to the applicable Capitation Rates.

iv. The BH I/DD Tailored Plan Target Services Ratio for Medicaid Expansion Eligible Member populations shall be calculated using the Target Services Ratio for each applicable rate cell documented in the BH I/DD Tailored Plan Rate Book and weighted by the BH I/DD Tailored Plan's capitation revenue for each rate cell (excluding revenue associated with additional utilization-based payments).

v. The BH I/DD Tailored Plan shall calculate the numerator and denominator terms of the Reported Services Ratio based on actual experience for the applicable Risk Corridor Measurement Period and report them to the Department in a format prescribed by the Department.

vi. The BH I/DD Tailored Plan shall provide an attestation of the accuracy of the information provided in its submitted risk corridor calculations as specified in 42 C.F.R. § 438.606.

vii. Terms of the Risk Corridor

1. If the Reported Services Ratio is less than the Target Services Ratio minus three percent (3%), the BH I/DD Tailored Plan shall pay the Department eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference between the Target Services Ratio minus three percent (3%) and the Reported Services Ratio.

2. If the Reported Services Ratio is greater than the Target Services Ratio plus three percent (3%), the Department shall pay the BH I/DD Tailored Plan eighty percent (80%) of the Reported Services Ratio denominator multiplied by the difference of the Reported Services Ratio and the Target Services Ratio plus three percent (3%).

(c) Risk Corridor Settlement and Payments

i. The Department will complete a settlement determination for each Risk Corridor Measurement Period. This determination shall be made for the Medicaid Expansion Eligible Member population independent of the non-Medicaid Expansion population determination.

ii. The BH I/DD Tailored Plan shall provide the Department with an interim Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

iii. The BH I/DD Tailored Plan shall provide the Department with a final Risk Corridor Services Ratio report on a timeline and in a format prescribed by the Department.

iv. The BH I/DD Tailored Plan shall provide explanations for any allocation methods required to split expenditures between Medicaid Expansion Eligible Member and non-Medicaid Expansion populations.

v. The BH I/DD Tailored Plan shall provide additional information and documentation at the request of the Department to support the Risk Corridor Settlement determination.

vi. The Department may choose to review or audit any information submitted by the BH I/DD Tailored Plan.

vii. The Department will complete a risk corridor settlement determination for each Risk Corridor Measurement Period. In preparing the settlement, the Department will make final decisions about covered costs included in the settlement.

viii. The Department will provide the BH I/DD Tailored Plan with written notification and corresponding documentation of the final risk corridor settlement determination prior to initiating a payment or remittance. The risk corridor settlement shall become final if dispute resolution is not requested pursuant to *Section VI.G. Dispute Resolution for Contract Performance* within thirty (30) Calendar Days of the final risk corridor settlement determination notice by the Department to the BH I/DD Tailored Plan.

ix. If the final risk corridor settlement requires the BH I/DD Tailored Plan to remit funds to the Department, the BH I/DD Tailored Plan must submit remittance to the Department within ninety (90) Calendar Days of the date of the Department's notification of the final risk corridor settlement determination.

x. At the sole discretion of the Department, the Department may allow the BH I/DD Tailored Plan to contribute all or a part of the amount otherwise to be remitted to:

1. Contributions to health-related resources targeted towards high-impact initiatives that align with the Department's Quality Strategy that have been reviewed and approved by the Department.
2. Contribute to initiatives that advance Health Equity in alignment with the Department's Quality Strategy that have been reviewed and approved by the Department.
3. To be considered for the in lieu of remittance option, the BH I/DD Tailored Plan must submit a proposal to the Department for review and approval concurrent with or prior to submission of the BH I/DD Tailored Plan's interim Risk Corridor Services Ratio report.
4. If the BH I/DD Tailored Plan has not made a required remittance payment within the final date required by this Section, the Department may choose to recover any obligation due from the BH I/DD Tailored Plan by offsetting payment owed from a subsequent monthly capitation payment.
5. If the final risk corridor settlement requires the Department to make additional payment to the BH I/DD Tailored Plan, the Department shall initiate payment within ninety (90) Calendar Days after the Department's notification of the final risk corridor settlement determination. If the BH I/DD Tailored Plan initiates a dispute as described in Section VI.G. Dispute Resolution, the deadline for the Department to make the additional required payments shall be stayed pending the outcome of the dispute.

xi. The Medicaid Expansion Eligible Member population risk corridor shall be settled in advance of the final minimum Medicaid Expansion MLR reporting and determination.

iiiii. ***Section V. B. Medicaid, 8. Technical Specifications, iii. Enrollment and Reconciliation, (i) Member Enrollment and Reconciliation, (a) Enrollment* is revised to add the following*:***

(4) By no later than the BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall have the ability to receive the current version of the 270 Eligibility Request File and send the current version of the 271 Eligibility Response File. This file should function near real-time mode and be able to be submitted in a SFTP delivery or via the provider portal.

jjjjj. ***Section V. B. Medicaid, 8. Technical Specifications, iii. Enrollment and Reconciliation, (i) Member Enrollment and Reconciliation, (b) Reconciliation, (4)* is revised and restated in its entirety as follows:**

(4) Reserved.

kkkkk. ***Section V. B. Medicaid, 8. Technical Specifications, v. Provider Directory, (i)* is revised and restated as follows with no revisions to subsections unless otherwise stated in this Amendment:**

(i) The Department's designated vendor shall validate and integrate the provider directory information transmitted by the BH I/DD Tailored Plan and supply the Enrollment Broker and NC Fast with a Consolidated Provider Directory to support BH I/DD Tailored Plan choice counseling and selection.

lllll. ***Section V. B. Medicaid, 8. Technical Specifications, v. Provider Directory, (i), (a)* is revised and restated as follows:**

(a) The BH I/DD Tailored Plan should use the National Provider Identifier (NPI) enrolled with the Department and the Department's specified key as the unique provider identifier for the location. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by the Department's system should be used.

mmmmm. ***Section V. B. Medicaid, 8. Technical Specifications, v. Provider Directory, (ii) Consolidated Provider Directory Data Transmissions, (b)* is revised and restated in its entirety as follows:**

(b) The BH I/DD Tailored Plan shall create a successfully processed full Provider Network File (PNF) including data (as defined in the Contract) on all contracted and sub-contracted Providers in their Network. The BH I/DD Tailored Plan shall deliver the file to the Department's designated vendor every Calendar Day by 5:00 PM EST. A successfully processed full PNF means that for each submission of the PNF by the BH I/DD Tailored Plan to the Department's designated vendor, the BH I/DD Tailored Plan has included all Provider records from the BH I/DD Tailored Plan's Network in the file submission and the BH I/DD Tailored Plan receives a Provider Network Response File (PNrF) from the Department's designated vendor in response to the PNF submission.

nnnnn. ***Section V.B. Medicaid, 8. Technical Specifications, vi. Technology Documents, (ii)* is revised and restated in its entirety as follows:**

(ii) Security Documentation: The BH I/DD Tailored Plan shall comply with all federal, State and NCDHHS Privacy and Security policies as outlined in the State and NCDHHS Security Manuals. These manuals are available at the following link, accurate as of October 1, 2024: https://it.nc.gov/documents/statewide-information-security-manual and https://policies.ncdhhs.gov/document/security-manual/. In compliance with this policy, the NC DHHS Privacy and Security Office and the Department of Information Technology require at a minimum the following three (3) documents to be submitted by the BH I/DD Tailored Plan as set forth below. As long as the Vendor Readiness Assessment Reports, System Security Plan, and SOC 2 Type II Reports or Self-Assessments clearly state that they apply to the BH I/DD Tailored Plan, they may apply to other LME/ MCO operations, including, without limitation, the PIHP.

(a) Vendor Readiness Assessment Report (VRAR) - The VRAR and its underlying assessment are intended to enable DHHS to reach a state-ready decision for a specific vendor solution, hosted on or off the State network based on organizational processes and the security capabilities of the information system. The VRAR must be submitted prior to the BH I/DD Tailored Plan launch, and annually thereafter no later than June 30th of each subsequent Contract year. The template for the VRAR can be accessed here: https://it.nc.gov/documents/vendor-readiness-assessment-report.

(b) System Security Plan (SSP): The BH I/DD Tailored Plan shall provide a plan that details how the BH I/DD Tailored Plan will comply with the Department Confidentiality, Privacy and Security Protections requirements as outlined in the Contract or in the State or NC DHHS security manuals referenced above using the template provided by the Department. The SSP must be submitted annually no later than June 30th of each Contract year. The SSP template is available upon request to the Department's Contract Administrator for Contractual Matters.

(c) SOC 2 Type II Report –

(1) The BH I/DD Tailored Plan must submit a completed Soc 2 Type II report within twelve (12) months of BH I/DD Tailored Plan launch, and annually no later than June 30th of each subsequent Contract year. If the technology platform used to deliver the services under this Contract has not been used in a production setting of the BH I/DD Tailored Plan, a Self-Assessment and externally conducted penetration test must be performed on the technology platform and submitted to the Department in lieu of the Soc 2 Type II report prior to the BH I/DD Tailored Plan launch.

i. The Self-Assessment and External Penetration Test submitted in lieu of the Soc 2 Type II report required under this Section shall be completed using either a template provided by the Department's PSO or NIST 800-53 Rev 5 version questionnaire. The BH I/DD Tailored Plan may only submit a Self-Assessment and External Penetration Test in lieu of the SOC 2 Type II at or prior to go-live.

ii. After a minimum of one hundred eighty (180) Calendar Days of production activity, the BH I/DD Tailored Plan shall perform a SOC 2 Type II assessment or other acceptable audit or assessment approved by the Department and submit the results of the assessment or audit to the Department no more than thirty (30) Calendar Days after completing the assessment unless another timeframe is approved by the Department.

iii. The BH I/DD Tailored Plan shall submit to the Department no later than June 30th of each Contract Year its SOC 2 Type II report and bridge letter covering the duration of the entire Contract Year.

(d) The BH I/DD Tailored Plan shall collect and review the final SOC 2 Type II reports or other acceptable audit or assessment from all of its Subcontractors to confirm Subcontractor compliance with the privacy and security requirements in this Contract and relevant Department, State, and federal security rules, regulations, policies, and statutes in accordance with Sections III.D.43. and III.E. of this Contract. Upon Department Request, the BH I/DD Tailored Plan shall provide to the Department a copy of the final SOC 2 Type II report(s) and/or other acceptable audit or assessment for the BH I/DD Tailored Plan's Subcontractor(s).

(e) Reserved.

(f) Reserved.

(g) Reserved.

(h) Reserved.

(i) Reserved.

ooooo. *Section V. Scope of Services, B. Medicaid, 8. Technical Specifications, vi. Technology Documents, (vi)* is revised and restated in its entirety as follows:

(vi) Reserved.

ppppp. *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, c)* is revised and restated in its entirety as follows:

c) The BH I/DD Tailored Plan shall report the waiting list to the Department on a quarterly basis.

qqqqq. *Section V. C. State-funded Services, 1. Recipients, a. Eligibility for State-funded BH, I/DD, and TBI Services* is revised to add the following:

xiii. TBI Screening

a) To assist with the identification of the prevalence of and service delivery needs for Members living with brain injury, the BH/IDD Tailored Plan shall conduct brain injury screening to identify Members who have likely sustained a brain injury in their lifetime. Screening shall be conducted at either the BH/IDD Tailored Plan call center or at a contracted

provider assessment agency, as determined by mutual agreement between the parties. Results shall be reported on a quarterly basis using the standardized traumatic brain injury (TBI) report template provided by the Department as defined in *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*

rrrrr. ***Section V. C. State-funded Services, 1. Recipients, e. Recipient Complaints and Appeals, v. Internal Plan Appeals for Utilization Review Decisions, b) Notice of Adverse Utilization Reviews Decisions, 10.*** **is revised and restated in its entirety as follows:**

10. In cases in which the decision upholds the previous decision, the BH I/DD Tailored Plan shall inform appellants in writing of the opportunity to appeal a decision regarding a State-funded service to the DMH/DD/SUS Non-Medicaid Appeals Panel according to 10A NCAC 27I .0600 and N.C. Gen. Stat. § 143B-147(a)(9).

sssss. ***Section V. C. State-funded Services, 2. Services, a. State-funded BH, I/DD and TBI Services, iv. Covered Services, Section V.C.2. Second 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 Third Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
All–Disability	1. Diagnostic assessment[22][21] 2. Facility based crisis for adults[23]* 3. Inpatient BH services* 4. Mobile crisis management* 5. Outpatient services[24]	1. BH urgent care* 2. Facility based crisis for children and adolescents*
Adult Mental Health	1. Assertive community treatment (ACT) 2. Assertive engagement[25] 3. Reserved. [26] 4. Community support team (CST) 5. Peer Support Services[27] 6. Psychosocial rehabilitation 7. Mental health recovery residential services[28] 8. Individual placement and support (IPS)-supported employment [29] 9. Transition management service 10. Critical Time Intervention 11. BH Comprehensive Case Management	1. Partial hospitalization
Child Mental Health	1. Reserved.[30] 2. Intensive in-home 3. Multi-systemic therapy 4. Respite 5. Assertive engagement	1. Mental health day treatment
I/DD and TBI	1. Residential Supports 2. Day Supports Group 3. Community Living & Support 4. Supported Living Periodic 5. Supported employment[31] 6. Respite	1. TBI long term residential rehabilitation 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

Section V.C.2 Third Revised and Restated Table 1: State-funded BH, I/DD, and TBI Services		
Disability Group	**Core Services**	**Non-Core Services**
	7. Adult Day Vocational Programs (ADVP) 8. I/DD and TBI Care Management[32]	
Substance Use Disorder - Adult	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 services[33] 5. Opioid Treatment Program Services 6. Medically Monitored Inpatient Withdrawal Management Services* 7. Peer supports[34] 8. Substance use residential services and supports[35] 9. Substance abuse halfway house 10. Substance abuse comprehensive outpatient treatment 11. Substance abuse intensive outpatient program 12. Substance abuse medically monitored community residential treatment 13. Substance abuse non-medical community residential treatment 14. Individual placement and support (IPS) supported employment 15. Community Support Team 16. BH Comprehensive Case Management 17. Medically monitored intensive inpatient services[35] 18. Clinically managed high-intensity residential services – Pregnant & Parenting[35] 19. Clinically managed high-intensity residential services[35]	1. Clinically managed residential withdrawal management services- *
Substance Use Disorder - Child	1. Multi-systemic therapy (MST) 2. SAIOP 3. Substance use residential services and supports 4. Reserved. 5. Assertive Engagement 6. Clinically managed medium-intensity residential services – Adolescent[35]	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 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.

ttttt. ***Section V. C. State-funded Services, 3. Care Management and Prevention, a. Model Overview and Prevention, i.*** **is revised and restated in its entirety as follows:**

i. The Department believes that Recipients of State-funded Services with the highest needs will benefit from care and case management to avoid unnecessary emergency department visits, hospitalizations and readmissions, and promote linkages to Medicaid and other resources.

uuuuu. ***Section V. C. State-funded Services, 3. Care Management and Prevention, b. Case Management for Recipients with Behavioral Health Conditions, i.-ii.*** **is revised and restated in its entirety as follows:**

i. The BH I/DD Tailored Plan shall offer behavioral health Comprehensive Case Management services, as detailed in *Section V.C.2. Services*, beginning January 1, 2025.

ii. The BH I/DD Tailored Plan shall hire a State-funded BH Case Management Coordinator to develop policies, practices, and systems that support the provision of case management services as detailed in *Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services*.

a) The State-funded BH Case Management Coordinator shall be responsible for all of the following activities:

1. Assessing the case management provider network and working with the network management staff to identify gaps in the case management provider network based upon the Network Access Plan as detailed in *Section V.C.4.a.xi*. and waiting list information as detailed in *Section V.C.1.a.xiii.*
2. Monitoring the delivery of case management services, including reviewing service authorizations for case management services to ensure fidelity of the services delivered, service plans, comprehensive clinical assessments, and person-centered plans.
3. Ensuring that potential referral sources (e.g., hospitals, community providers, law enforcement agencies, DSS) are aware of case management providers in their area.
4. Providing support to case management providers to develop a toolkit of medical, behavioral, social and other programs, services, and supports for Recipient linkages, leveraging NCCARE360 and 211.org for social services.
5. Assisting case management providers with identifying and coordinating appropriate placement for Recipients with complex needs that are creating barriers to securing an appropriate disposition, including but not limited to Recipients who:
    i. Are placed at an inappropriate level of care or are at risk of being discharged from their current placement due to their complex needs;
    ii. Have a medical co-morbidity (including pregnancy);
    iii. Have co-occurring mental health, SUD, I/DD, and/or TBI disorders;
    iv. Have complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions; or
    v. Have a legal history affecting ability to live in congregate settings and/or in proximity to children.

vvvvv. ***Section V. C. State-funded Services, 3. Care Management and Prevention, c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations, v.*** **is revised and restated in its entirety as follows:**

v. The BH I/DD Tailored Plan shall develop and maintain a waiting list for eligible potential Recipients with I/DD or TBI diagnoses who are waiting to receive care management consistent with the requirements in *Section V.C.1.a.xii.* The state-funded wait list does not create an entitlement to State-funded Services or appeal rights.

wwwww. ***Section V. C. State-funded Services, 3. Care Management and Prevention, f. System of Care, iii. System of Care Policy, d), 5., i)*** **is revised and restated in its entirety as follows:**

i) The DMH/DD/SUS System of Care Coordinator.

xxxxx. ***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, a)*** **is revised and restated in its entirety as follows:**

a) The Department has developed an intra-Departmental Emergency Closure "Adult Care Home (ACH) Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions – DHSR, DAAS, DMH/DD/SUS – BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program housed within the Area Authorities on Aging.

yyyyy. ***Section V. C. State-funded Services, 3. Care Management and Prevention, h. Relocation of Recipients Following Emergency Residential Care Facility Closures, iv. Emergency Closures of Group Homes, a)*** **is revised and restated in its entirety as follows:**

a) The Department has developed an intra-Departmental Emergency Closure "Group Home Response Hub" that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents and is comprised of the following Divisional partners: DHSR, DMH/DD/SUS, DHB and DAAS.

zzzzz. ***Section V. C. State-funded Services, 4. Providers, a. Provider Network, xi. Assurances of Adequate Capacity and Services, c)*** **is revised and restated in its entirety as follows:**

c) The BH I/DD Tailored Plan and its Network providers shall comply and cooperate with DMH/DD/SUS and DHHS vendors during annual validation activities of the BH I/DD Tailored Plan's State-funded network and compliance with State-funded network requirements.

aaaaaa. ***Section V. C. State – funded Services, 4. Providers, b. Provider network Management, iii. Provider Contracting, l), 1.*** **is revised and restated in its entirety as follows:**

1. The BH I/DD Tailored Plan shall notify the applicable Department Division(s) based on funding source and licensure, i.e. NC Medicaid, DMH/DD/SUS and/or DHSR.

bbbbbb. ***Section V. C. State – funded Services, 4. Providers, b. Provider network Management, iv. Critical Incident Reporting*** **is revised and restated in its entirety as follows:**

iv. Critical Incident Reporting

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

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

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

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

(e) The BH I/DD Tailored Plan shall ensure that Provider contracts with Category A and B Providers as defined in 10A NCAC 27G .0602(8) include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Fourth Revised and Restated Attachment G.2. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for State-Funded Services.* If a provider is not complying or there are trends in incident reporting, the BH I/DD Tailored Plan will utilize processes including but not limited to provider monitoring and corrective actions to minimize occurrence of preventable incidents and to ensure health and safety of Members and Recipients receiving services.

(f) Reserved.

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

cccccc. ***Section V. C. State – funded Services, 4. Providers, b. Provider network Management, vi. Credentialing and Re-credentialing Process, b)*** **is revised and restated in its entirety as follows:**

b) Each Provider that is credentialed to provide only State-funded Services ("State-funded only Provider") at BH I/DD Tailored Plan launch shall enroll in Medicaid during its next recredentialing period. The period between BH I/DD Tailored Plan launch and when all State-funded only Providers are credentialed with Medicaid will be considered the "State-funded Only Provider Credentialing Transition Period." During the State-funded Only Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall monitor and maintain credentialing records for State-funded only Providers to ensure continued compliance with credentialing requirements and ensure that each State-funded only Provider transitions to Medicaid enrollment during its recredentialing period. These records shall be made available to the Department for inspection if requested.

dddddd. ***Section V. C. State – funded Services, 4. Providers, b. Provider network Management, viii. Network Provider Credentialing and Re-credentialing Policy, c) Provider disenrollment and Termination, 1. Payment Suspension and Re-Credentialing, i.*** **is revised and restated in its entirety as follows:**

i. The BH I/DD Tailored Plan shall suspend claims payment to any Provider in its Network within one (1) Business Day of receipt of a notice from the Department that provider payment has been suspended for failing to submit documentation to the Department or otherwise failing to meet Department specifications. Claims payment suspension shall apply to Dates of Services after the effective date of notice by the Department.

eeeeee. ***Section V. C. State – funded Services, 5. Quality, a. Quality and Management and Quality Improvement, ii.*** **is revised and restated in its entirety as follows:**

ii. The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. DMH/DD/SUS's Quality Management plan outlines the Division's Quality Management Program, its values, guiding principles and improvement initiatives for providing access to high quality BH, SUD services and I/DD and TBI supports.

ffffff. ***Section V. C. State – funded Services, 5. Quality, a. Quality and Management and Quality Improvement, v*****. is revised and restated as follows with no revisions to subsections therein*:***

v. The BH I/DD Tailored Plan shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and QAPI Plan, and DMH/DD/SUS's Quality Management plan.

gggggg. ***Section V. C. State – funded Services, 7. Financial Requirement, c. Administrative Funding, i.*** **is revised and restated in its entirety as follows*:***

i. The BH I/DD Tailored Plan shall be allowed to expend up to twelve percent (12%) of the amount of Single Stream Funds expended in the prior year, each fiscal year on administrative expenses.

hhhhhh. ***Section V. C. State – funded Services, 7. Financial Requirement*** **is revised to add the following:**

j. State-Funded Services Spend Plan: By June 30th each year, the BH I/DD Tailored Plan shall submit projected State-Funded Spend Plan for the upcoming state fiscal year.

   i. The State-Funded Spend Plan shall be broken down by:
      a) Disability (MH, DD, SUS, TBI);
      b) Service type (Inpatient; Crisis; Residential; Enhanced, Support, and Community-based Services; Facility Based Day Supports; Based Supports; Supported Employment; Outpatient; Other);
      c) Special projects and initiatives; and
      d) Service provider.
   ii. The BH I/DD Tailored Plan shall also provide in the State-Funded Spend Plan an explanation for why it prioritized its planned State-funded spending the way that it did.
   iii. If the BH I/DD Tailored Plan does not budget in a way that is reportable under the terms of this section, it may instead explain in detail its process for strategically budgeting for State-funded Services, to the extent the BH I/DD Tailored Plan's State-funded Spending Plan differs from the process set forth in this Section.
   iv. The BH I/DD Tailored Plan shall also submit quarterly to the Department all budgeting and strategic planning documents that the BH I/DD Tailored Plan submits to its Board relating to State-funded Services.

III. Section VI. Contract Performance

Specific subsections are modified as stated herein.

a. ***Section VI. Contract Performance, G. Dispute Resolution for Contract Performance, 1.*** **is revised and restated in its entirety as follows:**

1. The Contractor shall exhaust the dispute processes as provided in the Contract to contest the imposition of intermediate sanctions, the assessment of liquidated damages, and/or for cause termination of the Contract whether pursuant to 42 C.F.R. § 438.708 or otherwise by the Department before pursuing any other administrative, legal, or equitable remedy that may be afforded to the Contractor under North Carolina or federal law or regulation.

b. ***Section VI. Contract Performance, G. Dispute Resolution for Contract Performance, 2.*** **is revised and restated in its entirety as follows:**

2. The Contractor shall have the right to dispute certain contract performance actions by the Department, including the imposition of intermediate sanctions, liquidated damages, or termination, through the dispute resolution process, except that the Contractor shall not have the right to dispute the Department's decision to require the Contractor to perform a remedial action.

IV. Modifications to Section VII. Attachments

Specific Attachments are modified as stated herein.

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

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

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

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

e. ***Section VII. Third Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts*** **is revised and restated in its entirety as** ***Section VII. Fourth Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts*** **and attached to this Amendment.**

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

g. ***Section VII. Attachment M. Policies Second Revised and Restated Attachment M.1 North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment M.1 North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*** **and attached to this Amendment.**

h. ***Section VII. Attachment M. Policies Second Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid and NC Health Choice Members*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid Members*** **and attached to this Amendment.**

i. ***Section VII. Attachment M. Policies Attachment M. 5. Case Management for High-Risk Pregnancy Policy for Medicaid*** **is revised and restated in its entirety as** ***Section VII. First Revised and Restated Attachment M. 5. Case Management for High-Risk Pregnancy Policy for Medicaid*** **and attached to this Amendment.**

j. ***Section VII. Attachment M. 7 Second Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid, and State-funded Providers*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers.***

k. ***Section VII. Attachment M. Policies Second Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment M. 9. Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*** **and attached to this Amendment.**

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

m. ***Section VII. Attachment M. Policies Attachment M. 13. Approved <TP NAME> In Lieu of Services*** **is revised and restated in its entirety as** ***Section VII. First Revised and Restated Attachment M. 13. Approved <TP NAME> In Lieu of Services*** **and attached to this Amendment.**

n. ***Section VII. Attachment M. Policies, Attachment M. 14. COVID-19 Public Health Emergency Managed Care Policy*** **is revised and restated in its entirety as** ***Section VII. First Revised and Restated Attachment M. 14. COVID-19 Public Health Emergency Managed Care Policy Sunset Effective October 1, 2024*** **and attached to this Amendment.**

o. ***Section VII. First Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities*** **is revised and restated in its entirety as** ***Section VII. Second Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities*** **and attached to this Amendment.**

p. ***Section VII. Second Revised and Restated Attachment P. Performance Metrics, Services Level Agreements and Liquidated Damages,*** **is revised and restated in its entirety as** ***Section VII. Third Revised and Restated Attachment P. Performance Metrics, Service Level Agreements and Liquidated Damages,*** **and attached to this Amendment.**

q. ***Section VII. RFA Attachments is revised to add Attachment U. Annual Housing Expectations*** **which is attached to this Amendment.**

V. Effective Date

This Amendment is effective July 1, 2024, unless otherwise explicitly stated herein, upon the later of the execution dates by the Parties, 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

_______________________________________ Date: _________________________

Jay Ludlam, Deputy Secretary
NC Medicaid

BH I/DD Tailored Plan Name

_______________________________________ Date: _________________________

BH I/DD Tailored Plan Authorized Signature

Fourth 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. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for overseeing assigned care managers. For Medicaid and State-funded Services, these individuals are responsible for reviewing all Care Plans (Medicaid only) and Individual Support Plans for quality control and providing guidance to care managers on how to address members' complex health and social needs. For Medicaid, these individuals are responsible for ensuring fidelity to the Tailored Care Management model. For State-funded Services, this position only services recipients with I/DD and TBI.	• Must meet North Carolina Residency requirements. • If serving Members with BH conditions, must hold a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession (examples include LCSW, LMFT, LCAS, LCMHC, LPA, RN). • Three years of experience providing care management, case management, or care coordination to the population being served. • Supervising care managers serving enrollees with an I/DD

Section VII. Fourth 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**
		or a TBI must have one (1) of the following minimum qualifications: ○ A bachelor's degree in a human service field and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI; OR ○ A master's degree in a human service field and three (3) years of experience providing care management, case management, or care coordination to complex individuals with an I/DD or a TBI; OR ○ A bachelor's degree in a field other than human services and five (5) years of experience providing care management, case management, or care coordination

Section VII. Fourth 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**
		to complex individuals with I/DD or TBI. • If an enrollee is dually diagnosed with a behavioral health condition and an I/DD or a TBI, BH I/DD Tailored Plan and assigned organization providing Tailored Care Management must ensure that the supervising care manager is qualified to oversee the enrollee's care manager. • The Department will grant a one-time staff exception ('grandfathering') for specified BH I/DD Tailored Plan staff that: ○ Were employed in the role of Care Manager and Care Management Supervisor at the time of BH I/DD Tailored Plan Contract Award (July 26, 2021). ○ This exception is based on the staff enrollee possession the required

Section VII. Fourth 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**
		number of years of experience, but not the required degree, degree type or licensure type.
3. State-funded BH Care Management Coordinator	This individual is responsible for developing policies, practices and systems that support the provision of case management services for State-funded Services recipients with BH conditions. In accordance with applicable provisions of N.C.G.S. 122C-115.4(g)(1), this individual shall serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated BH System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Juvenile Justice Section of the Division of Adult Correction and Juvenile Justice, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.	• Must meet North Carolina Residency requirements. • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or RN. • Must have three (3) years of supervisory experience working directly with complex individuals with a BH condition.
4. Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	For Medicaid, these individuals shall be responsible for providing integrated whole-person care management under the Tailored Care Management model, including coordinating across physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs. For State-funded Services, these individuals are responsible for providing care management for recipients with I/DD and TBI needs, including coordination across BH, I/DD, TBI and Unmet Health Resource Needs.	• Must meet North Carolina Residency requirements. • Care Managers must meet North Carolina's definition of Qualified Professional per 10A-NCAC 27G .0104 as updated by the Department's February 2022 waiver of experience requirement for Qualified Professionals.

Section VII. Fourth 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**
		• For care managers serving enrollees with LTSS needs: ○ Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring, and care management experience, in addition to the requirements cited above. ○ This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, above.
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).	• Must meet North Carolina Residency requirements.
6. Full-Time Transition Supervisor(s) for North Carolina Medicaid Managed Care	This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.	• Must meet North Carolina Residency requirements. • Must meet at least Qualified Professional (Mental

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
Program and State-funded Services		Health/Substance Abuse) minimums for education and training • BH I/DD Behavioral Health Tailored Plan may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
7. Reserved.		
8. Full-Time Peer Support Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members and recipients with BH diagnoses residing in a state psychiatric hospital or an ACH.	• Must meet North Carolina Residency requirements. • Must have NC Certified Peer Support Specialist Program Certification.
9. Full-Time In-Reach Specialist(s) for North Carolina Medicaid Managed Care Program	This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.	• Must meet North Carolina Residency requirements. • Must hold a Bachelor's degree in a human services field. • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians. • BH I/DD Behavioral Health Tailored Plan

Section VII. Fourth 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**
		may submit to the Department for approval alternate minimum qualifications for In-Reach and Transition staff.
10. Diversion Specialist(s) for State-Funded Services	These individuals are responsible for performing diversion functions and activities described in *Section V.C.3.d.iv. Diversion Activities* for recipients eligible to receive diversion services as described in *Section.V.C.3.d.ii. Eligibility for Diversion.*	• Must meet North Carolina Residency requirements. • Must: a. Be a Master's level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or licensed as a RN plus one (1) year of relevant experience working directly with individuals with SMI; **or** b. Have one (1) year prior relevant and direct experience providing diversion services under TCL.
11. System of Care Family Partner(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold high school diploma or GED. • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid or State-funded BH services.

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
12. System of Care Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	• Must meet North Carolina Residency requirements. • Must hold: a. A Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; **or** b. A Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems
13. DSOHF Admission Through Discharge Manager for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for: • Coordinating and/or performing transition functions and activities described in *Section V.B.3.viii.(iv)* and *Section V.C.3.e.iv* for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. Coordinating and/or performing discharge planning functions for BH I/DD Tailored Plan members and state-funded recipients who are not receiving transition functions and activities described in *Section V.B.3.viii.(iv)* and *Section V.C.3.e.iv* DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as the BH I/DD Tailored Plan liaison to ADATCs in the BH I/DD Tailored Plan's region.	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: • Must meet North Carolina Residency requirements. • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers:

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		• Must meet North Carolina Residency requirements. • Must hold: a. A Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; **or** b. A Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; **or** c. A Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
14. Member and Recipient Appeal Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates member and recipient appeals in a timely manner.	• Must meet North Carolina Residency requirements.

Section VII. Fourth 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**
15. Member and Recipient Complaint and Grievance Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates member and recipient complaints and grievances in a timely manner.	• Must meet North Carolina Residency requirements.
16. Full-Time Member and Recipient Complaint and Grievance Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient complaints and grievances in accordance with state and federal laws and this Contract.	• For grievances that involve clinical issues or regarding denial of expedited resolution of an appeal, the individuals must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing complaints and grievances.
17. Full-Time Peer Review and/or Member and Recipient Appeal Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient appeals in accordance with state and federal laws and this Contract.	• Peer reviewers must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing appeals.
18. Full-Time Member and Recipient	These individuals coordinate communication with members and recipients.	• Must meet North Carolina Residency requirements.

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
Services and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services		
19. Provider Relations and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communications between the BH I/DD Tailored Plan and providers.	• Must meet North Carolina Residency requirements.
20. Provider Network Relations Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals support the Provider Network Director in network development and management.	• Must meet North Carolina Residency requirements.
21. Provider Complaint, Grievance, and Appeal Coordinator for the North Carolina Medicaid Managed Care Program and	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	• Must meet North Carolina Residency requirements.

Section VII. Fourth 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**
State-funded Services		
22. Pharmacy Director for the Pharmacy Service Line for the North Carolina Medicaid Managed Care Program	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract.	• Must meet North Carolina Residency requirements. • Must be a North Carolina registered pharmacist with a current NC pharmacist license. • Minimum of three (3) years of pharmacy benefits call center experience.
23. Full-Time Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing. • Pharmacists shall be registered, with current NC Pharmacist license.
24. Full-Time I/DD and TBI Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	• Must meet North Carolina Residency requirements. • Must be a Qualified Professional in the area of Developmental Disabilities as specified in 42 C.F.R. § 483.430 (a) and N.C.G.S. § 122C-3.

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
25. PBM Liaison for the North Carolina Medicaid Managed Care Program	If the BH I/DD Tailored Plan partners with a third-party PBM, this individual serves as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	N/A
26. Tribal Provider Contracting Specialist (If applicable) for the North Carolina Medicaid Managed Care Program	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	• Must meet North Carolina Residency requirements.
27. Reserved.		
28. Liaison between the Department and the North Carolina Attorney General's MID for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the NC Attorney General's Medicaid Investigation Division.	• Must meet North Carolina Residency requirements.
29. Special Investigations Unit (SIU) Lead for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, or pre-law, or have at least five (5) years of relevant experience.

Section VII. Fourth Revised and Restated Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	**Duties and Responsibilities of the Role**	**Minimum Certifications and/or Credentials Requested by the Department**
		• Must complete CLEAR training or provide a timeframe as to when it will be complete.
30. Special Investigations Unit (SIU) Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	• Must hold an Associate's or Bachelor's degree in compliance, analytics, government/public administration, auditing, security management, pre-law, or criminal justice, **or** have at least three (3) years of relevant experience
31. Liaison to the Division of Social Services for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serves as a primary contact to triage and escalate member specific or BH I/DD Tailored Plan questions.	• Must meet North Carolina Residency requirements.
32. Waiver Contract Manager for the North Carolina Medicaid Managed Care Program	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1115 Waiver and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	• Must meet North Carolina Residency requirements Minimum of seven (7) years of management experience, preferably in human services.
33. Olmstead Manager	Provide coordination across BH I/DD Tailored Plan program areas to assist the BH I/DD Tailored Plan in putting in place an array of policies, procedures or practices that support the ADA/Olmstead integration mandate within the BH I/DD Tailored Plan and its provider network.	• Must meet North Carolina Residency requirements. • Must hold: a. A Bachelor's degree in an area specific to

Section VII. Fourth 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**
		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	The Housing Development Coordinator's job responsibilities shall include but not be limited to the following: 1. Map existing permanent supportive housing (PSH), PSH utilized by housed TCL individuals, and requested housing locations of TCL individual currently in pre-transition process. Utilize the map and other information sources to develop plans to target new stock development or access to	• 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

Section VII. Fourth 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**
	untapped existing stock within the BH I/DD Tailored Plan Region. 2. Engage public housing authorities (PHAs), Continuums of Care (COCs), and Balance of State (BoS) with the BH I/DD Tailored Plan, NCHFA, grant, and other housing resources to develop housing stock and access throughout the BH I/DD Tailored Plan Region. 3. Develop regional housing databases for the BH I/DD Tailored Plan's Region connecting public stock with private housing options for TCL staff. 4. Utilize public notices of newly initiated housing developments, assertively engage private developers linking them with BH I/DD Tailored Plan, NCHFA, HUD, and other resources for tax credit, bond, loan assistance, and rehabilitation in exchange for access agreements for individuals with disabilities. 5. Technically assist existing TCL staff and TCL provider engagement with their improved access of computerized housing availability systems, giving priority to, and more effectively offering and getting access for, TCL individuals to Targeted Key Housing. 6. Specify the pre-housing, day-of housing, post-housing, and proactive separation prevention expectations during pre-tenancy and post-tenancy transition teams. 7. Ad hoc participation in Local Barriers Committee to address housing barriers and participation on Housing Separation and Root Cause Analysis meetings to address provider practices contributing to separations. 8. In collaboration with DHHS Regional Housing Coordinators, develop effective housing access materials, training, and systems for early identification of reasonable accommodation letter needs, consistently quicker registering of those accommodation letters with landlords, informal intervention strategies accommodation denials, and connection to legal support agencies to remedy unfair housing practices. In collaboration with DAAS, improve timely communication	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.

Section VII. Fourth 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**
	between DHHS Regional Housing Coordinators, landlords and TCL service providers. 9. Work within the BH I/DD Tailored Plan and with external housing providers to develop Enhanced Bridge Housing, TCL priority to BH I/DD Tailored Plan or Public Housing Authority-held master leases, incentivized housing priority to landlords for TCL members, and other novel housing access approaches.	
35. TCL Quality Assurance (QA) Specialist	This position manages TCL Quality Assurance Performance Improvement (QAPI) activities. The TCL Quality Assurance Specialist job responsibilities shall include but not limited to the following: 1. Serve as the organization's TCL QAPI point of contact for DHHS and manage and coordinate the development and implementation of internal QAPI activities and implementation of State QAPI initiatives. 2. Develop, implement, and evaluate QAPI processes and procedures to monitor and ensure the quality and timelines of contracted TCL functions, including diversion, in-reach, discharge and transition planning, quality of life survey administration, and Root Cause Analyses (RCAs). 3. Develop and implement procedures including member outcomes monitoring to ensure the quality of mental health and employment services and that the frequency and intensity of services are sufficient to help individuals achieve increased independence and community integration, housing stability, and reduced institutional contacts and incidents of harm. Conduct regular review and analysis of TCL quality and performance measures, member surveys and assessments, incidents of harm, mental health and employment services data, institutional admissions, and other data sources to identify quality issues and performance deficits. 4. Design and implement Performance Improvement Projects (PIPs) and other QAPI processes to identify and address quality and performance issues. 5. Provide support for Local Barriers Committee to identify, aggregate, and report barriers to member community integration and transitions to and maintenance of supportive community housing.	• 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.

Section VII. Fourth 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**
	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.	
36. TCL Data Analyst	This position provides data support for TCL Quality Assurance Performance Improvement (QAPI) activities and required reporting and manages and carries out procedures to ensure TCL data accuracy. The TCL Data Analyst's responsibilities shall include but are not limited to the following: 1. Serve as the organization's TCL data quality point of contact for DHHS;. 2. Manage, coordinate, and carry out TCL Data Integrity Plan procedures and activities, including development, evaluation, and refinement of procedures to support data quality; 3. Regular and ongoing data review, validation, and cross-database reconciliation (e.g., TCLD, CLIVe, internal client data management systems, NCTracks extracts provided by the Department); 4. Identification of data quality issues and solutions; and data cleaning to ensure timely data entry and updates and data accuracy; 5. Collect and aggregate data for required TCL reporting; 6. Conduct ongoing monitoring to ensure timely Quality of Life survey administration; and 7. Assist with analysis, summary, and interpretation of data related to Performance Improvement Projects, member surveys, and other QAPI processes to support identification of individual and systemic quality issues that require intervention or improvement and evaluation of the effectiveness of QAPI activities and initiatives.	• Must hold a Bachelor's degree with a least two (2) years of experience in data management and analysis, preferably in a behavioral or medical managed care environment.

Section VII. Fourth 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**
37. Supported Employment Specialist	This individual's job responsibilities shall include but not be limited to the following: 1. As the BH I/DD Tailored Plan's point of contact, engage in statewide Departmental efforts to expand, improve, and standardize IPS service models such as NC CORE; 2. Assertively develop new Individual Placement and Support Supported Employment (IPS-SE) providers and provide technical assistance in the integration with conversion from a fee-for-service IPS model into a milestone payment model such as NC CORE; 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	• 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 Rehabilitation, or other research-based employment model).

Section VII. Fourth 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**
	contact with the Department for meetings involving the statewide benefits counseling electronic system; 8. Maintain the departmentally required TCL IPS data in conjunction with Quality Assurance and/or other related cross-functional BH I/DD Tailored Plan departments; 9. Actively participate in local, regional, and statewide job development efforts with businesses and corporations wanting to competitively employ individuals with SMI/SPMI and link those efforts to their IPS providers' workforce of the individuals they serve; 10. Assist linkage between community colleges, universities, employer internships/apprenticeships, with IPS providers increasing TCL individuals' access to supported education, technical training, job certification, internships, and apprenticeships; and 11. As opportunities arise, facilitate network development of other researched-based supported employment models aligned with the Settlement Agreement such as Customized Employment, Microenterprise, and similar nationally recognized models.	
38. Outreach Diversion Specialist	North Carolina Certified Peer Support Specialist with experience working with adults with SMI/SPMI on eliciting choices, preferences, and vision to obtain the social determinants of health serving recovery including but not limited to housing, competitive employment/education, community activity, financial and food security, and pro-recovery relationships. This position applies these skills to Transitions to Community Living for individuals being considered for admission into an Adult Care Home (ACH) through the Referral Screening Verification Process (RSVP). The Outreach Diversion Specialist's job responsibilities shall include but not be limited to the following: • Educating the member (and their family, as appropriate) on the choice to the remain in the community); • Providing referrals and linkages to available individualized community-based supports and services; • Developing a Community Integration Plan for those who choose to remain in the community; and	• Must meet North Carolina Residency Requirements • Must be a North Carolina Certified Peer Support Specialist (NC CPSS)

Section VII. Fourth 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**
	• Fully inform individuals/guardians about all the available alternatives to entry into an ACH and steps taken to address concerns and objections to the admission.	
39. BH I/DD Tailored Plan Transition Coordinator	This individual shall be solely responsible for performing the following tasks for TCL members, which cannot be delegated to the Tailored Care Manager: (a) Convene a transition team; (b) Schedule and convene transition planning / personal care plan meetings; (c) Facilitate discussion of a crisis plan, disaster plan, and emergency plan; (d) Ensure housing and financial support needs of the TCL member are addressed; (e) Ensure health and safety monitoring needs of the TCL member are addressed; and (f) Plan for and facilitate check-ins between the final transition planning meeting and move-in of the TCL member at the community-based supportive housing.	• Must meet North Carolina Residency requirements. Transition Coordinators serving individuals with SMI: • Must hold a Master's degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or • Must hold a Bachelor's degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. Transition Coordinators serving individuals with I/DD or TBI: • Must hold a Master's degree in

Section VII. Fourth 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**
		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	Role involves but is not limited to the following: • Creating, editing, and implementing existing or new housing policy; • Integrating the housing team into the Plan's TCL efforts and process to develop, fund, and maintain access to supportive housing for TCL members; and • Closely work with the TCL quality assurance staff to provide data reported internally and externally on the Plan's catchment-wide housing strategy, development, access, TCL member tenure, and other housing related issues.	Five or more years of full time experience working in the field of developing, managing, and/or coordinating access to affordable housing, including without limitation: (1) professional experience in successfully operating a Housing First Model as it applies to people with disabilities transitioning into their chosen community; (2) at least one year as a lead or supervisor of employees in

Section VII. Fourth 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**
		an affordable housing program. *Any existing staff employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a housing supervisor position shall be grandfathered and shall not be required to meet the qualifications set forth above.
41. TCL Program Manager	Role involves but is not limited to the following: • Facilitate cross-functional teams that create and implement recovery oriented, person-centered care plans; • Create and implement Housing First, Employment First, Integrated Care, Recovery-Oriented Care, and Social Drivers of Health policies and procedures; • 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.	• Three or more years of full-time experience as a licensed clinician, OR five or more years of Qualified Mental Health Professional experience planning and implementing the transition of people with disabilities to obtain affordable housing, supported employment, and community integration. • Candidates must have at least one year as a lead or supervisor of employees in behavioral health or integrated care coordination or care management *Any existing staff currently employed by the BH I/DD Tailored Plan prior to July 1, 2024 in a transition program manager position shall be

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

Section VII. Fourth 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**
	/ PIHP's root cause analysis process for deaths or level 3 incidents involving TCL members.	to meet the qualifications set forth above

Third Revised and Restated Attachment B: Summary of Medicaid Covered Services and Clinical Coverage Policies

Third 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. Third 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)

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Auditory Implant External Parts	NC Clinical Coverage Policy 13-A, Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair NC Clinical Coverage Policy 13B, Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement
Burn Treatment and Skin Substitutes	NC Clinical Coverage Policy 1G-1, Burn Treatment NC Clinical Coverage Policy 1G-2, Skin Substitutes
Cardiac Procedures	NC Clinical Coverage Policy 1R-1, Phase II Outpatient Cardiac Rehabilitation Programs NC Clinical Coverage Policy 1R-4, Electrocardiography, Echocardiography, and Intravascular Ultrasound
Certified pediatric and family nurse practitioner services	SSA, Title XIX, Section 1905(a)(21) 42 C.F.R. § 440.166 North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a
Chiropractic services	SSA, Title XIX, Section 1905(g) 42 C.F.R. § 440.60 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 11 NC Clinical Coverage Policy 1-F, Chiropractic Services
Clinic services	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 440.90 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4 NC Clinical Coverage Policy 1D-2, Sexually Transmitted Disease Treatment Provided in Health Departments NC Clinical Coverage Policy 1D-3, Tuberculosis Control and Treatment Provided in Health Departments
Dietary Evaluation and Counseling and Medical Lactation Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(b), 7(c) NC Clinical Coverage Policy 1-I, Dietary Evaluation and counseling and Medical Lactation Services
Durable medical equipment (DME)	North Carolina Medicaid State Plan, Att. 3.1-A, Page 3 NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 5A-3, Nursing Equipment and Supplies NC Clinical Coverage Policy 5B, Orthotics & Prosthetics
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	SSA, Title XIX, Section 1905(a)(4)(B) 42 U.S.C. 1396(d)(r) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage EPSDT Policy Instructions *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members*
Family planning services	SSA Title XIX, Section 1905(a)(4)(C) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2 NC Clinical Coverage Policy 1E-7, Family Planning Services
Federally qualified health center (FQHC) services	SSA, Title XIX, Section 1905(a)(2) (C) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Freestanding birth center services (when licensed or otherwise recognized by the State)	SSA, Title XIX, Section 1905(a)(28) North Carolina Medicaid State Plan Att. 3.1-A, Page 11
Gynecology	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-1, Hysterectomy NC Clinical Coverage Policy 1E-2, Therapeutic and Non-therapeutic Abortions
Hearing Aids	North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 6, 7a; Att. 3.1-B, Page 1 NC Clinical Coverage Policy 7, Hearing Aid Services
HIV case management services	Supplement 1 to Attachment 3.1-A, Part G Page 1 North Carolina Clinical Coverage Policy 12B, Human Immunodeficiency Virus (HIV) Case Management

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Home health services	SSA, Title XIX, Section 1905(a)(7) 42 C.F.R. §440.70 North Carolina Medicaid State Plan, Att. 3.1-A Page 3; Att. 3.1-A.l, Pages 13, 13a-13a.4 NC Clinical Coverage Policy 3A
Home infusion therapy	North Carolina Medicaid State Plan Att. 3.1-A.1, Page 13a.3 NC Clinical Coverage Policy 3H-1, Home Infusion Therapy
Hospice services	SSA, Title XIX, Section 1905(a)(18) 42 C.F.R. §418 North Carolina Medicaid State Plan 3.1-A, Page 7 NC Clinical Coverage Policy 3D, Hospice Services
ICF-IID services	42 C.F.R. 440.150 8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Innovations waiver services	8P: North Carolina Innovations (*Innovations waiver enrollees only)
Inpatient hospital services	SSA, Title XIX, Section 1905(a)(1) 42 C.F.R. §440.10 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1 North Carolina Medicaid State Plan, Att. 3.1-E NC Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services NC Clinical Coverage Policy 2A-2, Long Term Care Hospital Services NC Clinical Coverage Policy 2A-3, Out of State Services
Inpatient psychiatric services for individuals under age 21	SSA, Title XIX, Section 1905(a)(16) 42 C.F.R. § 440.160 North Carolina Medicaid State Plan, Att. 3.1-A, Page 7; Att. 3.1-A.1, Page 17 NC Clinical Coverage Policy 8B, Inpatient BH Services
Inpatient substance use services	NC Clinical Coverage Policy 8B, Inpatient BH Services: Medically managed intensive inpatient withdrawal services Medically managed intensive inpatient services

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Inpatient and Outpatient BH services	North Carolina Medicaid State Plan Att. 3.1-A.1, Pages 12b, 15-A.1-A.5, 15a-15a.35 NC Clinical Coverage Policy 8A: Enhanced Mental Health and Substance Abuse Services limited to services listed: Mobile Crisis Management Intensive-In-Home Services Multisystemic Therapy Psychosocial Rehabilitation Child and Adolescent Day Treatment Partial Hospitalization Professional Treatment Services in a Facility Based Crisis System Substance Use Comprehensive Outpatient Program Medically Monitored Intensive Inpatient Services (substance abuse medically monitored community residential treatment) Clinically Managed Residential Services (substance abuse non-medical community residential treatment) NC Clinical Coverage Policy 8A-1: Assertive Community Treatment (ACT) Program NC Clinical Coverage Policy 8A-2: Facility-Based Crisis Management for Children and Adolescents NC Clinical Coverage Policy 8A-6: Community Support Team (CST) NC Clinical Coverage Policy 8A-7: Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification) NC Clinical Coverage Policy 8A-8: Ambulatory Withdrawal Management with Extended On-Site Monitoring NC Clinical Coverage Policy 8A-10: Clinically Managed Residential Withdrawal Services (social setting detoxification) NC Clinical Coverage Policy 8A-11: Medically Monitored Inpatient Withdrawal Services (non-hospital medical detoxification) North Carolina Clinical Coverage Policy 8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21 North Carolina Clinical Coverage Policy 8D-2: Residential Treatment Services

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 8D-4: Clinically Managed Population-Specific High Intensity Residential Program NC Clinical Coverage Policy 8D-5: Clinically Managed Residential Services (Substance abuse non-medical community residential treatment) £ NC Clinical Coverage Policy 8D-6: Medically Monitored Intensive Inpatient Services £ NC Clinical Coverage Policy 8B: Inpatient BH Services NC Clinical Coverage Policy 8C: Outpatient BH Services Provided by Direct-enrolled Providers NC Clinical Coverage Policy 8F – Researched Based BH Treatment for Autism Spectrum Disorders NC Clinical Coverage Policy 8G – Peer Supports NC Clinical Coverage Policy 8I – Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under-21 Population (BH) NC Clinical Coverage Policy 8A-5: Diagnostic Assessment NC Clinical Coverage Policy 8A-9: Opioid Treatment Program (OTP) NC Clinical Coverage Policy 8A-12: Substance Abuse Intensive Outpatient Program (SAIOP) NC Clinical Coverage Policy 8A-13: Substance Use Comprehensive Outpatient Treatment Program (SACOT)
Laboratory and X-ray services	42 C.F.R. § 410.32 42 C.F.R. § 440.30 NC Medicaid State Plan, Att. 3.1-A, Page 1; Att. 3.1-A.1, Pages 6a, 7a, 11; Att. 3.1-B, Page 2; Att. 3.1-C NC Clinical Coverage Policy 1S-1, Genotyping and Phenotyping for HIV Drug Resistance Testing NC Clinical Coverage Policy 1S-2, HIV Tropism Assay NC Clinical Coverage Policy 1S-3, Laboratory Services NC Clinical Coverage Policy 1S-4, Genetic Testing

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

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

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring NC Clinical Coverage Policy 1K-1, Breast Imaging Procedures NC Clinical Coverage Policy 1K-2, Bone Mass Measurement NC Clinical Coverage Policy 1K-6, Radiation Oncology NC Clinical Coverage Policy 1K-7, Prior Approval for Imaging Services
Maternal Support Services	North Carolina Medicaid State Plan, Att. 3.1-B, Pages 7(a), 7(a.1) NC Clinical Coverage Policy 1M-2, Childbirth Education NC Clinical Coverage Policy 1M-3, Health and Behavioral Intervention NC Clinical Coverage Policy 1M-4, Home Visit for Newborn Care and Assessment NC Clinical Coverage Policy 1M-5, Home Visit for Postnatal Assessment and Follow-up Care NC Clinical Coverage Policy 1M-6, Maternal Care Skilled Nurse Home Visit
Non-emergent transportation to medical care	42 C.F.R. § 431.53 42 C.F.R. § 440.170 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1.-A.1, Page 18 Non-Emergency Medical Transportation Managed Care Policy
Nursing facility services	SSA, Title XIX, Section 1905(a)(4)(A) 42 C.F.R. §440.40 42 C.F.R. §440.140 42 C.F.R. §440.155 NC Medicaid State Plan, Att. 3.1-A, Pages 2, 9 NC Clinical Coverage Policy 2B-1, Nursing Facility Services NC Clinical Coverage Policy 2B-2, Geropsychiatric Units in Nursing Facilities
Obstetrics	North Carolina Medicaid State Plan, Att. 3.1-B, Page 7(a) NC Clinical Coverage Policy 1E-3, Sterilization Procedures NC Clinical Coverage Policy 1E-4, Fetal Surveillance NC Clinical Coverage Policy 1E-5, Obstetrics NC Clinical Coverage Policy 1E-6, Pregnancy Medical Home

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Occupational therapy	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Office Based Opioid Treatment (OBOT)	NC Clinical Coverage Policy 1A-41, Office Based Opioid Treatment: Use of Buprenorphine & Buprenorphine-Naloxone
Ophthalmological Services	NC Clinical Coverage Policy 1T-1, General Ophthalmological Services NC Clinical Coverage Policy 1T-2, Special Ophthalmological Services
Optometry services	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 441.30 NC Medicaid State Plan, Att. 3.1-A, Page 3; Att. 3.1-A.1, Page 10a G.S. § 108A-70.21(b)(2) NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21
Other diagnostic, screening, preventive and rehabilitative services	SSA, Title XIX, Section 1905(a)(13) North Carolina Medicaid State Plan, Att. 3.1-A, Page 5
Outpatient hospital services	SSA, Title XIX, Section 1905(a)(2) 42 C.F.R. §440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 1
Personal care	SSA, Title XIX, Section 1905(a)(24) 42 C.F.R. § 440.167 North Carolina Medicaid State Plan, Att. 3.1-A, Page 9; Att. 3.1-A.1, Pages 19-29 NC Clinical Coverage Policy 3L, State Plan Personal Care Services (PCS)
Pharmacy	North Carolina Medicaid State Plan, Att. 3.1-A.1, Page 12(c), Pages 14-14h NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-the- Counter-Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older
Physical therapy	SSA, Title XIX, Section 1905(a)(11) 42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Pages 7c, 7c.15, 13e ID775NC Clinical Coverage Policy 5A, Durable Medical Equipment NC Clinical Coverage Policy 5A-1, Physical Rehabilitation Equipment and Supplies NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Physician services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. §440.50 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a; Att. 3.1-A.l, Page 7h NC Clinical Coverage Policy 1A-2, Adult Preventive Medicine Annual Health Assessment NC Clinical Coverage Policy 1A-3, Noninvasive Pulse Oximetry NC Clinical Coverage Policy 1A-4, Cochlear and Auditory Brainstem Implants NC Clinical Coverage Policy 1A-5, Case Conference for Sexually Abused Children NC Clinical Coverage Policy 1A-6, Invasive Electrical Bone Growth Stimulation NC Clinical Coverage Policy 1A-7, Neonatal and Pediatric Critical and Intensive Care Services NC Clinical Coverage Policy 1A-8, Hyperbaric Oxygenation Therapy NC Clinical Coverage Policy 1A-9, Blepharoplasty/Blepharoptosis (Eyelid Repair) NC Clinical Coverage Policy 1A-11, Extracorporeal Shock Wave Lithotripsy NC Clinical Coverage Policy 1A-12, Breast Surgeries NC Clinical Coverage Policy 1A-13, Ocular Photodynamic Therapy NC Clinical Coverage Policy 1A-14, Surgery for Ambiguous Genitalia

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 1A-15, Surgery for Clinically Severe or Morbid Obesity NC Clinical Coverage Policy 1A-16, Surgery of the Lingual Frenulum NC Clinical Coverage Policy 1A-17, Stereotactic Pallidotomy NC Clinical Coverage Policy 1A-19, Transcranial Doppler Studies NC Clinical Coverage Policy 1A-20, Sleep Studies and Polysomnography Services NC Clinical Coverage Policy 1A-21, Endovascular Repair of Aortic Aneurysm NC Clinical Coverage Policy 1A-22, Medically Necessary Circumcision NC Clinical Coverage Policy 1A-23, Physician Fluoride Varnish Services NC Clinical Coverage Policy 1A-24, Diabetes Outpatient Self-Management Education NC Clinical Coverage Policy 1A-25, Spinal Cord Stimulation NC Clinical Coverage Policy 1A-26, Deep Brain Stimulation NC Clinical Coverage Policy 1A-27,Electrodiagnostic Studies NC Clinical Coverage Policy 1A-28, Visual Evoked Potential (VEP) NC Clinical Coverage Policy 1A-30, Spinal Surgeries NC Clinical Coverage Policy 1A-31, Wireless Capsule Endoscopy NC Clinical Coverage Policy 1A-32, Tympanometry and Acoustic Reflex Testing NC Clinical Coverage Policy 1A-33, Vagus Nerve Stimulation for the Treatment of Seizures NC Clinical Coverage Policy 1A-34, End Stage Renal Disease (ESRD) Services NC Clinical Coverage Policy 1A-36, Implantable Bone Conduction Hearing Aids (BAHA) NC Clinical Coverage Policy 1A-38, Special Services: After Hours NC Clinical Coverage Policy 1A-39, Routine Costs in Clinical Trial Services for Life Threatening Conditions NC Clinical Coverage Policy 1A-40, Fecal Microbiota Transplantation NC Clinical Coverage Policy 1A-42, Balloon Ostial Dilation NC Clinical Coverage Policy 1B, Physician's Drug Program NC Clinical Coverage Policy 1-O-5, Rhinoplasty and/or Septorhinoplasty

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Podiatry services	SSA, Title XIX, Section 1905(a)(5) 42 C.F.R. § 440.60 G.S. § 90-202.2 North Carolina Medicaid State Plan, Att. 3.1-A, Page 2a NC Clinical Coverage Policy 1C-1, Podiatry Services NC Clinical Coverage Policy 1C-2, Medically Necessary Routine Foot Care
Prescription drugs and medication management	SSA, Title XIX, Section 1905(a)(12) 42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Pages 14-14h NC Preferred Drug List NC Beneficiary Management Lock-In Program NC Clinical Coverage Policy 9, Outpatient Pharmacy Program NC Clinical Coverage Policy 9A, Over-The- Counter Products NC Clinical Coverage Policy 9B, Hemophilia Specialty Pharmacy Program NC Clinical Coverage Policy 9C, Mental Health Drug Management Program Administrative Procedures NC Clinical Coverage Policy 9D, Off Label Antipsychotic Safety Monitoring in Beneficiaries Through Age 17 NC Clinical Coverage Policy 9E, Off Label Antipsychotic Safety Monitoring in Beneficiaries 18 and Older North Carolina Medicaid Pharmacy Newsletters *Section V.B.2.iii. Pharmacy Benefits* of the Contract
Private duty nursing services (PDN)	SSA, Title XIX, Section 1905(a)(8) 42 C.F.R. § 440.80 North Carolina Medicaid State Plan, Att. 3.1-A, Page 3a; Att. 3.1-A.1, Page 13b NC Clinical Coverage Policy 3G-1, Private Duty Nursing for Beneficiaries Age 21 and Older NC Clinical Coverage Policy 3G-2, Private Duty Nursing for Beneficiaries Under 21 years of Age
Prosthetics, orthotics and supplies	SSA, Title XIX, Section 1905(a)(12)

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	42 C.F.R. § 440.120 North Carolina Medicaid State Plan, Att. 3.1-A, Page 5; Att. 3.1-A.1, Page 7b NC Clinical Coverage Policy 5B, Orthotics and Prosthetics
Reconstructive Surgery	NC Clinical Coverage Policy 1-O-1, Reconstructive and Cosmetic Surgery NC Clinical Coverage Policy 1-O-2, Craniofacial Surgery NC Clinical Coverage Policy 1-O-3, Keloid Excision and Scar Revision NC Clinical Coverage Policy, 1-O-5: Rhinoplasty and/or Septorhinoplasty
Respiratory care services	SSA, Title XIX, Section 1905(a)(20) SSA, Title XIX, Section 102(e)(9)(A) North Carolina Medicaid State Plan, Att. 3.1-A, Page 8a; Appendix 7 to Att. 3.1-A, Page 2; Att. 3.1-A.1, Page 7c NC Clinical Coverage Policy 5A-2, Respiratory Equipment and Supplies NC Clinical Coverage Policy 10D, Independent Practitioners Respiratory Therapy Services
Rural health clinic services (RHC)	SSA, Title XIX, Section 1905(a)(9) 42 C.F.R. § 405.2411 42 C.F.R. § 405.2463 42 C.F.R. § 440.20 North Carolina Medicaid State Plan, Att. 3.1-A, Page 4; Att. 3.1-A, Page 1 NC Clinical Coverage Policy 1D-4, Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics
Services for individuals age 65 or older in an institution for mental disease (IMD)	SSA, Title XIX, Section 1905(a)(14) 42 C.F.R. § 440.140 North Carolina Medicaid State Plan, Att. 3.1-A, Page 6; Att. 3.1-A.1, Page 15b NC Clinical Coverage Policy 8B, Inpatient BH Services
Speech, hearing and language disorder services	42 C.F.R. § 440.110 North Carolina Medicaid State Plan, Att. 3.1-A.1, Pages 7c, 7c.16, 13e NC Clinical Coverage Policy 10A, Outpatient Specialized Therapies NC Clinical Coverage Policy 10B, Independent Practitioners (IP)
Telehealth, Virtual Patient	42 C.F.R. § 410.78

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
Communications and Remote Patient Monitoring	NC Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications and Remote Patient Monitoring
Tobacco cessation counseling for pregnant women	SSA, Title XIX, Section 1905(a)(4)(D) North Carolina Medicaid State Plan, Att. 3.1-A, Page 2
Transplants and Related Services	North Carolina Medicaid State Plan, Page 27, Att. 3.1-E, Pages 1-9 NC Clinical Coverage Policy 11A-1, Hematopoietic Stem-Cell or Bone Marrow Transplantation for Acute Lymphoblastic Leukemia (ALL) NC Clinical Coverage Policy 11A-2, Hematopoietic Stem-Cell and Bone Marrow Transplant for Acute Myeloid Leukemia NC Clinical Coverage Policy 11A-3, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Chronic Myelogenous Leukemia NC Clinical Coverage Policy 11A-5, Allogeneic Hematopoietic and Bone Marrow Transplant for Generic Diseases and Acquired Anemias NC Clinical Coverage Policy 11A-6, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Genetic Treatment of Germ Cell Tumors NC Clinical Coverage Policy 11A-7, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Hodgkin Lymphoma NC Clinical Coverage Policy 11A-8, Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and Primary Amyloidosis NC Clinical Coverage Policy 11A-9, Allogeneic Stem-Cell and Bone Marrow Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms NC Clinical Coverage Policy 11A-10, Hematopoietic Stem-Cell and Bone Marrow Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma NC Clinical Coverage Policy 11A-11, Hematopoietic Stem-Cell and Bone Marrow Transplant for Non- Hodgkin's Lymphoma NC Clinical Coverage Policy 11A-14, Placental and Umbilical Cord Blood as a Source of Stem Cells NC Clinical Coverage Policy 11A-15, Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

Section VII. Third Revised and Restated Attachment B. Table 1: Summary of Medicaid Covered Services & Clinical Coverage Policies	
SERVICE	**KEY REFERENCES**
	NC Clinical Coverage Policy 11A-16, Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL) NC Clinical Coverage Policy 11A-17, CAR-T Cell Therapy NC Clinical Coverage Policy 11B-1, Lung Transplantation NC Clinical Coverage Policy 11B-2, Heart Transplantation NC Clinical Coverage Policy 11B-3, Islet Cell Transplantation NC Clinical Coverage Policy 11B-4, Kidney Transplantation NC Clinical Coverage Policy 11B-5, Liver Transplantation NC Clinical Coverage Policy 11B-6, Heart/Lung Transplantation NC Clinical Coverage Policy 11B-7, Pancreas Transplant NC Clinical Coverage Policy 11B-8, Small Bowel and Small Bowel/Liver and Multivisceral Transplants
Ventricular Assist Device	North Carolina Medicaid State Plan, Att. 3.1-E, Page 2 NC Clinical Coverage Policy 11C, Ventricular Assist Device
Vision Services	North Carolina Medicaid State Plan, Att. 3.1-A, Pages 5-6, Page 10a, Page 15; Att. 3.1-B, Pages 1, 4, and 5 NC Clinical Coverage Policy 6A, Routine Eye Exam and Visual Aids for Recipients Under Age 21 NC Clinical Coverage Policy 6B, Routine Eye Examination and Visual Aids for Beneficiaries 21 Years of Age and Older
1915(i) Option Services	NC Clinical Coverage Policy 8H-1: Supported Employment for IDD and TBI NC Clinical Coverage Policy 8H-2: Individual Placement and Support (IPS) NC Clinical Coverage Policy 8H-3: Individual and Transitional Support (ITS) NC Clinical Coverage Policy 8H-4: Respite NC Clinical Coverage Policy 8H-5: Community Living and Supports (CLS) NC Clinical Coverage Policy 8H-6: Community Transition

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Third 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 *Third* Revised and Restated *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* (e.g., for updates to the quality metrics posted in January 2023, the BH I/DD Tailored Plan would report the results in June 2024).
d. An asterisk (*) indicates that the measure is calculated by the Department.

The BH I/DD Tailored Plan will also be required to report the Innovations and TBI waiver measures listed *in Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measurers* and *Section VII. Third 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. Third 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.

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Section VII. Third 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. Third Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures			
Ref #	**NQF #**	**Measure Name**	**Steward**
1.	0105	Antidepressant Medication Management (AMM)	NCQA
2.	0032	Cervical Cancer Screening (CCS/CCS-E)	NCQA
3.	0033	Chlamydia Screening in Women (CHL)	NCQA
4.	0059/ 0575	Glycemic Status Assessment for Patients with Diabetes (GSD) ^	NCQA
5.	3389	Concurrent use of Prescription Opioids and Benzodiazepines (COB)	PQA
6.	3175	Continuity of Pharmacotherapy for Opioid Use Disorder	USC
7.	0018	Controlling High Blood Pressure (CBP)^	NCQA
8.	1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
9.	Reserved.		
10.	0576	Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA
11.	0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*	NCQA
12.	1768	Plan All-Cause Readmissions (PCR)[Observed versus expected ratio]	NCQA
13.	0418/0418e	Screening for Depression and Follow-Up Plan (CDF)	CMS
14.	Reserved		
15.	Reserved		
16.	NA	Rate of Screening for Health-Related Resource Needs (HRRN)*	NC DHHS
17.	NA	Total Cost of Care (TCOC)	Health Partners
18.	NA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	NCQA
19.	1800	Asthma Medication Ratio (AMR)	NCQA

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

Section VII. Third Revised and Restated Attachment E.1. Table 2: Survey Measures and General Measures			
Ref #	**NQF #**	**Measure Name**	**Steward**
20.	0058	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	NCQA
21.	0034	Colorectal Cancer Screening (COL-E)	NCQA
22.	Reserved.		
23.	1516	Child and Adolescent Well-Care Visits (WCV)	NCQA
24.	0038	Childhood Immunization Status (Combination 10) (CIS/CIS-E)	NCQA
25.	0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	NCQA
26.	1407	Immunizations for Adolescents (Combination 2) (IMA/IMA-E)	NCQA
27.	2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	NCQA
28.	1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA
29.	2801	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	NCQA
30.	NA	Low Birth Weight*[64]	NC DHHS
31.	NA 1517	Prenatal and Postpartum Care (PPC)66	NCQA
32.	NA	Rate of Screening for Pregnancy Risk*[Ù^]	NC DHHS
33.	3620	Adult Immunization Status (AIS-E)	NCQA
34.	NA	Antibiotic Utilization for Respiratory Conditions (AXR)	NCQA
35.	2372	Breast Cancer Screening (BCS-E)	NCQA
36.	3489	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA

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

Section VII. Third 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. Third 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. Third 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 of Innovations waiver applicants who received a preliminary screening for potential eligibility.	NC DHHS	Annually Fiscal Year	November 1
3.	Proportion of Level of Care evaluations completed at least annually for enrolled participants.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
4.	Proportion of Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
5.	Proportion of New Level of Care evaluations completed using approved processes and instrument.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
6.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
7.	Proportion 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.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing waiver services.	NC DHHS	Annually Fiscal Year	November 1
9.	Proportion of 1915 (c) waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of non-licensed, non-certified 1915(c) waiver providers with a required plan of correction.	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of monitored non-licensed, non-certified providers that are compliant with Innovations Waiver requirements.	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
13.	Reserved.			
14.	Percentage of beneficiaries reporting that their Individual Support Plan has the services that they need.	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans that address identified health and safety risk factors.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1
16.	Proportion of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
17.	Proportion of individuals whose annual Individual Support Plan was revised or updated.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1~~1~~
18.	Proportion of individuals for whom an annual Individual Support Plan took place.	NC DHHS	Semi-Annually a. July 1 – December 31 b. January 1 – June 30	a. May 1 b. November 1~~1~~
19.	Number and percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the Care Coordinator to address their changing needs.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
20.	Reserved.			
21.	Proportion of new Innovations waiver beneficiaries who are receiving services according to their Individual Support Plan within forty-five (45) Calendar Days of Individual Support Plan approval.	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
22.	Proportion of records that contain a signed freedom of choice statement.	NC DHHS	Annually Fiscal Year	November 1
23.	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available.	NC DHHS	Annually Fiscal Year	November 1
24.	Proportion of Innovations waiver beneficiaries reporting they have a choice between providers.	NC DHHS	Annually Fiscal Year	November 1
25.	Number and percentage of Innovations waiver beneficiary deaths where required BH I/DD 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

Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
26.	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
27.	Percentage of beneficiaries who received appropriate medication.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
28.	Percentage of medication errors not 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
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
30.	The percentage of survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and-unexplained death.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
31.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
32.	Number and percentage of level 2 or 3 incidents where required BH I/DD 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.	Percentage of level 2 and 3 incidents reported within required timeframes.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
34.	Reserved.			
35.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
36.	Percentage of restrictive interventions (both restraint and seclusion) that did not result in medical treatment.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1
37.	The proportion of claims paid by the BH I/DD Tailored Plan for Innovations Waiver services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 5: Innovations Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
38.	The consistency of NC Innovations capitated rates (The proportion of the BH I/DD Tailored Plan Innovations year to date PMPM compared to the NC Innovations capitated rate PMPM).	NC DHHS	Annually Fiscal Year	November 1
39.	Reserved.			
40.	Reserved.			
41.	Reserved.			
42.	Reserved.			
43.	Proportion of Members who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan.	NCDHHS	Annually Fiscal Year	November 1
44.	The percentage of Innovations Waiver Members age 21 and older who had a primary care or preventative care visit during the Innovations Waiver year.	NCDHHS	Annually Fiscal Year	November 1
45.	The percentage of Innovations Waiver Members under the age of 21 who had a primary care or preventative care visit during the waiver year.	NC DHHS	Quarterly a. July 1 – September 30 b. October 1 – December 31 c. January 1 – March 31 d. April 1 – June 30	a. February 1 b. May 1 c. August 1 d. November 1

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

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

Section VII. Third Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	Measure Name	Steward	Measurement Period	Date of Submission
13.	Percentage of participants reporting that their Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of person-centered plans that are completed in accordance with the State Medicaid Agency's requirements	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of individuals for whom an annual plan and/or needed update took place	NC DHHS	Semi-Annually July 1 – December 31 January 1 – June 30	May 1 November 1
17.	Proportion of new waiver beneficiaries receiving services according to their Individual Support Plan within 45 days of Individual Support Plan approval	NC DHHS	Annually Fiscal Year	November 1
18.	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 3 April 1 – June 30	February 1 May 1 August 1 November 1
19.	Proportion of beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually Fiscal Year	November 1
20.	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
21.	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually Fiscal Year	November 1
22.	Number and Percent of Actions Taken to Protect the Beneficiary, where indicated	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
23.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Third Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
24.	Number and Percentage of deaths where required BH I/DD TP follow-up interventions were completed as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
25.	Percentage of medication errors resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
26.	Percentage of beneficiaries who received appropriate medication	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
27.	Percentage of level 2 and 3 incidents reported within required time frames	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
28.	Percentage of level 2 or 3 incidents where required BH I/DD TP follow-up interventions were completed as required.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
29.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
30.	Percentage of restrictive interventions resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
31.	Percent of restrictive interventions used in an emergency after exhausting all other possibilities	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Third Revised and Restated Attachment E.1. Table 6: TBI Waiver Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
32.	Percent of restrictive interventions used by a trained staff member.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
33.	Percent of restrictive interventions that are documented according to state policy.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
34.	The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	The percentage of waiver beneficiaries age 22 and older who had a primary care or preventative care visit during the waiver year	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
36.	The proportion of claims paid by the PIHP for NC TBI wavier services that have been authorized in the service plan	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third 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. Third 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 11
9.	Proportion of new independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
10.	Proportion of independent evaluations completed using approved processes and instrument	NC DHHS	Annually Fiscal Year	November 1
11.	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually Fiscal Year	November 1
12.	Proportion of providers determined to be continually compliant with certification, contract and 1915(i) standards according to PIHP monitoring schedule.	NC DHHS	Annually Fiscal Year	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
13.	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to furnishing 1915(i) services.	NC DHHS	Annually Fiscal Year	November 1
14.	Proportion of 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
15.	Proportion of non-certified 1915(i) service providers with a required plan of correction	NC DHHS	Annually Fiscal Year	November 1
16.	Proportion of monitored non-certified providers that are compliant with 1915(i) requirements.	NC DHHS	Annually Fiscal Year	November 1
17.	Proportion of monitored providers wherein all staff completed all mandated training (excluding restrictive interventions) within the required time frame.	NC DHHS	Annually Fiscal Year	November 1
18.	Reserved.			
19.	Percentage of beneficiaries reporting that their Care Plan/ISP Individual Support Plan has the services that they need	NC DHHS	Annually Fiscal Year	November 1
20.	Reserved.			
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.			

Section VII. Third Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
26.	Proportion of new 1915(i) beneficiaries who are obtaining services according to their Care Plan/ISP Individual Support Plan within 45 days of ISP Individual Support Plan approval.	NC DHHS	Annually Fiscal Year	November 1
27.	Reserved.			
28.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting their Care Manager helps them to know what 1915(i) services are available	NC DHHS	Annually Fiscal Year	November 1
29.	Proportion of BH I/DD Tailored Plan members using 1915(i) services reporting they have a choice between providers	NC DHHS	Annually Fiscal Year	November 1
30.	Reserved.			
31.	Reserved.			
32.	Reserved.			
33.	Reserved.			
34.	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation, as required	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
35.	Percentage of BH I/DD Tailored Plan Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually July 1 – June 30	November 1

Section VII. Third Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
36.	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
37.	Reserved.			
38.	Reserved.			
39.	Percentage of level 2 or 3 incident reports where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually Fiscal Year	November 1
40.	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
41.	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
42.	The proportion of claims paid by the BH I/DD Tailored Plan for 1915(i) services that have been authorized in the service plan.	NC DHHS	Annually Fiscal Year	November 1
43.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services (ages 3 and older) who also received a primary care or preventative health service.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

Section VII. Third Revised and Restated Attachment E.1. Table 7: 1915(i) Service Performance Measures				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Date of Submission**
44.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages three (3) to six (6) who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
45.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1
46.	The percentage of continuously enrolled BH I/DD Tailored Plan members using 1915(i) services ages twenty (20) and older who received a primary care or preventative health service during the measurement period.	NC DHHS	Quarterly July 1 – September 30 October 1 – December 31 January 1 – March 31 April 1 – June 30	February 1 May 1 August 1 November 1

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

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

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

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

	Calendar Days		April - June	
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

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. Third 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. Third Attachment E.2. Table 4: BH I/DD Tailored Plan Combined Quality Metrics for Medicaid and State-funded Services				
Ref #	**Measure Name**	**Steward**	**Measurement Period**	**Department Provided**
1.	Ready for Discharge: Number of Members and Recipients who are clinically stabilized and no longer need the level of care provided by the State Psychiatric Hospital.	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month
2.	Children in PRTFs: Number of Members and Recipients eighteen years of age or younger	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month

Section VII. Third 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**
	in PRTF, including admissions (in state, out of state within 40 miles, out of state & DSS involved/not DSS involved) and re-admissions.			
3.	Members and Recipients on the Innovations Waiver waitlist who are receiving any Medicaid or State-funded BH I/DD Tailored Plan service	NC DHHS	Quarterly (Rolling 3-Month Period)	30th of the Month

Third Revised and Restated Attachment F: BH I/DD Tailored Plan Network Adequacy Standards

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

At a minimum, BH I/DD Tailored 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. Third Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid* and *Section VII. Third Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time for Medicaid.*

Section VII. Third Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1.	Primary Care[1]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
2.	Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
3.	Hospitals*	≥ 1 hospitals within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospitals within 30 minutes or 30 miles for at least 95% of members
4.	Pharmacies*	≥ 2 pharmacies within 30 minutes or 10 miles for at least 95% of members	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of members
5.	Obstetrics[2]	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
6.	Occupational, Physical, or Speech Therapists*	≥ 2 providers (of each provider type) within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers (of each provider type) within 30 minutes or 30 miles for at least 95% of members
7.	Outpatient BH Services	≥ 2 Providers of each outpatient Behavioral Health service within 30 minutes or 30 miles of residence for at least 95% of Members • *Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard	≥ 2 Providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of Members • Research-*Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
8.	Location-Based Services	• P*sychosocial rehabilitation, Substance Abuse Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2	• P*sychosocial rehabilitation, Substance* Abuse *Comprehensive Outpatient Treatment, Substance Abuse Intensive Outpatient Program, and Outpatient Opioid Treatment (OTP):* ≥ 2

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

Section VII. Third 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**
		providers of each service within 30 minutes or 30 miles of residence for at least 95% of ~~m~~Members ○ *Child and Adolescent Day Treatment Services:* Not subject to standard	Providers of each service within 45 minutes or 45 miles of residence for at least 95% of Members. • *Child and Adolescent Day Treatment Services:* Not subject to standard
9.	Crisis Services	• *Professional treatment services in facility-based crisis program:* The greater of: ○ 2+ facilities within each BH I/DD Tailored Plan Region, OR ○ 1 facility within each Region per 450,000 total regional population (Total regional population as estimated by combining NC OSBM county estimates). • *Facility-based crisis services for children and adolescents:* ≥ 1 provider within each BH I/DD Tailored Plan Region • *Medically Monitored Inpatient Withdrawal Services:(non-hospital medical detoxification)* ≥ 2 Providers within each BH I/DD Tailored Plan Region • *Ambulatory Withdrawal Management without Extended On-Site Monitoring (ambulatory detoxification), Ambulatory Withdrawal Management with Extended On-Site Monitoring, Clinically managed residential withdrawal services (social setting detoxification), Mobile Crisis Management:* ≥ 2 Providers of each crisis service within each BH I/DD Tailored Plan Region • *Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult)*: Not subject to standard	
10.	Inpatient BH Services	≥ 1 provider of each inpatient BH service within each BH I/DD Tailored Plan region	
11.	Partial Hospitalization	≥ 1 provider of partial hospitalization within 30 minutes or 30 miles for at least 95% of members	≥ 1 provider of partial hospitalization within 60 minutes or 60 miles for at least 95% of members
12.	Community/ Mobile Services	≥ 2 providers of community/mobile services within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients.	
13.	All State Plan LTSS (except nursing facilities	≥ 2 LTSS provider types (Home Care providers and Home Health providers, including home health services, private duty nursing services, personal care services, and hospice services), identified by	

<table>
<tr><th colspan="4">Section VII. Third Revised and Restated Attachment F.1. Table 1: BH I/DD Tailored Plan Time/Distance Standards for Medicaid</th></tr>
<tr><th>Reference Number</th><th>Service Type</th><th>Urban Standard</th><th>Rural Standard</th></tr>
<tr><td></td><td>and 1915(i) services)*</td><td colspan="2">distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.</td></tr>
<tr><td>14.</td><td>Nursing Facilities*</td><td colspan="2">≥ 1 nursing facility accepting new patients in every county.</td></tr>
<tr><td>15.</td><td>Residential Treatment Services</td><td colspan="2">• Residential Treatment Facility Services: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region,
• Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to 10A NCAC 27G.3400)
• Clinically Managed Residential Services (Substance abuse non-medical community residential treatment):
  o Adult: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established
  o Adolescent: Contract with all designated CASPs statewide
  o Women & Children: Contract with all designated CASPs statewide
• Clinically Managed Population-Specific High-Intensity Residential Program: contract with all designated CASPs
• Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house):
  o Adult: Access to ≥1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[1]
  o Adolescent: Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600)
• Psychiatric Residential Treatment Facilities (PRTFs) & Intermediate Care Facilities for individuals with intellectual disabilities ICF-IID: Not subject to standard</td></tr>
<tr><td>16.</td><td>1915(c) HCBS Waiver Services: NC Innovations</td><td colspan="2">• Community Living & Support, Community Networking, Residential Supports, Respite, Supported Employment, Supported Living: ≥ 2 providers of each Innovations waiver service within each BH I/DD Tailored Plan Region.</td></tr>
</table>

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

Section VII. Third 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**
		• *Crisis Intervention & Stabilization Supports, Day Supports, Financial Support Services:* ≥ 1 provider of each Innovations waiver service within each BH I/DD Tailored Plan Region. • *Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Individual Directed Goods and Services, Natural Supports Education, Specialized Consultation, Vehicle Modification*: Not subject to standard.	
17.	1915(c) HCBS Waiver Services: NC TBI Waiver (applicable to TBI Waiver participating counties only)	• *Community Networking, Life Skills Training, Residential Supports, Resource Facilitation, In-Home Respite, Supported Employment:* ≥ 2 providers of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Day Supports, Cognitive Rehabilitation, Crisis Intervention & Stabilization Supports:* ≥ 1 provider of each TBI waiver service within each BH I/DD Tailored Plan Region. • *Adult Day Health, Assistive Technology Equipment and Supplies, Community Transition, Home Modifications, Natural Supports Education, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Vehicle Modification*: N/A.	
18.	Employment and Housing Services	• *Individual Placement and Supports (IPS) – Supported Employment (Adult MH):* Eligible individuals shall have the choice of at least (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients.	
19.	1915(i) Services	• *Community Living and Supports, Individual and Transitional Supports, Out-of-Home Respite, Supported Employment (for Members with I/DD and TBI), Individual Placement and Support (for Members with a qualifying mental health condition or SUD):* ≥ 2 providers of each 1915(i) service within each BH I/DD Tailored Plan Region. • *In-Home Respite:* ≥ 2 providers within 45 minutes of the member's residence.	

Section VII. Third Revised and Restated Attachment F.1. Table 2: Definition of Service Category for Behavioral Health Time/Distance Standards for Medicaid		
Reference Number	**Service Type**	**Definition**
1.	Outpatient BH Services	• Outpatient BH services provided by direct-enrolled providers (adults and children) • Diagnostic Assessment • Research-based BH treatment for Autism Spectrum Disorder (ASD)
2.	Location-Based Services (BH I/DD)	• Psychosocial Rehabilitation • Substance Abuse Comprehensive Outpatient Treatment • Substance Abuse Intensive Outpatient Program • Outpatient Opioid treatment (OTP) (adult) • Child and adolescent day treatment services
3.	Crisis Services	• Facility-based crisis services for children and adolescents • Professional treatment services in facility-based crisis program (adult) • Ambulatory Withdrawal Management without Extended On-Site Monitoring (Ambulatory detoxification) • Ambulatory Withdrawal Management with Extended On-Site Monitoring • *Clinically managed residential withdrawal services (social setting detoxification)* • *Medically monitored inpatient withdrawal services (Non-hospital medical detoxification)* (adult) • Medically supervised or alcohol drug abuse treatment center (ADATC) detoxification crisis stabilization (adult) • Mobile Crisis Management

4.	Inpatient BH Services	• Inpatient Hospital – Adult
		  • Acute care hospitals with adult inpatient psychiatric beds
		  • Medically managed intensive inpatient withdrawal management (Acute care hospitals with adult inpatient substance use beds)
		  • Medically managed intensive inpatient services (Acute care hospitals with adult inpatient substance use beds)
		
		Inpatient Hospital – Adolescent/Children
		  • 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

Section VII. Third 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**
5.	Partial Hospitalization	• Partial hospitalization (adults and children)
6.	Residential Treatment Services	• Residential treatment facility services • Medically Monitored Intensive Inpatient Services (Substance abuse medically monitored residential treatment): • Clinically Managed Residential Services (Substance abuse non-medical community residential treatment): • Clinically Managed Population-Specific High Intensity Residential Program • Clinically Managed Low-Intensity Residential Treatment Services (substance abuse halfway house): • Psychiatric Residential Treatment Facilities (PRTFs) • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)
7.	Community/Mobile Services	• Assertive Community Treatment (ACT) • Community Support Team (CST) • Intensive In-Home (IIH) services • Multi-systemic Therapy (MST) services • Peer Supports Services • Diagnostic Assessment
8.	1915(c) HCBS Waiver Services: NC Innovations	• Assistive Technology Equipment and Supplies • Community Living and Support • Community Networking • Community Transition • Crisis Services: Crisis Intervention & Stabilization Supports • Day Supports • Financial Support Services • Home Modifications • Individual Directed Goods and Services • Natural Supports Education • Residential Supports • Respite • Specialized Consultation • Supported Employment • Supported Living • Vehicle Modifications

Section VII. Third 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**
9.	1915(c) HCBS Waiver Services: NC TBI Waiver	• Adult Day Health • Assistive Technology • Cognitive Rehabilitation (CR) • Community Networking • Community Transition • Crisis Supports Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education • Occupational Therapy • Physical Therapy • Remote supports • Residential Supports • Resource Facilitation • Respite • Specialized Consultation • Speech and Language Therapy • Supported Employment • Supported living • Vehicle Modifications
10.	Employment and Housing Services	• Individual Placement and Support-Supported Employment (Adult MH)
11.	1915(i) Services	• Community Living and Supports • Community Transition • Individual and Transitional Supports • Respite • Supported Employment (for Members with I/DD and TBI) • Individual Placement and Support (for Members with a qualifying mental health condition or SUD)

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

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

Section VII. Third Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
			hundred sixty-five (365) days a year}
7	Urgent Care Services	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within twenty-four (24) hours
8	Routine/Check-up without Symptoms	Non-symptomatic visits for health check.	Within thirty (30) Calendar Days
Behavioral Health, I/DD, and TBI Services			
9	Mobile Crisis Management Services	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within two (2) hours
10	Facility-Based Crisis Management Services (FBC for Child & Adolescent, FBC for Adults, Non-Hospital Medical Detox)	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Emergency Services available immediately available twenty-four (24) hours a day, 7 days a week.
11	Emergency Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, 7 days a week.

Section VII. Third Revised and Restated Attachment F.1. Table 3: Appointment Wait Time Standards for Medicaid			
Reference Number	**Visit Type**	**Description**	**Standard**
12	Emergency Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Immediately available twenty-four (24) hours a day, 7 days a week.
13	Urgent Care Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
14	Urgent Care Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within twenty-four (24) hours
15	Routine Services for Mental Health	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within fourteen (14) Calendar Days
16	Routine Services for SUDs	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within forty-eight (48) hours

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

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

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

At a minimum, BH I/DD Tailored 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 conducted at least annually. Offeror should reference *Section VII. Third 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. Third 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. Third Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards			
Reference Number	**Service Type**	**Urban Standard**	**Rural Standard**
1.	Outpatient BH Services	≥ 2 providers of each outpatient Behavioral Health service within 30	≥ 2 providers of each outpatient Behavioral Health service within 45 minutes or 45 miles of residence for at least 95% of recipients

Section VII. Third 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**
		minutes or 30 miles of residence for at least 95% of recipients[1] *Research-Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard	Research-*Based Behavioral Health Treatment for Autism Spectrum Disorder (ASD):* Not subject to standard
2.	Location-Based Services^	*Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 30 minutes or 30 miles of residence for at least 95% of recipients *Child and Adolescent Day Treatment Services*: Not subject to standard	*Psychosocial Rehabilitation, Substance Abuse Comprehensive Outpatient, Substance Abuse Intensive Outpatient Program, Outpatient Opioid Treatment (OTP)*: ≥ 2 providers of each location-based service within 45 minutes or 45 miles of residence for at least 95% of recipients *Child and Adolescent Day Treatment Services*: Not subject to standard

3.	Crisis Services^	• *Facility based crisis for adults:* The greater of:
		  ○ 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).
		• *Non-Hospital Medical Detoxification:* ≥ 2 provider within each BH I/DD Tailored Plan Region
		• *Ambulatory Detoxification:* ≥ 1 provider of each crisis service within each BH I/DD Tailored Plan Region	

4.	Inpatient BH Services	≥ 1 provider within each BH I/DD Tailored Plan Region	
5.	Reserved		
6.	Community/ Mobile Services^	Each service, 100% of eligible recipients must have a choice of 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥ 1 provider that is accepting new patients. High Fidelity Wraparound ≥ 2 provider within one hour	
		Assertive Engagement: 2 providers of each outpatient BH service within	*Assertive Engagement: ≥ 2 providers of each outpatient BH service within 45 minutes or 45*

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

Section VII. Third 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**
		30 minutes or 30 miles of residence for at least 95% of recipients[1]	*miles of residence for at least 95% of recipients*
7.	Residential Treatment Services	• *Residential Treatment Facility Services*: Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region • *Substance Abuse Halfway House*: o *Adult:* Access to ≥ 1 male and ≥1 female program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E)[2] o *Adolescent:* Access to ≥1 program per BH I/DD Tailored Plan Region (Refer to 10A NCAC 27G.5600E) • *Substance Abuse Medically Monitored Community Residential Treatment*: Access to ≥1 licensed provider • *Substance Abuse Non-Medical Community Residential Treatment*: o *Adult:* Access to ≥ 1 licensed provider per BH I/DD Tailored Plan Region (refer to licensure requirements to be determined by the Department: Not subject to standard until ninety (90) Calendar Days after licensure requirements are established) o *Adolescent:* Contract with all designated CASPs statewide o *Women & Children:* Contract with all designated CASPs statewide III. *Substance Use Residential Supports & Mental Health Recovery Residential Services:* To be determined	
8.	Employment and Housing Services	• *Residential Services (I/DD and TBI and Adult MH), Respite Services, Individual Placement and Support (I/DD and TBI and Substance Use).* Eligible individuals shall have the choice of at least 2 provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *Individual Placement and Support-Supported Employment (Adult MH):* 100% of eligible individuals must have a choice of two (2) provider agencies within each BH I/DD Tailored Plan Region. Each county in BH I/DD Tailored Plan Region must have access to ≥1 provider that is accepting new patients. • *I/DD & TBI Day Supports. Community Living & Support, I/DD & TBI Residential Services,* IDD Supported Employment: 100% of eligible recipients must have access to ≥1 provider agency within each BH I/DD Tailored Plan Region. • *Clinically Managed Population-specific High Intensity Residential Programs*: To be determined • *TBI long-term residential rehabilitation services:* To be Determined	

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

[2] BH I/DD Tailored Plans must also ensure that gender non-conforming recipients have access to substance abuse halfway house 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. Third Revised and Restated Attachment F.2. Table 1: BH I/DD Tailored Plan Time or Distance Standards and Section VII. Third Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards.*

Section VII. Third Revised and Restated Attachment F.2. Table 2: Classifications of Service Category for Behavioral Health Time or Distance Standards							
Reference Number	**Service Type**	**Classification**	**Disability Group**				
			I/DD or TBI	**Adult MH**	**Child MH**	**Adult SUD**	**Child SUD**
1.	Outpatient BH Services	Outpatient Services	Y	Y	Y	Y	Y
		Diagnostic Assessment	Y	Y	Y	Y	Y
2.	Location-Based Services^	Psychosocial Rehabilitation		Y			
		Substance Abuse Comprehensive Outpatient				Y	
		Substance Abuse Intensive Outpatient Program				Y	Y
		Outpatient Opioid Therapy				Y	
3.	Crisis Services^	Facility-based crisis program for adults	Y	Y		Y	
		Mobile Crisis	Y	Y	Y	Y	Y
		Non-hospital Medical Detoxification				Y	
		Ambulatory Detoxification				Y	
4.	Inpatient BH Services	Inpatient Hospital (including Three-way Contract Bed)	Y	Y	Y	Y	Y
5.	Reserved						
6.	Residential Treatment Services	Substance Abuse Halfway House				Y	Y
		Substance Abuse Medically				Y	

Section VII. Third 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**
		Monitored Residential Treatment					
		Substance Abuse Non-Medical Community Residential Treatment				Y	
		Substance Use Residential Service & Supports				Y	Y
		Mental Health Recovery and Residential Services		Y			
		Clinically managed population specific high intensity residential services				Y	
7.	Community/ Mobile Services^	Assertive Community Treatment		Y			
		Assertive Engagement		Y		Y	
		Community Support Team		Y		Y	
		Peer Supports		Y		Y	
		Transition Management Service		Y			
		High Fidelity Wraparound			Y		Y
		Intensive In-home			Y		Y
		Case Management		Y		Y	
		Multi-Systemic Therapy			Y		Y
8.	Employment and Housing Services	I/DD & TBI Day Supports	Y				
		Community Living & Support	Y				

Section VII. Third 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**
		I/DD & TBI Residential Services	Y				
		Supported Employment	Y				
		Residential Supports	Y	Y			
		Respite Services	Y		Y		Y
		Individual Placement and Supports (IPS)-Supported Employment		Y		Y	
		TBI Long-term Residential Rehabilitation Services	Y				
		Clinically Managed Population-specific High Intensity Residential Programs				Y	

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

Section VII. Third Revised and Restated Attachment F.2. Table 3: Appointment Wait Time Standards			
Reference Number	**Visit Type**	**Description**	**Standard**
BH Care/I/DD			
1.	Mobile Crisis Management Services	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid Members and State-funded Recipients*	Within two (2) hours
2.	Facility-Based Crisis Management Services (FBC for Adult, Non-Hospital Medical Detox)	Refer to *Section VII. Second Revised and Restated Attachment M.9. BH Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care*	Immediately available twenty-four (24) hours a day, three hundred sixty-

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

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

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

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

1. **Contracts between the BH I/DD Tailored Plan and providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
    b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid Member materials issued in conjunction with the Medicaid Managed Care Program.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section II.A.* of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.
    c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the State includes an extension option.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination. 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 organizations.

dd. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found *in Section V.B.4.~~i~~v.* 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. Second Revised and Restated Attachment M.2. Advanced Medical Home Program Policy for Medicaid Members*

c. *Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid Members*

d. *Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid Members*

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

a. Compliance with state and federal laws

The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [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 at lesser of thirty (30) Calendar Days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.
3. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.

ii. For Pharmacy Claims:

1. The [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 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 July 1, 2025, 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 shall at a minimum include the following in relation to the implementation of a partial 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 July 1, 2025, Contracts with all other Medicaid providers shall at a minimum include the following in relation to the implementation of a tobacco-free policy.
   [Provi*der] shall develop and implement a tobacco-free policy covering any portion of the property on which [Provider] operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible products and the use of non-combustible tobacco products, such as electronic, heated, and smokeless tobacco products, and nicotine products not approved by the FDA as tobacco use treatment medications. A tobacco-free policy also*

includes prohibition on [Provider] from purchasing, accepting as donations, or distributing tobacco products to individuals [Provider] serves.

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

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

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

1. **Contracts between the BH I/DD Tailored Plan and Providers, must, at a minimum, include provisions addressing the following:**
    a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices that constitute the entire contract between the parties.
    b. Definitions: The contract must define technical State-funded Services terms used in the contract, and if those definitions are referenced in other documents distributed to providers and recipients, ensure that definitions are consistent.
        i. In the case of the definition of Medical Necessity/Medically Necessary, the contract shall either indicate the BH I/DD Tailored Plan utilizes the definition as found in *Section III.A*. of the BH I/DD Tailored Plan Contract or include the definition verbatim from that section.
    c. Contract Term: BH I/DD Tailored Plan Contract may include the option to extend the contract's term if the BH I/DD Tailored Plan Contract with the state includes an extension option.
    d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH

I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a network contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division.

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

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

j. Eligibility Verification: The contract must address the BH I/DD Tailored Plan's obligation to provide a mechanism that allows providers to verify member eligibility before rendering health care services and reporting of eligibility information to the BH I/DD Tailored Plan.

k. Medical Records: The contract must require that providers:

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

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

  iii. Make copies of such records available to the BH I/DD Tailored Plan and the Department in conjunction with its regulation of the BH I/DD Tailored Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

l. Recipient Appeals and Grievances: The Contract must address the provider's obligation to cooperate with the recipient in regard to recipient appeals and grievance procedures.

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

n. Provider Network: The contract must include a provider network provision that ensures that LGBTQ recipients who obtain covered services are not subject to treatment or bias that does not affirm their orientation.

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

p. Data to the Provider: The contract must address the BH I/DD Tailored Plan's obligations to provide data and information to the provider, such as:

  i. Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.

  ii. Information on benefit exclusions; administrative and UM requirements; credential verification programs; quality assessment programs; and provider sanction policies.

  iii. Notification of changes in these requirements shall also be provided by the BH I/DD Tailored Plan, allowing providers time to comply with such changes.

q. Utilization Management: The contract must address the provider's obligations to comply with the BH I/DD Tailored Plan's UM programs, quality management programs, and provider sanctions programs with the proviso that none of these shall override the

professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.

r. Quality Management: The contract must address the provider’s participation in the compliance process and the Network Continuous Quality Improvement process.
s. Provider Directory: The provider's authorization and the BH I/DD Tailored Plan's obligation to include the name of the provider or the provider group in the provider directory distributed to members.
t. Dispute Resolution: Any process to be followed to resolve contractual differences between the BH I/DD Tailored Plan and the provider. Such provision must comply with the guidelines on Provider Complaint and Appeals as found in *Section V.C.4.e. Provider Grievances and Appeals.*
u. Assignment: Provisions on assignment of the contract must include that:
    i. The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the BH I/DD Tailored Plan.
    ii. The BH I/DD Tailored Plan shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.
v. Government Funds: The contract must include a statement that the funds used for provider payments are government funds.
w. Interpreting and Translation Services: The contract must have provisions that indicate:
    i. The provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the recipient.
    ii. The provider must ensure the provider’s staff is trained to appropriately communicate with recipients with various types of hearing loss.
    iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
x. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
y. Chapter 58 requirements: The contract must include provisions that address the following statutes and subsections:
    i. G. S. 58-3-200(c).
    ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
    iii. G.S. 58-50-270(1), (2), and (3a).
    iv. G.S. 58-50-275 (a) and (b).
    v. G.S. 58-50-280 (a) through (d).
    vi. G.S. 58-50-285 (a) and (b).
    vii. G.S. 58-51-37 (d) and (e).

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

aa. Providers Subject to Other Payment Directives: For all contracts with providers subject to specific payment provisions as found in *Section V.C.4.iv.* Provider Payments, a provision that indicates the terms and conditions of each applicable payment methodology/requirement.

bb. Clinical Records Requests for Claims Processing: the contract shall indicate that the BH I/DD Tailored Plan shall accept delivery of any requested clinical documentation through a mutually agreed to solution via secure electronic means available to the Provider and shall not require that the documentation be transmitted via facsimile.

cc. Amendment of Previous Authorizations for Outpatient Procedures: The contract must describe that the BH I/DD Tailored Plan shall accept retroactive requests for authorization of outpatient procedures in those instances where, in accordance with generally accepted North Carolina community practice standards and meeting the North Carolina Medicaid Medical Necessity Standard, an authorized outpatient procedure was modified or supplemented as a results of clinical findings or outcomes arising during the authorized outpatient procedure. Provider shall submit such retroactive requests for authorization within three (3) business days of concluding the authorized outpatient procedure.

dd. Physician Advisor Use in Claims Dispute: The contract must indicate that the BH I/DD Tailored Plan shall accept Provider's designated, North Carolina licensed, physician advisor with knowledge of the unit and care of the Member as Provider's approved representative for a claim or prior authorization in review or dispute.

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

a. Compliance with state laws

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

b. Hold Recipient Harmless

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

c. Liability

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

d. Non-discrimination: Equitable Treatment of Recipients:
   The [Provider] agrees to render Provider Services to recipients of State-funded Services with the same degree of care and skills as customarily provided to the [Provider's] patients who are not recipients, according to generally accepted standards of medical practice. The [Provider] and [Company] agree that recipients and non-recipients should be treated equitably. The [Provider] agrees not to discriminate against recipients on the basis of race, color, national origin, age, sex, gender, LGBTQ status, or disability.
e. Access to provider records
   The [Provider] agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and any records, books, documents, and papers that relate to the [BH I/DD Tailored Plan and Provider Contract/Agreement] and/or the [Provider's] performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:
   i. NC DHHS, its State-funded Services personnel, or its designee;
   ii. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;
   iii. The North Carolina Office of State Auditor, or its designee;
   iv. A state law enforcement agency; and
   v. Any other state entity identified by NC DHHS, or any other entity engaged by NC DHHS.
f. The [Provider] shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other Program Integrity activities conducted by the 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.

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

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

Section VII. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
8. SED In Reach, Diversion, Transition Activity Report	This report is for SED members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g. SMI, SED), and by setting (e.g. ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., SMI, SED), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
9. TBI In Reach, Diversion, Transition Activity Report	This report is for TBI members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., TBI), and by setting (e.g., CF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly

Section VII. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., TBI), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	
10. I/DD In Reach, Diversion, Transition Activity Report	This report is for IDD Members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that	Quarterly

Section VII. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	a 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).	
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
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. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
3. IDD In Reach, Diversion, Transition Activity Report	This report is for I/DD members related to: In Reach: Number and percentage of members who are referred for or request placement in an institutional setting or ACH who are then placed in an institutional setting or ACH. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Diversion: Number and percentage of members eligible for diversion activities who are engaged for diversion activities; number and percentage of members who remain in the community after engaging in diversion activities. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH). Transition: Number and Percentage of Members identified for transition who are discharged through the transition planning process; number of days following discharge that a member began receiving community services; and information related to both successful and unsuccessful transitions. To be reported by diagnosis (e.g., I/DD), and by setting (e.g., ICF-IID Not Operated by the State, State Developmental Center, state psychiatric hospital, PRTF, Residential Treatment Levels II/Program Type, III, and IV, ACH).	Quarterly
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

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

Section VII. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
3. Website Functionality Report	Quarterly website utilization and statistics compared to SLAs, including scheduled/unscheduled downtime, website speed, number of hits, and electronic communication response rate.	Quarterly
4. Training Evaluation Outcome Report	Monthly report on staff training including number of trainings conducted, outcomes, proposed changes/improvements to the training program (including cross-functional training).	Monthly
5. BH SFS Waitlist / Rate of Institutionalization Report	Quarterly report capturing metrics of individuals being placed on waitlists, including type of services requested, reason for removal from waitlist, and dates of requesting and receiving services.	Quarterly
6. Reserved.		
H. Compliance		
1. Third Party Liability Report	Quarterly claim-level detail of third party or cost avoidance activities by the BH I/DD Tailored Plan, including type of service, provider rendering services, and total amount paid and recovered/avoided.	Quarterly
2. Fraud, Waste, and Abuse Report: Providers	Quarterly summary of potential and actual fraud, waste and abuse by providers, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
3. Fraud, Waste, and Abuse Report: Members	Quarterly summary of potential and actual fraud, waste and abuse by members and recipients, including date of fraud, description of allegation/complaint, key findings, recoupments, and coordination with Department and OIG.	Quarterly
4. Other Provider Complaints Report	Monthly report detailing a cumulative listing of provider complaints not included in other Fraud, Waste, and Abuse reports. Include date of complaint, description of allegation/complaint, how complaint identified, issues, and resolution.	Monthly
5. Reserved.		
6. Overpayment Recoveries Report	Annual report of overpayment recoveries.	Annually
7. Network Provider Terminations Report	Monthly report on network terminations, including NPI, provider name, location, date of termination or non-renewal, and reason for termination.	Monthly
8. Cost Avoidance Report	The cost avoidance report is used by the plans to report cost avoidance savings due to other found insurance paying as the primary payer.	Weekly

Section VII. Third Revised and Restated Attachment J. Table 1: BH I/DD Tailored Plan Reporting Requirements for Medicaid and State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
9. Recipient Explanation of Medical Benefit (REOMB)	The Plans are responsible for the creation of Recipient Explanation of Medical Benefits (REOMB) for detecting payment problems. The Plans send REOMBs to random sample of members based on claims from the previous month. The REOMB provides information on the Medicaid services paid on behalf of the member(s). The communication includes the provider's name, the date(s) of services, service name, and the payment amount(s). Instructions are included on how to respond to the REOMB. The Plans are required to submit quarterly reports to the Office of Compliance and Program Integrity (OCPI) of NC Medicaid summarizing REOMB statistics, detailed survey results, and follow up on the results.	Quarterly

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

Section VII. Third Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Members		
1. Reserved.		
2. Annual Member Incentive Programs Report	Annual report of member outreach, utilization, and metrics for all Member Incentive Programs.	Annually
3. Change in Member Circumstances Report	Weekly report used to notify NC Medicaid of changes in member circumstances in accordance with 42 C.F.R. § 438.608(a)(3).	Weekly
4. Non-Verifiable Member Addresses and Returned Mail Report	Weekly report including the template and process flow for Non-Verifiable Member Addresses and Returned Mail.	Weekly
5. Nursing Facility Admission Disenrollment Report	Ad-hoc report including the process for a member's disenrollment from a BH I/DD Tailored Plan due to a Nursing Facility stay longer than ninety (90) days.	Ad-Hoc[1]
6. Monthly Enrollment Reconciliation Extract	Monthly extract of each member with eligibility through the current month and the health plan they are assigned to. This report will be used for member data reconciliation purposes across systems. *Note* If the date the extract is being submitted is prior to July 1, 2022, the extract would include member eligibility as of July 1, 2022.	Monthly
B. Benefits		
1. Institute of Mental Disease (IMD) Report	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

[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. Third Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
6. Financial Arrangements with Drug Companies Report	Description of all financial terms and arrangements between the Tailored Plan and any pharmaceutical drug manufacturer or distributor.	Annually
7. EPSDT Reports	Quarterly EPSDT reporting including Member and Provider EPSDT outreach.	Quarterly
8. Non-Emergency Medical Transportation (NEMT) Report	Monthly report listing NEMT utilization and each request received and the status of the request, approved, denied and open.	Monthly
9. Annual Prevention and Population Health Report	Annual report of all members outreached, utilization and key program metrics.	Annually
10. Quarterly Opioid Misuse and Prevention Program Report	Quarterly report on utilization and outcomes of the Opioid Misuse Prevention Program.	Quarterly
11. Reserved.		
12. Crossover- Related NEMT Appointments Scheduled Report	Weekly report identifying and monitoring NEMT appointment activity during the Crossover time period.	Weekly
13. UM and Clinical Coverage Report	The BH I/DD Tailored Plan shall provide analysis of their compliance with attestation upon request	Ad-Hoc[1]
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

[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. Third Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
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
C. Care Management		
1. CMHRP Corrective Action Plan Report	Quarterly Care Management for High-Risk Pregnancy report on corrective action plan and the associated decision reasoning.	Quarterly
2. Care Needs Screening Report	Quarterly report of member screening results, including Healthy Opportunity & Care Needs Screening of members who have opted out of Tailored Care Management or who are ineligible for Tailored Care Management due to receipt of a duplicative service.	Quarterly
3. Local Health Department (LHD) Contracting Report	Monthly report of LHD care management contracting.	Monthly
4. Reserved.		
5. TCM Provider Contracting and Integration Report	Weekly TCM Provider contracting and integration status report.	Weekly
6. Nursing Facility Transitions Report	Quarterly report listing BH I/DD Tailored Plan members discharged from a nursing facility and to where they were discharged.	Quarterly
7. Reserved.		
8. Reserved.		
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.		

Section VII. Third Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
6. Reserved.		
7. Reserved.		
8. Out-of-Network (OON) Services Request Reports	Monthly report on all requests for out-of-network services, including status of requests of each request, determination, and basis for determination.	Monthly
9. Reserved.		
10. Capitation Reconciliation Report	Monthly report to inform the State of any capitation related payment discrepancies observed. BH I/DD Tailored Plans will include records of members where no payment was received from the State or payment received differed from the amount expected. BH I/DD Tailored Plans will only include member records with discrepancies on this report to the State. The BH I/DD Tailored Plan Capitation Reconciliation Report will be submitted on a monthly cadence. BH I/DD Tailored Plans will indicate expected values and values observed on ASC x12 834 monthly file for members.	Monthly
11. Reserved.		
12. PCP Tailored Plan Panel Capacity Limit Report	PCP Tailored Plan Panel Capacity Limit Report.	Weekly until launch and then monthly
F. Quality and Value		
1. Annual Quality Measures Report	Annual BH I/DD Tailored Plan performance on quality measures.	Annually
G. Stakeholder Engagement		
1. Tribal Engagement Report	Annual report of quantity and type of services offered to members of federally recognized tribes, including number of members served.	Annually
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.		

Section VII. Third Revised and Restated Attachment J. Table 3: BH I/DD Tailored Plan Reporting Requirements for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
3. Reserved.		
4. Claims Monitoring Report	Monthly summary of claims that have been received, paid, pended, rejected, denied, accepted, and deemed clean by professional, institutional, and pharmacy. As well as the top 10 denial reasons by volume and dollar amount. Pended claims should reflect current inventory at the end of the reporting period, while received, paid, rejected, denied, accepted, and clean should reflect claims that were received, paid, rejected, denied, accepted, and deemed clean during the entire reporting period.	Monthly
5. Risk Corridor Report	The corridor compares the capitation revenue to service costs and treatment planning costs, not sure what other costs and nuances are involved since the BH I/DD Tailored Plan template is still in the planning/preliminary stage. The target treatment ratios and associated thresholds determine whether or not the State pays or recoups from the entities.	Annually
6. Emergency Department Boarding for Children	Weekly report of all Members under age eighteen (18) who are boarding in an Emergency Department setting awaiting medically necessary treatment for Behavioral Health, IDD, or TBI services. For any Member in the Emergency Department over thirty (30) consecutive hours, document escalation to appropriate parties including but not limited to BH I/DD Tailored Plan Clinical Director or designee.	Weekly
7. Service Associated Request Report	Tailored Plan decision regarding the service requested on the Request to Move: Provider Form.	Monthly

Section VII. Third Revised and Restated Attachment J. Table 4: BH I/DD Tailored Plan Data Extracts for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Members		
1. Clearinghouse Daily Uploads Extract	Daily extract of each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan to a member. In accordance with the Notice of Adverse Benefit Determination Clearinghouse Upload Instruction Policy.	Daily
B. Benefits and Care Management		
1. Care Management Reason Beneficiary Extract	Monthly extract containing financial, utilization, and outcome data at the provider and member level for all care management programs.	Monthly
2. Medical Prior Authorization Extract	Weekly extract providing information on medical prior approval requests by individual member, service type, determination date, and approval status.	Weekly
3. Pharmacy Prior Authorization Extract	Weekly extract of pharmacy prior authorizations.	Weekly
4. Reserved.		

Section VII. Third Revised and Restated Attachment J. Table 5: BH I/DD Tailored Plan Medicaid Alerts and Notifications for Medicaid		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. Reserved.		

Section VII. Third Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
A. Eligibility		
1. Reserved.		
B. Care Management and Prevention		
1. TBI Services Quarterly Expenditures Report*	Quarterly report on administration of State-funded TBI programming expenditures and associated services.	Quarterly

Section VII. Third Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
2. Reserved.		
3. Substance Abuse/Juvenile Justice Initiative Quarterly Report*	Monthly report of information on juvenile justice and SUD programming, screening, and use of evidence-based treatment through the Juvenile Justice Substance Abuse Mental Health Partnerships Data Survey.	Monthly
4. Work First/Child Protective Services (CPS) Substance Use Initiative Report	Quarterly report of recipients in Work First or with families with substantiated CPS cases who receive substance use assessments, and care coordination through a Qualified Professional in Substance Abuse (QPSA).	Quarterly
5. TBI Annual Report	The annual report consists of a combination of both quantitative and qualitative information, which provides a more holistic understanding of service usage, trends and network adequacy for the TBI population within North Carolina's publicly funded service system.	Annually
C. Quality and Value		
1. Quarterly Quality Measures Report	The NC Department of Health and Human Services (NCDHHS), Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) has been tracking the effectiveness of community systems through statewide performance indicators since 2006. These indicators provide a means for Executive Leadership, the NC public and General Assembly to monitor how the public service system is performing its responsibilities. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities. These performance indicators describe an observed level of activity (percent of persons that received a service for a MH, I/DD, or SUD condition or that received a timely follow-up service), but do not explain why the level is as it is. Results do not reveal the substantial "behind-the-scene" activities, processes and interactions involving service providers, LME-MCO and state staff, consumers, and family members, and cannot reveal which factors account for differences in measured levels of quality. Identifying and understanding these factors	Quarterly

Section VII. Third Revised and Restated Attachment J. Table 6: BH I/DD Tailored Plan Reporting Requirements for State-funded Services		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
	require additional investigation and may serve as the starting point for program management initiatives or quality improvement efforts. The performance indicators in this report were chosen to reflect: • accepted standards of care, • fair and reliable measures, and • readily available data sources.	
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 Abuse Prevention and Treatment Block Grant (SAPTBG) Narrative Compliance Report	Bi-annual narrative report on compliance with target and outcome prevention activities and measures for priority populations, as detailed in the SAPTBG.	Bi-Annual
4. Financial Reporting Tool	Monthly report containing State non-UCR expenditures, county fund utilization, and Federal non-UCR expenditures. This report will contain a certification portion attesting that all information included is accurate.	Monthly

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

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

Section VII. Third Revised and Restated Attachment J. Table 8: TCL Reporting Requirements		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
1. TCL Housing Entry and Exit Report	Report on TCL individuals who are entering or exiting the TCL program, including tracking of reasonable accommodations submitted, disposition on behalf of TCL members, reasons for separations	Monthly – due 15th of the month, or the first Business Day following the 15th if the 15th 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. Third Revised and Restated Attachment J. Table 8: TCL Reporting Requirements		
BH I/DD Tailored Plan Report Name	**BH I/DD Tailored Plan Report Description**	**Frequency**
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)	Monthly
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

Attachment M. Policies

Third 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*;

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[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.

i. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina;

j. Beneficiaries who have a qualifying I/DD diagnosis code as described in *Section V.B.1.i.(ii) BH I/DD Tailored Plan Eligible Populations;*

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:

[4,5] 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.

i. The Department will regularly review encounter, claims and other relevant and available data to identify beneficiaries enrolled in Standard Plans, new Medicaid beneficiaries, and NC Medicaid Direct beneficiaries who meet BH I/DD Tailored Plan data-based eligibility criteria.
ii. The Department will send beneficiaries identified as BH I/DD Tailored Plan eligible a notice informing them of their BH I/DD Tailored Plan eligibility and auto-enroll them in NC Medicaid Direct/the LME/MCO in their Region.

t. Beneficiaries who are not identified and auto-enrolled through the Department's data review will have the option to request to enroll in NC Medicaid Direct/LME/MCO by submitting a request for to the Department for review.

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

v. Beneficiaries who no longer meet the BH I/DD Tailored Plan eligibility criteria will be auto-enrolled in Standard Plans at BH I/DD Tailored Plan launch unless they are excluded from Standard Plan enrollment, in which case, they will be auto-enrolled in NC Medicaid Direct.

w. The Department will send beneficiaries who continue to meet the BH I/DD Tailored Plan eligibility criteria based on data reviews or the request to enroll in a BH I/DD Tailored Plan process at the point of the reassessment a notice indicating that they will be enrolled in a BH I/DD Tailored Plan and can elect to enroll in a Standard Plan at any point during the coverage year unless they are excluded from Standard Plans, in which case they can enroll in NC Medicaid Direct at any point during the coverage year.

x. The Department will transmit BH I/DD Tailored Plan assignment to the BH I/DD Tailored Plan through an 834 eligibility file.

y. If a beneficiary selects a Standard Plan prior to the scheduled transition date to BH I/DD Tailored Plans, the Enrollment Broker will transmit the Standard Plan selection to the Department. The Department will transmit Standard Plan selection to the Standard Plan through an 834 eligibility file. In instances where a BH I/DD Tailored Plan eligible beneficiary chooses to enroll in a Standard Plan, the beneficiary will not have access to services only covered by BH I/DD Tailored Plans (unless the beneficiary is under age 21 and the service is covered through EPSDT).

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

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

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

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

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

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

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

a. The Department will allow a beneficiary who is enrolled in a Standard Plan, the 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 Enroll in a BH I/DD Tailored Plan: Beneficiary Form
  ii. Request to Enroll in a BH I/DD Tailored Plan: Provider Form

iii. Reserved.

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

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

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

g. The beneficiary (or authorized representative8 2) must sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.

h. Request to Enroll in a BH I/DD Tailored Plan: Provider Form
   i. In cases where a beneficiary uses the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, the beneficiary (or guardian/legally responsible person) may work with their provider to complete a form indicating the reason(s) the beneficiary is believed to be eligible for the BH I/DD Tailored Plan.
   ii. The provider must sign the form, attesting that the request is accurate and is in the best interest of the beneficiary.
   iii. The beneficiary (or authorized representative) must also sign the form providing permission for the Department to contact the provider and indicating an understanding that if the request is approved, the beneficiary will be moved to a BH I/DD Tailored Plan.
   iv. The beneficiary or authorized representative or provider transmits the completed form.
   v. The Enrollment Broker will transmit the request to the Department for review within twenty-four (24) hours of receipt.
   vi. The Department will review the form and determine whether the beneficiary is eligible for a BH I/DD Tailored Plan according to the following timeframes:
      (a) Request to Enroll in a BH I/DD Tailored Plan: Beneficiary Form will be reviewed in eight (8) Calendar Days
      (b) Request to Enroll in a BH I/DD Tailored Plan: Provider Form will be reviewed in five (5) Calendar Days

i. The Department will transmit the beneficiary's transfer to a BH I/DD Tailored Plan through an 834 eligibility file. Coverage by the assigned BH I/DD Tailored Plan will begin on the first day of the month following the transfer, unless there is a service need as outlined in the next section.

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

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

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

k. Beneficiaries enrolled in Standard Plans who have a need for a service only available in BH I/DD Tailored Plans (i.e., a service-related request) will be able to transfer to a BH I/DD Tailored Plan through the following process.

l. The provider must submit the service authorization request and the Request to Enroll in a BH I/DD Tailored Plan: Provider Form to the Department on behalf of the Standard Plan member.

m. The Standard Plan member or legal guardian must sign the Request to Enroll in a BH I/DD Tailored Plan: Provider Form, which acknowledges the request and that approval will lead to immediate disenrollment from Standard Plan and enrollment in a BH I/DD Tailored Plan.

n. The Department will review and enroll the Standard Plan member in a BH I/DD Tailored Plan effective within one (1) business day retroactive to the date of the request.[9]

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

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

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

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

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

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

a. On an ongoing basis, the Department will review the service utilization of BH I/DD Tailored Plan members as well as Standard Plan members who had been flagged in the past as BH I/DD Tailored

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

Plan eligible but chose to enroll in a Standard Plan, to determine whether they should continue to be enrolled, or eligible to enroll, in BH I/DD Tailored Plans.

b. Behavioral Health I/DD Tailored Plan-eligible individuals, whether they are enrolled in a Standard Plan or BH I/DD Tailored Plan, will continue to be eligible for a BH I/DD Tailored Plan if they either have a qualifying I/DD diagnosis, have TBI needs as described in *Section V.B.1.i.* Eligibility and Enrollment for BH I/DD Tailored Plans or have used a Medicaid or State-funded BH service other than outpatient therapy and medication management in the past twenty-four (24) months prior to their annual redetermination date.

c. Beneficiaries who do not meet one of the criteria above and are Medicaid Managed Care mandatory will be transferred to a Standard Plan at renewal and noticed as part of the annual redetermination notice. Beneficiaries who do not meet one of the criteria above and are excluded from Standard Plan enrollment will be enrolled in NC Medicaid Direct.

g. Medicaid Eligibility Redeterminations

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

b. If the member's eligibility has moved to a county that is part of a different BH I/DD Tailored Plan Region, the Department will auto-assign the member into the BH I/DD Tailored Plan in the member's new county of eligibility.

c. The member will continue to have the opportunity to elect to enroll in a Standard Plan at any point during the coverage year. Members who are excluded from Standard Plan enrollment have the opportunity to elect to enroll in NC Medicaid Direct at any point during the coverage year.

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

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

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

h. Special Enrollment Cases

Exempt populations

a. Exempt populations as defined in *Section V.B.1.i.(iii)(a)* that are BH I/DD Tailored Plan eligible will be able to enroll in BH I/DD Tailored Plans.

b. The Enrollment Broker will provide choice counseling to exempt populations and support BH I/DD Tailored Plan, Standard Plan, NC Medicaid Direct, EBCI Tribal Option (as applicable), and PCP selection throughout the beneficiary's eligibility year.

c. If a beneficiary in an exempt population selects a BH I/DD Tailored Plan, the Enrollment Broker will transmit the BH I/DD Tailored Plan selection to the Department. The Department will transmit BH I/DD Tailored Plan selection to the BH I/DD Tailored Plan through an 834 eligibility file.

d. If a beneficiary in an exempt population elects to move from a BH I/DD Tailored Plan to a Standard Plan or other delivery system (such as NC Medicaid Direct or EBCI Tribal Option) at any point during the beneficiary's eligibility year, coverage of the beneficiary by Standard Plan or delivery system begins on the first day of the next month in which the beneficiary selected the Standard Plan or delivery system. [10]

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

f. Deemed newborns

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

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

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

b. Member requested disenrollment
   i. A member, or an authorized representative, may submit a verbal or written request for disenrollment from the BH I/DD Tailored Plan to the Enrollment Broker by phone, mail, in-person, or electronically.
   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.

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[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.

[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.

iv. The member, or the authorized representative, must contact the Enrollment Broker in order to initiate a disenrollment request.
v. At the time of the disenrollment request, choice counseling for the member or his or her representative will be available from the Enrollment Broker.
vi. The Enrollment Broker will process disenrollment requests in accordance with the following:
vii. The Enrollment Broker will evaluate the request and will approve it if the member is not enrolled in the Innovations or TBI waiver.
viii. The Enrollment Broker will notify the Department of its decision by the next business day following receipt of the request.

c. Notice of disenrollment determination
   i. The Department will notify the member or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the disenrollment request and, if approved, the disenrollment will be effective the first day of the month following receipt of the request by the Enrollment Broker.
   ii. The effective date of an approved disenrollment request will be no later than the first day of the second month following the month in which the member requests disenrollment. If the Enrollment Broker or the Department fails to make a disenrollment determination within the specified timeframes, the disenrollment is considered approved for the first day of the following month unless there is an urgent need.[12]

d. Expedited review of member initiated requests for disenrollment
   i. A member, or an authorized representative, may request an expedited review of his or her disenrollment request when the member has an urgent medical need. For purposes of this subsection, an urgent medical need means continued enrollment in the BH I/DD Tailored Plan could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
   ii. The Enrollment Broker will process requests for expedited review in accordance with the following:
      a) The Enrollment Broker will transmit expedited review requests to the Department for evaluation within twelve (12) hours of receipt of the request.
      b) The Department will evaluate and decide whether to approve or deny the request.
   iii. The Department will notify the member, or authorized representative, and the BH I/DD Tailored Plan of the approval or denial of the expedited disenrollment request. If approved, the disenrollment effective date, will be within three (3) calendar days of receipt of the request by the Enrollment Broker.

e. Disenrollment required by the Department
   i. The Department may disenroll a member from Medicaid Managed Care for any of the following reasons:
      (a) Loss of eligibility
         1. If the Department determines that a member is no longer eligible for Medicaid, the member will be notified by the Department and the member will be

[12] 42 C.F.R. § 438.56(e).

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. The disenrollment effective date will be the date when the member's change in eligibility category was effective.

(c) Nursing facility long-term stays

1. A member with a nursing facility stay that exceeds ninety (90) continuous calendar days will be disenrolled from the BH I/DD Tailored Plan on the first day of the next month following the ninetieth (90th) day of stay and receive services through NC Medicaid Direct.[14]
2. The BH I/DD Tailored Plan shall utilize the Department-developed standardized process for monitoring length of stay for members in nursing facilities to ensure members receive appropriate levels of care and to report to the Department members who need to be disenrolled due to stays that exceed ninety (90) calendar days.

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

i. Within thirty (30) days of admission to a nursing facility, the BH I/DD Tailored Plan will assess a member's health care needs and estimate the potential length of stay. If the member requires a stay for longer than ninety (90) calendar days, the BH I/DD Tailored Plan must notify the Department in writing within five (5) calendar days of the assessment, the results of the assessment, the facility admission date, and the estimated discharge date.

ii. The BH I/DD Tailored Plan is responsible for tracking the total continuous length of stay for each member residing in a nursing facility.

iii. The Department will send the BH I/DD Tailored Plan and the member, or authorized representative, a written notice of disenrollment at least fourteen (14) calendar days before the effective date of the member's disenrollment from the BH I/DD Tailored Plan.

iv. The BH I/DD Tailored Plan must notify the Department with an attestation of any member still enrolled in Medicaid Managed Care prior to the first day of the next month following the 90th day of stay, if there is a delay in the Department's disenrollment notification.

g. Coverage of the member by the BH I/DD Tailored Plan will end on the effective date provided by the Department.

[13] 42 C.F.R. § 438.56(g).
[14] Session Law 2015-245, as amended by Session Law 2018-49.

h. Neuro-Medical Centers and Veterans Homes

i. A beneficiary, otherwise eligible for enrollment in the BH I/DD Tailored Plan, residing in a state-owned Neuro-Medical Center[15] or a DMVA-operated Veterans Home[16] when the Department implements the BH I/DD Tailored Plan is excluded and will receive care in these facilities through NC Medicaid Direct.

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.

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

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

Attachment M. POLICIES

Third Revised and Restated Attachment M. 2. Advance Medical Home Program Policy for Medicaid and NC Health Choice Members

a. Background

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

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

1) Accept members and be listed as a PCP in the BH I/DD Tailored Plan's member-facing materials for the purpose of providing care to members and managing their healthcare needs.
2) Provide primary care and patient care coordination services to each member, in accordance with BH I/DD Tailored Plan policies.
3) Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
4) Provide direct patient care a minimum of thirty (30) office hours per week.
5) Provide preventive services, in accordance with *Section VII. Third Revised and Restated Attachment M.2. Table 1: Required Preventive Services.*
6) Maintain a unified patient medical record for each member following the BH I/DD Tailored Plan's medical record documentation guidelines.
7) Promptly arrange referrals for medically necessary healthcare services that are not provided directly and document referrals for specialty care in the medical record.
8) Transfer copies of the member's medical record to the receiving provider upon the change of PCP at the request of the new PCP or BH I/DD Tailored Plan (if applicable) and as authorized by the member within thirty (30) days of the date of the request, free of charge.
9) Authorize care for the member or provide care for the member based on the standards of appointment availability as defined by the BH I/DD Tailored Plan's network adequacy standards.
10) Refer for a second opinion as requested by the member, based on Department guidelines and BH I/DD Tailored Plan standards.

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

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

Reference Number	AMH Preventative Health Requirements	0 to 5	6 to 21	22 to 121
1	Adult Preventative and Ancillary Health Assessment			Y
2	Blood Lead Level Screening	*		
3	Cervical Cancer Screening (applicable to females only)		As Needed	Y
4	Vaccines per ACIP recommendations ACIP Vaccine Recommendations| CDC	Y	Y	Y
5.	Reserved.			
6	Health Check Screening Assessment	*	*	
7	Hearing	*	*	
8 & 9	Hemoglobin or Hematocrit	*	*	As Needed
10	Reserved.			
11	Reserved.			
12	Reserved.			
13	Reserved.			
14	Reserved.			
15	Standardized Written Developmental	*		
16	Reserved.			
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	*	*	Y
18	Urinalysis		*	Y
19	Reserved.			
20	Vision Assessment	*	*	Y

* Please refer to the American Academy of Pediatrics: Bright Futures Periodicity Schedule for information on when preventive services should be delivered to children under the age of 21. The AAP Bright Futures Periodicity Schedule can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

First Revised and Restated Attachment M. 5. Care Management for High-Risk Pregnancy Policy for Medicaid

a. **Background**

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

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

3) After Contract Year 2, Care Management for High-Risk Pregnancy shall be fully subsumed into the Tailored Care Management model.

b. **Scope**

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

c. **General Contracting Requirement**

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

d. **Care Management for High-Risk Pregnancy: Outreach**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

g. **Care Management for High-Risk Pregnancy: Interventions**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. **Care Management for High-Risk Pregnancy: Training**

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

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

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

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

k. **Care Management for High-Risk Pregnancy: Staffing**

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

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

d. Bachelor's degree in a human service field with five (5) or more years of care management/case management experience working with the specific population of low-income, pregnant individuals and/or children ages 0-5.
e. Bachelor's degree in a human service field with three (3) or more years of care management/case management experience working with the specific population of (low-income, pregnant individuals and/or children ages 0-5) and has certification as a Case Manager (Commission for Case Manager (CCM) Certification preferred).
f. Program staff hired prior to September 1, 2011, without a bachelor's or master's degree in social work may retain their existing position only. This grandfathered status does not transfer to any other position.

2) LHD shall ensure that Community Health workers for Care Management for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.
3) LHD shall include both registered nurses and social workers on their team in order to best meet the needs of the target population with medical and psychosocial risk factors.
4) If the LHD has only a single care manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.
5) LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcomes. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions.
6) LHD shall ensure that pregnancy care managers demonstrate:
    a. Proficiency with the technologies required to perform care management functions
    b. Motivational interviewing skills and knowledge of adult teaching and learning principles
    c. Ability to effectively communicate with families and providers
    d. Critical thinking skills, clinical judgment and problem-solving abilities
7) LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include:
    a. Provision of program updates to care managers
    b. Daily availability for case consultation and caseload oversight
    c. Regular meetings with direct service care management staff
    d. Utilization of reports to actively assess individual care manager performance
    e. Compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual
8) LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following BH I/DD Tailored Plan/Department guidance about communication with the BH I/DD Tailored Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.
    a. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by the BH I/DD Tailored Plan.

Third Revised and Restated Attachment M. 7. Uniform Credentialing and Re-credentialing Policy for Medicaid, and State-funded Providers

a. Background

This Uniform Credentialing and Re-credentialing Policy for Medicaid, and State-funded Providers outlines the expectations of the Department with regard to the Centralized Provider Enrollment and Credentialing Process and standards utilized by a BH I/DD Tailored Plan in determining whether to allow a provider to be included in the BH I/DD Tailored Plan's Network based upon the inclusion of a provider in the daily Provider Enrollment File, which signifies the provider has met the Department's criteria as a Medicaid Enrolled provider. For network providers of Medicaid BH, I/DD, and TBI services, the BH I/DD Tailored Plan has the authority to maintain a closed network for these services as set forth in Section 4.(10)(a)(1)(IV) of Session Law 2018-48. The Uniform Credentialing and Re-credentialing Policy also outlines the expectations of the Department with regard to the process and standards utilized by the BH I/DD Tailored Plan in selection and retention of network providers for Medicaid BH, I/DD, and TBI services.

b. Scope

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

c. Policy Statement

The BH I/DD Tailored Plan shall implement the Provider Credentialing and Re-credentialing Policy described below by developing and maintaining written provider selection and retention policies and procedures relating to initial or continued contracting with their medical services providers consistent with the Department's Credentialing and Re-credentialing Policy.

d. Provider Enrollment and Credentialing

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

i. The Department, or Department designated vendor, shall collect information and verify credentials, through a centralized credentialing process for all providers currently enrolled or seeking to enroll in North Carolina's Medicaid program or as a State-funded Services provider.

1. The information shall be collected, verified, and maintained according to the Department's Medicaid Enrollment/Credentialing criteria as required to participate as a Medicaid Enrolled provider or State-funded Services Enrolled provider.
2. The Department may, at its option, contract with a vendor to provide any aspect of provider data management and/or credentials verification services necessary for operation of the CCRP.

ii. The Department shall apply the credentialing policies to any providers who furnish, order, prescribe, refer or certify eligibility for Medicaid or State-funded Services, including all providers that must be credentialed under credentialing standards established by a nationally-recognized accrediting body. 42 C.F.R. § 438.602(b).

iii. The process and information requirements shall meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the NCQA as the Plan accrediting organization. The applicable data and processing standards shall be consistent with current waivers or exceptions as outlined in agreements with the National Committee for Quality Assurance, and in effect consistent with the effectiveness of the waiver/exceptions.

iv. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid or State-funded Services Enrolled provider, with the application serving for enrollment as a NC Medicaid Direct provider and a Medicaid Managed Care provider.

v. The Department shall not mandate Medicaid Managed Care providers enrolled with the State participate in the NC Medicaid Direct program or provide State-funded services.

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

vii. A BH I/DD Tailored Plan shall use the BH I/DD Tailored Plan's Provider Manual to outline the process for contracting with providers who have met the Department's Objective Quality Standards and how the BH I/DD Tailored Plan will routinely evaluate its Provider Network to confirm a provider's continued active status as a Medicaid or State-funded Services Enrolled provider in accordance with the standards contained in this Policy

viii. The Department, or its designated vendor, will publish a daily Provider Enrollment File containing demographic information for all active Medicaid Enrolled providers. The BH I/DD Tailored Plan shall use the Provider Enrollment File to identify active Medicaid Enrolled providers who are eligible for contracting.

e. **Provider Credentialing and Re-credentialing Policy**

a. The BH I/DD Tailored Plan shall develop and implement, as part of its Provider Manual, written policies and procedures for the selection and retention of network providers. The BH I/DD Tailored Plan's policies and procedures, at a minimum, must:

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

ii. Meet the requirements specified in this Contract;

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

iv. Establish that the BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department and shall not request any additional credentialing information without the Department's approval.

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

vi. Prohibit BH I/DD Tailored Plan from discriminating against particular providers that service high-risk populations or specialize in conditions that require costly treatment; 42 C.F.R. § 438.214(c).

vii. Prohibit discrimination in the participation, reimbursement, or indemnification of any provider who is providing a covered service and who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. 42 C.F.R. § 438.12.

viii. Prohibit BH I/DD Tailored Plan to employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act;

ix. Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers or State-funded Services providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E; and

x. Identify standards and establish a documented process for making network contracting decisions on Medicaid providers of BH, I/DD, and TBI services. At a minimum, these standards shall assess a provider's ability to deliver care.

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

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

xiii. Describe the process by which the BH I/DD Tailored Plan will demonstrate that its network providers are credentialed in accordance with. 42 C.F.R. § 438.206(b)(6).

xiv. If BH I/DD Tailored Plan requires a provider to submit additional information as part of its contracting process, the BH I/DD Tailored Plan's policy shall include a description of all such information.

xv. BH I/DD Tailored Plan shall make network contracting decisions for Medicaid providers of physical health and pharmacy services based solely upon the appearance of a provider on the daily Provider Enrollment File and the provider's acceptance of the contracting terms and rates BH I/DD Tailored Plan shall re-credential providers as follows:

    1. The Department shall evaluate a provider's continued eligibility based on timelines defined in the Contract. During the Provider Credentialing Transition Period, no less frequently than every five (5) years.

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

xvi. BH I/DD Tailored Plan shall follow the Department's Uniform Credentialing and Re-credentialing Policy when making a contracting decision for in-state, border (i.e., providers that reside within forty (40) miles of the NC state line), and out-of-state Network providers.

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

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

a. Background

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

b. Behavioral Health Services Definitions

1. Outpatient Opioid Treatment (adults only): a location-based service for the purpose of network adequacy standards.
2. Adult Facility-Based Crisis Services: a state-funded crisis service for the purpose of network adequacy standards.
3. Facility-based crisis services for children and adolescents: a Medicaid crisis service for the purpose of network adequacy standards.
4. Professional treatment services in facility-based crisis: a Medicaid crisis service for the purpose of network adequacy standards.
5. Ambulatory withdrawal management without extended on-site monitoring (Ambulatory detoxification services): a Medicaid crisis service for the purpose of network adequacy standards.
6. Ambulatory withdrawal management with extended on-site monitoring: a Medicaid crisis service for the purpose of network adequacy standards.
7. Clinically managed residential withdrawal services (social setting detoxification): a Medicaid crisis service for the purpose of network adequacy standards.
8. Medically monitored inpatient withdrawal services (non-hospital medical detoxification): a crisis service for the purpose of network adequacy standards.
9. Medically managed intensive inpatient withdrawal services (acute care hospitals with adult inpatient substance use beds): a Medicaid crisis service for the purpose of network adequacy standards.
10. Medically Supervised Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
11. Alcohol Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization (adults only): a crisis service for the purpose of network adequacy standards.
12. Acute Care Hospitals with adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
13. Hospitals with Adult Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.

14. Medically managed intensive inpatient services (Acute Care Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.
15. Medically managed intensive inpatient withdrawal services (Acute Care Hospitals with Adult Inpatient Substance Use Beds): inpatient BH services for the purpose of network adequacy standards
16. Hospitals with Adult Inpatient Substance Use Beds (ASAM 4 and ASAM 4WM): inpatient BH services for the purpose of network adequacy standards.
17. Acute Care Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
18. Hospitals with Adolescent Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
19. Acute Care Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
20. Hospitals with Adolescent Inpatient Substance Use Beds: inpatient BH services for the purpose of network adequacy standards.
21. Acute Care Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
22. Hospitals with Child Inpatient Psychiatric Beds: inpatient BH services for the purpose of network adequacy standards.
23. Partial hospitalization: partial hospitalization for children and adults for the purposes of the network adequacy standards.
24. Mobile Crisis Management Services: Mobile crisis services, for adults and children that are direct and periodic services available at all times, twenty-four (24) hours a day, seven (7) days a week, 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: Partial hospitalization for children and adults for the purposes of the network adequacy standards.

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

1) Background

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

Indian Health Care Provider (IHCP) refers to a "health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Providers operated by state recognized tribes are not considered IHCPs.

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

2) Scope

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

3) Policy Statement

The BH I/DD Tailored Plan shall implement:

a) Claim Submission

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

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

b) Payment

i) Eligible Tribal Providers will receive the All-Inclusive Rate (AIR), also referred to as the OMB rate, for applicate AIR services rendered at CIHA and using the CIHA Billing NPI. This rate is established annually, published annually in October and effective in January. The BH I/DD Tailored Plan shall honor the rate and schedule for implementation. Providers who have other fee schedules or settlement processes with BH I/DD Tailored Plan_shall continue to follow those arrangements.

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

    (1) Medical

    (2) Dental;

    (3) Behavioral; and,

    (4) One (1) other such as optical

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

        (a) High-cost drugs are excluded and are paid based on DHBs outpatient pharmacy 'lessor of logic'
        (b) If more than 2 drugs are filled, additional drugs beyond the 2 will be paid at $0 and should be used by the Tailored Plan for medication reconciliation.

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

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

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

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

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

            (ii) The Medicaid Fee-for-Service rate for services that do not have an applicable encounter rate.

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

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

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

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

c) Prompt Pay

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

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

(a) Medical Claims

(i) The BH I/DD Tailored Plan shall, within eighteen (18) calendar days of receiving a Medical claim, notify the provider whether the claim is Clean, or Pend the claim and request from the provider all additional information needed to timely process the claim.

(ii) The BH I/DD Tailored Plan shall pay or deny a Clean Medical Claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

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

(b) Pharmacy Claims

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

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

(c) Reserved.

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

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

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

(3) Claim Submission Timeframes:

Pursuant to N.C. Gen. Stat. § 58-3-225(f), the BH I/DD Tailored Plan may require that claims be submitted within three hundred sixty-five (365) Calendar Days after the date of the provision of care to the Member by the health care provider and, in the case of health care provider facility claims, within three hundred sixty-five (365) Calendar Days after the date of the Member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days . Unless otherwise agreed to by the BH I/DD Tailored Plan and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

(a) When a member is retroactively enrolled, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than three hundred and sixty-five (365) Calendar Days from the date of enrollment.

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

(4) Interest and Penalties

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

(b) Reserved.

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

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

(6) For purposes of actions which must be taken by a BH I/DD Tailored Plan as found in BH I/DD Tailored Plan Contract *Section V.H.1.d.,* Prompt Pay Standards, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

d) Other Payment Sources

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

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

e) Sovereignty

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

Attachment M. Policies

First 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:

Each Plan's individual table is being provided directly to that Plan and will be inserted prior to execution.

Service Name	Revenue/ Procedure Code	Approved	End Date (Glidepath only)	Description

First Revised and Restated Attachment M.13. Approved Alliance Health In Lieu of Services						
ILOS Service Name	**Revenue/ Procedure Code**	**Approved**	**End Date (Glidepath Only)**	**Description/ Definition**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
Child Assertive Community Treatment	H0040 U5 HA	ES		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.	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	Psychiatric Residential Treatment Facility (PRTF) Level III Group Home
Long Term Community Supports (LTCS)	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			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.	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. The scope of the service does not violate federal requirements prohibiting room and board.	Individuals with Intellectual Disabilities (ICF)
In-Home Therapy Services	H2022 HE U5 H2022 TS U5	ES		Children and adolescents in need of individual and family therapy services, parenting and coping strategies due to complex psychosocial situations and/or multisystem involvement.	Eligible population includes 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	Intensive In-Home Services (IIHS)

					and/or multisystem involvement.	
Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	ES		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.	Eligible population includes 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.	Residential Level II Family Type (TFC) Psychiatric Residential Treatment Facility (PRTF)
Transitional Youth Services (TYS)	H2022 U5	ES		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.	Eligible 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.	Residential Level II Family Type (TFC) Level III Residential Facility Services
Behavioral Health Crisis Assessment and Intervention (BHCAI)	T2016 U5 or T2016 U6	ES		BH CAI is designed to provide triage, crisis risk assessment, evaluation and intervention within a Behavioral Health Urgent Care (BHUC) setting.	Eligible population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards.	Inpatient Psychiatric Hospitalization Facility Based Crisis Behavioral Health Urgent Care (BHUC)
Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160	ES		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.	Eligible population includes Medicaid members with Mental Health (MH) and Substance Use Disorders (SUD) who require inpatient behavioral health treatment.	Emergency Depts Inpatient Psychiatric Hospitalization
High Fidelity Wraparound	H0032 - U5	ES		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered supportive service that provides coordinated,	Eligible population includes children, youth, and young adults with Serious Emotional Disturbance (SED) that	Residential Level II Family Type (TFC)

				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. For individuals with dual diagnoses, a case-by-case determination will be made related to appropriateness for HFW.	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).	Residential Treatment Services Level II Group Home
Short Term Residential Stabilization	T2016 TF U5	ES		Short Term Residential Stabilization (STRS) consists of a broad range of services for adults with developmental disabilities who, through the person-centered plan (PCP) process choose to access active habilitation services and supports to assist them with skill acquisition to live as independently as possible in the community. STRS is a community-based, comprehensive service for adults with intellectual and/or developmental disabilities (I/DD).	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. The scope of the service does not violate federal requirements prohibiting room and board.	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Facility Based Crisis
Residential Services for Individuals with Complex Needs for Children with IDD and co-occurring MH diagnosis	H0018 HA	ES		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	Eligible population includes Individuals 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	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Psychiatric Residential Treatment Facility (PRTF)

(Residential Services – Complex Needs)				diagnoses or significant behavioral characteristics.	challenges for which services and supports require significant experience and expertise in dual diagnosis. The scope of the service does not violate federal requirements prohibiting room and board.	

First Revised and Restated Attachment M.13. Approved Partners Health Management In Lieu of Services						
ILOS Service Name	**Revenue/ Procedure Code**	**Approved**	**End Date (Glidepath Only)**	**Description/ Definition**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
Long Term Community Supports (LTCS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5	ES		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)	Adults with intellectual and/or developmental disabilities who are potentially eligible for ICF-IID or Innovations Waiver supports per CCP 8E; age 18+ and out of school. 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.	Individuals Community and Residential (ICF-IDD)
Rapid Response	S9484 U5 (low), S9484 HK U5 (high)	ES		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, provide short term treatment, and prevent or minimize the need for out-of-home placements.	Target population includes youth are presenting in crisis but 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.	Emergency Department-Family Based Crisis (ED/FBC) Psychiatric Residential Treatment Facility (PRTF)
In-Home Therapy Services	H2022 HE U5 U1 H2022 HE U5 TS	ES		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	Target population includes children and adolescents in need of individual and family therapy services, as well as coordination of care	Intensive In-Home (IIHS)

				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.	due to complex psychosocial situations and/or multisystem involvement.	
Behavioral Health Urgent Care (BHUC)	T2016 U5	ES		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.	Target population includes MH, SUD, co-occurring MH/IDD and experiencing a behavioral health crisis that meets emergent or urgent triage standards.	Emergency Department Visit Inpatient Psychiatric Hospital Admission
Assertive Community Treatment Team –ACTT Youth-Youth	H0040 U5 HA	ES		Assertive Community Treatment (Youth ACTT) 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).	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.	Psychiatric Residential Treatment Facility
Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160	ES		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.	Target population includes members aged 21-64 enrolled in Medicaid with Mental Health (MH) or Substance Use Disorders (SUD) who require inpatient treatment	Inpatient Psychiatric Hospitalization
Rapid Care Services Children and Adults with Mental Illness and/or Substance Use Disorders	S9480 U5: Rapid Care Services Low S9480 HK U5: Rapid Care Services High	ES		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;	Target population includes an alternative to Emergency Room and Inpatient Psychiatric Hospitalization for eligible individuals who have a mental illness and/or substance use disorder diagnoses. The	Emergency Department Visit Inpatient Psychiatric Hospitalization

				response to any administered medication; or other treatment interventions to determine the ongoing treatment needs of the member.	scope of the service does not violate federal requirements prohibiting room and board.	
Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	ES		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 designed to promote permanency goals and to reduce length of stay in residential and/or PRTF facilities.	Target population includes Children and adolescents ages 3 up to 21 who may be facing involvement in the juvenile justice system, out-of-home placements, and/or reunification and may display emotional and behavioral challenges, often severe due to maltreatment (neglect, abuse), trauma (from domestic violence, sexual abuse, substance abuse, etc.), and/or serious mental health disorders	Intensive In-Home (IIH) Residential Treatment Level III
Individual Rehabilitation Coordination, & Support Services	H2017 U5	ES		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.	Target population includes individuals that received a comprehensive clinical assessment and has been diagnosed with serious and persistent mental illness.	Psychosocial Rehabilitation
High Fidelity Wraparound (HFW)	H0032 - U5	ES		High Fidelity Wraparound (HFW) is an intensive, team-based, person-centered service that provides coordinated, integrated, family-driven care to meet the complex needs of youth/young adults who are involved with multiple systems (e.g. mental health, physical health, child welfare, juvenile/criminal justice, and education), 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 any residential setting and/or are transitional age youth involved with Department of Social Services (DSS) and Juvenile Justice System.	Target population includes Youth with a primary mental health or substance use disorder diagnosis as defined by the DSM-5, or any subsequent editions of this reference material, may have a co- occurring diagnosis of intellectual and developmental disability. Or have a primary I/DD diagnosis as defined by DSM-5, or any subsequent editions of this reference material, and a co-occurring diagnosis of mental health or substance use disorder.	Psychiatric Residential Treatment Facility (PRTF) Residential Level III Placement

Young Adults in Transition	H2022 U5	ES		The Young Adults in Transition service is a home and community-based outpatient intervention that supports transition-age members (ages 16-24) with behavioral health diagnoses of mental health disorder, with or without a co-occurring substance use disorder, in reestablishing the knowledge and skills necessary to live independently.	Target population includes members ages 16-24 are eligible for this service when there is a mental health, 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 two instrumental Activity of Daily Living (IADL).	Residential Level II Family Type (TFC) and Rapid Response Intensive In-Home Services (IIHS)

First Revised and Restated Attachment M.13. Approved Trillium Health Resources In Lieu of Services						
ILOS Service Name	**Revenue/ Procedure Code**	**Approved**	**End Date (Glidepath Only)**	**Description/ Definition**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
Behavioral Health Crisis Assessment and Intervention (BH-CAI)	T2016 U5 or T2016 U6	ES		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.	Target population includes members experiencing a behavioral health crisis meeting Emergent or Urgent triage standards. The scope of the service does not violate federal requirements prohibiting room and board.	Emergency Departments
Family Centered Treatment (FCT)	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	ES		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.	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. The scope of the service does not violate federal requirements prohibiting room and board.	Intensive In-Home Services (IIHS) Psychiatric Residential Treatment Facility (PRTF)
Community Living Facilities and Support (CLFS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1	ES		Community Living Facilities and Supports (CLFS) consist of a broad range of services for adults with developmental disabilities who, through the Person Center Plan (PCP) process, choose to access active treatment to assist them with skills to live as	Target Population includes individuals in need of, and receiving, active treatment (AT) services. •Medicaid eligible	Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)-Community & Institutional

	T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5			independently as possible in the community.	•Meet NC GS 122c definition for Developmental Disability The scope of the service does not violate federal requirements prohibiting room and board.	
High Fidelity Wraparound (HFW)	H0032 - U5	ES	12/31/2023	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, 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.	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.	Level II Group Setting & Program Level II Family Setting & Program
Family Navigator	T2041 U5		12/31/2023	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.	Targeted Population includes Member diagnosed with intellectual/developmen tal disability or traumatic brain injury. Member is unable to access care as a result of challenges navigation complex systems.	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)
Acute and Subacute Services Provided in an	RC 0160			This service provides 24-hour access to continuous intensive evaluation and treatment delivered in an Institute for Mental Disease (IMD) as defined in CFR	Target population include Medicaid members with Mental Health (MH) and Substance Use Disorders	Emergency Departments Inpatient Hospital

Institute for Mental Disease				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 fifteen (15) days per calendar month in an IMD.	(SUD) who require inpatient behavioral health treatment.	

First Revised and Restated Attachment M.13. Approved Vaya Health In Lieu of Services						
ILOS Service Name	**Revenue/ Procedure Code**	**Approved**	**End Date (Glidepath Only)**	**Description/ Definition**	**Clinically Oriented Definition for Target Population(s) for ILOS Service**	**Covered Medicaid State Plan Service or Setting(s) Substituted**
Acute and Subacute Services Provided in an Institute for Mental Disease	RC 0160	ES	12/31/2023	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.	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.	Inpatient hospitalization Facility Based Crisis
Outpatient Plus	H2021 U5		12/31/2023	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.	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.	Intensive In-Home Community Support Team
Critical Time Intervention	H0032 U5 HK		12/31/2023	Critical Time Intervention (CTI) is an intensive 9-month case management model designed to assist adults ages 18 years and older with mental illness who are going through critical transitions, and who have functional impairments which preclude them from managing their transitional need adequately. For this definition,	Target Population includes individuals discharge from psychiatric inpatient settings, release from correctional settings, transition out of foster care settings into adult services, transition from	Community Support Assertive Community Treatment Team Emergency Department visits Inpatient Psychiatric Admission

				CTI defines a critical transition as occurring within no more than 45 days from the start of service.	homelessness in housing.	
Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)	T2016 U5 or T2016 U6	ES		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.	Targeted Population includes members experiencing a behavioral health crisis meeting emergent or urgent triage standards.	Emergency Department Inpatient Hospital
Family Centered Treatment	H2022 U5 U1 H2022 U5 U2 H2022 U5 U3 H2022 U5 U4	ES		Family Centered Treatment® (FCT) is an evidence-based practice designed to prevent out-of-home placements for children and adolescents. It is delivered by clinical staff trained and certified in FCT and promotes direct intervention with both the child and the family. Coordination and intervention also target other systems, such as schools, child welfare departments, the legal system, and primary care physicians. FCT includes the provision of crisis services.	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.	Residential Level II Program Type Residential Level III (1-4 beds)
Residential Services – Complex Needs	H0018 HA	ES		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.	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. The scope of the service does not violate federal requirements prohibiting room and board.	Psychiatric Residential Treatment Facility (PRTF) Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)

Rapid Care Services	S9480 U5 Rapid Care Services Low S9480 HK U5 Rapid Care Services High	ES		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. This includes observation in a secure, medically staffed and psychiatrically monitored setting as an alternative to the community hospital/ emergency department (ED).	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. The scope of the service does not violate federal requirements prohibiting room and board.	Emergency Department Inpatient Hospital
High Fidelity Wrap -around	H0032U5	ES		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	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.	Residential Level II
In-Home Therapy Services	H2022 HE U5 H2022 TS U5	ES		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.	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,	Intensive In-Home

					coordinated clinical interventions; evidence of problems in at least two major life domains that are significantly affecting the member's behavioral health needs.	
Enhanced Crisis Response (ECR)	H2011 U5 U1 weekly unit	ES		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.	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.	Emergency Department Inpatient Hospitalization
Long-Term Community Supports (LTCS)	T2016 U5 U1 through U5 U4 and U5-U6 T2016 U5 U1 – Level 1 T2016 U5 U2 – Level 2 T2016 U5 U3 – Level 3 T2016 U5 U4 – Level 4 T2016 U5 U6 – Level 5	ES		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).	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. The scope of the service does not violate federal	Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF-IID)

					requirements prohibiting room and board.	
Child- Focused Assertive Community Treatment	H0040 U5 HA	ES		Child-Focused Assertive Community Treatment (Child ACT) is a team-based, multi-disciplinary 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).	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.	Psychiatric Residential Treatment Facility (PRTF)
Transitional Youth Services	H2022 U5	ES		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.	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.	Level II Family Type, Therapeutic Foster Care Residential Level II Program Type Residential Level III
Assertive Community Treatment Step Down (ACT SD)	H0040 U5		12/31/2023	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.	Target Population includes beneficiaries with severe and persistent mental illness (SPMI) who have been participating in ACT services for at least six months.	Assertive Community Treatment (ACT)

First Revised and Restated Attachment M. 14. COVID-19 Public Health Emergency Managed Care Policy Sunset Effective October 1, 2024

The Department's goal in implementing Medicaid Managed Care is to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which purchases health while addressing both medical and non-medical drivers of health. During the ongoing response to the Coronavirus-19 (COVID-19) pandemic, it is critical that the Department work with Contractor to institute efforts to keep Members healthy by taking steps to protect Members from infectious disease providing access to testing, treatment and vaccine administration for COVID-19, ensuring care for ongoing chronic or acute conditions, and supporting Members and providers through the Public Health Emergency Unwinding.

1. Member materials
   i. Within forty-five (45) Business Days of execution of this Amendment, the BH I/DD Tailored Plan shall begin including inserts in the Member Welcome Packet and handbooks that address COVID-19 and the COVID-19 Federal Public Health Emergency Unwinding (PHE Unwinding).
      a. The inserts must include links to Federal and State guidance and resources, including information on the PHE and impact of the PHE unwinding on Medicaid eligibility.
      b. The BH I/DD Tailored Plan may distribute COVID-19 inserts to Members without prior approval from the Department, however, the BH I/DD Tailored Plan shall make changes to the inserts as requested by the Department after initial distribution.
   ii. The BH I/DD Tailored Plan may include informational materials on COVID-19 when sending other member communications, including but not limited to explanations of benefits and communications for appeals and grievances.
   iii. No later than January 1, 2023, the BH I/DD Tailored Plan shall make available within two clicks of the homepage of its member website information regarding changes to benefits, eligibility, and enrollment during the term of this Amendment.
      a. The BH I/DD Tailored Plan shall include within one click of the homepage information on what Members should do if they are experiencing symptoms of COVID-19.
      b. The BH I/DD Tailored Plan shall include link(s) on its member website to the State website on the COVID-19 response and the PHE Unwinding.
   iv. No later than January 1, 2023, the BH I/DD Tailored Plan shall update member smartphone apps to include information on benefit, eligibility and enrollment changes during the term of this Amendment, what the Member should do if they experience symptoms of COVID-19, and links to the State website on the COVID-19 response and the PHE Unwinding.
   v. All updates to Member materials will be subject to language and accessibility requirements in *Section V.B.1.iii* of the Contract.
   vi. The Department reserves the right to review and request changes to the BH I/DD Tailored Plan's COVID-19 updates to any required member materials or marketing materials defined in the Contract.

2. Advisory Committees

The BH I/DD Tailored Plan shall consult with its CFAC and LTSS Member Advisory Committee on the BH I/DD Tailored Plan's response to COVID-19 and the PHE Unwinding.

3. Call Centers
   i. No later than January 1, 2023, the BH I/DD Tailored Plan shall ensure all call center staff are aware of and are prepared to answer Member questions related to changes in eligibility, enrollment, benefits and provider networks related to COVID-19 and the PHE Unwinding.
   ii. The BH I/DD Tailored Plan shall ensure Member services call center nurse staff line and behavioral health crisis line staff:
      a. Are aware of and can direct Members to further information on statewide programs and initiatives related to COVID-19, best practices for limiting disease spread, testing sites, vaccine administration, and policy changes stemming from COVID-19 and the PHE Unwinding;
      b. Are able to refer Members to housing specialists, as needed;
      c. Are able to assist Members in finding providers offering telehealth and other virtual care;
      d. Are able to inform Members of resources to meet unmet health-related resource needs, such as food, housing and transportation, and direct Members to additional information on these resources; and
      e. Are able to link to Member's Tailored Care Manager, as applicable.
   iii. The BH I/DD Tailored Plan shall ensure nurse staff lines are aware of and can refer Members to guidance for prevention, symptom monitoring, and testing, as well as refer members to other State resources related to the COVID-19 response.
   iv. The BH I/DD Tailored Plan shall update call center scripts to include the information required in this Section and submit to the Department as defined in the Contract.

4. Benefits
   a. The BH I/DD Tailored Plan shall cover COVID-19 testing according to guidance issued by the Department.
   b. During the COVID-19 Public Health Emergency, the BH I/DD Tailored Plan shall cover the testing, treatment, and vaccine administration for COVID-19 and comply with cost-sharing requirements as defined in the Department's approved CMS waivers, state plan amendments, and concurrence letters related to COVID-19.
   c. After the end of the COVID-19 Public Health Emergency, the Department reserves the right to require the BH I/DD Tailored Plan's to cover the testing, treatment, and vaccine administration for COVID-19 without cost-sharing for members.

5. Population Health
   i. No later than March 1, 2023, the BH I/DD Tailored Plan shall conduct outreach to Members under 18 years of age to encourage routine immunization and provide information on how to safely access routine immunizations.
   ii. The BH I/DD Tailored Plan shall develop and implement new health education programs to educate Members about symptoms, prevention guidance, and treatment for COVID-19.

6. Provider Communications

i. The BH I/DD Tailored Plan shall post through appropriate channels provider-focused guidance developed by the Department in response to COVID-19 including changes to eligibility, benefits, new Federal and State flexibilities, payment processes, how to comply with Federal and/or State guidance and the PHE unwinding,

7. Provider Payments
   i. The BH I/DD Tailored Plan shall update providers reimbursements, consistent with rate floor requirements, to reflect Department defined COVID-19 related fee schedule changes as defined in the Contract.

For providers without a rate floor requirement, the BH I/DD Tailored Plan shall adjust negotiated provider reimbursement rates by an amount no less than the associated dollar change in the fee schedule made by the Department in the fee-for-service program in response to COVID-19.

Second Revised and Restated Attachment N. Addendum for Division of State Operated Healthcare Facilities

1. **Background**
   The Division of State Operated Healthcare Facilities (DSOHF) operates state-owned healthcare facilities that treat adults and children with mental illness, SUDs and I/DDs.[1] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework. The BH I/DD Tailored Plan shall execute a single standardized contract with DSOHF for all levels and types of services provided or offered by the state-owned facilities operated by DSOHF, using a contract template developed by the Department that covers all facilities and encompasses the required regulations.

2. **Scope**
   The provisions of this Addendum address the requirements related to admissions, authorization of services, event reporting, grievances and appeals pertaining to services provided by DSOHF facilities that must be included and reflected in the contract between the BH I/DD Tailored Plan and DSOHF facilities*.*

3. **Admissions.**
   When admitting a member or recipient to a DSOHF facility, the BH I/DD Tailored Plan must comply with applicable laws, program requirements, and applicable policies and protocols established by the Department for the facility as set forth below:
   a. Psychiatric Hospitals and Alcohol and Drug Abuse Treatment Centers (ADATCs):
      i. The community provider (e.g., BH community provider or hospital/emergency department) shall complete and referral via the Department's bed registry electronic referral system or submit a Regional Referral Form to DSOHF until electronic referral is available. The Regional Referral Form is located on the Department's website2 as defined in *Section III.A. Definitions* to the DSOHF facility.
      ii. The BH I/DD Tailored Plan must review the admission based on review of the information provided in the Regional Referral Form or bed registry electronic referral.
      iii. In cases where the member or recipient presents directly to a psychiatric hospital or ADATC for admission, the BH I/DD Tailored Plan shall comply with applicable provisions of EMTALA and other applicable laws (Section 1867(a) of the Social Security Act) related to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care provided to an individual who is determined to be stable by a medical screening examination.
      iv. The BH I/DD Tailored Plan shall ensure that a BH I/DD Tailored Plan-employed utilization management staff member is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year for discussions with the DSOHF facility's staff regarding admissions, prior to the issuance of the referral and throughout the admission;
      v. For members or recipients subject to involuntary commitment proceedings, the BH I/DD Tailored Plan must provide information or a representative who can assist the district

[1] DSOHF facilities serve a distinct patient population and operate within a distinct regulatory and operational framework.

court in determining if the member requires continued services. If the BH I/DD Tailored Plan elects to send a representative to appear in court, the representative may be a community provider or other designated provider (e.g., contracted BH provider, hospital or emergency department representative) as determined by the BH I/DD Tailored Plan.

vi. For members who have multiple disorders and medical fragility or have multiple disorders and deafness, the BH I/DD Tailored Plan shall be designated by the Department to determine whether members have a high level of disability that alternative care is inappropriate, consistent with N.C.G.S. 122C-261(e)(4).

vii. In determining whether Members and Recipients are eligible for referral and/or authorization for admission to a State psychiatric hospital, the BH I/DD Tailored Plan must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.

b. State Developmental Centers:

i. The BH I/DD Tailored Plan must exhaust all options for community care and supports before it refers a member or recipient to a State Developmental Center.

ii. When a BH I/DD Tailored Plan refers a member or recipient to a State Developmental Center, the BH I/DD Tailored Plan must submit an application packet, inclusive of a letter of endorsement, to the State Developmental Center Admission/Discharge Coordinator;

iii. The BH I/DD Tailored Plan must comply with the DSOHF admission criteria and protocols; and

iv. The BH I/DD Tailored Plan must ensure timely execution of the Memorandum of Agreement (MOA)[3] with the member's or recipient's guardian regarding the member's discharge plan.

4. Authorization

The BH I/DD Tailored Plan must authorize benefits provided by DSOHF facilities in accordance with the relevant Medicaid and State-funded clinical coverage policies as detailed in *Section V.B.2.i.(v) Utilization Management* and *Section V.C.2.a.vii. Utilization Management*, respectively, as well as the specific requirements listed below.

a. General Requirements for State Psychiatric Hospitals and ADATCs:

i. Emergency Services:

A. The BH I/DD Tailored Plan must cover emergency medical services provided by the DSOHF facility without regard to prior authorization.

B. The BH I/DD Tailored Plan cannot refuse to cover emergency services based upon the DSOHF facility failing to notify the member's or recipient's PCP or BH I/DD Tailored Plan of the individual's screening and treatment following presentation for emergency services.

ii. Inpatient Services:

A. The BH I/DD Tailored Plan must issue a decision to approve or deny the inpatient service within seventy-two (72) hours after it receives the request for services,

[3] The MOA is a formal agreement made between the State Developmental Center, legally responsible person/guardian, and the BH I/DD Tailored Plan identifying the responsibilities of all parties in supporting the individual to return to their home or community setting within the identified length of admission as specified in the MOA.

provided that the deadline may be extended for one additional business day if: (i) the individual or DSOHF facility requests the extension; and (ii) the BH I/DD Tailored Plan justifies to the DSOHF facility a need for additional information and how the extension is in the member's or recipient's interest.

B. The BH I/DD Tailored Plan must authorize an admission authorization for a minimum of ten (10) days for inpatient psychiatric services and for a minimum of seven (7) days for ADATC services.

C. Following initial admission authorization, the BH I/DD Tailored Plan must review and evaluate for possible re-authorization at an interval of every fifteen (15) days for inpatient psychiatric and every seven (7) days for ADATC services.

D. To request re-authorization, the psychiatric hospital or ADATC shall submit the electronic re-authorization for continued stay request to the BH I/DD Tailored Plan prior to the expiration of the prior authorization no later than the last covered day of the existing authorization, or the previous business day if the last covered day occurs on a weekend or holiday.

E. The BH I/DD Tailored Plan must issue an authorization decision and notify the psychiatric hospital or ADATC within seventy-two (72) hours after receipt of the re-authorization request.

b. Requirements for Assessment and Stabilization

i. The BH I/DD Tailored Plan shall be responsible for payment to the psychiatric hospital or ADATC for assessment and stabilization of members or recipients who are admitted and treated pursuant to the involuntary commitment statutes in Chapter 122C of the North Carolina General Statutes, or who present at the facility directly for emergency medical services and are admitted for stabilization subject to requirements of EMTALA (Section 1867(a) of the Social Security Act).

ii. The BH I/DD Tailored Plan must identify an appropriate discharge plan for all such members or recipients beginning at admission.

c. Requirements for State Developmental Centers:

i. Initial authorization:

A. Prior to admission to a State Developmental Center, the BH I/DD Tailored Plan shall complete the ICF-IID level of care determination form (Level of Care Form) including obtaining the physician signature and send a copy to the facility's reimbursement office to complete the authorization to bill Medicaid.

B. If authorization is not received from the BH I/DD Tailored Plan by the time of admission to a State Developmental Center, the BH I/DD Tailored Plan shall promptly provide retrospective authorization after:

- The State Developmental Center sends the EAR to the BH I/DD Tailored Plan; and
- The State Developmental Center receives the Level of Care Form from the BH I/DD Tailored Plan, completes it and submits it to the BH I/DD Tailored Plan

ii. Re-authorization:

A. To reauthorize services in a State Developmental Center, the facility must send a completed Level of Care Form, Person Centered Plan (PCP) if it has been updated since the previous authorization, and psychological evaluation to the BH I/DD Tailored Plan prior to the expiration of the initial authorization.

B. Upon receipt of the required documentation, the BH I/DD Tailored Plan must approve or deny the request in accordance with the standard timeframes for service authorization requests. Authorization shall be for at least 180 days from the date of the physician signature on the Level of Care Form.

iii. Facility-based respite services for members enrolled in the Innovations waiver:

A. The BH I/DD Tailored Plan shall issue prior authorization for Respite Facility Based services provided at a State Developmental Center prior to a member's admission.

5. Member and Recipient Grievances

a. The DSOHF facility and the Department will manage and resolve all member or recipient clinical concerns, or grievances related to the clinical services provided, in accordance with applicable North Carolina law governing Department facility grievance procedures and reports (including but not limited to, 10A NCAC 28B.0203 through .0205) and other applicable laws, in accordance with grievance procedures established by the Department.

b. The BH I/DD Tailored Plan must agree that DSOHF facilities shall refer any unresolved patient grievances to the Secretary of the Department. The DSOHF facility will have in place a written policy for a complaint and grievance Process and procedures for review and disposition of patient Grievances, which shall include making available to patients the BH I/DD Tailored Plan Hotline number for reporting any grievances.

6. Event Reporting and Abuse/Neglect/Exploitation.

a. The BH I/DD Tailored Plan must agree that the Department and the North Carolina Quality Center Patient Safety Organization (PSO) oversee and manage any abuse, neglect, exploitation allegations and incidents pertaining to members or recipients receiving services provided by DSOHF (collectively, individual safety events/allegations) in accordance with the federal Patient Safety and Quality Improvement Act of 2005.

b. The BH I/DD Tailored Plan must agree to maintain the confidential and privileged framework for management of individual safety events/allegations with the PSO.

c. The DSOHF facility will cooperate with the BH I/DD Tailored Plan's written request for information regarding any individual safety events/allegations involving members or recipients to the extent required by applicable laws and permitted under the Patient Safety Act and Rules, including but not limited to providing the BH I/DD Tailored Plan with any RL6 incident report logs that are not subject to PSO privilege and confidentiality, within three (3) Business Days after receipt of the BH I/DD Tailored Plan's request.

d. The BH I/DD Tailored Plan shall have the right to conduct its own investigation of any events reported to determine whether any claims were paid in error or to ensure compliance with practice guidelines by the facility. The BH I/DD Tailored Plan shall provide the DSOHF a written summary of its finding within thirty (30) days. (Note: During such an investigation, if any issues are cited as out of compliance with applicable laws, the DSOHF facility may be required to document and implement a plan of correction.)

Third 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. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	A. Administration and Management	
1.	Failure to meet plan Readiness Review deadlines as set by the Department.	$2,500 per Calendar Day
2.	Failure to comply with conflict of interest requirements described in *Section III.D.15.* ***DISCLOSURE OF CONFLICTS OF INTERESTS*** and *Section V.A.1.ix.(xiii) Conflicts of Interest.*	$5,000 per occurrence
3.	Failure to timely provide litigation and criminal conviction disclosures as required by *Section III.D.16.* ***DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION****.*	$500 per Calendar Day
4.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.D.17.* ***DISCLOSURE OF OWNERSHIP INTEREST****.*	$1,250 per contractor/subcontractor disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a contractor/subcontractor that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 C.F.R. part 455, subpart B.
5.	Failure to perform necessary oversight of Subcontractors as described in *Section III.D.46* ***SUBCONTRACTORS****.*	Up to $25,000 per occurrence
	B. Members	
1.	Engaging in prohibited marketing activities or discriminatory practices or failure to market in an entire Region as prescribed in *Section V.B.1.iv. Marketing.*	$2,500 per occurrence
2.	Failure to comply with Member enrollment and disenrollment processing timeframes as described in *Section V.B.1.i.(v) Medicaid Managed Care Enrollment and Disenrollment.*	$250 per occurrence per Member
3.	Reserved.	

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to establish or maintain required consumer and stakeholder advisory groups and engage with these groups as described in *Section V.B.1.iii.(xvi) Engagement with Consumers, Section V.B.1.c.xvii. Engagement with Beneficiaries Utilizing Long Term Services and Supports, and Section V.B.1.iii.(xviii) Engagement with Innovations and TBI Waiver Members.*	Up to $25,000 per occurrence
5.	Failure to comply with Member notice requirements for denials, reductions, terminations, or suspensions of services within the timeframes specified in *Section V.B.1.vi. Member Grievances and Appeals.*	$250 per occurrence
6.	Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department.	$2,500 per occurrence
7.	Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable North Carolina or federal law, and all court orders governing appeal procedures as they become effective as described in *Section V.B.1.vi. Member Grievances and Appeals.*	The value of the reduced or terminated services as determined by Department for the timeframe specified by the Department. AND $500 per Calendar Day for each day the BH I/DD Tailored Plan fails to provide continuation or restoration as required by Department.
8.	Failure to attend mediations and hearings as scheduled as specified in *Section V.B.1.vi. Member Grievances and Appeals.*	$500 for each mediation or hearing that BH I/DD Tailored Plan fails to attend as required
9.	Failure to comply with Transition of Care requirements as specified *Section V.B.1.ii. Transition of Care.*	$50 per Calendar Day, per Member AND The value of the services the BH I/DD Tailored Plan failed to cover 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	$250 per occurrence.

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	Hours of the timestamp on the Department's communication or (2) standard State Fair Hearing requests, including failure to upload any documentation reviewed by the BH I/DD Tailored Plan in connection with the internal plan appeal within the requirements in *Section III.D. 38.* ***RESPONSE TO STATE INQUIRIES AND REQUEST FOR INFORMATION.***	
	C. Benefits	
1.	Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on a member as prohibited under the Contract or not in accordance with an approved policy.	$2,500 per occurrence per Member
2.	Failure to confer a timely response to a service authorization request in accordance with 42 C.F.R. § 438.210(d) as specified *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package and V.B.2.iii. Pharmacy Benefits.*	$2,500 per standard authorization request $3,750 per expedited authorization request
3.	Failure to allow a member to obtain a second medical opinion at no expense and regardless of whether the provider is a network provider as specified *Section V.B.4.i. Provider Network.*	$500 per occurrence
4.	Failure to follow Department required Clinical Coverage Policies as specified *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package.*	$1,250 per occurrence
5.	Failure to timely update pharmacy reimbursement schedules as required by as specified *Section V.B.2.iii. Pharmacy Benefits.*	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $1,250 per Calendar Day per occurrence
6.	Failure to ensure that a member receives the appropriate means of transportation as specified in 42 C.F.R. § 440.170 and as specified *Section V.B.2.iv. Non-Emergency Transportation.*	$250 per occurrence per Member
7.	Failure to comply with driver requirements as defined in the Department's NEMT Policy.	$750 per occurrence per driver
8.	Failure to comply with the assessment and scheduling requirements as defined in the Department's NEMT Policy.	$125 per occurrence per Member
9.	Failure to comply with vehicle requirements as defined in the Department's NEMT Policy.	$750 per calendar day per vehicle
10.	Reserved.	

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	D. Care Management	
1.	Failure to timely develop and furnish to the Department its Care Management and Care Coordination Policy as required by *Section V.B.3.ii. Tailored Care Management.*	$125 per Calendar Day
2.	Failure to develop a care management comprehensive assessment, Care Plan, or ISP for a member that includes all required elements as described in *Section V.B.3.ii. Tailored Care Management* (including a failure by an AMH+ practice, CMA, or CIN or other partner to comply).	$250 per deficient/missing care management comprehensive assessment or plan
3.	Reserved.	
4.	Reserved.	
5.	Failure to notify the Department within 14 days that the BH I/DD Tailored Plan determined that an AMH+ or CMA is not meeting Tailored Care Management requirements as set forth in *Section V.B.3.ii.(xix) Oversight.*	$250 per Calendar Day
6.	Failure to meet annual requirements established by the Department for the percentage of Members actively assigned to a Provider-based Care Management as set forth in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*. (Effective July 1, 2024).	Up to $50,000 per percentage below the requirement each calendar year
7.	Failure to comply with federal conflict-free case management requirements for members enrolled in the Innovations or TBI waiver	$250 per occurrence per Member
8.	Failure to timely notify the Department of a notice of underperformance sent to an LHD or the termination of a contract with an LHD.	$250 per Calendar Day
9.	Failure to implement and maintain an Opioid Misuse Prevention and Treatment Program and Member Lock-In Program as *described in Section V.B.3.i. Prevention and Population Health Programs.*	Beginning at BH I/DD Tailored Plan Launch: $1,000 per occurrence for Opioid Misuse and Prevention and Treatment Program Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $1,000 per occurrence for Member Lock-in Program
10.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to prevent authorization of duplicative services offered under Healthy Opportunities Pilot and the BH I/DD	$50 per identified instance of duplicated service delivery AND

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	Tailored Plan in at least ninety-five percent (95%) of Pilot service authorizations, as required in *Section V.B.3.x. Healthy Opportunities*.	Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service that was duplicated for each identified instance of duplication
11.	*For BH I/DD Tailored Plans operating in Healthy Opportunities Pilot Regions:* Failure to use BH I/DD Tailored Plan capitation to cover member's benefits prior to use of Healthy Opportunities Pilot program funds or as otherwise required in *Section V.B.3.x. Healthy Opportunities*.	$125 per occurrence AND Refund of the BH I/DD Tailored Plan's Pilot program budget for total amount spent on Pilot service in each identified instance
	E. Providers	
1.	Failure to update online and printed provider directory with accurate provider information as required by *Section V.B.4.ii. Provider Network Management.*	$500 per confirmed incident
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan's provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the affected Members within the timeframes required by *Section V.B.4.ii. Provider Network Management.*	$50 per calendar day per Member for failure to timely notify the affected Member or Department
3.	Reserved.	
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.B.4.i. Provider Network*.	$2,500 per Calendar Day
5.	Failure to ensure that covered services are provided within the timely access, distance, and wait-time standards as described in *Section V.B.4.i. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$1,250 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a BH I/DD Tailored Plan Network Data File that meets the Department's specifications.	$125 per Calendar Day
7.	Reserved.	
8.	Failure to remove Providers that are not actively enrolled in NC Medicaid from the BH I/DD Tailored Plan PHP Network File within one (1) Business Day as specified in *Section V.B.4. Provider Network Management.*	$50 per provider per Business Day.

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
9.	Failure to submit a successfully processed full Provider Network File (PNF) to the Department, or to its designated vendor, within the timeframe specified in *Section V.D.K.5. Technical Specifications.*	$500 per occurrence
	F. Quality and Value	
1.	Failure to submit all required quality measures including audited HEDIS results within the timeframes specified in *Section V.B.5.a. Quality Management and Quality Improvement.*	$2,500 per Calendar Day
2.	Failure to timely submit appropriate PIPs to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$500 per Calendar Day
3.	Failure to timely submit QAPI to the Department as described in *Section V.B.5.i. Quality Management and Quality Improvement.*	$500 per Calendar Day
4.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in *Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.*	$50,000 per month for every month beyond the month NCQA accreditation must be obtained until such time as the BH I/DD Tailored Plan is terminated in accordance with *Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Association.*
	G. Claims and Encounter Management	
1.	Failure to timely submit monthly encounter data set certification.	$500 per Calendar Day
	H. Financial Requirements	
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day
2.	Failure to timely submit complete and accurate cost allocation plan to the Department as described in *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day
3.	Failure to timely and accurately submit the Medical Loss Ratio Report in accordance with the timeframe described in *Section V.B.7.ii. Medical Loss Ratio* and *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
4.	Failure to timely and accurately submit financial reports in accordance with *Section VII. Third Revised and Restated Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$500 per Calendar Day
	I. Compliance	
1.	Failure to establish and maintain a Special Investigative Unit as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services.*	$2,500 per Calendar Day that Department determines BH I/DD Tailored Plan is not in compliance
2.	Failure to timely submit on an annual basis the Compliance Program report as described in *Section V.K.1. Compliance Program* and *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day
3.	Failure to timely submit the Recoveries from Third Party Resources Report described in *Section V.A.3.iv. Third Party Liability (TPL) for Medicaid* and *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$125 per Calendar Day
4.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$1,250 per incident for failure to fully cooperate during an investigation
5.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan's own conduct, a provider, or a member.	$125 per Calendar Day
6.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services* and *Section VII. Third Revised and Restated Attachment J. Reporting Requirements.*	$1,000 per Calendar Day

Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	J. Technical Specifications	
1.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$250 per Member per occurrence
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of Member PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$250 per occurrence
3.	Failure by the BH I/DD Tailored Plan to timely report a HIPAA breach or a security incident or timely provide Members a notification of breach or notification of provisional breach.	$250 per Member per occurrence, not to exceed $5,000,000
	K. Directives and Deliverables	
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$250 per Calendar Day
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

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
Section VII. Third Revised and Restated Attachment P: Table 1: Liquidated Damages for Medicaid (Effective July 1, 2024)		
6.	Engaging in gross customer abuse of Members by Contractor service line agents as prohibited by *Section V.A.2.(xxiv) Gross Customer Abuse.*	$1,000 per occurrence
7.	Failure to timely report incidents of gross customer abuse to the Department in accordance with *Section V.A.2.(xxiv) Gross Customer Abuse.*	$250 per Business Day the Contractor fails to timely report to Department.
8.	Failure to upload Notices of Adverse Benefit Determination and Notices of Resolution to the Appeals Clearinghouse within the specified timeframes for upload of notices.	$250 per occurrence.

No.	PROGRAM COMPLIANCE ISSUE	LIQUIDATED DAMAGE
Section VII. Third Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2024)		
	A. Administration and Management	
1.	Failure to comply with conflict of interest requirements described in *Section III.D.15.* ***DISCLOSURE OF CONFLICTS OF INTERESTS*** *and Section V.A.1.ix.(xiii) CONFLICT OF INTEREST*.	$2,500 per occurrence
2.	Failure to timely provide conflict of interest or criminal conviction disclosures as required by *Section III.D.15.* ***DISCLOSURE OF CONFLICTS OF INTERESTS*** and *Section III.D.16.* ***DISCLOSURE OF LITIGATION AND CRIMINAL CONVICTION OR ADVERSE FINANCIAL CONDITION.***	$250 per Calendar Day
3.	Failure to require and ensure compliance with ownership and disclosure requirements as required in *Section III.D.17* ***DISCLOSURE OF OWNERSHIP.***	$625 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements.
4.	Failure to perform necessary oversight of Subcontractors as described in *Section III.D.46.* ***SUBCONTRACTORS.***	Up to $12,500 per occurrence
	B. Providers	
1.	Failure to update online and printed provider directory as required by *Section V.C.4.b. Provider Network Management.*	$250 per confirmed incident
2.	Failure to report notice of provider termination from participation in the BH I/DD Tailored Plan's provider network (includes terminations initiated by the provider or by the BH I/DD Tailored Plan) to the Department or to the	$50 per Calendar Day per recipient for failure to timely notify the affected recipient or Department

Section VII. Third Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	affected recipients within the timeframes required by *Section V.C.4.b. Provider Network Management.*	
3.	Reserved.	
4.	Failure to submit timely initial and updated, compliant Network Access Plan as described in *Section V.C.4.a. Provider Network*	$500 per Calendar Day
5.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in *Section V.C.4.a. Provider Network* (excludes Department approved exceptions to the network adequacy standards).	$625 per month for failure to meet any of the listed standards, either individually or in combination
6.	Failure to timely submit a PIHP Network Data File that meets the Department's specifications.	$125 per Calendar Day
7.	Reserved.	
	C. Claims Management	
1.	Reserved.	
D. Financial Requirements		
1.	Failure to timely submit complete and accurate unaudited and audited annual financial statements to the Department as described in *Section VII. Second Revised and Restated Attachment J. Reporting Requirements.*	$500 per Calendar Day
2.	Failure to timely and accurately submit monthly financial reports in accordance with *Section VII. Second Revised and Restated Attachment J. Reporting Requirements* or comply with any other ad-hoc request for financial reporting as directed by the Department.	$250 per Calendar Day
	E. Compliance	
1.	Failure to cooperate fully with the Department and/or any other North Carolina or federal agency during an investigation of fraud or abuse, complaint, or grievance.	$625 per incident for failure to fully cooperate during an investigation
2.	Failure to timely report, or report all required information, for any credible allegation or confirmed instance of fraud or abuse relating to the BH I/DD Tailored Plan's own conduct, a provider, or a recipient.	$125 per Calendar Day
3.	Failure to timely submit a Fraud Prevention Plan or the Fraud Prevention Report that includes all required components as described in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded*	$500 per Calendar Day

Section VII. Third Revised and Restated Attachment P: Table 2: Liquidated Damages for State-funded Services (Effective July 1, 2024)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
	Services and *Section VII. Third Revised and Restated Attachment J. Reporting Requirements*.	
F.	**Technical Specifications**	
1.	Failure by the BH I/DD Tailored Plan to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of the Department Member's PHI.	$125 per recipient per occurrence
2.	Failure by the BH I/DD Tailored Plan to execute the appropriate agreements to effectuate transfer and exchange of recipient PHI confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party pursuant to the Contract.	$125 per recipient per occurrence
3.	Failure by the BH I/DD Tailored Plan to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$125 per recipient per occurrence, not to exceed $2,500,000
G.	**Directives and Deliverables**	
1.	Failure to respond to or comply with any formal written requests for information or a directive made by the Department within the timeframe provided by the Department.	$125 per Calendar Day that Department determines BH I/DD Tailored Plan is not in compliance
2.	Failure to establish or participate on any committee as required under the Contract, by the Department, or pursuant to North Carolina or federal law or regulation.	$250 per occurrence per committee
3.	Failure to obtain approval of any agreements or materials requiring review and approval by the Department prior to distribution as specified in the Contract.	$125 per Calendar Day the unapproved agreement or materials are in use
4.	Failure to implement and maintain a plan or program as required under the Contract (e.g. prevention and population health management programs, drug utilization review program).	$5,000 per occurrence per plan or program
5.	Failure to provide a timely and acceptable corrective action plan or comply with a CAP as required by the Department.	$125 per Calendar Day for each day the CAP is late, or for each day the BH I/DD Tailored Plan fails to comply with an approved corrective action

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

Section VII. Second Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Service Line Outage	There shall be no more than five (5) consecutive minutes of unscheduled time in which any of the service lines are unable to accept incoming calls.	The number of consecutive minutes a service line is unable to accept new incoming calls.	Monthly	$5,000 per service line per month
2.	Call Response Time/Call Answer Timeliness – Member and Recipient Service Line	The BH I/DD Tailored Plan shall answer at least eighty-five percent (85%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
3.	Call Wait/Hold Times – Member and Recipient Service Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes or abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Section VII. Second Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
4.	Call Abandonment Rate – Member and Recipient Service Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
5.	Call Wait/Hold Times – Behavioral Health Crisis Line	The BH I/DD Tailored Plan shall answer at least ninety-eight percent (98%) of calls within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$15,000 per month
6.	Call Abandonment Rate – Behavioral Health Crisis Line	The abandonment call rate shall not exceed two percent (2%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$15,000 per month
7.	Call Response Time/Call Answer Timeliness – Provider Support Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds or abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$5,000 per month
8.	Call Wait/Hold Times – Provider Support Line	The BH I/DD Tailored Plan PHP shall answer at least ninety-five percent (95%) of calls	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	Monthly	$5,000 per month

Section VII. Second Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
		within three (3) minutes.	service line during the measurement period.		
9.	Call Abandonment Rate – Provider Support Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice divided by the total number of calls received by the service line during open hours of operation.	Monthly	$5,000 per month
10.	Provider Welcome Packet Timeliness	The BH I/DD Tailored Plan shall meet or exceed ninety-eight percent (98%) of Provider Welcome Packets mailed within the timeframes specified in Section *V.B.4. iii Provider Relations and Engagement*.	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 *Applies if the BH I/DD Tailored Plan utilizes separate mailings*	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 Members enrolled in the BH I/DD Tailored Plan during the measurement period.	Monthly	98.99% - 95%: $2,500 per month 94.99% - 80%: $3,750 per month 79.99% or less: $5,000 per month

Section VII. Second Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
	to send components of the Welcome Packet	cards) mailed within the timeframes specified in *V.B.1.iii. Member Engagement.*			
12.	Member Welcome Packet Timeliness – Single Mailing of Entire Welcome Packet *Applies if the BH I/DD Tailored Plan utilizes a single mailing to send all components of the Welcome Packet (welcome letter, Member handbook, and identification card)*	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. Member Engagement*.	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	Monthly	99.25%-99.49% = $7,500 per month 99.01%-99.24% = $10,000 per month

Section VII. Second Revised and Restated Attachment P: Table 3: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid and State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
			trips approved by the BH I/DD Tailored Plan. *NEMT trips for hospital discharges will not be included in determining compliance with this SLA.*		99% or less = $12,500 per month

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

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
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. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Member Grievance Resolution	The BH I/DD Tailored Plan shall resolve at least ninety-eight percent (98%) of member grievances within the specified timeframes.	The number of grievances with notices of resolution issued by the BH I/DD Tailored Plan within the required timeframe of the filing date of the grievance divided by the total number of grievances filed during the measurement period.	Monthly	96.00% - 97.99% = $1,750 per month 95.99% or less = $2,500 per month
C.	**Pharmacy Benefits**				
1.	Adherence to the Preferred Drug List	The BH I/DD Tailored Plan shall maintain at least a ninety-five percent (95%) compliance rate with the Medicaid PDL.	The number of pharmacy claims for drugs listed as preferred on the Medicaid PDL divided by the total number of pharmacy claims for drugs listed as preferred and non-preferred on the Medicaid PDL.	Quarterly	$50,000 per quarter
D. Care Management					
1.	Contracting with AMH+ and CMAs	The BH I/DD Tailored Plan shall contract with one hundred percent (100%) of the certified and willing AMH+ practices and CMAs located in its Region, except for the exceptions cited in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*.	In each Region, the number of providers certified by the Department as AMH+ practices and CMAs contracted by the BH I/DD Tailored Plan divided by the total number of certified and willing AMH+ practices and CMAs.	Monthly	$25,000 per month
E.	**In-Reach and Diversion**				
1.	Reserved.				

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
F.	**Service Lines**				
1.	Call Response Time/Call Answer Timeliness – Nurse Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds of being queued to an agent and abandoned within thirty (30) seconds of being queued to an agent divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
2.	Call Wait/Hold Times - Nurse Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
3.	Call Abandonment Rate – Nurse Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation.	Monthly	$10,000 per month
4.	Call Response Time/Call Answer Timeliness - Pharmacy Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
5.	Call Wait/Hold Times - Pharmacy Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month
6.	Call Abandonment Rate – Pharmacy Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $10,000 per month
7.	Call Response Time/Call Answer Timeliness - NEMT Member Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
8.	Call Wait/Hold Times - NEMT Member Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
9.	Call Abandonment Rate – NEMT Member Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
10.	Call Response Time/Call Answer Timeliness - NEMT Provider Line	At least eighty-five percent (85%) of calls shall be answered within thirty (30) seconds.	The number of incoming calls answered by a live operator within thirty (30) seconds and abandoned within thirty (30) seconds divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
11.	Call Wait/Hold Times - NEMT Provider Line	The BH I/DD Tailored Plan shall answer at least ninety-five percent (95%) of calls within three (3) minutes.	The number of incoming calls answered by a live operator within three (3) minutes and abandoned within three (3) minutes divided by the total number of calls received by the service line during the measurement period.	Monthly	$10,000 per month
12.	Call Abandonment Rate – NEMT Provider Line	The abandonment call rate shall not exceed five percent (5%).	The number of calls disconnected by the caller or the system before being answered by a live voice (excluding calls disconnected by the caller in less than 10 seconds) divided by the total number of calls received by the service line during open hours of operation during the measurement period.	Monthly	$10,000 per month
13.	Reserved.				

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
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 encounte rs 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. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
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. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
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. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
19.	Encounter Data Reconciliation—Pharmacy	The encounters submitted by the BH I/DD Tailored Plan shall reconcile to at least ninety-eight percent (98%) of paid claims amounts reported on financial reports within sixty (60) Calendar Days or at least ninety-nine percent (99%) of paid claim amounts reported on financial reports within one hundred twenty (120) Calendar Days.	The paid amounts on submitted individual encounter records compared to the paid claims amounts reported on financial reports submitted to the Department by the BH I/DD Tailored Plan.	Monthly	Beginning at BH I/DD Tailored Plan Pharmacy POS Launch: $5,000 per month
G. Website Functionality					
1.	Website User Accessibility	The BH I/DD Tailored Plan's website shall be accessible to users twenty-four (24) hours per day, seven (7) days per week, except for Department approved, pre-announced downtime due to system upgrades or routine maintenance.	Any occurrence during which the website is not accessible, except for those occurrences that have been Department approved and pre-announced.	Daily	$2,500 per occurrence
2.	Website Response Rate	The response rate shall not exceed five (5) seconds ninety-nine percent (99%) of the time.	The elapsed time between the command to view by the user and the response appears or loads to completion.	Monthly	$2,500 per month

Section VII. Third Revised and Restated Attachment P: Table 4: Performance Metrics, Service Level Agreements and Liquidated Damages for Medicaid (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
3.	Timely response to electronic inquiries	The BH I/DD Tailored Plan shall respond to ninety-nine and one-half percent (99.5%) of electronic inquiries within three (3) Business Days of receipt.	Electronic inquires include communications received via email, fax, web or other communications received electronically by the BH I/DD Tailored Plan (excludes communications and other correspondence with response timelines specified in the Contract).	Monthly	$100 per occurrence
4.	Access to Primary/ Preventive Care for Individuals under NC Innovations waiver	Ninety percent (90%) of Innovations waiver beneficiaries will have a primary care or preventative health service	The percentage of Medicaid enrollees continuously enrolled for the 12-month contract period under the 1915(c) NC Innovations waiver (ages 3 and older) who received at least one service under the NC Innovations waiver during the measurement period who also received a primary care or preventative health service. For Innovations Waiver beneficiaries three (3) to six (6) years of age and twenty (20) years of age and older, the person received a primary care or preventative health service during the measurement period. For Innovations Waiver beneficiaries seven (7) to nineteen (19) years of age, the person received a primary care or preventative health service during the previous two measurement periods.	Annually	$50,000 per year

Section VII. Third Revised and Restated Attachment P. Table 5: Performance Metrics, Service Level Agreements and Liquidated Damages for State-funded Services (Effective July 1, 2024)					
No.	**Measure**	**Performance Standard**	**Definition**	**Measurement Period**	**Liquidated Damage**
1.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility Based Crisis Services for Mental Health Treatment	Forty percent (40%) or more of individuals discharged during the measurement quarter shall receive a follow-up visit within one to seven (1-7) Calendar Days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven (1-7) Calendar Days of discharge.	Quarterly	$50,000 per quarter
2.	Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for Substance Use Disorder Treatment	40% or more of individuals discharged during the measurement quarter shall receive a follow-up visit within one to seven (1-7) Calendar Days after discharge.	The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use treatment in a community-based hospital, state psychiatric hospital, state ADATC, or detox/facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven (1-7) Calendar Days after discharge.	Quarterly	$50,000 per quarter

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Section VII. Third Revised and Restated Attachment P. Table 6: Liquidated Damages for Healthy Opportunities Pilot (Applies to Plans participating in the Pilot)		
No.	**PROGRAM COMPLIANCE ISSUE**	**LIQUIDATED DAMAGE**
1.	Reserved.	
2.	Failure to use NCCARE360 for the Healthy Opportunities Pilot-related functionalities in accordance with the requirements.	$250 per Calendar Day that the Department determines the BH I/DD Tailored Plan is not in compliance
3.	Failure to authorize or deny Pilot services for Members within the Department's required authorization timeframes.	$250 per Calendar Day
4.	Failure to pay Pilot invoices to HSOs within the Department's required payment timeframes.	$250 per Calendar Day per HSO
5.	Failure to comply with the following provisions enumerated in *Healthy Opportunities Pilot Interpersonal Violence (IPV)-Related Services: Conditions, Requirements, and Standards* of to protect the safety, privacy, and confidentiality of Healthy Opportunities Pilot Members who have IPV-related needs: • Ensure that BH I/DD Tailored Plan workforce and care managers with Healthy Opportunities Pilot responsibilities complete IPV-Related Data Training before accessing IPV-Related Service Data; • Receive Department approval on Member-facing materials targeting individuals who may be, or are currently, experiencing IPV before distributing the materials; and • Ensure that Care Managers with Healthy Opportunities Pilot responsibilities receive and complete relevant trainings, each as provided or approved in advance by the Department, prior to such Care Manager initiating a Member contact or an initial Pilot assessment.	$250 per occurrence

Attachment U: Annual Housing Expectations

The TCL Settlement Agreement (SA) specified the number of individuals expected to transition into the community within five population categories. The Department devised an annual transition expectation method to fairly distribute the numbers required to meet substantial compliance. As of the fifth SA extension, 600 more individuals must transition into community-based permanent supportive housing through TCL by June 30, 2025. The BH I/DD Tailored Plan's transition expectation apportioning method equally divides the first half of 600 expected transitions. The second half of the 600 transitions is apportioned to each BH I/DD Tailored Plan based upon each BH I/DD Tailored Plan's percentage of Medicaid covered lives and local need. Quarterly Department monitoring keeps pace with each BH I/DD Tailored Plan to both ensure transition expectation progress, and early identification of transition barriers.

Section VII. Attachment U. Table 1: Annual Housing Expectations*

BH I/DD Tailored Plan	Percentage of the population to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during SFY 23/24	Number of individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan based upon equal division of half of the number of individuals to be transitioned during SFY 23/24	Number of individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan based upon the proportionate population to be served during SFY 23/24	Total number of individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during SFY 23/24	Quarterly Number of Individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during Quarters 3 and 4 of SFY 23/24
Alliance Health	34%	50	102	152	38
Partners Health Management	15%	50	45	95	24
Trillium Health Resources	15%	50	45	95	24
Vaya Health	18%	50	54	104	26
Total	82%	200	246	446	112

*Population based on pre and post BH I/DD Tailored Plan launch for four (4) LME/MCOs post consolidation.

Section VII. Attachment U. Table 2: Annual Housing Expectations SFY 24/25					
BH I/DD Tailored Plan	**Percentage of the population to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during SFY 24/25**	**Number of individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan based upon equal division of half of the number of individuals to be transitioned during SFY 24/25**	**Number of individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan based upon the proportionate population to be served during SFY 24/25**	**Total number of Individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during SFY 24/25**	**Quarterly Number of Individuals to be transitioned to community based supportive housing by the BH I/DD Tailored Plan during SFY 24/25**
Alliance Health	26%	75	78	153	38
Partners Health Management	20%	75	45	120	30
Trillium Health Resources	36%	75	108	183	45
Vaya Health	18%	75	33	108	27
Total	100%	300	300*	600*	150*

* 36 housing slots are reserved and will be allocated to BH I/DD Tailored Plans based upon local need