

Request for Application 30-2020-052-DHB BH I/DD Tailored Plan

Section V. Scope of Services, A - B

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V. Scope of Services

A. Unified

1. Administration and Management
 - i. Medicaid Program and State-funded Services Administration
 - (i) In the State of North Carolina, the Department is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance and the single state authority for the SAMHSA Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant. The Division of Health Benefits (DHB) is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for both the Medicaid and NC Health Choice programs. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is designated with the administration of State-funded mental health, developmental disability, TBI and substance use services.
 - (ii) In addition to the Department's oversight, CMS also monitors North Carolina's Medicaid Managed Care activities through its Regional Office in Atlanta, Georgia and its Center for Medicaid, CHIP and Survey & Certification, Division of Integrated Health Systems in Baltimore, Maryland and SAMHSA monitors North Carolina's block grant-funded activities.
 - (iii) The Department has the authority to administer the program in the way outlined in this RFA under the terms of the State's waiver under Section 1115 of the Social Security Act and various Medicaid State Plan Amendments.
 - (iv) During the term of the Contract, and in future years, the Department will modify its Medicaid and NC Health Choice Programs, and its State-funded BH, I/DD and TBI services system, including Medicaid Managed Care and the supporting technical and operational infrastructure, to conform with Federal and State requirements or Department policies and goals. Modifications may be communicated through State Plan Amendments, Waiver amendments, and/or administrative memos and bulletins issued by the Department. The BH I/DD Tailored Plan is obligated to review such memos and bulletins to assist in staying informed of program changes.
 - (v) The Department will remain responsible for all aspects of the North Carolina Medicaid, NC Health Choice programs and State-funded Services system, and will delegate the direct management of certain health services, including physical health, BH, I/DD, pharmacy, LTSS, and TBI services, and financial risks to the BH I/DD Tailored Plan as defined in the Contract. Certain functions delegated to the BH I/DD Tailored Plan pursuant to this Contract are the duty and responsibility of the Department as the grantee of federal grant funds. Nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Department to perform any of the duties assigned to the Department or its Secretary by the North Carolina General Statutes, the terms and conditions of the federal funds and their applicable laws and regulations or other federal laws and regulations regarding any federal funding which is used by the BH I/DD Tailored Plan to reimburse the BH I/DD Tailored Plan for any of its duties under this Contract. The BH I/DD Tailored Plan will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the BH I/DD Tailored Plan has an adequate Network, delivers high quality care, and operates a successful Medicaid Managed Care program and State-funded Services system.

- (vi) The BH I/DD Tailored Plan shall work cooperatively with the Department to be good stewards of Department funds, and Department personnel time, and to ensure effective administration of the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.
 - (vii) In partnership with the Department, the BH I/DD Tailored Plan shall develop processes and procedures to ensure the BH I/DD Tailored Plan is soliciting stakeholder input, including, but not limited to, input from members and recipients, as applicable, and providers, to drive policy development and continual improvement in the Medicaid Managed Care program and State-funded BH, I/DD and TBI services.
 - (viii) The BH I/DD Tailored Plan shall provide certification concurrently with the submission of all data, documentation, or information required under federal and state law and under this Contract to the Department. For Medicaid Managed Care, the BH I/DD Tailored Plan shall provide such certification in accordance with 42 C.F.R. § 438.606.
 - (ix) The BH I/DD Tailored Plan shall cooperate with the Department in the administration of North Carolina's federal Medicaid waivers (e.g., Section 1115, 1915(c), and other active waivers) including providing reporting and data, engaging with the Department's External Evaluators, and supporting waiver-required stakeholder engagement.
 - (x) The BH I/DD Tailored Plan shall comply with the following Department policies, as may be amended from time to time, and any other Department policy as directed:
 - (a) North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy;
 - (b) Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members;
 - (c) AMH+ Practice and CMA Certification Policy;
 - (d) Pregnancy Management Program Policy for Medicaid and NC Health Choice Members;
 - (e) Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members;
 - (f) Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members;
 - (g) Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice and State-funded Providers;
 - (h) Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members;
 - (i) Behavioral Health Service Classifications for Appointment Wait Time and Routine, Urgent and Emergent Care Standards for Medicaid and NC Health Choice Members and State-funded Recipients Policy;
 - (j) NC Medicaid Managed Care NEMT Policy; and
 - (k) Tribal Payment Policy.
 - (xi) When reasonable, under these unified provisions, State-funded Services for which federal regulations do not apply, Contract reference to such regulation sets a requirement standard for State-funded services that must be met by the Contractor regardless of regulatory applicability.
- ii. Entity Requirements for Medicaid and State-funded Services
- (i) Operational Authority & Licensure
 - (a) A BH I/DD Tailored Plan operating a contract with the Department for the provision of Medicaid Managed Care and State-funded BH, I/DD and TBI services must be a local political subdivision of the State and operate as a LME/MCO, as that term is defined in N.C. Gen. Stat. § 122C-3(20c), at the time of application and as required by the Contract.
 - (b) Contingent on a change in state law, the BH I/DD Tailored Plan must, at least ninety days (90) before the end of Contract Year 3, be licensed as a Prepaid Health Plan (PHP) set forth by the North Carolina Department of Insurance (DOI), as outlined in Article 93 of Chapter 58 of the N.C. General Statutes.
 - (1) A PHP license is not required as a condition of award.
 - (2) At the discretion of the Department, failure to obtain a license shall result in termination of the Contract between the BH I/DD Tailored Plan and the Department.

- (3) Upon request by the Department, the BH I/DD Tailored Plan shall share with the Department any information related to its Medicaid business that was provided to the DOI.
 - (4) Upon obtaining a PHP license and upon request by the Department, the BH I/DD Tailored Plan shall share with the Department a copy of the license and any information related to its State-funded BH, I/DD, and TBI services business that was provided to the DOI.
- (ii) BH I/DD Tailored Plan Governance and Operations for Medicaid and State-funded Services
- (a) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, compensation, and maintenance of the entity's governing board, which governs all aspects of BH I/DD Tailored Plan operations, including both Medicaid and State-funded Services
 - (b) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the composition, meeting schedule, training, and support of the Consumer and Family Advisory Committee (CFAC), which advises all aspects of BH I/DD Tailored Plan operations, including both Medicaid and State-funded Services.
 - (c) The BH I/DD Tailored Plan shall comply with applicable provisions of Chapter 122C of the General Statutes regarding the establishment and maintenance of any other required advisory boards, including both Medicaid and State-funded Services.
- (iii) BH I/DD Tailored Plan Operating Plan
- (a) The Department seeks the most qualified BH I/DD Tailored Plans to serve within the North Carolina Medicaid Managed Care program and to manage State-funded BH, I/DD and TBI services with whom the Department may entrust the care of its members and recipients.
 - (b) The BH I/DD Tailored Plan shall develop and maintain an up-to-date BH I/DD Tailored Plan Operating Plan that details the role(s), responsibilities, function(s), and qualifications of each entity involved in core Medicaid and State-funded Services operations of the legal entity holding the Contract with the Department to provide Medicaid Managed Care and State-funded Services.
 - (1) Core Medicaid and State-funded operations include:
 - i. Managing Medicaid Managed Care member lives including Member services and the administration of clinical benefits and services;
 - ii. Managing member and recipient services, including utilization management and the administration of clinical benefits and services;
 - iii. Managing the provider network;
 - iv. Performing care management and care coordination functions;
 - v. Performing quality management and data reporting;
 - vi. Processing and paying claims;
 - vii. Managing single stream funding and other non-Medicaid funds for State-funded Services; and
 - viii. Assuming risk through a capitated contract for Medicaid.
 - (2) Entities included in the Operating Plan shall include Subcontractors, business partners, and any other entities involved in core Medicaid and State-funded operations.
 - (3) The BH I/DD Tailored Plan Operating Plan shall:
 - i. Identify each entity by corporate or other legal entity name, address, and telephone number;
 - ii. Describe generally the roles, responsibilities and functions that the entity performs;
 - iii. Describe the BH I/DD Tailored Plan's legal or contractual relationship with each entity;
 - iv. Describe how the BH I/DD tailored Plan trains vendor staff; and

- v. Describe how the BH I/DD Tailored Plan manages and oversees each entity and ensures compliance with the standards described in the Contract.
 - (4) For Department review and approval, after the first year and annually thereafter provide a Delegation report for each core Medicaid operations entity and State-funded Services, including evidence of the BH I/DD Tailored Plan's oversight activities, and describing entity performance including key operating priorities, key metrics, corrective actions taken, and sanctions.
 - (5) The BH I/DD Tailored Plan shall respond to any additional requests for information pursuant to this subsection as directed by the Department.
 - (c) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Operating Plan to the Department for review and approval:
 - (1) Within thirty (30) days after Contract Award;
 - (2) Annually, on June 30 of the calendar year; and
 - (3) Within three (3) Business Days after request from the Department.
 - (d) The BH I/DD Tailored Plan must provide written notice to the Department within ten (10) Business Days of any material changes to the BH I/DD Tailored Plan Operating Plan.
 - (1) Such written notice must provide information about the level of experience and qualifications of any entities with new roles, responsibilities, or functions under the Plan.
 - (2) At the Department's discretion, the BH I/DD Tailored Plan will be subject to a reevaluation and Readiness Review prior to approval of the amended BH I/DD Tailored Plan Operating Plan.
 - (3) The BH I/DD Tailored Plan may be responsible for any cost to the Department of such review.
 - (e) The BH I/DD Tailored Plan shall provide the information necessary in response to any additional requests for information pursuant to this subsection as directed by the Department.
- iii. National Committee for Quality Assurance (NCQA) Accreditation
 - (i) The BH I/DD Tailored Plan shall achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3.
 - (a) The BH I/DD Tailored Plan shall submit accreditation information to the Department, including:
 - (1) Accreditation status;
 - (2) Accreditation level;
 - (3) Accreditation survey type, if applicable;
 - (4) Accreditation results (corrective action plans, summaries of findings), if applicable; and
 - (5) Accreditation expiration date.
 - (ii) The BH I/DD Tailored Plan shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO.
- iv. Third Party (Subcontractor) Contractual Relationships
 - (i) The BH I/DD Tailored Plan shall contract with a PHP.
 - (a) Consistent with N.C. Gen. Stat. § 108D-60(5), LME/MCOs operating a BH I/DD Tailored Plan must contract with "an entity that holds a PHP license and that covers the services required to be covered under a Standard Benefit Plan contract." These contracts will be subject to the contractual requirements outlined in this section.
 - (b) The BH I/DD Tailored Plan shall meaningfully leverage PHP expertise to support and strengthen BH I/DD Tailored Plan capabilities to ensure readiness and ability to manage all applicable aspects of the Contract.
 - (c) Consistent with *Section V.A.1.ii Entity Requirements for Medicaid and State-funded Services*, the BH I/DD Tailored Plan Operating Plan must detail the role(s), responsibilities, function(s), and qualifications of any PHP involved in core Medicaid and State-funded Services operations.

- (ii) The BH I/DD Tailored Plan must demonstrate its ability to manage Subcontractors and ensure integrated approaches to plan operations and member or recipient's care, as applicable. Accordingly, the BH I/DD Tailored Plan shall comply with the following operational requirements:
 - (a) The BH I/DD Tailored Plan must ensure that care managers delivering the Tailored Care Management model coordinate across a member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy, and unmet-health related resource needs. See *Section V.B.3.ii. Tailored Care Management* for more information on the Tailored Care Management model.
 - (b) The BH I/DD Tailored Plan must provide a single phone line for member- and recipient-facing services, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement. See applicable requirements throughout *Section V.B. Medicaid* and *Section V.C. State-funded Services* for more information on requirements for operational services.
 - (c) The BH I/DD Tailored Plan must provide a single phone line for provider-facing services, including utilization management, claims payments, provider relations, and provider-facing plan operations, noting that phone lines may route callers based on service selected from a larger menu of services. Separate phone lines for emergency services are exempt from this requirement. The BH I/DD Tailored Plan is encouraged to implement other provider-facing operational solutions to align processes across service types and reduce the administrative burden on providers. Such solutions may include, but are not limited to, provider contracting. See applicable requirements in *Section V.B.4. Providers*, *Section V.B.6. Claims and Encounter Management*, and elsewhere throughout *Section V.B. Medicaid* and *Section V.C. State-funded Services* for more information on other operational services.
 - (d) The utilization management process must support an integrated, holistic look at a member's physical health, BH, I/DD, TBI, pharmacy, and LTSS needs, noting that standard utilization protocols or guidelines may not be appropriate in light of a member's complete clinical and other support needs. See *Section V.B.2.i.(v) Utilization Management* for more information.
 - (e) The Medicaid member appeals processes must follow Department policy and must be centralized, regardless of service type. See *Section V.B.1.vi. Member Grievances and Appeals* for more information.
 - (f) The State-funded Services recipient appeals processes must be centralized, regardless of service type. See *Section V.C.1.e. Recipient Complaints and Appeals* for more information.
 - (g) The BH I/DD Tailored Plan is required to have a single Medicaid and NC Health Choice Provider Network directory, encompassing all providers regardless of service type, available in both electronic and paper versions. See *Section V.B.4.ii. Provider Network Management* and *Section V.B.8.v. Provider Directory* for more information.
- (iii) The BH I/DD Tailored Plan shall comply with the following financial requirements for all third party subcontracting contracts:
 - (a) A BH I/DD Tailored Plan and Subcontractor may not split physical and BH risk or savings in a way that is inconsistent with integrated care.
 - (1) A BH I/DD Tailored Plan and Subcontractor may not segregate risk based on type of service or percent of premium allocated to service type. For example, a BH I/DD Tailored Plan may not enter a contract with a PHP that sub-capitates all physical health services and holds the PHP accountable for the risk associated with those services.
 - (2) Limited scope sub-capitation arrangements (e.g., for primary care services or bundled payments) are permitted.
 - (b) A BH I/DD Tailored Plan and subcontractor may enter a contract under which the two plans share savings from reduced medical expenditures, however:

- (1) Any savings must be shared across the total cost of care of both physical and behavioral health (including I/DD and TBI services); and
 - (2) Physical and behavioral health cannot be divided into separate budgets.
- v. Implementation for BH I/DD Tailored Plan Services
- (i) The BH I/DD Tailored Plan shall have a fully assembled implementation team ready to begin work immediately following Contract Award. The team shall include an implementation manager and separate implementation resources for, at a minimum, the following workstreams:
 - (a) Administration & Management;
 - (b) Members and Recipients;
 - (c) Benefits and Services (including contact for transition of care and utilization management);
 - (d) Care Management;
 - (e) Providers;
 - (f) Quality and Value;
 - (g) Stakeholder Engagement & Community Partnerships;
 - (h) Program Operations;
 - (i) Claims and Encounter Management;
 - (j) Financial Requirements;
 - (k) Compliance; and
 - (l) Technological Specifications.
 - (ii) Additional resources to support the implementation of all workstreams identified as part of the services and requirements of the Contract shall be added to the implementation team no later than twenty (20) Calendar Days after the Contract Award unless an exception has been made by the Department in writing.
 - (iii) The BH I/DD Tailored Plan shall be responsible for developing business requirements documents, implementation plan and test plans for each workstream. The Department shall review and approve these documents.
 - (iv) The BH I/DD Tailored Plan shall provide to the Department an updated, draft implementation plan fourteen (14) Calendar Days after Contract Award that defines the tasks necessary to develop the following capabilities or milestones for Medicaid and State-funded Services as applicable:
 - (a) Network development, including provider education, training and contracting;
 - (b) Member and recipient engagement, including educational materials, welcome and enrollment materials, and community outreach;
 - (c) Service line operations;
 - (d) Utilization management development and implementation;
 - (e) Care and case management program development and implementation;
 - (f) PCP assignment;
 - (g) Transition of Care data exchange;
 - (h) Quality management infrastructure;
 - (i) Member, recipient and provider enrollment systems;
 - (j) Claims and encounter systems;
 - (k) Required system interfaces;
 - (l) Design, development, and testing activities; and
 - (m) Other administrative supports.
 - (v) To support Medicaid Managed Care and State-funded Services implementation and operations, the BH I/DD Tailored Plan shall perform the following testing and technology operations:
 - (a) Software Delivery Life Cycle (SDLC) Testing, defined as Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable.

- (b) End-to-End Testing, defined as interface integration to verify that the application works end to end as per the solution, utilizing the State defined scripts and Test Management Tool for tracking and reporting.
 - (c) Production defect resolution and testing of production incidents.
 - (vi) The Department maintains the discretion to require the BH I/DD Tailored Plan to establish additional implementation teams, plans and testing requirements, including distinct environments to support testing and implementation, on an ongoing basis as new program requirements are implemented or prior to the BH I/DD Tailored Plan effectuating, for example, a material program, operational or technical change.
- vi. Readiness Review Requirements
- (i) The Department is committed to ensuring the BH I/DD Tailored Plan is prepared and able to serve as a good administrator of Medicaid Managed Care and State-funded BH, I/DD and TBI services. The Department will engage in a thorough Readiness Review of the following functions immediately after Contract Award through at least the first six (6) months, or a different period as determined by the Department and shall include all areas identified in 42 C.F.R. § 438.66 and others to be identified by the Department.
 - (ii) The Department and its partners will conduct a Readiness Review to verify the BH I/DD Tailored Plan, its staff, providers, Subcontractors and other individuals and organizations are prepared to provide Medicaid Managed Care and State-funded BH, I/DD and TBI services on behalf of the Department, consistent with the terms of the Contract and at the Department's discretion.
 - (iii) The BH I/DD Tailored Plan shall demonstrate to the Department's satisfaction that it is able to meet the requirements of the Contract through a Readiness Review; the Department may require multiple rounds of Review.
 - (a) The BH I/DD Tailored Plan shall participate in Readiness Review(s) conducted by the Department to review the BH I/DD Tailored Plan's readiness to begin and sustain operations throughout the term of the Contract.
 - (1) The requirements covered within the Readiness Review shall be determined by the Department and communicated to the BH I/DD Tailored Plan at least fifteen (15) Calendar Days prior to the Readiness Review.
 - (2) The Department may determine, at its discretion, the frequency and intensity of the Readiness Review requirements and may tailor the particular Readiness Review to a specific issue or BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan must meet these Readiness Review requirements and Contract requirements in the time frame specified by the Department.
 - (b) Readiness Reviews must include, but are not limited to, onsite reviews, desktop reviews, policy reviews, financial reviews, system demonstrations, staff interviews and self-audit evaluations.
 - (c) Readiness Reviews will also consider the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* to the degree a Subcontractor relationship applies.
 - (iv) The Department maintains the discretion to conduct Readiness Reviews on an ongoing basis as new program requirements are implemented or prior to the BH I/DD Tailored Plan effectuating, for example, a material program, operational or technical change.
 - (v) Readiness Reviews are different and distinct from program integrity, program audits, quality reviews, routine oversight or other compliance activities which the Department may initiate at its own discretion consistent with this Contract.
 - (vi) Based upon results of the Readiness Review(s), the Department reserves the right to:
 - (a) Offer acceptance to allow the BH I/DD Tailored Plan to commence full operations;
 - (b) Offer conditional acceptance to allow the BH I/DD Tailored Plan to commence operations if the BH I/DD Tailored Plan is found not to meet certain requirements of the Readiness Review(s), so long as the BH I/DD Tailored Plan develops and executes a Department-approved corrective

- action plan describing how it will meet Readiness Review criteria within the timeframe specified by the Department;
- (c) Offer limited acceptance to limit the BH I/DD Tailored Plan's level of participation in Medicaid Managed Care and State-funded BH, I/DD and TBI services based on the results of the Readiness Review and any resulting corrective action plans;
 - (d) Determine a remedy consistent with the terms of this RFA, including corrective action, liquidated damages or sanctions up to and including removal of key personnel; or
 - (e) Terminate this Contract in accordance with the termination provisions of the Contract.
- (vii) Prior to allowing a BH I/DD Tailored Plan to be assigned Medicaid Managed Care members or to manage State-funded Services for recipients under this Contract, the BH I/DD Tailored Plan shall demonstrate compliance with the Department's solvency requirements specified in *Section V.B.7.iii.(vii) Financial Viability* and *Section V.C.7.i. Financial Viability*. If the BH I/DD Tailored Plan uses the services of a TPA, the TPA shall be licensed no later than ninety (90) Calendar Days after Contract Award.
- (viii) As part of Readiness Review, the BH I/DD Tailored Plan shall submit to the Department all required reports for approval prior to commencing operations or performing services according to the terms of this Contract.
- (ix) The BH I/DD Tailored Plan shall submit to the Department all policies and procedures that require review and/or approval or as requested by the Department within this RFA and defined in the Contract.
- vii. Non-discrimination for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall comply with all applicable federal and North Carolina laws and existing regulations, guidelines, and standards, or those that may be lawfully adopted pursuant to the statutes, prohibiting discrimination, including, but not limited to the following:
 - (a) Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color, or national origin;
 - (b) Title VII of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, religion, sex, sexual orientation, gender identify and national origin;
 - (c) Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap;
 - (d) Title IX of the Education Amendments of 1972, as amended, 20 U.S.C. 1681 et seq., which prohibits discrimination on the basis of sex;
 - (e) The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age;
 - (f) Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs;
 - (g) The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities;
 - (h) Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities;
 - (i) The North Carolina Equal Employment Practices Act, Article 49A of Chapter 143 of the General Statutes, which prohibits employment discrimination on the basis of race, religion, color, national origin, age, sex or handicap by employers which regularly employ fifteen (15) or more employees;
 - (j) The North Carolina Persons with Disabilities Protection Act, Chapter 168A of the General Statutes, which prohibits disability discrimination;

- (k) The North Carolina Retaliatory Employment Discrimination Act, Article 21 of Chapter 95 of the General Statutes, which prohibits employer retaliation against employees who in good faith take or threaten to take protected action under the law; and
- (l) Abide by the non-discrimination provisions in North Carolina Executive Order 24 dated October 18, 2017 by maintaining or implementing employment policies that prohibit discrimination by reason of race, color, ethnicity, national origin, age, disability, sex, pregnancy, religion, National Guard or Veteran's status, sexual orientation, and gender identity or expression.
- (ii) The BH I/DD Tailored Plan shall not discriminate against members, recipients, providers, or employees in the provision of services or administration of the program.
- (iii) The BH I/DD Tailored Plan shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services. 42 C.F.R. § 438.3(d)(3)
- (iv) The BH I/DD Tailored Plan shall develop and adhere to a written Non-discrimination Policy specifying the prohibition against discrimination.
 - (a) At a minimum, the Non-Discrimination Policy shall include:
 - (1) The definition of discrimination under federal law and regulation, as amended;
 - (2) How the BH I/DD Tailored Plan will collaborate with all of the Department's thirteen (13) divisions to identify resources and address the needs of individuals with disabilities (example: Division of Services for the Deaf and Hard of Hearing);
 - (3) How the BH I/DD Tailored Plan's policy will apply to clinical, marketing, and care management programs offered to members and recipients;
 - (4) The BH I/DD Tailored Plan's internal complaint process for members, recipients, and employees including liquidated damages;
 - (5) The legal recourse, investigative, and complaint process available for members and recipients through the Department and for employees through the U.S. Equal Employee Opportunity Commission and the North Carolina Human Relations Commission; and
 - (6) Instructions on how to contact the Department, the U.S. Equal Employee Opportunity Commission, and the North Carolina Human Relations Commission.
 - (b) The BH I/DD Tailored Plan shall make the Non-discrimination Policy available for Department review, upon request.
 - (c) The BH I/DD Tailored Plan shall make updates to its Non-discrimination Policy as necessary, and, at a minimum, the BH I/DD Tailored Plan shall review its Non-discrimination Policy for updates annually.
 - (d) The BH I/DD Tailored Plan shall make the Non-discrimination Policy available to members, recipients, and employees of the BH I/DD Tailored Plan.
- viii. Advance Directives for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall comply with all state and federal laws and regulations related to Advance Directives (including advance instructions for mental health treatment), including Article 23 of Chapter 90 of the General Statutes and Part 2 of Article 3 of Chapter 122C of the General Statutes.
 - (ii) The BH I/DD Tailored Plan shall maintain and implement written policies and procedures on Advance Directives for all adult members and recipients receiving care arranged by the BH I/DD Tailored Plan. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(a)-(b), and 489.102(a); Part 2 of Article 3 of Chapter 122C of the General Statutes.
 - (iii) The BH I/DD Tailored Plan shall reflect changes in State law in its written Advance Directives information as soon as possible, but no later than ninety (90) days after the effective date of the change. 42 C.F.R. § 438.3(j)(4)
 - (iv) The BH I/DD Tailored Plan shall be prohibited from conditioning the provision of care or otherwise discriminating against a member based on whether or not the member or recipient has executed an Advance Directive. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(F), and 489.102(a)(3).

- (v) The BH I/DD Tailored Plan shall educate staff concerning their policies and procedures on Advance Directives. 42 C.F.R. §§ 438.3(j)(1)-(2), 422.128(b)(1)(ii)(H), and 489.102(a)(5).
- (vi) The BH I/DD Tailored Plan shall provide adult members and recipients with written information on Advance Directives (including advance instructions for mental health treatment), including the following:
 - (a) Member and recipient rights under State law;
 - (b) BH I/DD Tailored Plan policies with respect to the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives;
 - (c) Information on the advance directive policies of the BH I/DD Tailored Plan;
 - (d) Each member's and recipient's right to file a Grievance with the State Certification and Survey Agency for fully licensed services and the BH I/DD Tailored Plan for unlicensed services concerning any alleged noncompliance with the advance directive law. Each member or recipient has the right to file a Grievance with other applicable agencies such as Disability Rights North Carolina, licensing boards, etc.; and
 - (e) Option to register his or her Advance Directive with the Secretary of State's Office so the Advance Directive can be available to medical professionals.
- ix. Staffing and Facilities for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall have in place sufficient administrative personnel and an organizational structure to comply with all requirements described in this Contract. The BH I/DD Tailored Plan shall provide qualified persons in numbers appropriate to the BH I/DD Tailored Plan's size of enrollment and consistent with the requirements to successfully operate the BH I/DD Tailored Plan for Medicaid Managed Care and State-funded Services.
 - (ii) Unless otherwise specified, the BH I/DD Tailored Plan may combine or split the listed responsibilities across Medicaid and State-funded Services populations and among the BH I/DD Tailored Plan's personnel if the BH I/DD Tailored Plan demonstrates that the responsibilities are being met and that someone is accountable on behalf of the plan. Similarly, the BH I/DD Tailored Plan may contract with a third-party (subcontractor) to perform one or more of these responsibilities as outlined in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*. In a format to be specified by the Department, the BH I/DD Tailored Plan shall identify proportion of responsibilities across Medicaid and State-funded Services fulfilled by key personnel to allow for appropriate cost allocation across Medicaid and State-funded Services.
 - (iii) The BH I/DD Tailored Plan shall be responsible for screening all employees and subcontractors to ensure these individuals have not been excluded from participation in Federal health care programs, prior to employment or contract.
 - (a) The BH I/DD Tailored Plan shall not employ or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610 (a) and (b)].
 - (iv) Key BH I/DD Tailored Plan Personnel
 - (a) The BH I/DD Tailored Plan shall hire Key Personnel (defined in *Section V.A.1.i: Table 1 Key Personnel Requirements*) to be assigned, unless otherwise indicated, exclusive to the North Carolina Medicaid and State-funded Services market, and shall ensure these Key Personnel positions are filled for the duration of this Contract. Key Personnel shall be identified and mapped to the Staffing Roles provided in *Section V.A.1.ix.(iv) Key BH I/DD Tailored Plan Personnel*. The BH I/DD Tailored Plan shall include the name of the proposed individual to perform each role as part of the Applicant's Application.
 - (b) Key Personnel shall be directly employed by the BH I/DD Tailored Plan unless an exception request has been submitted and approved by the Department.

(c) Key Personnel include the following as identified in *Section V.A.1.i.: Table 1. Key Personnel Requirements*:

Section V.A.1.i.: Table 1. Key Personnel Requirements			
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Master’s degree from an accredited college or university
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for accounting and finance operations, including financial audit activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor’s degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years’ of progressive accounting experience, of which three (3) years are supervisory
3.	Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor’s degree from an accredited college or university • Minimum of seven (7) years’ experience in a managed care organization
4.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members	<ul style="list-style-type: none"> • Must reside in North Carolina

Section V.A.1.i.: Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
Program and State-funded Services	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.	<ul style="list-style-type: none"> • Must be a primary care physician or psychiatrist, fully licensed to practice in NC and in good standing. • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If a primary care physician, clinical experience with child/adolescent and adult populations is preferred. If individual does not have experience with all populations, direct medical staff reports must have experience. • If a psychiatrist, clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience)
5. Chief Compliance Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and manages all fraud, waste, and abuse and compliance activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university
6. Chief Information Security Officer (CISO) or Chief Risk Officer (CRO)	Individual responsible for establishing and maintaining the security processes to ensure	<ul style="list-style-type: none"> • Must hold a Bachelor's degree in information

Section V.A.1.i.: Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
of the North Carolina Medicaid Managed Care Program and State-funded Services	information assets and technologies are protected	security or computer science from an accredited college or university <ul style="list-style-type: none"> • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years' experience in health care
7. Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred
8. Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and related member and provider appeals. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g.

Section V.A.1.i.: Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		LCSW, LCMHC, RN, MD, DO, LMFT)
9.	Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of combined network operations, provider relations, and management experience
10.	Deputy Chief Medical Officer of North Carolina Medicaid Managed Care Program and State-funded Services	<p>Individual who oversees and is responsible for activities as assigned by the CMO including but not limited to the proper provision of covered services to members, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for supporting CMO in ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs. Individual reports to the CMO.</p> <ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If the CMO is a psychiatrist: <ul style="list-style-type: none"> ○ Must be a primary care physician fully licensed to practice in NC and in good standing. ○ Minimum of five (5) years clinical experience and two (2) years' experience in managed care ○ Clinical experience with child/adolescent and adult populations is preferred. If individual does not have child/adolescent and adult populations experience, direct

Section V.A.1.i.: Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<p>medical staff reports must have experience with these populations.</p> <ul style="list-style-type: none"> • If the CMO is a primary care physician: <ul style="list-style-type: none"> ○ Must be a psychiatrist fully licensed to practice in NC and in good standing ○ Minimum of five (5) years' experience in a BH and/or I/DD clinical setting and two (2) years' experience in managed care ○ 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)
<p>11. I/DD and TBI Clinical Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual who oversees and is responsible for all I/DD and TBI clinical activities, including but not limited to the proper provision of covered Medicaid, State-funded, and Innovations and TBI waiver services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management of I/DD and TBI benefits and integration of I/DD and TBI</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a Doctorate-level clinical psychologist, developmental pediatrician, or psychiatrist with appropriate expertise in I/DD/TBI

Section V.A.1.i.: Table 1. Key Personnel Requirements		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	benefits with physical health and BH benefits. Individual reports to the CMO.	<ul style="list-style-type: none"> • Minimum of seven (7) years of utilization review, care management, and/or habilitative and case management experience in I/DD care
12.	Director of Population Health and Care Management of North Carolina Medicaid Managed Care Program and State-funded Services	<ul style="list-style-type: none"> • Must reside in North Carolina • 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	<ul style="list-style-type: none"> • 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

- (v) The BH I/DD Tailored Plan shall:
 - (a) Ensure that Key Personnel hold no more than one (1) position that is required by the Contract, with time limited exceptions for vacancies. The Department may specify in future guidance a deadline for all Key Personnel positions to be filled.
 - (b) Ensure all Key Personnel meet the Key Personnel role and minimum certification and/or credentialing requirements.
- (vi) Key Personnel shall be available to meet during normal Business Hours at the Department’s requested location within twenty-four (24) hours’ notice from the Department unless they are able to provide good cause exceptions.

- (vii) The Department may, at its sole discretion, require the removal of any Key Personnel providing services under this Contract.
- (viii) The BH I/DD Tailored Plan shall not substitute Key Personnel without prior written approval by the Department. The BH I/DD Tailored Plan shall inform the Department in writing within seven (7) Calendar Days of staffing changes in Key Personnel positions, including vacancies. The BH I/DD Tailored Plan shall fill Key Personnel roles with permanent qualified replacements within ninety (90) Calendar Days of the departure of the former staff member. At no time, however, shall a Key Personnel Role be vacant. It is the BH I/DD Tailored Plan's responsibility to keep the role filled until the Department approves a substitution.
- (ix) Upon filling a Key Personnel vacancy, the BH I/DD Tailored Plan shall demonstrate that BH I/DD Tailored Plan staff proposed as Key Personnel have the proper credentials and experience to perform all duties and responsibilities of that role. The BH I/DD Tailored Plan shall provide the following to the Department for each position:
 - (a) Name;
 - (b) Role;
 - (c) Experience relevant to the services to be provided under this Contract;
 - (d) Resume;
 - (e) Proof of North Carolina Residency; and
 - (f) Any certifications, licenses or credentials for the role where requested by the Department.
- (x) If the BH I/DD Tailored Plan is unable to find a candidate for a Key Personnel Position that meets the required credentials, the BH I/DD Tailored Plan may submit an exception request for the Department's approval. The exception request shall include the proposed candidate and mitigation and reporting strategy to fulfill the full requirements of the Contract. The Department reserves the right to provide input on the mitigation and reporting strategy, specify conditions for approval, and request documentation and provide feedback on performance of the candidate.
- (xi) Organization Roles and Positions
 - (a) The BH I/DD Tailored Plan shall ensure that it has the appropriate, qualified staff to fill the roles and positions listed in *Section VII. Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*.
 - (b) Member and Recipient Services Staffing
 - (1) The BH I/DD Tailored Plan shall adequately staff and operate its Member and Recipient Services Department to meet the requirements and performance standards established by the Department and ensure that it is staffed with individuals trained and capable of resolving issues related with Medicaid Managed Care and State-funded Services for the populations covered by the BH I/DD Tailored Plans.
 - (2) The BH I/DD Tailored Plan shall ensure that unlicensed Member and Recipient Services staff are prohibited from providing health-related advice to members requesting clinical information and instead shall triage/refer such requests to licensed staff with appropriate clinical expertise in treating the member's or recipient's condition or disease.
 - i. Annually, all unlicensed Member and Recipient Services staff and Member and Recipient Services management will submit an attestation that the staff and management understand and adhere to the requirements of the prohibition.
 - (c) Fraud, Waste and Abuse Staffing
 - (1) The BH I/DD Tailored Plan shall establish a single point of contact to serve as a liaison with the Department, including DHB and DMH/DD/SAS program integrity staff, and Medical Investigation Division (MID) and to facilitate timely response to Department requests for information, including claims data.
 - (2) The BH I/DD Tailored Plan shall establish a custodian of records to authenticate the business records of the BH I/DD Tailored Plan, provide the business records of the BH I/DD

Tailored Plan to the Department, and have the requisite qualifications to sign an affidavit certifying or, if necessary, testify that the records were:

- i. Made at or near the time of the events by a person with knowledge;
 - ii. Kept in the normal course of regularly conducted business activity; and
 - iii. Made in the regular practice of the BH I/DD Tailored Plan's business activity.
- (d) The BH I/DD Tailored Plan shall submit resumes for any employee or subcontracted employee upon request by the Department.
- (e) The BH I/DD Tailored Plan shall provide a detailed staffing contingency plan in the event of public health emergencies, natural disasters, sudden and unexpected increases in enrollment, and service area expansions, with a description on how the plan shall be implemented and coordinated with the Department, upon request by the Department.
- (f) The BH I/DD Tailored Plan shall provide staffing levels, hiring, layoff activity, and plans upon request by the Department.
- (g) BH I/DD Tailored Plan staff with prior professional experience providing diversion, in-reach or transition services under TCLI who do not meet the minimum credentials for "Transition Coordinator" or "Diversion Specialist" as defined in *Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions* shall be permitted to fill the "Transition Coordinator" or "Diversion Specialist" role.
- (xii) Physical Presence in North Carolina
- (a) The BH I/DD Tailored Plan shall have a physical presence in North Carolina by having one or more offices located in the BH I/DD Tailored Plan's region.
- (b) The BH I/DD Tailored Plan shall establish an office in North Carolina within ninety (90) days after Contract Award that shall be maintained for the duration of the Contract.
- (c) The BH I/DD Tailored Plan shall begin implementing call center(s) in North Carolina within ninety (90) days after Contract Award and ensure for call center(s) are established for Readiness Review.
- (d) The Department requires the BH I/DD Tailored Plan establish an office that serves to support in care management functions and member, recipient, provider and stakeholder engagement requirements of the Contract by BH I/DD Tailored Plan launch within one hundred fifty (150) days of Contract award.
- (e) Additionally, the following personnel and roles, at a minimum, shall be located in and operate from within the State of North Carolina (as found in *Section VII. Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services*):
- (1) Implementation and Readiness Review Staff;
 - (2) Supervising Care Managers;
 - (3) State-funded BH Care Management Coordinator;
 - (4) Care Managers;
 - (5) Care Management Housing Specialist(s);
 - (6) Transition Supervisor(s);
 - (7) Transition Coordinator(s);
 - (8) Peer Support Specialist(s);
 - (9) In-Reach Specialist(s) for Medicaid;
 - (10) Diversion Specialist(s) for State-funded Services;
 - (11) System of Care Family Partner(s);
 - (12) System of Care Coordinator(s);
 - (13) DSOHF Discharge and Transition Managers;
 - (14) Member and Recipient Appeal Coordinator;
 - (15) Member and Recipient Complaint and Grievance Coordinator;
 - (16) Member and Recipient Complaint and Grievance Staff;

- (17) Member and Recipient Appeal Staff;
- (18) Member and Recipient Services and Service Line Staff;
- (19) Provider Relations and Service Line Staff;
- (20) Provider Network Relations Staff;
- (21) Provider Complaint, Grievance, and Appeal Coordinator;
- (22) Utilization Management Staff;
- (23) I/DD and TBI Utilization Management Staff;
- (24) Pharmacy Benefit Manager (PBM) Liaison;
- (25) Tribal Provider Contracting Specialist (if applicable);
- (26) Liaison to DHB and the DMH/DD/SAS;
- (27) Liaison between the Department and the MID;
- (28) SIU Lead;
- (29) SIU Staff;
- (30) Liaison to the DSS; and
- (31) Waiver Contract Manager.

(xiii) Conflict of Interest

- (a) The BH I/DD Tailored Plan shall verify that its employees, directors, and contractors comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the SSA, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C.
- (b) The BH I/DD Tailored Plan shall undertake reasonable actions to verify that employees or contractors who have been officers or employees of the State, and have been responsible for the expenditure of substantial amounts of federal, state, or county money under the North Carolina Medicaid or NC Health Choice programs, abide by all applicable federal conflict of interest requirements in accordance with N.C. Gen. Stat. § 108A-65.
- (c) The BH I/DD Tailored Plan and its employees and directors shall:
 - (1) Not offer, promise, or engage in discussions regarding future employment or business opportunity with any current Department employee (or such employee's spouse or minor child) if such Department employee participated personally and substantially in the procurement of the BH I/DD Tailored Plan's contract or the oversight of such contract as a Department employee.
 - (2) Not promise or give a gift to any Department employee or any family member of a Department employee.
 - (3) Fully and completely disclose to the Department any situation that may present a conflict of interest.
 - (4) Not undertake any work that represents a potential conflict of interest without prior written approval of the Department.
 - (5) Not solicit or obtain from the Department any non-public information relating to the Department's criteria or processes for evaluating bids to enter into or renew a BH I/DD Tailored Plan contract.
- (d) The BH I/DD Tailored Plan shall ensure that financial considerations do not influence decisions to provide medically appropriate care.
- (e) The BH I/DD Tailored Plan shall validate that all its employees, directors, subcontractors or owners who are fully licensed providers abide by their professional obligations to their members and recipients and shall not take any actions which conflict with such obligations.
- (f) The BH I/DD Tailored Plan shall not serve as a legal guardian or representative payee for any of its members or recipients.
- (g) No official or employee of the BH I/DD Tailored Plan shall acquire any personal interest, direct or indirect, in any provider or vendor contracted with State or Federal funds that would be considered a conflict of interest under this Contract.

- (h) The BH I/DD Tailored Plan Board of Directors, advisory committees, employees, volunteers, agents, and contractors shall not participate in clinical or administrative activities or decision in which there is or may be a conflict of interest.
- (i) As required by N.C. Gen. Stat. § 143B-139.6C, the BH I/DD Tailored Plan shall not use a former Department employee, director, or contractor in the administration of its BH I/DD Tailored Plan contract for six (6) months after such person's employment or contract with the Department is terminated, if such person personally participated in the following activities:
 - (1) The award of the Contract to the BH I/DD Tailored Plan;
 - (2) An audit, decision, investigation, or other action affecting the BH I/DD Tailored Plan; or
 - (3) Regulatory or licensing decisions that applied to the BH I/DD Tailored Plan.
- (j) The BH I/DD Tailored Plan shall also adopt a written Conflict of Interest Policy for its employees to ensure the integrity of business practices. The BH I/DD Tailored Plan shall submit its written Conflict of Interest Policy for its employees to the Department for review upon request.

2. Program Operations

i. Service Lines for Medicaid and State-funded Services

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

Section V.A.2.a. Table 1: Member, Recipient, and Provider Support Call Center Operations

Service Line Name	Hours of Operation	Required to be staffed by persons located in North Carolina	Include on Member ID card	Date Service Line Required to be Active
1. Member and Recipient Service Line for Medicaid and State-funded Services	a. Non-emergency member and recipient issues: Monday – Saturday: 7AM – 6PM ET for member and recipient questions and additional hours as required by the Department during times of expected high volume (e.g., BH I/DD Tailored Plan launch) b. Emergency member and recipient issues: open twenty-four (24) hours per day/seven (7) days per week	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
2. Provider Support Service Line for Medicaid and State-funded Services	a. Monday – Saturday: 7AM – 6PM ET	Yes	Yes	At least thirty (30) Calendar Days prior to open enrollment
3. Behavioral Health Crisis Line for Medicaid and State-funded Services	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	Yes	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
4. Pharmacy Service Line for Medicaid Program	a. Monday – Saturday: 7AM – 6PM ET b. Prescriber prior authorization services available to meet 24-hour review requirements as defined in <i>Section V.B.2.iii. Pharmacy Benefits</i>	Yes	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch
5. Nurse Line for Medicaid Program	a. Twenty-four (24) hours per day/seven (7) days per week/three hundred sixty-five (365) days per year	No	Yes	At least thirty (30) Calendar Days prior to BH I/DD Tailored Plan launch

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

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

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

- (16) Other topics as identified by the Department.
- (c) All service line scripts shall be made available to the Department upon request, and all Member and Recipient Service Line, Nurse Line, and Behavioral Health Crisis Line scripts shall be approved by the Department prior to use or when Significant Changes are made.
- (xv) The BH I/DD Tailored Plan shall document all call center interactions with members, recipients authorized representative and providers. The record of contact must include:
 - (a) Current or potential member's or recipient's name;
 - (b) Medicaid/NC Health Choice/State-funded Services identification number (preferred);
 - (c) Channel of interaction/Service Line;
 - (d) Demographics, including, but not limited to
 - (1) Phone number; and
 - (2) Emergency or alternative number, if needed;
 - (e) Notes summary of current or potential member or recipient's interaction (e.g., summary of issue, if issue was resolved or addressed, what information was provided by the BH I/DD Tailored Plan's representative);
 - (f) Record of the time and date of interaction;
 - (g) Contact agent;
 - (h) Resolution and/or if additional follow-up is or was required; and
 - (i) Interpreter requests and the language requested.
- (xvi) The BH I/DD Tailored Plan shall develop and maintain a Call Center and Service Line Policy that defines how the BH I/DD Tailored Plan will meet and maintain the requirements of the Contract. The Call Center and Service Line Policy shall be made available to the Department, upon request.
 - (a) The Call Center and Service Line Policy shall include at a minimum:
 - (1) Service line process flows and call-tree routing options;
 - (2) Service line script topics;
 - (3) Staffing and licensure requirements;
 - (4) Quality assurance and monitoring approach;
 - (5) Member, recipient, and provider issue tracking and resolution process; and
 - (6) Incorporation of member, recipient, and provider issues into broader BH I/DD Tailored Plan QI activities.
- (xvii) Member and Recipient Service Line:
 - (a) Emergency member issues shall be defined as a member or recipient having an Emergency Medical Condition or in need of emergency services.
 - (1) The Member and Recipient Services Line shall adhere to language, information, and accessibility requirements including the availability of translation and interpreter services as defined in *Section V.B.1.iii. Member Engagement and Section V.C.1.b. Recipient Engagement*.
 - (2) Notwithstanding the preceding Warm Transfer requirements in *Section V.A.2.i.(viii)*, the BH I/DD Tailored Plan Member and Recipient Service Line must be able to connect to the BH I/DD Tailored Plan Behavioral Health Crisis Line via a Warm Transfer twenty-four (24) hours per day, seven (7) days per week.
- (xviii) The Nurse Line shall integrate with the BH I/DD Tailored Plan's overall care management program.
 - (a) Within forty-eight (48) hours of a member call, the Nurse Line shall follow up with the member's care manager or organization providing Tailored Care Management to share relevant clinical and follow up information.
- (xix) Pharmacy Service Line:
 - (a) The Service Line Policy shall include standards to meet twenty-four (24) hour prior authorization requirement as defined in *Section V.B.2.iii. Pharmacy Benefits*.

- (xx) Behavioral Health Crisis Line:
 - (a) The BH I/DD Tailored Plan Behavioral Health Crisis Line must be staffed with licensed BH professionals.
 - (b) The BH I/DD Tailored Plan Behavioral Health Crisis Line must be able to address mental health, SUD, I/DD, and TBI-related crisis events.
 - (c) The BH I/DD Tailored Plan Behavioral Health Crisis Line must immediately connect to the crisis response systems.
 - (d) The BH I/DD Tailored Plan Behavioral Health Crisis Line must have patch capabilities to 911 emergency services. In instances where there is immediate danger to self or others, the BH I/DD Tailored Plan shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
 - (e) The BH I/DD Tailored Plan Behavioral Health Crisis Line must follow up with the member's care manager or organization providing Tailored Care Management to share relevant clinical and follow up information.
 - (f) The BH I/DD Tailored Plan Behavioral Health Crisis Line must not:
 - (1) Allow members or recipients to receive a busy signal in order to meet the minimum performance requirements;
 - (2) Allow member or recipient calls to be answered by an automated response;
 - (3) Allow members or recipients to leave messages and receive a call back;
 - (4) Shift calls to an overflow system during high volume call times; or
 - (5) Allow maximum call duration limits.
- (xxi) In all communications with members, recipients, and their families, the BH I/DD Tailored Plan shall comply with HIPAA and all other applicable confidentiality provisions set forth in state and federal law. The BH I/DD Tailored Plan shall:
 - (a) Respond appropriately to inquiries by members, recipients, and their family members (including those with limited English proficiency);
 - (b) Connect members, recipients, family members, and stakeholders to crisis services, when clinically appropriate, twenty-four hours (24) per day, seven (7) days per week, 365 days per year;
 - (c) Provide information to members, recipients, and their family members on where and how to access BH services; and
 - (d) Train its staff to recognize third-party insurance issues and member or recipient complaints, grievances, and appeals and to route these issues to the appropriate individual or BH I/DD Tailored Plan department.
- ii. Forensic Evaluator Program for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall maintain the Forensic Evaluator Program as described in 10A NCAC 27H .0205.
- iii. Staff Training for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall meet the Department's goals and objectives of providing support and services to meet member, recipient, and provider needs by training and educating BH I/DD Tailored Plan staff members and contractors on the requirements, policies and procedures of Medicaid Managed Care, State-funded Services and the unique needs of Medicaid Managed Care members and State-funded Services recipient, or by contracting with a qualified training entity (as described in this section and in other sections in the RFA).
 - (ii) The BH I/DD Tailored Plan shall participate in Department initiatives to educate members, recipients, and providers about implementation activities, including but not limited to:
 - (a) Assistance with the development of call center scripts;
 - (b) Participation in Department-sponsored educational activities; and

- (c) Integration of Department developed implementation-related content into member- and recipient-facing and provider-facing educational materials.
- (iii) The BH I/DD Tailored Plan shall ensure that staff and contractors, at all levels and across all disciplines, receive initial and ongoing training and education to fulfill the responsibilities of its positions under the Contract. Staff members having contact with members, recipients, or providers, or with the Department or the county Departments of Social Services staff shall receive training regarding the appropriate identification and handling of questions and concerns.
- (iv) The BH I/DD Tailored Plan shall begin training new staff to the North Carolina Medicaid Program and State-funded Services within seven (7) Calendar Days of their start date and complete within sixty (60) Calendar Days, unless otherwise approved by the Department.
- (v) The BH I/DD Tailored Plan shall conduct due process training at least annually for all relevant staff.
- (vi) The training program shall include distinct training for:
 - (a) Member and recipient services staff and contractors;
 - (b) Provider relations staff and contractors;
 - (c) Staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators; and
 - (d) Staff and contractors whose work integrates with the Department.
- (vii) The BH I/DD Tailored Plan shall be responsible for ensuring training directed toward member and recipient services staff and contractors include, but are not limited to:
 - (a) Overall understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals; and
 - (2) BH I/DD Tailored Plan eligibility, benefits, and services, including State-funded Services and waiver services.
 - (b) Services which the BH I/DD Tailored Plan is required to make available to all members;
 - (c) Awareness of:
 - (1) All supports and services that may be appropriate for the member or recipient;
 - (2) Unique needs of the member and recipient populations;
 - (3) Stakeholders who may interact with members and recipients;
 - (4) Other programs that serve distinct populations;
 - (5) The role of certain social factors, such as substandard housing, food instability, and lack of access to telephone or transportation, to members' and recipients' health and health care needs; and
 - (6) Benefits and limitations of video remote interpreting (VRI) and familiarity with minimum operational and technological requirements for effective use of VRI.
 - (d) Awareness of and sensitivity to:
 - (1) Different cultural health beliefs and practices;
 - (2) Low-socioeconomic individuals and/or families;
 - (3) Individuals with disabilities;
 - (4) Learning preferences to receiving information;
 - (5) Health disparities for Historically Marginalized Populations; and
 - (6) Individuals with trauma.
 - (e) Ability to communicate appropriately with individuals in need of communication and language assistance.
 - (1) Use of interpreters, sign language interpreters both in-person and through video remote interpreting, Relay Video Conferencing Captioning, video relay services, 711 relay services, TTY machines, or assertive communication devices;
 - (f) Member and recipient rights and responsibilities;

- (g) Member and recipient Grievances, Complaints, and Appeals processes, including State Fair Hearing Process;
- (h) The BH I/DD Tailored Plan's Medicaid and State-funded Services provider networks;
- (i) Overcoming barriers to accessing medical care for Medicaid members and for State-funded Services recipients (to the degree those resources are available and known by the BH I/DD Tailored Plan);
- (j) Linking members and recipients to other state and local programs or assistance, including but not limited to social services, state-funded BH services, law enforcement and the criminal justice system;
- (k) Fraud, waste, and abuse detection, investigation, and prevention;
- (l) Process for offering suggestions to improve the member, recipient, or provider experience;
- (m) Unique needs, experiences of members of federally recognized tribes, including EBCI, and other tribes native to North Carolina, including:
 - (1) The significance of extended families including an understanding that the definition of extended families is different than non-native families;
 - (2) The potential services available for family members of enrolled members in EBCI or other federally recognized tribes;
 - (3) Some blended families may be trilingual (English, Cherokee or other native languages, and Spanish); and
 - (4) Respect for traditions where gender and age may play an important role;
 - (5) Elders have a highly respected status due to their life experiences;
 - (6) Elders tend to be non-verbal;
 - (7) Pregnant individuals; and
 - (8) Veterans.
- (n) The different service types and benefit plans available through the EBCI Tribal Option; and
- (o) HIPAA and the Department's privacy and security requirements.
- (viii) The BH I/DD Tailored Plan shall be responsible for training care managers and supervising care managers as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements*.
- (ix) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards provider relations staff and contractors include, but are not limited to:
 - (a) Understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals;
 - (2) BH I/DD Tailored Plan eligibility and services, including State-funded Services and waiver services;
 - (3) Unique needs of member and recipient populations; and
 - (4) Learning preferences to receiving information.
 - (b) Awareness of:
 - (1) All supports and services that enhance the provider experience;
 - (2) Stakeholders who may interact with providers; and
 - (3) Other programs that serve distinct populations.
 - (c) Awareness and sensitivity to:
 - (1) Different cultural health beliefs and practices; and
 - (2) Individuals with trauma.
 - (d) Covered Medicaid and State-funded Services;
 - (e) EPSDT criteria for members;
 - (f) Provider rights and responsibilities;
 - (g) Fraud, waste, and abuse detection, investigation, and prevention;

- (h) Use of interpreters, sign language interpreters, Relay Video Conference Captioning, Relay NC, TTY machines, or assistive communication devices;
 - (i) Unique needs and requirements of Indian Health Care Providers; and
 - (j) HIPAA and the Department's privacy and security requirements.
- (x) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the county Departments of Social Services, including eligibility workers and social work program administrators include, but are not limited to:
- (a) Overall understanding of Medicaid Managed Care and State-funded Services, including program eligibility, benefits, services, cost sharing, key initiatives and priorities, and program goals;
 - (b) Overall understanding of BH I/DD Tailored Plan eligibility and services, including State-funded Services and waiver services;
 - (c) Overall understanding of the unique needs of member and recipient populations;
 - (d) Awareness of member and recipient supports and services;
 - (e) Member and recipient rights and responsibilities;
 - (f) Member and recipient Grievances, Complaints, and Appeals processes;
 - (g) Awareness of other programs that serve distinct populations;
 - (h) Fraud, waste, and abuse detection, investigation, and prevention; and
 - (i) HIPAA and the Department's privacy and security requirements.
- (xi) The BH I/DD Tailored Plan shall be responsible for ensuring training directed towards staff and contractors whose work integrates with the Department includes topics identified for all other training programs as described above, including, but not limited to:
- (a) Overall understanding of:
 - (1) Medicaid Managed Care and State-funded Services, including program eligibility, benefits and services, utilization management and clinical practice guidelines, cost sharing, key initiatives and priorities, and program goals; and
 - (2) BH I/DD Tailored Plan eligibility, benefits, and services, including State-funded Services and waiver services.
- (xii) Submission and Approval
- (a) No later than ninety (90) Calendar Days after Contract Award, the BH I/DD Tailored Plan shall submit a training and evaluation program to the Department.
 - (1) The training program shall comply with all state and federal provisions, and should utilize Department resources where available.
 - (2) Each training program shall be approved by the Department before use with BH I/DD Tailored Plan staff and contractors.
 - (3) The BH I/DD Tailored Plan shall initiate training within five (5) Calendar Days of approval by the Department.
 - (b) Training materials shall include, but are not limited to:
 - (1) Training policies and procedures;
 - (2) Training plan;
 - (3) Training curriculum; and
 - (4) Evaluation methodology.
 - (c) The BH I/DD Tailored Plan shall update the training materials and conduct training of its staff and contractors annually, as changes are made to Medicaid Managed Care or State-funded Services, in response to improving the member and recipient experience, improving the provider experience, improving staff and contractor performance, and/or as requested by the Department.
 - (1) The BH I/DD Tailored Plan shall submit all updates and changes to the Department for review and approval before use with BH I/DD Tailored Plan staff and contractors.

- (xiii) The BH I/DD Tailored Plan must collaborate with the Department on providing training to Department, county DSS staff, the EBCI, the Ombudsman program and Enrollment Broker.
 - (a) Training must:
 - (1) Be completed at least ninety (90) Calendar Days prior to BH I/DD Tailored Plan launch;
 - (2) Be hosted at multiple locations as defined by the Department;
 - (3) Contain information on the role of the BH I/DD Tailored Plan;
 - (4) Describe the relationship and integration of the BH I/DD Tailored Plan with the Department, Enrollment Broker, county DSS staff, the EBCI PHHS, and the Ombudsman program; and
 - (5) Describe how to navigate the public facing websites.
 - (b) Materials for the training must be provided to the Department no later than thirty (30) days prior to scheduled events for review.
 - (xiv) No later than fourteen (14) days after identification, the BH I/DD Tailored Plan shall update any materials publicly posted on the BH I/DD Tailored Plan's website that are inconsistent with the terms of this subsection or inconsistent with any trainings provided by the Department.
- iv. Reporting for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall comply with all the reporting requirements established by the Contract for Medicaid and State-funded Services.
 - (ii) The Department shall provide the BH I/DD Tailored Plan with the appropriate reporting formats, instructions, submission timetables, and technical assistance as defined in *Section VII. Attachment J. Reporting Requirements*.
 - (iii) The Department may, at its discretion, change the content, format or frequency of reports or require the BH I/DD Tailored Plan to submit additional reports both ad hoc and recurring.
 - (a) If the Department requests any revisions to the reports already submitted, the BH I/DD Tailored Plan shall make the changes and re-submit the reports, according to the time period and format required by this Contract or by the Department.
 - (iv) The BH I/DD Tailored Plan shall submit all reports to the Department, unless indicated otherwise in this Contract or subsequent guidance.
 - (v) The BH I/DD Tailored Plan shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate.
 - (vi) Except as otherwise specified, all reports shall be specific to each Region covered by this Contract.
 - (vii) The BH I/DD Tailored Plan shall provide all necessary information and reporting to support the Department in submission of federal and state reporting and audit requirements including in the administration of North Carolina's 1115 and 1915(c) waivers and SPAs, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Community Mental Health Block Grant (CMHBG) by supporting the Department in monitoring BH I/DD Tailored Plan progress towards clinical quality and outcomes goals and maximizing federal match of state funds.
 - (viii) Upon request, the BH I/DD Tailored Plan shall provide the Department with all underlying data required to produce reports required under the Contract for Medicaid and State-funded Services.
- v. BH I/DD Tailored Plan Policies for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall develop policy documents outlining key business processes, procedures and staffing requirements as required in this Contract for Medicaid and State-funded Services.
 - (ii) Each policy document shall include:
 - (a) Processes and procedures;
 - (b) Key staff/roles involved in processes and procedures, including key personnel accountable for policy;
 - (c) Define required BH I/DD Tailored Plan and Department systems;
 - (d) Role of subcontractors; and

- (e) Describe BH I/DD Tailored Plan’s continuous improvement approach to update policies.
 - (iii) All required BH I/DD Tailored Plan policies are outlined in the Contract. The BH I/DD Tailored Plan shall submit policy documents for Medicaid and State-funded Services to the Department for review and approval as defined in the Contract.
 - (iv) After initial approval, the BH I/DD Tailored Plan shall submit any material modifications, additions, or deletions of all Medicaid and State-funded Services policies to the Department at least thirty (30) Calendar Days prior to implementation, unless another time frame has been specified in the Contract.
- vi. Business Continuity for Medicaid and State-funded Services
- (i) The BH I/DD Tailored Plan shall develop and maintain a Business Continuity Plan for Medicaid and State-funded Services that is acceptable to the Department, and demonstrate the adequacy of the Plan at the Department’s request. The BH I/DD Tailored Plan shall adhere to all applicable published Department privacy and security policies, (located at <https://it.nc.gov/documents/statewide-information-security-manual> and <https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-80/man/>) and all other requirements set forth in the Contract.
 - (ii) The BH I/DD Tailored Plan shall demonstrate how it will restore call center operations, website and clinical support functions within twenty-four (24) hours and resume all remaining operations within three (3) Calendar Days following a natural or manmade disaster or state of emergency. The BH I/DD Tailored Plan shall meet recognized industry standards for security and disaster recovery requirements.
 - (iii) The BH I/DD Tailored Plan shall identify disaster or emergency situations that can result in a major failure or disruption in care, including but not limited to: fire, flood, hurricanes/tornadoes, terrorist event, earthquake, epidemic or pandemic.
 - (iv) As part of the BH I/DD Tailored Plan’s business continuity planning, the BH I/DD Tailored Plan shall identify and review all federal or state disaster or emergency declarations made by the Governor of North Carolina or the Federal Government affecting North Carolina in the last five (5) years before Contract Award to inform future disaster or emergency planning.
 - (v) The BH I/DD Tailored Plan shall provide disaster or emergency-related care coordination for high-risk Medicaid members who are obtaining care management as described in *Section V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations* (e.g., high-risk pregnant women, dialysis patients, medically frail, hemophiliacs, long-term care population, individuals receiving Medication Assisted Treatment) during three (3) emergency timeframes, as applicable:
 - (a) Pre-Emergency:
 - (1) Incorporate disaster planning in the care planning process; and
 - (2) Increase member outreach to ensure that members and recipients have adequate shelter, access to support to address their Unmet Health Related Resource Needs, access to back-up equipment and/or caretaker training if equipment fails, or arrange NEMT for evacuation if the member is unable to safely shelter in place (for Medicaid members only).
 - (b) During an Emergency:
 - (1) Continue to check-in on high risk members and recipients to ensure safety, and access to supports to address their Unmet Health-Related Resource Needs; and
 - (2) Arrange for NEMT to evacuate, if needed (Medicaid members, only).
 - (c) Post-Emergency:
 - (1) Check-in on high-risk members to ensure they were able to shelter safely and identify additional behavioral or medical needs, or Unmet Health-Related Resource Needs.
 - (vi) The BH I/DD Tailored Plan shall comply with any additional requirements released by the Department to ensure continuity of care during an epidemic or pandemic, including those related

to care coordination, care management, and supports to address their Unmet Health-Related Resource Needs.

- (vii) BH I/DD Tailored Plans shall comply with any additional guidance released by the Department during any type of disaster or emergency, including guidance on provider payments.
- (viii) When directed by the Department during a disaster or emergency, the BH I/DD Tailored Plan shall ensure continuity for Medicaid members and State-funded Services recipients by:
 - (a) Offering extended service line hours with staff available and trained to answer and triage calls, including disaster or emergency-related queries.
 - (b) Removing and/or reducing required prior authorizations and concurrent review for Medicaid and State-funded Services;
 - (c) Providing emergency physical health to Medicaid members and BH services to Medicaid members and State-funded Services recipients residing in shelters;
 - (d) Providing all Medicaid members and State-funded Services recipients with access to out-of-network and Telehealth providers; and
 - (e) Increasing Medicaid member access to medications by removing maximum dosage limits for required medication, including medication assisted treatment (MAT), antipsychotics, and insulin.
- (ix) The BH I/DD Tailored Plan shall support the Department's priorities for state-wide and local disaster or emergency planning and response including:
 - (a) Participation in the development of community disaster emergency response plans;
 - (b) Collaboration with other State department vendors to align efforts, as needed;
 - (c) Appointment of at least one representative to the statewide disaster or emergency planning and response efforts; and
 - (d) Recruitment and training for in-network Medicaid and State-funded BH providers to staff disaster shelters; and
 - (e) Responding to resource requests from the Emergency Management Division within the North Carolina Department of Public Safety.
- (x) Within thirty (30) Calendar Days of the Contract Award, the BH I/DD Tailored Plan shall submit its Business Continuity Plan for all requirements specified in the Contract (see *Section VII. Attachment O. Business Continuity Management Plan*), including:
 - (a) The preventive measures that would be instituted to minimize impact;
 - (b) The back-up, off-site storage, and other pre-disaster or emergency safeguards that would be implemented to minimize any disruption; the data back-up policy and procedures shall include:
 - (1) Descriptions of the controls for back-up processing, including how frequently backups occur;
 - (2) Documented back-up procedures;
 - (3) The location of data that has been backed up (off-site and on-site, as applicable);
 - (4) Identification and description of what is being backed up as part of the back-up plan;
 - (5) Any change in back-up procedures in relation to the BH I/DD Tailored Plan's technology changes;
 - (6) A list of all back-up files to be stored at remote locations and the frequency with which these files are updated; and
 - (c) Approach for providing care coordination activities to high risk Medicaid members in accordance with *Section V.A.2.vi.(v)*;
 - (d) Approach for ensuring continuity of care during an emergency for Medicaid members and State-funded Services recipients in accordance with *Section V.A.2.vi.(viii)*;
 - (e) Approach for supporting the Department's priorities for statewide and local disaster or emergency planning in accordance with *Section V.A.2.vi.(ix)*;

- (f) Processes to provide information and resources to Medicaid members and State-funded Services recipients on how to protect themselves during a disaster or emergency and assist members and recipients with understanding how and when to access Medicaid benefits and State-funded Services;
- (g) Approach to provide prompt member access to providers appropriately trained in disaster or emergency-specific care, including out-of-network access in the event of the unavailability of an appropriate participating provider to treat a member;
- (h) Processes to ensure that providers deliver all necessary care to members during a disaster or emergency;
- (i) Processes to provide guidance and education to providers and promptly answer all provider questions and concerns during a disaster or emergency;
- (j) Approach to supporting providers in the event of provider revenue disruptions;
- (k) Approach to changing the Quality Management and Improvement Program to address issues related to a disaster or emergency;
- (l) The tasks that would be involved in implementing the Business Continuity Plan, and identify by job description or title the BH I/DD Tailored Plan's staff and the Department's staff involvement;
- (m) Current contact information for all critical staff and relevant personnel;
- (n) The recovery procedures that would be instituted to achieve normal operation, including any remote access relocation plans or alternate worksite locations;
- (o) The timeframe required to accomplish full recovery from the point of interruption;
- (p) A vendor list to include contact information to provide for quick ship and/or replacement of equipment, software and supplies;
- (q) The procedures for coordinating with the Department in the event of a disaster or emergency;
- (r) Notification procedures (call trees);
- (s) Employee training and awareness detailing activation process;
- (t) Document recovery time results;
- (u) Schedule for testing and exercising the entire plan or components of the plan which can be tested independently of one another and documentation process for recovery time results; and
- (v) The procedures for notifying the Department, Enrollment Broker, members, personnel, and other relevant parties detailing the status of the system and any alternative phone numbers and/or business plans.
- (xi) The Business Continuity Plan should be marked as follows: "Confidential information – Not subject to public disclosure under G.S. §132" to prevent such document from being produced in a response to public record's request.
- (xii) The BH I/DD Tailored Plan shall update the Business Continuity Plan as necessary, every six (6) months at minimum.

3. Compliance

i. Compliance Program for Medicaid and State-funded Services

- (i) The BH I/DD Tailored Plan shall implement a comprehensive Compliance Program for Medicaid and State-funded Services focused on ensuring the BH I/DD Tailored Plan is in compliance with all applicable federal and state laws, including robust Program Integrity strategies, best practices to prevent and reduce fraud, waste and abuse, and a fully integrated third-party liability (TPL) approach.
- (ii) The BH I/DD Tailored Plan's Compliance Program shall comply with 42 C.F.R. § 438.608, and must include for Medicaid and State-funded Services:
 - (a) Written policies, procedures, and standards of conduct that articulate the BH I/DD Tailored Plan's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:

- (1) Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a Network provider's circumstances that may affect the Network provider's eligibility to participate in the Medicaid Managed Care program or State-funded Services, including termination of the provider agreement with the BH I/DD Tailored Plan. 42 C.F.R. § 438.608(a)(4)
 - (2) Retention policies for the treatment of recoveries of all overpayments from the BH I/DD Tailored Plan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 C.F.R. § 438.608(d)(1)(i).
 - (3) Processes, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the BH I/DD Tailored Plan is not permitted to retain some or all of the recoveries of overpayments. 42 C.F.R. § 438.608(d)(1)(iii).
 - (4) Reporting to the Department within sixty (60) Calendar Days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. 42 C.F.R. § 438.608(c)(3).
 - (5) Arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network providers were received by members and the application of such verification processes on a regular basis. 42 C.F.R. § 438.608(a)(5).
 - (6) Process for providers to report and promptly return overpayments within sixty (60) days of identifying the overpayment. 42 C.F.R. § 438.608(d)(2).
- (b) The designation of a Chief Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract for Medicaid and State-funded Services and who reports directly to the Chief Executive Officer and the Board of Directors.
 - (c) The establishment of a Regulatory Compliance Committee of the Board of Directors for Medicaid and State-funded Services and at the senior management level charged with overseeing the BH I/DD Tailored Plan's Compliance Program and its compliance with the requirements under the Contract.
 - (d) A system for training and education for the Compliance Officer, the BH I/DD Tailored Plan's senior management, and the BH I/DD Tailored Plan's employees on the federal and state standards and requirements under the Contract.
 - (e) Effective lines of communication between the Compliance Officer and the BH I/DD Tailored Plan's employees.
 - (f) Enforcement of standards through well-publicized disciplinary guidelines.
 - (g) Identification of potential and actual compliance risks.
 - (h) Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.
- (iii) The BH I/DD Tailored Plan shall develop a Compliance Plan which defines the BH I/DD Tailored Plan's Compliance Program for Medicaid and State-funded Services.
 - (a) The BH I/DD Tailored Plan shall provide the Compliance Plan to the Department:
 - (1) As part of the Implementation Plan, during Readiness Review;
 - (2) Annually thereafter; and
 - (3) Upon request by the Department.

- (b) The BH I/DD Tailored Plan shall revise the BH I/DD Tailored Plan’s Compliance Plan as requested by the Department.
 - (c) The BH I/DD Tailored Plan shall submit any requested document within five (5) Calendar Days of the Department’s request to review the BH I/DD Tailored Plan’s Compliance Plan, and any other policy or procedures governing the BH I/DD Tailored Plan’s compliance activities for Medicaid and State-funded Services.
 - (d) Annually, the BH I/DD Tailored Plan shall develop monitoring and auditing work plan(s) for the upcoming year for Medicaid and State-funded Services.
 - (1) The BH I/DD Tailored Plan shall submit a Compliance Program report for Medicaid and State-funded Services describing the work plans for the upcoming year.
 - (2) The report shall be submitted ninety (90) days prior to BH I/DD Tailored Plan launch.
 - (3) Following Contract Year 1 of BH I/DD Tailored Plan, the Compliance Program report shall include proposed work plan(s) for the upcoming year and summarize of the status of the previous year’s work plan including whether all planned activities were completed, if identified risks were mitigated, and any other significant outcomes.
 - (e) Compliance with federal and state requirements for State-funded Services
 - (1) The BH I/DD Plan’s Compliance Program shall address how it will ensure that the BH I/DD Tailored Plan staff and its subcontractors shall fully comply with all requirements and restrictions of all state and federal grant programs, and their accompanying State-fund Maintenance of Effort (MOE) requirements in all BH I/DD Tailored Plan expenditures and reimbursements using state and federal funds, and in all BH I/DD Tailored Plan subcontracting with entities that are eligible to receive these funds.
 - (2) The Department shall apprise the BH I/DD Tailored Plan in writing of the requirements and restrictions of these funding sources.
 - (3) The BH I/DD Tailored Plan shall notify all staff and contractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.
 - (4) The BH I/DD Tailored Plan staff and contractors shall fully comply with the monitoring and auditing activities of the Department as instructed.
- ii. Program Integrity (PI) for Medicaid and State-funded Services
- (i) To ensure the effective use and management of public resources in the delivery of services to Medicaid Managed Care members and State-funded Services recipients, the BH I/DD Tailored Plan shall also increase awareness within its organization and across its provider Network of methods to prevent, detect and report potential fraud, waste and abuse. In support of such efforts, the BH I/DD Tailored Plan shall comply with all applicable federal and state laws and regulations including, but not limited to Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, and 42 C.F.R. § 438.608.
 - (ii) To promote PI, the BH I/DD Tailored Plan shall adhere to the following program standards, at a minimum:
 - (a) Validation of Exclusion List Status for Medicaid and State-Funded Services
 - (1) The BH I/DD Tailored Plan shall, prior to contracting, check the exclusion status of all providers against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal funds to excluded persons or entities.
 - (2) The BH I/DD Tailored Plan shall disclose to the Department within thirty (30) Calendar Days of BH I/DD Tailored Plan’s knowledge any disciplinary actions that have been imposed on any licensed physician, physician assistant, nurse practitioner, psychologist or, other licensed health professional or their governing body related to fraud, waste, or abuse as defined within the Contract.

- (3) The BH I/DD Tailored Plan shall check, at least every month, the exclusion status of persons with an ownership or controlling interest in the BH I/DD Tailored Plan (as applicable), agents and managing employees of the BH I/DD Tailored Plan, network providers, delegated entities, and subcontractors against the Exclusion Lists to ensure that the BH I/DD Tailored Plan does not pay federal funds to excluded persons or entities. The BH I/DD Tailored Plan shall not be controlled by a sanctioned individual. 42 C.F.R. § 438.808(a).
 - (4) The BH I/DD Tailored Plan shall take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one or more of the Exclusion Lists (each an “Excluded Person”), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.
 - (5) The BH I/DD Tailored Plan shall report to the Department within two (2) Business Days of identification of an Excluded Person the following information:
 - i. The name(s) of the Excluded Person(s);
 - ii. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
 - iii. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.
- (b) Prohibited Relationships for Medicaid and State-funded Services
- (1) In accordance with 42 C.F.R. § 438.610, the BH I/DD Tailored Plan shall not knowingly have a relationship with any of the following:
 - i. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
 - ii. An individual or entity who is an affiliate, as defined in the FAR at 48 C.F.R. § 2.101, of a person.
 - iii. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
 - (2) For the purposes of this Section, a “relationship” means any of the following:
 - i. A director, officer, governing board member, or partner of the BH I/DD Tailored Plan;
 - ii. A subcontractor of the BH I/DD Tailored Plan, as governed by 42 C.F.R. § 438.230;
 - iii. A person with beneficial ownership of five percent (5%) or more of the BH I/DD Tailored Plan’s equity; or
 - iv. A network provider or person with an employment, consulting or other arrangement with the BH I/DD Tailored Plan for the provision of items and services that are significant and material to the BH I/DD Tailored Plan’s obligations under this Contract.
 - (3) If the Department learns that the BH I/DD Tailored Plan has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the BH I/DD Tailored Plan has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with the BH I/DD Tailored Plan unless the United States Secretary of the Department of Health & Human Services

directs otherwise. 42 C.F.R. § 438.610(d)(2); 42 C.F.R. § 438.610(a); Exec. Order No. 12549. However, the Department may not renew or extend the existing agreement with the BH I/DD Tailored Plan unless the United States Secretary of the Department of Health & Human Services provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

(c) Suspensions and Withholds for Payments to Providers for Program Integrity for Medicaid and State-funded Services

- (1) The BH I/DD Tailored Plan shall cooperate with the Department as directed to impose a payment suspension or withhold or lift a payment suspension or withhold for Medicaid and State-funded Services providers.
- (2) The BH I/DD Tailored Plan shall develop a policy describing its processes and how it will cooperate with the Department to impose or lift a payment suspension or withhold for Medicaid and State-funded Services providers.
- (3) When the Department notifies the BH I/DD Tailored Plan that payments to a provider have been suspended or are being withheld, the BH I/DD Tailored Plan shall suspend payments to or withhold payments from the provider in accordance with the Department's instructions within one (1) Business Day of receipt of the notice or as otherwise instructed. The BH I/DD Tailored Plan shall continue the payment suspension or withhold until it receives notice from the Department to lift the suspension or withhold.
- (4) The BH I/DD Tailored Plan shall commence a payment suspension or withhold in accordance with the Department's instructions and such suspension or withhold shall continue until the BH I/DD Tailored Plan receives notice from the Department to lift the suspension or withhold.
- (5) The BH I/DD Tailored Plan shall lift the suspension or withhold within three (3) Business Days of receipt of the notice of a payment suspension or a payment withhold lift from the Department, effective as of the date the notice was received, and process all claims in accordance with prompt pay standards within the Contract.
- (6) The BH I/DD Tailored Plan shall obtain the Department's written approval of the suspension prior to suspending payments to any provider due to suspected fraud or abuse. The BH I/DD Tailored Plan shall initiate such suspension within one (1) Business Day of receipt of the approval if the Department approve the suspension of payment.
- (7) The BH I/DD Tailored Plan shall provide the following information to the Department to request a suspension or withhold of payment to any provider:
 - i. Name of the Network provider or non-contract provider and NPI;
 - ii. The nature of the suspected fraud;
 - iii. Basis for the suspension/withhold;
 - iv. Desired date for the suspension/withhold to begin;
 - v. Proposed length of the suspension/withhold;
 - vi. Proposed percentage of the withhold, if applicable; and
 - vii. If applicable, the good cause rationale for imposing a partial payment suspension.
- (8) The BH I/DD Tailored Plan shall be permitted to immediately stop payment to providers in the case of credible fraud, waste, or abuse.

(d) Coordination of Provider Monitoring and Auditing for Medicaid and State-Funded Services

- (1) The BH I/DD Tailored Plan may conduct an audit of a provider or accept a self-disclosure from a provider even when the Department or MID conducted an audit of the same

provider or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period with prior permission from the Department.

- (2) The BH I/DD Tailored Plan shall comply with any Department directive not to conduct an audit of a provider.
- (e) The BH I/DD Tailored Plan shall report to the Department and, upon request, to the United States Secretary of the Department of Health & Human Services, the Inspector General of the US DHHS, and the Comptroller General a description of transactions between the BH I/DD Tailored Plan and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
- (1) Any sale or exchange, or leasing of any property between the BH I/DD Tailored Plan and such a party;
 - (2) Any furnishing for consideration of goods, services (including management services), or facilities between the BH I/DD Tailored Plan and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; and
 - (3) Any lending of money or other extension of credit between the BH I/DD Tailored Plan and such a party. Section 1903(m)(4)(A) of the Social Security Act.
- (f) Deficit Reduction Act (DRA) Reporting for Medicaid
- (1) The BH I/DD Tailored Plan shall have a policy and procedure which complies with the requirements of the DRA of 2005, which requires entities that make or receive annual Medicaid payments of five million (\$5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal liquidated damages for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
 - (2) The BH I/DD Tailored Plan shall submit annually to the Department, in the format prescribed by the Department, policies and procedures in accordance with the DRA.
 - (3) Providers and Subcontractors
 - (4) The BH I/DD Tailored Plan shall require Network providers and Subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the DRA of 2005 requirements.
 - (5) The BH I/DD Tailored Plan shall provide its Network providers and Subcontractors with training materials regarding fraud, waste, and abuse prevention.
 - (6) The BH I/DD Tailored Plan shall annually certify that no payments are made for services or items provided to a provider, subcontractor, or financial institution located outside of the United States.
 - (7) In accordance with federal regulations, the BH I/DD Tailored Plan shall require Network providers and non-contract providers to have and implement a policy recognizing Medicaid as the payer of last resort.
- (g) Prohibited Payments for Medicaid and State-funded Services
- (1) The BH I/DD Tailored Plan shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
 - i. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act.
 - ii. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XX, or XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Social Security Act and when the person furnishing such item or service knew, or had reason to know,

- of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- iii. Furnished by an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.
- (2) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
 - (3) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP. Section 1903(i) of the Social Security Act.
- (h) Notice of Certain Reporting and Audit Requirements for State-Funded Services
- (1) In accordance with the Federal Funding Accountability and Transparency Act (FFATA), BH I/DD Tailored Plans that receive a sub award of more than \$25,000 in federal financial assistance (through block grants or other federal grants, exclusive of Medicaid) are required to obtain a DUNS number at <http://fedgov.dnb.com/webform> and to register in the System for Award Management (SAM) at www.sam.gov.
 - (2) The BH I/DD Tailored Plan shall send proof of the DUNS number prior to the initiation of the contract and the receipt of any sub award payments to the Department.
 - (3) The BH I/DD Tailored Plan shall use or expend the funds available under this Contract only for the purposes for which they were appropriated by the General Assembly or received by the State.
 - (4) State funds include federal grant funds that flow through the State.
 - (5) In addition, specific state funds allocated to the BH I/DD Tailored Plan by the Department must be used in accordance with the requirements set out in the allocation letters which accompany those funds, to the extent that such requirements are not inconsistent with the terms and conditions of this Contract. The BH I/DD Tailored Plan is subject to the requirements of 2 CFR Part 200, known as the OMB Super Circular, and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.
 - (6) The BH I/DD Tailored Plan shall furnish to the State Auditor, upon his/her request, all books, records, and other information that the State Auditor needs to fully account for the use and expenditure of state funds in accordance with N.C.G.S. §147-64.7.
- (i) Post-Payment Clinical and Administrative Reviews for State-Funded Services
- (1) The BH I/DD Tailored Plan shall conduct post-payment reviews of state-funded BH and I/DD services to monitor whether services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Records Management and Documentation Manual; the DMH/DD/SAS State-funded Enhanced Mental Health and Substance Abuse Services Manual and the DMH/DD/SAS Service Definitions; the Person-Centered Planning Instruction Manual; DMH/DD/SAS policies; and the NC General Statutes, as applicable.
 - (2) In accordance with 42 USC 300x-5 and 300x-31 and 42 USC 300x-55, the BH I/DD Tailored Plan shall:
 - i. Develop and implement a policy and/or procedure mandating that the federal program requirements are conveyed to intermediaries and providers of block grant services.
 - ii. Cooperate with the Department monitoring activities of the BH I/DD Tailored Plan's appropriate use of block grant and State funds, including:
 - iii. Budget review;
 - iv. Claims payment adjudication;

- v. Expenditure report analysis;
 - vi. Compliance reviews;
 - vii. Recipient level encounter/use/performance analysis data; and
 - viii. Audits.
 - (3) The BH I/DD Tailored Plan shall implement payment method controls to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
- iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services
- (i) To promote integrity in all BH I/DD Tailored Plan activities and combat fraud, waste, and abuse, the BH I/DD Tailored Plan shall:
 - (a) Design a proactive fraud prevention, detection, and referral process which guards against internal (staff) and external (members, providers, subcontractors or others) fraud, waste, or abuse of benefits, program funds and misuse of the systems that support Medicaid Managed Care and State-funded Services;
 - (b) Establish effective policies, processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, or abuse prior to enrollment or the Department's issuance of benefits for Medicaid members or the disbursement of funds for State-funded Services recipients;
 - (c) Develop and implement solutions for establishing effective processes, systems, edits, and controls to prevent and detect internal and external fraud, waste, and abuse;
 - (d) Develop and apply criteria for preventing, detecting, and referring cases of suspected fraud, waste, or abuse;
 - (e) Create processes to investigate suspected fraud, waste, and abuse that do not infringe on the rights of individuals and are consistent with due process of law;
 - (f) Develop and implement policies and processes to identify, report, and investigate suspected fraud, waste, or abuse;
 - (g) Refer all credible allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department;
 - (h) Define the quality and data integrity standards maintained by the BH I/DD Tailored Plan to produce accurate clinical quality metrics and reporting to the Department; and
 - (i) Have an identified individual(s) testify to the potential financial loss due to fraud, waste, and abuse upon request by the Department.
 - (ii) Fraud, Waste, and Abuse Investigation Staffing
 - (a) The BH I/DD Tailored Plan shall have adequate staffing and resources to investigate fraud, waste and abuse and develop and implement corrective action plans to assist the BH I/DD Tailored Plan in preventing and detecting fraud and abuse.
 - (b) The BH I/DD Tailored Plan shall establish a Special Investigations Unit (SIU) sixty (60) Calendar Days prior to BH I/DD Tailored Plan launch, responsible for investigating potential instances of fraud, waste or abuse, developing the Fraud Prevention Plan, and implementing or ensuring implementation of the Fraud Prevention Plan inclusive of Medicaid and non-Medicaid funding. The BH I/DD Tailored Plan shall maintain the SIU throughout the term of the Contract and any investigation open at termination or expiration of the Contract shall be referred to the Department.
 - (1) The SIU will consist of dedicated staff members who are located in North Carolina.
 - (2) The BH I/DD Tailored Plan's Chief Compliance Officer may not serve as a member of the SIU, although he or she may oversee the SIU.
 - (3) The BH I/DD Tailored Plan shall ensure that SIU members have adequate training and experience to effectively carry out their duties and responsibilities. At a minimum, each

member of the SIU shall have an associate's or bachelor's degree in compliance, analytics, government/public administration, auditing, security management or pre-law, or have at least three (3) years of relevant experience.

- (4) The BH I/DD Tailored Plan shall require that the members of its SIU, as well as its Chief Compliance Officer, participate in annual Department and MID compliance and fraud, waste, and abuse prevention training.

(iii) Investigation Coordination

- (a) The BH I/DD Tailored Plan shall refer credible allegations of fraud for Medicaid and State-funded Services, including instances involving the BH I/DD Tailored Plan's own conduct to the Department, using the Department's defined Fraud, Waste, and Abuse Submission Form, within five (5) days of making the credibility determination.
- (b) Once a credible allegation of fraud has been referred to the Department, until further written notice by the Department, the BH I/DD Tailored Plan shall not take any further action including the following:
 - (1) Contacting the subject of the investigation about any matters related to the investigation;
 - (2) Continuing the investigation into the matter;
 - (3) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
 - (4) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.
- (c) The BH I/DD Tailored Plan shall cooperate with all appropriate state and federal agencies, including MID, the DMH/DD/SAS Financial Audit and Program Integrity teams and/or federal OIG, in investigating fraud and abuse.
- (d) The BH I/DD Tailored Plan shall provide data or information requested by the Department including the DMH/DD/SAS Financial Audit and Program Integrity teams or MID, as relevant, in the standardized format within five (5) Calendar Days of receiving the request.
- (e) The BH I/DD Tailored Plan shall cooperate with the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID, as relevant, to mitigate any potential financial or other harm caused by a potentially fraudulent provider's action due to the Department's or MID's own investigation of the matter.
- (f) If the BH I/DD Tailored Plan is directed to complete the investigation into potential instances of fraud, then the BH I/DD Tailored Plan shall report to Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID, as relevant, in a specified format, its finding within ten (10) Calendar Days of the conclusion of the investigation.
- (g) The BH I/DD Tailored Plan shall report new information related to a previously referred potential instance of fraud where PI, the DMH/DD/SAS Financial Audit and Program Integrity teams and MID did not intervene in the investigation to the Department. The BH I/DD Tailored Plan shall submit the new information using the Fraud, Waste, and Abuse Submission Form within five (5) Calendar Days of receiving or identifying the new information.
- (h) The BH I/DD Tailored Plan cannot take action, such as termination or suspension, or withhold of payment, related to potential findings of fraud, waste or abuse without approval of the Department including the DMH/DD/SAS Financial Audit and Program Integrity teams and/or MID. Any such action taken after BH I/DD Tailored Plan has received approval by the Department must be reported to the Department within five (5) Calendar Days of taking the action.
- (i) Action by the BH I/DD Tailored Plan shall not preclude the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams or MID from conducting an audit or accepting a self-disclosure from a provider even if the BH I/DD Tailored Plan has conducted an

audit or accepted a self-disclosure from the same provider on a similar matter or covering a similar time period.

- (j) The BH I/DD Tailored Plan must participate in:
 - (1) Monthly calls with the Department regarding fraud, waste, and abuse;
 - (2) Quarterly in-person meetings with the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID regarding fraud and abuse; and
 - (3) Ad hoc calls or meetings as requested by the Department, including the DMH/DD/SAS Financial Audit and Program Integrity teams and MID.

(iv) Whistleblower Protections

- (a) The BH I/DD Tailored Plan shall develop and maintain a Whistleblower Policy related to whistleblower protections for Medicaid and State-funded Services and submit to the Department for review ninety (90) days after Contract Award.
- (b) The BH I/DD Tailored Plan shall include fraud, waste, and abuse policies and procedure information in the BH I/DD Tailored Plan's employee handbook with reference to and description of the applicable federal and state fraud and abuse laws and regulations, the right of employees to be protected as whistleblowers, and information about the BH I/DD Tailored Plan's compliance policies and how to access those policies.

(v) Fraud Prevention Plan

- (a) The BH I/DD Tailored Plan shall develop and maintain a Fraud Prevention Plan for Medicaid and State-funded Services subject to Department review and approval. The BH I/DD Tailored Plan shall submit the Plan to the Department:
 - (1) Ninety (90) days after Contract Award;
 - (2) Annually thereafter;
 - (3) When substantive or material changes are made to the Fraud Prevention Plan; and
 - (4) Upon request by the Department.
- (b) The BH I/DD Tailored Plan shall make any modification to the Fraud Prevention Plan as required by the Department. The Department has the right to require the BH I/DD Tailored Plan to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the BH I/DD Tailored Plan's Fraud Prevention Plan.
- (c) The Fraud Prevention Plan shall include the following:
 - (1) The definitions of fraud and abuse, that, at a minimum, are consistent with how those terms are defined in 42 C.F.R. § 455.2 and *Section III.A. Definitions*;
 - (2) Name of the Chief Compliance Officer;
 - i. The Chief Compliance Officer shall be responsible for making the decisions on which fraud, waste, or abuse cases to refer to the Department.
 - (3) Description of the SIU, the roles within the SIU, description of the SIU staff qualifications staffing by title, and their relationship and percent of time working on behalf of Medicaid Managed Care and/or State-funded Services;
 - (4) Description of other staff assigned to fraud, waste, and abuse functions;
 - (5) Budget associated with the compliance department and the fraud, waste, and abuse prevention efforts;
 - (6) Internal controls and policies and procedures that are designed to prevent, detect, and report known, potential or suspected fraud and abuse activities;
 - (7) Processes and procedures to ensure that all suspected fraud and abuse are reported in compliance with the Contract;
 - (8) Processes and procedures for Medicaid and State-funded network provider and BH I/DD Tailored Plan staff terminations related to suspected or confirmed fraud and abuse;
 - (9) Processes and procedures by which the BH I/DD Tailored Plan avoids fraud, waste and abuse engaged in by out-of-network Medicaid and State-funded providers;

- (10) Processes and procedures for notifying the Department of suspected or confirmed fraud and abuse by members or recipients;
- (11) Training procedures for directors, officers, employees, delegated entities, and subcontractor education on federal and state laws, as well as BH I/DD Tailored Plan practices for detection, identification, reporting and prevention of fraud, waste and abuse;
- (12) Processes and procedures for ensuring in and out-of-network providers, members and recipients know and understand fraud, waste and abuse obligations;
- (13) Processes and procedures for putting a provider on and taking a provider off prepayment review including, the metrics used and frequency of evaluating whether prepayment review continues to be appropriate. The policy shall be included in the BH I/DD Tailored Plan's Provider Manual;
- (14) Description of the BH I/DD Tailored Plan's specific controls to detect and prevent potential fraud, waste and abuse, including, without limitation:
 - i. A list of automated pre-payment claims edits;
 - ii. A list of automated post-payment claims edits;
 - iii. A list of desk audits on post-processing review of claims planned;
 - iv. A list of reports on Medicaid and State-funded network provider and out-of-network provider profiling used to aid program and payment integrity review;
 - v. The methods the BH I/DD Tailored Plan will use to identify high-risk claims and the BH I/DD Tailored Plan's definition of "high-risk claims;"
 - vi. Visit verification procedures and practices, including sample sizes and targeted providers types or locations;
 - vii. A list of surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Medicaid, waiver, Pilot, or State-funded Services;
 - viii. Policies and procedures used by the BH I/DD Tailored Plan designed to prevent, detect, and report known or suspected fraud, waste and abuse for Medicaid and State-funded Services;
 - ix. A list of references in provider and member and recipient material regarding fraud and abuse referrals (e.g. on member EOB);
 - x. Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly; and
 - xi. The process by which the SIU shall monitor the BH I/DD Tailored Plan's marketing representative activities to ensure that the BH I/DD Tailored Plan does not engage in inappropriate activities, such as provision of inducements.
- (15) Assurance that the identities of individuals reporting violations by the BH I/DD Tailored Plan are protected and that there is no retaliation against such persons;
- (16) Description of criminal background and Exclusion List screening processes for its owners, agents, delegated entities, employees, Network providers and subcontractors; and
- (17) Process and procedures for working and coordinating with the Department, including its state and federal partners, in investigating and prosecuting suspected fraud, waste or abuse.

iv. Third Party Liability (TPL) for Medicaid

- (i) The BH I/DD Tailored Plan shall be responsible for actively seeking and identifying third party resources for the purposes of the following:
 - (a) Cost avoidance;
 - (b) Credit balance;

- (c) Commercial health insurance;
 - (d) Medicare disallowance;
 - (e) Casualty insurance; and
 - (f) Liability insurance.
- (ii) Cost Avoidance
- (a) The BH I/DD Tailored Plan shall provide the following for each policy added for cost avoidance to the Department, in a format to be defined by the Department:
 - (1) Policy number;
 - (2) Policyholder's name;
 - (3) Group Policy number;
 - (4) Group Policy name;
 - (5) Identification of whether the policyholder is the non-custodial parent;
 - (6) Member Medicaid/NC Health Choice ID;
 - (7) Member relationship to policy holder;
 - (8) The begin date of insurance coverage; and
 - (9) The end date of insurance coverage.
 - (iii) The BH I/DD Tailored Plan shall engage in third party resource recovery and cost avoidance for all other types of recovery. BH I/DD Tailored Plan shall not use State-funded Services or Pilot services to cost avoid.
 - (iv) The BH I/DD Tailored Plan shall record and provide the actual start date of insurance coverage for each policy added for cost avoidance to the Department, regardless if the start date began prior to the member becoming Medicaid eligible or was enrolled with the BH I/DD Tailored Plan.
 - (v) The BH I/DD Tailored Plan shall report cost recovery and cost adjustments through the encounter process, including denials.
 - (vi) The BH I/DD Tailored Plan shall make every reasonable effort to determine the liability of third parties to pay for services rendered to members and to cost avoid and/or cost recover such liability from the third party.
 - (vii) The BH I/DD Tailored Plan shall treat all funds recovered by the BH I/DD Tailored Plan from third party resources as income to the BH I/DD Tailored Plan.
- (viii) TPL Recovery
- (a) The BH I/DD Tailored Plan shall demonstrate, upon request, to the Department that reasonable effort has been made to seek, collect and/or report third party recoveries.
 - (b) The BH I/DD Tailored Plan shall open a new case upon receipt of a TPL Accident Information Report form from the member's attorney or other reliable leads that indicate third party recovery might be possible.
 - (c) The BH I/DD Tailored Plan shall be responsible for attorneys retained for tort action, through contact with the members, participating providers, and the Department for seeking and identifying third party resources.
 - (d) The Department shall review the effectiveness of the BH I/DD Tailored Plan's TPL recovery programs annually and may revoke TPL activities from a BH I/DD Tailored Plan if the BH I/DD Tailored Plan's recovery programs do not meet the effectiveness criteria defined by the Department. The effectiveness criteria for the BH I/DD Tailored Plan's TPL recovery programs may include:
 - (1) A comparison to annual Medicaid Fee-for-Service recovery averages to BH I/DD Tailored Plan recovery averages per beneficiary.
 - (2) The percentage of recoveries over total spend.
 - (3) The percentage of cost avoidance over total spend.
 - (4) The average turnaround time from the remittance to recovery.

- (5) The average number of policy adds in comparison to historical Medicaid Fee-for-Service policy adds on a monthly basis.
- (6) Quarterly audits on BH I/DD Tailored Plan encounter data.
- (e) The Department shall be solely responsible for estate, trust, and annuity related recoveries and shall retain funds recovered through these activities.
- (ix) Identification of Other Forms of Insurance
 - (a) The BH I/DD Tailored Plan shall notify the Department within five (5) Calendar Days if it has identified that a member has another form of insurance.
 - (b) The BH I/DD Tailored Plan shall load and submit to the Department updates and additions on other forms of insurance into its system within thirty (30) Calendar Days of matching and verification.
 - (c) The BH I/DD Tailored Plan shall provide the Department with the complete documentation of all policy information including source documents for other forms of insurance that have been updated in the BH I/DD Tailored Plan's system or submitted by the BH I/DD Tailored Plan to the Department for Medicaid Managed Care members.
 - (d) The BH I/DD Tailored Plan shall ensure that the information on member's other forms of insurance is accurately tracked and maintained within the member record. The BH I/DD Tailored Plan must correct all errors made in its submission of other forms of insurance to the Department within five (5) Business Days of becoming aware of the other forms of insurance and must provide proof of such corrections upon request from the Department.
 - (e) The BH I/DD Tailored Plan shall review paid claims to determine which paid claims should have been paid by the member's other forms of insurance instead of by the BH I/DD Tailored Plan.
 - (f) The BH I/DD Tailored Plan shall notify the Department of overpayments paid to the BH I/DD Tailored Plan from an insurance carrier for recovery claims billed by the BH I/DD Tailored Plan for members with other forms of coverage.
 - (g) The BH I/DD Tailored Plan shall bill the applicable insurance carriers for Medicaid Managed Care members' major medical, prescription drug and dental claims within thirty (30) Calendar Days of matching the claims to TPL segments pertaining to members' active insurance policies for commercial insurance direct billing.
 - (1) The BH I/DD Tailored Plan shall adhere to the billing requirements of each commercial insurance carrier.
 - (2) In instances where the carrier will not accept the claim without supporting medical records, the BH I/DD Tailored Plan shall exercise all reasonable efforts to obtain and provide the records to the carrier within thirty (30) Calendar Days of becoming aware of the need for medical records by the commercial insurance to bill.
 - (h) Within ten (10) Business Days after receipt of a direct claim billing denial or other types of denials, the BH I/DD Tailored Plan shall verify the termination date of an existing insurance policy and the activation date of a new policy; update the Department; update insurance policy information in the BH I/DD Tailored Plan's IT system; and resubmit the claim to the appropriate insurance carrier.
- (x) Subrogation Cases
 - (a) Pursuant to 42 C.F.R. § 438.608, the BH I/DD Tailored Plan agrees that all claims experience used for rate setting is net of any third-party recoveries of subrogation activities.
 - (b) The BH I/DD Tailored Plan lien in each subrogation case shall be equal to the payments made by the BH I/DD Tailored Plan.
 - (c) The BH I/DD Tailored Plan shall identify the BH I/DD Tailored Plan paid medical claims amounts for each subrogation case using data from the paid claims file.
 - (d) Relevant information in the subrogation case at the time of closure shall include:
 - (1) Settlement sheet listing all providers with medical subrogation rights.

- (2) Original lien amount of each entity with subrogation right.
 - (3) The BH I/DD Tailored Plan recovered amount.
 - (4) The amount disbursed to each entity involved.
 - (e) The BH I/DD Tailored Plan shall review the diagnosis code and member's past medical history to determine which services were rendered as a result of the accident or injury and shall establish a lien in the appropriate amount.
 - (f) A subrogation case shall be closed with recovery after the BH I/DD Tailored Plan lien has been satisfied to the statutory limits, as referenced in N.C. Gen. Stat. § 108A-57. A subrogation case can be closed either with or without recovery. The Department will approve the closing of a case without recovery only after the BH I/DD Tailored Plan provides relevant and adequate documentation supporting the reason for case closure without recovery. The BH I/DD Tailored Plan shall obtain and record all relevant information in the subrogation case at the time of closure.
 - (g) In accordance with N.C. Gen. Stat. § 108A-57(a1), the BH I/DD Tailored Plan shall collect the amount of the BH I/DD Tailored Plan lien or up to one-third (1/3) of the amount of the member's gross recovery in the personal injury or wrongful death case, whichever is less.
 - (h) The BH I/DD Tailored Plan shall coordinate collection of the settlement amount with the member or the member's attorney.
 - (i) The BH I/DD Tailored Plan shall discuss the case with the Department's designated legal counsel in the event of a dispute regarding the BH I/DD Tailored Plan's claim to any part of the proceeds of any settlement.
 - (j) The BH I/DD Tailored Plan shall not compromise, waive or reduce the BH I/DD Tailored Plan's lien without written authorization from the Department or its designated legal counsel.
 - (k) The BH I/DD Tailored Plan shall document all of its case activities including meetings, phone calls and correspondence for subrogation cases. This documentation shall become a permanent part of the case record.
 - (l) The BH I/DD Tailored Plan shall monitor the status of aged subrogation cases and take specific action on these cases as directed by the Department.
 - (xi) The BH I/DD Tailored Plan shall develop and maintain a TPL Policy for review and approval by the Department.
 - (a) The TPL Policy shall include the following:
 - (1) Cost avoidance activities;
 - (2) Payment recovery activities;
 - (3) Identification of other forms of insurance processes and procedures; and
 - (4) Subrogation, including:
 - i. The analysis of the State motor vehicle accident report file data exchange required under 42 C.F.R. § 433.138(d)(4)(ii) to identify potential subrogation claims and identify beneficiaries with a legal liable third party; and
 - ii. Methods for conducting diagnosis and trauma code editing to identify potential subrogation claims. This editing should, identify claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or claims submitted with an accident trauma indicator of 'Y.'
 - (b) The BH I/DD Tailored Plan shall submit the TPL Policy:
 - (1) Ninety (90) days after Contract Award;
 - (2) Annually thereafter; and
 - (3) Upon request by the Department.
- v. TPL for State-funded Services

- (i) The BH I/DD Tailored Plan shall require its providers to pursue all applicable first and third-party payments for services, including Medicaid funding and the Division of Vocational Rehabilitation (DVRs) funding for Supported Employment, in order to minimize the usage of State resources.
 - (ii) In the event that a recipient has third party coverage, the BH I/DD Tailored Plan shall coordinate benefits so that costs for services otherwise payable by non-Medicaid funds are avoided or recovered from any liable third-party payers.
 - (iii) The BH I/DD Tailored Plan's claims system shall include appropriate edits for coordination of benefits coordination of benefits and first and third-party liability.
 - (iv) The BH I/DD Tailored Plan shall develop and implement monitoring of provider compliance with first and third-party requirements.
- vi. Medicaid Service Recipient Explanation of Medical Benefit (REOMB) for Medicaid
- (i) The BH I/DD Tailored Plan shall create the REOMB using the previous month's claims for North Carolina Medicaid (i.e. February claims comprise March REOMB sample).
 - (ii) The BH I/DD Tailored Plan shall include the following in the REOMB:
 - (a) List of services provided and billed to the BH I/DD Tailored Plan;
 - (b) The name of the provider administering the service;
 - (c) The date(s) on which the service was administered;
 - (d) The paid and unpaid services; and
 - (e) The reason a service was not paid.
 - (iii) The BH I/DD Tailored Plan shall exclude those claims that include sensitive information, claims that have been adjusted, and Medicare crossover claims when creating the REOMB. Sensitive information shall be defined as any procedures for allergies, newborn treatment and care, and any treatment for a member's reproductive health including but not limited to screening and treatment for communicable diseases, pregnancy, sterilization, and substance abuse disorder information protected by 42 C.F.R. Part 2.
 - (iv) The BH I/DD Tailored Plan shall exclude sensitive information for minors when creating the REOMB sample as defined by the Department. Minor shall be defined in accordance with N.C. Chapter 48A.
 - (v) The BH I/DD Tailored Plan shall send a REOMB for at least ten percent (10%) of all claims or 500 claims for the month, whichever is less. (Excluded claims include those in referenced in this Section).
 - (vi) The BH I/DD Tailored Plan shall send the REOMB via US mail to randomly selected members who have been approved by the Department. The BH I/DD Tailored Plan shall collect responses from the REOMB mailing.
 - (vii) The BH I/DD Tailored Plan shall use a Department approved sampling method to determine the population to receive the REOMB and include it in the BH I/DD Tailored Plan's annual Fraud Prevention Plan.
 - (viii) The BH I/DD Tailored Plan shall follow the defined Department policies for investigating and reporting suspected fraud, waste, and abuse identified from the REOMB response.
 - (ix) The BH I/DD Tailored Plan shall provide a REOMB to a member upon request.
4. Stakeholder Engagement and Community Partnerships
- i. Engagement with Tribes for Medicaid Only
 - (i) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of all tribal members and other individuals eligible to receive Indian Health Services, including North Carolina's federally recognized tribe (the Eastern Band of Cherokee Indians) and state-recognized tribes.
 - (ii) As specified in N.C. Gen. Stat. § 160-40(a)(5) and (5a), members of federally recognized tribes are exempt from mandatory enrollment in Medicaid Managed Care, and the Department will seek statutory authorization to exempt from mandatory enrollment in Medicaid Managed Care other

individuals eligible to receive Indian Health Services, consistent with federal law. Members of state-recognized tribes are required to enroll in Medicaid Managed Care unless they are Members of otherwise excluded populations.

- (iii) The Department is collaborating with the EBCI to develop the EBCI Tribal Option that considers and addresses the unique cultural, physical/medical behavioral, and social determinants of health needs of federally recognized tribal members and other individuals eligible to receive Indian Health Services.
- (iv) Federally recognized tribal members and other individuals eligible to receive Indian Health Services will be enrolled in the Tribal Option if they live in the five western counties of Swain, Jackson, Haywood, Cherokee, and Graham counties. Individuals will have the ability to opt out of the Tribal Option if they reside in those five counties and participate in Medicaid Managed Care (either a Standard Plan or BH I/DD Tailored Plan, as applicable) or NC Medicaid Direct.
- (v) The BH I/DD Tailored Plan shall establish an ongoing meaningful partnership and collaboration with any state- and federally-recognized Tribes located within the service area of the BH I/DD Tailored Plan. All BH I/DD Tailored Plans are required to establish a partnership with the Eastern Band of the Cherokee as they manage and operate the IHCPs in NC in which all federally recognized tribal members are entitled to access regardless of location or geography.
- (vi) The BH I/DD Tailored Plan shall implement a Tribal Engagement Strategy which maximizes accessible, patient and family centered quality health and behavioral and I/DD care and supports for the individual, family, or community members of both state- and federally-recognized tribes. The Strategy should adapt individual engagement interventions unique to the Tribe's respective culture, address access to programs, and policies that target health and social determinant disparities, demonstrate Cultural and Linguistic Competency, respect and honor and fit the historical and cultural context of the individual, family, or community members of Tribes. The Strategy should clearly articulate differences (e.g., Medicaid enrollment options, federal payment and funding allowances, etc.) for members of state- and federally-recognized tribes. The engagement strategy should outline the impact of tribal history on the issues facing native Americans in today's environment as it relates to their health status.
- (vii) The Tribal Engagement Strategy shall include:
 - (a) A proposal of an administrative, clinical and operating model intended to meet the needs of tribal members in the service area of the BH I/DD Tailored Plan;
 - (b) A proposal to access IHCP services for federally recognized tribal members regardless of location of the BH I/DD Tailored Plan;
 - (c) Culturally and Linguistically Competent, proactive, innovative methods for engaging and communicating with tribal members and tribal leadership;
 - (d) A proposal and strategy to improve communication through the utilization of the state or regional health information exchange like Health Connex in order to improve coordination of care and health outcomes for tribal members and reduce duplication and administration as a result of multiple IT systems;
 - (e) A description of how the BH I/DD Tailored Plan's care management and quality strategies take into consideration the needs of tribal members and working with tribal providers, utilizing those quality measures already in place for Standard Plans or with the Tribal Option;
 - (f) A description of the proposed relationship with the Tribal AMH/AMH+;
 - (g) A description of how the plan will coordinate with the EBCI Family Safety Office, the Tsali Public Health Agency and other programs within EBCI;
 - (h) A description of how the BH I/DD Tailored Plan will integrate with and coordinate with tribal organizations or agencies (e.g., community-based organizations, services or entities) serving tribal members in the service area of the BH I/DD Tailored Plan or that have the right to access IHCPs;

- (i) Medicaid Managed Care education and resources that address the unique needs, cultural experiences of Native Americans and how historical experience may lead to health disparities, create barriers to health care, provider access and service delivery; and
- (j) A description of how the BH I/DD Tailored Plan will coordinate with tribal organizations to address tribal needs which may be different and outside of the traditional safety-net system, such as Family Safety (child welfare and adult protective services), energy assistance programs, and commodities managed and operated by the Tribe. The plan shall address both tribal operated and county operated services that are accessed by Tribal members.
- (viii) The Tribal Engagement Strategy shall be submitted to the Department for review and approval within ninety (90) days of Contract Award. The Strategy shall be updated annually, with consultation with the Tribe and resubmitted to the Department for review.
- (ix) The BH I/DD Tailored Plan shall consult with the Indian Tribes and Tribal Organizations, in a manner agreed upon by the individual Tribes regarding Medicaid Managed Care initiatives impacting tribal populations or providers.
- (x) The BH I/DD Tailored Plan shall collaborate with the Tribes in the service area of the BH I/DD Tailored Plan to facilitate, in a manner agreed upon by the individual Tribes, meetings and forums with tribal leaders and IHCPs that serve tribal members.
- (xi) The BH I/DD Tailored Plan shall collaborate with the Tribes in developing any member education and training materials. The manner for such collaboration shall be outlined in the Tribal Engagement Strategy and must be approved by the Tribes.
- (xii) The BH I/DD Tailored Plan shall make member education and training material available to licensed and unlicensed physical and BH personnel who work with Tribal members, upon request by such personnel.
- (xiii) The BH I/DD Tailored Plan shall comply with the IHCP payment requirements and the IHCP contracting requirements as defined in the Contract, to the extent such requirements are applicable and the DHHS Tribal Payment Policy.
- (xiv) The BH I/DD Tailored Plan shall provide and maintain a single point of contact for IHCP billing issues to the Department and with the Tribe.
- (xv) The BH I/DD Tailored Plan shall ensure its staff, materials, and resources adhere to the requirements described in *Section V.B.1.iii. Member Engagement*.
- (xvi) Annually, the BH I/DD Tailored Plan shall train its staff regarding the BH I/DD Tailored Plan's Tribal Engagement Strategy and in providing Culturally and Linguistically Competent and consumer-specific supports to the tribal population as referenced in *Section V.A.2.iii. Staff Training for Medicaid and State-funded Services*. Training materials used referencing federally recognized tribes shall be reviewed by the EBCI prior to training. Reasonable time for review shall be established as part of the Tribal engagement strategy.
- ii. Engagement with Community and County Organizations for Medicaid and State-Funded Services
 - (i) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of North Carolina's local communities, including county agencies (e.g., LHDs, county mental health associations, local Department of Social Services, Area Agency on Aging, Local Education Agencies, housing authorities, county commissioners, children's developmental services agencies, local systems of care programs, law enforcement, justice and judicial agencies such as sheriff departments, police departments, pre and post-trial release programs, reentry councils, county magistrates) and county and community based organizations (e.g., homeless shelters, continuums of care, homelessness and housing providers, faith-based organizations, food pantries, domestic violence agencies, consumer and peer run organizations) to help guide and support the delivery of services to members, recipients and their families in their Region.

- (ii) The BH I/DD Tailored Plan shall engage with CFACs as required by Chapter 122-C-171, non-profits and county and community-based organizations (CBOs) to understand the potentially unique resources and needs of each community.
- (iii) The BH I/DD Tailored Plan shall include strategies to effectively integrate its model of care and eliminate service access barriers within the local communities it serves. The BH I/DD Tailored Plan shall establish an ongoing partnership with the Department and North Carolina County Agencies (“County Agencies”), CFACs, nonprofits, and CBOs in the Region that the BH I/DD Tailored Plan is contracted to cover with the primary goals of getting feedback from members, families and advocates to improve service delivery, access, and outcomes.
 - (a) This shall include providing support staff to local or regional CFACs with the goals of assisting CFACs in performing their statutory duties as outlined in NC G.S. 122c-170 and all relevant statutory provisions with the primary goals of working to address service barriers, identify system gaps, and assess policies impacting service delivery and access.
- (iv) The BH I/DD Tailored Plan shall develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with County Agencies, CFACs and CBOs and build partnerships at the local level to improve the health of their members and recipients.
 - (a) The Local Community Collaboration and Engagement Strategy shall address how the BH I/DD Tailored Plan will work to reduce potential local barriers to health such as program eligibility, enrollment continuity, member and recipient engagement, unmet resource needs (e.g. transportation, food insecurity, housing) and local continuums of care.
 - (1) The strategy shall include:
 - i. An approach to understand the unique needs of the counties and communities the BH I/DD Tailored Plan serves;
 - ii. Methods of collaborative outreach and engagement with county agencies, CBOs, and other community partners;
 - iii. Measures of successful engagement and collaboration;
 - iv. Measures to foster community inclusion supporting BH I/DD Tailored Plan members and recipients; and
 - v. Reporting of outcomes to County Agencies, CFACs, CBOs, and other community partners.
 - (b) The BH I/DD Tailored Plan shall submit the Local Community Collaboration and Engagement Strategy to the Department for review and approval ninety (90) days following BH I/DD Tailored Plan Contract Award. The Strategy shall be updated annually and resubmitted to the Department for review.
 - (v) The BH I/DD Tailored Plan shall consult with the County Agencies, county executives and/or the county commissioners’ association quarterly regarding Medicaid Managed Care and State-funded Services initiatives impacting counties and community organizations.
 - (vi) The BH I/DD Tailored Plan shall facilitate, at least semi-annually, meetings and forums with the County Agencies, county executives and/or the county associations to report on progress of Local Community Collaboration and Engagement Strategy.
 - (vii) The BH I/DD Tailored Plan shall support local collaboratives that are focused on addressing the unique needs of the populations they serve.
 - (a) The BH I/DD Tailored Plan shall staff city or county Community Collaboratives, work to address service barriers, identify system gaps, and develop cross system training plans for children receiving services in their areas as referenced in *Section V.B.3.vii. System of Care*; and
 - (b) The BH I/DD Tailored Plan shall participate in local crisis collaboratives as detailed in *Section V.A.4.v. Community Crisis Services Plan for Medicaid and State-funded Services*.

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

- (ii) The BH I/DD Tailored Plan shall work in collaboration with the Department and with other public agencies, local, regional and statewide housing and homeless populations' service providers and Department housing staff to support the expansion of supportive housing opportunities available to persons with mental illness, I/DD, TBI and/or SUDs.
- (iii) The BH I/DD Tailored Plan shall develop and annually update a BH I/DD Tailored Plan Regional Housing Plan for its members and recipients that reflects the unique aspects of each Region, is parallel to the goals that will be outlined within the Statewide Housing Plan to reduce homelessness, increase entry into and sustain supportive housing, promote independence for people with disabilities, improve an individual's health and help individuals retain employment; and will be due to the Department as determined upon the adoption of the Statewide Housing Plan.
 - (a) The Department is in the process of developing a Statewide Housing Plan for the broader North Carolina population that will inform the BH I/DD Tailored Plan's Regional Housing Plan.
- (iv) The BH I/DD Tailored Plan Regional Housing Plan shall:
 - (a) Incorporate housing inventory data from existing local housing stock in the BH I/DD Tailored Plan's Region for persons with mental illness, SUDs, I/DD and/or TBI;
 - (b) Include strategies for implementation of housing objectives, milestones/goals, including to: reduce homelessness, increase entry into and sustain supportive housing, promote independence for members and recipients with disabilities, improve members' and recipients' health, help members and recipients retain employment, increase landlord engagement to increase available units for members;
 - (c) Identify and address gaps in housing programs and infrastructure, including to: offer rapid rehousing services and/or partner with local agencies to build local capacity; and
 - (d) Be updated, submitted to and reviewed by the Department no less than quarterly.
- (v) The BH I/DD Tailored Plan shall employ care management housing specialists to act as experts on supportive housing for members and organizations providing Tailored Care Management as referenced in *Section V.B.3.ii. Tailored Care Management*.
 - (a) The housing staff shall have the knowledge, expertise and experience to support and oversee affordable and supportive housing programs in local municipalities and local geographic areas including census tracts.
- (vi) The BH I/DD Tailored Plan's care management housing specialist(s) shall attend the four (4) quarterly meetings and any ad hoc meetings of Housing Specialists that are facilitated by the Department.
- (vii) Education and Outreach
 - (a) The BH I/DD Tailored Plan shall provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable and supportive housing, and on negotiating reasonable accommodations.
 - (b) The BH I/DD Tailored Plan shall:
 - (1) Collaborate with Department professionals and their vendors along with other stakeholders to identify and secure housing as referenced in *Section V.B.3.ii. Tailored Care Management*.
 - (2) Make available in multiple venues where service providers convene information to identify housing resources, expand knowledge of eligibility requirements for different housing programs, how to access affordable housing resources, including information on, for example: the Fair Housing Act, Landlord and Tenant Rights, barriers associated with Not In My Back Yard (NIMBY), and information to reduce stigma associated with mental illness, I/DD, TBI and SUDs.

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

(viii) Collaborative Relationships

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

- (9) Provide technical assistance and support to identified agencies applying for state and federal funding opportunities for supportive housing (e.g., justification of need, providing data and information as it relates to available support services) as resources allow.
 - (ix) For State-funded Services, the BH I/DD Tailored Plan shall provide housing subsidy administration services in accordance with the Professional Services Agreement Between the Department, the North Carolina Housing Finance Agency and the BH I/DD Tailored Plan.
- v. Community Crisis Services Plan for Medicaid and State-funded Services
 - (i) The BH I/DD Tailored Plan shall implement the community crisis services plan as defined in N.C. General Statute § 122c-202.2.
 - (ii) The community crisis services plan defined in the statute, shall cover the BH I/DD Tailored Plan's entire Region and shall be comprised of one or more local area crisis plans.
 - (iii) The BH I/DD Tailored Plan shall submit an updated community crisis services plan to the Department at least every two years and when there are Significant Changes as defined by the Department.
 - (iv) The BH I/DD Tailored Plan shall include in the Crisis Planning Committee all affected agencies, including all Standard Plans that cover any of the counties covered in the local area crisis plan when updating the community crisis services plan.
 - (v) The community crisis services plan shall not be considered complete by the Department unless all affected agencies have signed and agreed to each local area crisis plan.
 - (vi) The BH I/DD Tailored Plan shall coordinate with Standard Plans and local communities around efforts to increase access to and secure the sustainability of BH crisis options, including through development of innovative approaches to BH crisis management as defined in each community crisis services plan and alternatives to involving law enforcement in behavioral health crisis response.
 - (vii) The BH I/DD Tailored Plan shall participate in local or regional crisis collaboratives with local magistrates, law enforcement, county commissioners, crisis providers, and hospitals, to meet and regularly share information on improvements to the crisis continuum.

B. Medicaid

1. Members

- i. Eligibility and Enrollment for BH I/DD Tailored Plans
 - (i) Department Roles and Responsibilities
 - (a) Pursuant to Article 4. of Chapter 108D of the General Statutes, the Department was directed to transition certain North Carolina Medicaid and NC Health Choice populations, including populations eligible for BH I/DD Tailored Plans from a Medicaid Fee for Service structure to a Medicaid Managed Care structure. The Department shall maintain authority in determining North Carolina Medicaid and NC Health Choice eligibility and defining populations to be transitioned into Medicaid Managed Care consistent with Article 4. of Chapter 108D of the General Statutes.
 - (b) The Department shall maintain sole authority for performing, managing, and maintaining all Medicaid eligibility, BH I/DD Tailored Plan eligibility, enrollment and cost sharing determinations. The BH I/DD Tailored Plan shall be responsible for adhering to Medicaid eligibility, enrollment and cost sharing determinations made by the Department. It is the responsibility of the Enrollment Broker, the BH I/DD Tailored Plan and other partners of the Department operating within Medicaid Managed Care to adhere to the determinations made by the Department. The Department reserves the right to modify the eligibility criteria and populations eligible to enroll in a BH I/DD Tailored Plan, for all or a limited package of benefits, as authorized under current or future state law.

- (c) The Department shall be responsible for determining if a beneficiary is Medicaid Managed Care excluded, exempt or mandatory at any point in time.
 - (d) The Department shall be responsible for determining if a beneficiary is BH I/DD Tailored Plan eligible and will conduct regular data reviews over a defined lookback period to identify beneficiaries who are BH I/DD Tailored Plan eligible.
 - (e) The Department will review requests to enroll in a BH I/DD Tailored Plan submitted by, or on behalf of, beneficiaries who are not identified as BH I/DD Tailored Plan eligible based upon available data.
 - (f) The Department shall be responsible for transmitting to the BH I/DD Tailored Plan all information related to North Carolina Medicaid and NC Health Choice eligibility and cost sharing via the Medicaid Managed Care eligibility file format.
 - (g) Consistent with 42 C.F.R. § 438.810, the Department may contract with an Enrollment Broker to:
 - (1) Educate beneficiaries on Medicaid Managed Care;
 - (2) Provide choice counseling and enrollment assistance to beneficiaries and/or to their authorized representatives who want to select a Standard Plan or BH I/DD Tailored Plan or a primary care provider (PCP); and
 - (3) Transmit enrollment selections and approved disenrollment requests to the Standard Plan or BH I/DD Tailored Plan to effectuate.
- (ii) BH I/DD Tailored Plan Eligible Populations
- (a) In accordance with N.C. Gen. Stat. § 108D-40(a)(12), the following populations who are not otherwise excluded from Medicaid Managed Care as described in *Section V.B.1.i.(iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care* shall be eligible for enrollment in BH I/DD Tailored Plans upon their launch:
 - (1) Individuals with a serious emotional disturbance (SED) or a diagnosis of severe substance use disorder (SUD) or traumatic brain injury (TBI).
 - (2) Individuals with a developmental disability as defined in N.C. Gen. Stat. § 122C-3(12a).
 - (3) Individuals with a mental illness diagnosis who also meet any of the following criteria:
 - i. Individuals with serious mental illness (SMI) or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transitions to Community Living Initiative (TCLI) settlement agreement.
 - ii. Individuals with two (2) or more psychiatric hospitalizations or readmissions within the prior eighteen (18) months.
 - iii. Individuals who have had two (2) or more visits to the emergency department for a psychiatric problem within the prior eighteen (18) months and are assessed by the Department as eligible for the BH I/DD Tailored Plan.
 - iv. Individuals known to the Department or an LME/MCO to have had one (1) or more involuntary treatment episodes within the prior eighteen (18) months.
 - (4) Individuals who, regardless of diagnosis, meet any of the following criteria:
 - i. Individuals who have had two (2) or more episodes using BH crisis services within the prior eighteen (18) months and are assessed by the Department as eligible for the BH I/DD Tailored Plan.
 - ii. Individuals receiving any of the BH, I/DD, or TBI services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered by a Standard Plan in accordance with N.C. Gen. Stat. § 108D-35(1).

- iii. Individuals who are receiving or need to be receiving BH, I/DD, or TBI services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
 - iv. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina.
 - v. Children aged zero (0) to three (3) years old with, or at risk for, developmental delay or disability.
 - vi. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department.
- (iii) Populations Excluded, Exempt and Delayed from Medicaid Managed Care
- (a) In accordance with N.C. Gen. Stat. § 108D-40(a), the following populations shall be excluded from Medicaid Managed Care, including BH I/DD Tailored Plans¹:
 - (1) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing;
 - (2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
 - (3) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
 - (4) Medically needy Medicaid beneficiaries except for beneficiaries enrolled in the Innovations or TBI waivers²;
 - (5) Presumptively eligible beneficiaries, during the period of presumptive eligibility;
 - (6) Beneficiaries who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program except for beneficiaries enrolled in the Innovations or TBI waivers³;
 - (7) Beneficiaries enrolled under the Medicaid Family Planning program;
 - (8) Beneficiaries who are inmates of prisons;
 - (9) Beneficiaries being served through CAP/C;
 - (10) Beneficiaries being served through CAP/DA (includes beneficiaries receiving services under CAP/Choice); and
 - (11) Beneficiaries with services provided through the PACE.⁴
 - (12) Beneficiaries enrolled in the Optional COVID-19 (MCV) Testing Program.⁵
 - (b) Because the Innovations and TBI waivers shall only be offered by the BH I/DD Tailored Plans upon their launch, the Department has authority under N.C. Gen. Stat. § 108D-40(b) to enroll

¹ The Department is seeking a change in State law to clarify that individuals enrolled in the Optional COVID-19 (MCV) Testing Program, authorized under Section 4.5 of S.L. 2020-4, are also excluded from Medicaid Managed Care, if the coverage is still available at the launch of Medicaid Managed Care.

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

³ Because the Innovations and TBI waivers will only be offered by the BH I/DD Tailored Plans upon their launch, Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

⁴ The Department includes beneficiaries with services provided through the PACE program as a population excluded from managed care pursuant to N.C. Gen. Stat. § 108D-35(3), which excludes all PACE program services from Medicaid Managed Care.

⁵ The Department is seeking a change in State law to clarify that individuals enrolled in the Optional COVID-19 (MCV) Testing Program, authorized under Section 4.5 of S.L. 2020-4, are also excluded from Medicaid Managed Care, if the coverage is still available at the launch of Managed Care.

beneficiaries enrolled in the Innovations or TBI waiver in BH I/DD Tailored Plans, regardless of whether they otherwise are part of a group that is delayed or excluded from managed care.

- (1) All provisions of this contract shall apply to BH I/DD Tailored Plan members who are enrolled in the Innovations or TBI waiver unless otherwise noted. BH I/DD Tailored Plans that do not offer the TBI waiver will not be subject to provisions of this contract that apply to the TBI waiver.
 - (2) Beneficiaries who are enrolled in the Innovations or TBI waiver and are also medically needy or participants in the NC HIPP program shall enroll in a BH I/DD Tailored Plan at BH I/DD Tailored Plan launch for all Medicaid-covered services.
- (c) In accordance with N.C. Gen. Stat. § 108D-40(a)(5) and (5a), the following population shall be exempt from Medicaid Managed Care, including BH I/DD Tailored Plans:
- (1) Beneficiaries who are members of federally recognized tribes and beneficiaries eligible to receive services from the Indian Health Service are exempt from Medicaid Managed Care. These beneficiaries will default to the Tribal Option or NC Medicaid Direct depending on their county of residence, but will have the choice to enroll in a Standard Plan or BH I/DD Tailored Plan (if eligible). More details of these options can be found in *Section V.B.4.i.(iii)(c) Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)*.
- (d) In accordance with N.C. Gen. Stat. § 108D-40(a)(13), the following populations are temporarily excluded, for a period not to exceed five (5) years from the date Standard Plan contracts begin, and shall be treated as excluded until the Department includes them in Medicaid Managed Care, including BH I/DD Tailored Plans:
- (1) Beneficiaries who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of ninety (90) days or longer and (ii) are not being served through CAP/DA. If an individual enrolled in a BH I/DD Tailored Plan resides in a nursing facility for ninety (90) days or more, such an individual shall be disenrolled from the BH I/DD Tailored Plan on the first day of the month following the ninetieth (90th) day of the stay and enrolled in NC Medicaid Direct.
 - i. The Department considers beneficiaries residing in or determined eligible for and transferred to a state-owned Neuro-Medical Center operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) or a Veterans Home operated by the Department of Military and Veterans Affairs (DMVA) to be temporarily excluded until the beneficiary is discharged and determined eligible for Medicaid Managed Care.
 - ii. For members of the BH I/DD Tailored Plan determined eligible for and transferred for treatment to a DSOHF Neuro-Medical Center or state-owned Veterans Home after BH I/DD Tailored Plan implementation, the Department shall disenroll the member in accordance with the *Section VII. Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and the Contract.
 - (2) Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing, excluding beneficiaries served through CAP/DA and beneficiaries enrolled in the Innovations or TBI waivers⁶.

⁶ Because the Innovations and TBI waivers will only be offered by the BH I/DD Tailored Plans upon their launch, Beneficiaries who are otherwise excluded from Medicaid Managed Care but are enrolled in those waiver programs will need to enroll in a BH I/DD Tailored Plan, pursuant to N.C. Gen. Stat. § 108D-40(b), to continue to access those services.

- (3) Recipients who are enrolled in the foster care system, receiving Title IV-E adoption assistance, under the age of twenty-six (26) and formerly were in the foster care system, or under the age of twenty-six (26) and formerly received adoption assistance.
- (e) Pursuant to N.C. Gen. Stat. § 108D-40(b), populations excluded from Medicaid Managed Care or populations who have been temporarily excluded from Medicaid Managed Care may be enrolled at any time, as determined by the Department, if eligible to receive a service that is not available in NC Medicaid Direct but is offered by the BH I/DD Tailored Plan.
- (f) At any time during the Contract Term, the Department reserves the right to amend the contract based on an increase or decrease in covered populations included in the Medicaid Managed Care program based on federal or state law or regulatory changes, federally approved Medicaid waivers for North Carolina, or a change in the enrollment processes or BH I/DD Tailored Plan eligibility criteria.
- (iv) The Department believes that certain groups of beneficiaries meeting one or more of the BH I/DD Tailored Plan eligibility criteria who are otherwise excluded from Medicaid Managed Care will benefit from BH I/DD Tailored Plan enrollment. The following legislative changes will impact eligibility or coverage of services by a BH I/DD Tailored Plan upon becoming law:
 - (a) The Department is seeking a change in State law to allow Beneficiaries who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing are eligible to enroll in a BH I/DD Tailored Plan at BH I/DD Tailored Plan launch for Medicaid-covered BH, I/DD, and TBI services if they meet one of the BH I/DD Tailored Plan eligibility criteria. They will receive all other Medicaid-covered services through NC Medicaid Direct.
 - (b) The Department is exploring seeking a change in State law to allow Beneficiaries who are medically needy, participate in the NC HIPP program, or are enrolled in the CAP/C or CAP/DA waivers if they meet one of the BH I/DD Tailored Plan eligibility criteria to enroll in a BH I/DD Tailored Plan for Medicaid-covered BH, I/DD, and TBI services. They would receive all other Medicaid-covered services through NC Medicaid Direct.
- (v) Medicaid Managed Care Enrollment and Disenrollment
 - (a) BH I/DD Tailored Plan Roles and Responsibilities
 - (1) The BH I/DD Tailored Plan must adhere to BH I/DD Tailored Plan eligibility decisions made by the Department and enroll or disenroll beneficiaries in accordance with those decisions and this Contract.
 - (2) The BH I/DD Tailored Plan shall accept all new enrollment from individuals, as directed by the Department, in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the Contract. 42 C.F.R. § 438.3(d)(1).
 - (3) The BH I/DD Tailored Plan shall have staff with sufficient knowledge about the North Carolina Medicaid and NC Health Choice programs and eligibility categories to process and resolve exceptions related to eligibility and enrollment member information as defined by the Department.
 - (4) The BH I/DD Tailored Plan shall notify the Department in a format defined by the Department within five (5) Business Days after it identifies information in a member's circumstances that may affect the member's Medicaid or NC Health Choice eligibility, including changes in the member's residence, such as out-of-state claims, or the death of the member. 42 C.F.R. § 438.608(a)(3).
 - (5) The BH I/DD Tailored Plan shall ensure automatic reenrollment of a member who is disenrolled solely because he or she loses North Carolina Medicaid or NC Health Choice eligibility for a period of two (2) months or less. 42 C.F.R. § 438.56(g).
 - (6) The BH I/DD Tailored Plan shall only process enrollment for beneficiaries who are eligible for BH I/DD Tailored Plan coverage.

- (7) The BH I/DD Tailored Plan shall notify the Department in a format defined by the Department of the receipt of enrollment information for any beneficiary who is ineligible for BH I/DD Tailored Plan within five (5) Business Days.
 - (8) The BH I/DD Tailored Plan shall adhere to the Department's Medicaid Managed Care enrollment approach, including but not limited to BH I/DD Tailored Plan enrollment format and processes, as defined in *Section VII. Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and consistent with federal regulations
 - (9) The BH I/DD Tailored Plan shall direct the member to the NC FAST online portal or perform a Warm Transfer to the local DSS office if a beneficiary contacts it regarding changes to demographic information (e.g., mailing address, phone number, etc.); this requirement does not apply to the choice of Standard Plan or BH I/DD Tailored Plan, PCP or, if applicable, prescriber.
 - (10) The BH I/DD Tailored Plan shall, if a member contacts the BH I/DD Tailored Plan to change to a Standard Plan or another BH I/DD Tailored Plan (e.g., if they change Regions), perform a Warm Transfer to the Enrollment Broker.
 - (11) The BH I/DD Tailored Plan shall ensure as outlined in *Section V.A.2. Program Operations* that its telephone system will have the functionality to transfer beneficiaries and authorized representatives from the call center to local DSS office without disconnecting the call.
 - (12) If a member's demographic information is not updated during the next member reconciliation cycle with the BH I/DD Tailored Plan and the Department, the BH I/DD Tailored Plan shall follow up with members to provide them with information on how to change their demographic information and assist in making a connection to the local DSS office or NC FAST online portal.
- (b) Beneficiary Disenrollment
- (1) The BH I/DD Tailored Plan shall adhere to the Department's Medicaid Managed Care disenrollment approach as defined in *Section VII. Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy* and consistent with federal regulations at 42 C.F.R. § 438.56, including but not limited to:
 - i. Member disenrollment requests; and
 - ii. Department disenrollment requests.
 - (2) The BH I/DD Tailored Plan shall accept and process all BH I/DD Tailored Plan enrollments and disenrollments within twenty-four (24) hours of receipt of the standard eligibility file defined by the Department and effectuate enrollment and disenrollment according to the effective date provided on the standard eligibility file.
 - (3) The BH I/DD Tailored Plan shall comply with the Department's membership reconciliation process as defined in *Section V.B.8. Technical Specifications*.
 - (4) The BH I/DD Tailored Plan shall develop and maintain a Member Enrollment policy. No later than ninety (90) days after the Contract Award the policy shall be submitted to the Department for review and approval. The BH I/DD Tailored Plan shall submit to the Department for review any updates to the policy at least ninety (90) days prior to implementation.
- ii. Transitions of Care
- (i) Ongoing Requirements
 - (a) The BH I/DD Tailored Plan shall develop policies, processes and procedures to support members transitioning between BH I/DD Tailored Plans, from Standard Plans to BH I/DD Tailored Plans, BH I/DD Tailored Plans to Standard Plans, other types of plans established by

the Department (e.g., Tribal Option or Statewide Specialized Foster Care Plan) or between delivery systems (e.g., from NC Medicaid Direct to a BH I/DD Tailored Plan).

- (b) Sixty days (60) following Contract Award, the BH I/DD Tailored Plan shall provide the Department with a contact person who will coordinate Transitions of Care for newly enrolling members on behalf of the BH I/DD Tailored Plan, including for the initial transition to BH I/DD Tailored Plan.
- (c) The BH I/DD Tailored Plan shall accept and transfer member's claims/encounter history, prior authorizations and transition file content, as described in *Section V.B.1.ii.(i) Transitions of Care: Ongoing Requirements*, between BH I/DD Tailored Plans, Standard Plans and other authorized Department Business Associates in accordance with the Department's data transfer protocols and related privacy and security requirements. The BH I/DD Tailored Plan shall adhere to the Department's Transition of Care Policy for newly enrolling members and members transitioning out of the BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall at a minimum:
 - (1) Identify newly enrolled members, as defined in *Section VII. Attachment M.1. North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*, who are transitioning from another BH I/DD Tailored Plan, Standard Plan, other plan established by the Department, or other delivery system such as NC Medicaid Direct. Protocols shall be made available to the Department, upon request.
 - (2) Provide for the transfer and receipt of relevant member information, including a summary page narrative of member-specific circumstances that are time-sensitive or potentially impact continuity of care, a summary listing of the member's providers, treatment records that would encompass both physical and BH, care management records, open service authorizations, prescheduled appointments, NEMT, historic claims and encounter data, and other pertinent materials, to the transitioning member's receiving entity (the entity, such as the BH I/DD Tailored Plan, Standard Plan, other type of plan established by the Department, or NC Medicaid Direct, that is enrolling the transitioning member and receiving the member's information) upon notification of the transition. Transferred information described here is collectively referred to as the transition file content.
 - i. If a member enrolls with the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall, within five (5) Business Days from the Department's notification of the member's anticipated enrollment date, contact the member, if necessary, to confirm the name of the former BH I/DD Tailored Plan, Standard Plan, other plan established by the Department, or other entity, such as NC Medicaid Direct, to request relevant member information.
 - ii. If the BH I/DD Tailored Plan is contacted by another BH I/DD Tailored Plan or other receiving entity, such as a Standard Plan, other plan established by the Department, or designated entity within NC Medicaid Direct, requesting relevant member information, the BH I/DD Tailored Plan shall provide such data to the entity within five (5) Business Days of receiving the request.
 - iii. If the BH I/DD Tailored Plan enrolls new members who were previously enrolled in NC Medicaid Direct, the BH I/DD Tailored Plan must contact the Department's designated transferring entity (i.e., the entity, disenrolling the transitioning member and transferring the member's information) within five (5) Business Days of the Department's notification to the BH I/DD Tailored Plan of the member's anticipated enrollment date, to request the necessary medical records and treatment information.
 - iv. If the BH I/DD Tailored Plan becomes aware that a member will transfer to another BH I/DD Tailored Plan or another receiving entity, such as a Standard Plan, other type

of plan established by the Department or NC Medicaid Direct, the BH I/DD Tailored Plan shall contact the other entity within five (5) Business Days of becoming aware of the member's transfer and shall share relevant member information and respond to questions regarding the member's care needs and services.

- (3) The BH I/DD Tailored Plan shall ensure that any member enrolling into the BH I/DD Tailored Plan is held harmless by the provider for the costs of medically necessary covered services except for applicable cost sharing.
- (4) The BH I/DD Tailored Plan shall allow a member to complete an existing service authorization period for a Medicaid-covered State Plan or waiver service established by their previous Standard Plan, BH I/DD Tailored Plan, another plan established by the Department or NC Medicaid Direct.
 - i. If applicable, the BH I/DD Tailored Plan shall assist the member in transitioning to an in-network provider at the end of the service authorization period established by their previous Standard Plan, BH I/DD Tailored Plan or NC Medicaid Direct.
- (5) In instances in which a member transitions into a BH I/DD Tailored Plan from NC Medicaid Direct, a Standard Plan, another BH I/DD Tailored Plan, another type of plan established by the Department or another type of health insurance coverage, and the member is in an ongoing course of treatment or has an Ongoing Special Condition, the BH I/DD Tailored Plan shall permit the member to continue seeing their Medicaid-enrolled provider, regardless of the provider's network status, in accordance with N.C. Gen. Stat. § 58-67-88(d)-(g), and as otherwise required by the Contract. A member's I/DD, mental health diagnosis, substance use disorder or TBI shall be considered a special condition under N.C. Gen. Stat § 58-57-88(a)(1). In lieu of the transitional period established in N.C. Gen. Stat. § 58-67-88(d), the BH I/DD Tailored Plan shall honor a transitional period of 180 days.
- (6) The BH I/DD Tailored Plan shall allow pregnant members to continue to receive services from their BH treatment provider or obstetrician, without any form of prior authorization, until the birth of the child, the end of the pregnancy, or loss of Medicaid eligibility during the pregnancy, whichever is later.
- (7) The BH I/DD Tailored Plan shall bear the financial responsibility for the diagnosis-related group (DRG) based inpatient facility claims of an enrolled member who is admitted to an inpatient facility or prior in the case of a member who is inpatient on their first day of enrollment in the BH I/DD Tailored Plan if there is no prior Medicaid Managed Care or NC Medicaid Direct coverage for inpatient services. If the member was already inpatient on their first day of enrollment in the BH I/DD Tailored Plan and was previously not eligible for Medicaid, the BH I/DD Tailored Plan shall bear the financial responsibility for the full amount of the DRG-based inpatient facility claims.
- (8) For facilities paid a per diem rate, the BH I/DD Tailored Plan shall only be responsible for the days the member resides in the facility and is also enrolled with the BH I/DD Tailored Plan.
 - i. The BH I/DD Tailored Plan's financial responsibility shall not extend beyond the date of disenrollment.
 - ii. Post-discharge care shall be coordinated prior to discharge in accordance with *Section V.B.3. Care Management*.
- (9) The BH I/DD Tailored Plan shall establish a written Transition of Care Policy.
 - i. The BH I/DD Tailored Plan Transition of Care Policy shall include, at a minimum, the requirements in 42 C.F.R. § 438.62(b)(1), 42 C.F.R. § 438.208(b)(2)(ii), and include processes and procedures for coordinating care for:
 - a) Members who have an ongoing special condition;

- b) Members transitioning to the BH I/DD Tailored Plan from another BH I/DD Tailored Plan, Standard Plan, other types of plans established by the Department or NC Medicaid Direct, including processes and procedures specific to Standard Plan members transitioning to the BH I/DD Tailored Plan to obtain services only available in the BH I/DD Tailored Plans as detailed in *Section VII. Attachment M.1 North Carolina Medicaid Managed Care and BH I/DD Tailored Plan Enrollment Policy*;
 - c) Members transitioning from the BH I/DD Tailored Plan into another BH I/DD Tailored Plan, Standard Plan, other type of plan established by the Department or NC Medicaid Direct.
 - d) Members covered by the Management of Inborn Errors of Metabolism (IEM) Program, as defined in *Section V.B.3.ix. Prevention and Population Health Programs*;
 - e) Services delivered through other delivery systems including NC Medicaid Direct; and
 - f) Other requirements as defined in this Section and the Department's Transition of Care Policy as revised.
- (10) Transition of Care Requirements for Members Actively Engaged in Care Management and Members Disenrolling from the BH I/DD Tailored Plan:
- i. The BH I/DD Tailored Plan's Transition of Care Policy shall integrate processes and procedures for managing the transition of members actively engaged in care management and of members transitioning between delivery systems.
 - ii. Processes and procedures shall be consistent with the Department's Transition of Care Policy and ensure:
 - a) Timely Warm Handoffs as defined in *Section III.A. Definitions* with the other transition entity.
 - b) Proactive communication with the other transition entity (e.g., Standard Plan, other BH I/DD Tailored Plans, NC Medicaid Direct) throughout the transition process;
 - c) Population and service-specific coordination with other entities to ensure the member's continuity of care.
- (11) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Transition of Care Policy to the Department for review and approval ninety (90) Calendar Days after Contract Award.
- (d) 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. 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).
 - ii. 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.

- (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. Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts* from the terminated provider within the sixty (60) Calendar Day 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 within seven (7) Calendar Days of termination 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.
- (ii) Crossover Population
 - (a) The BH I/DD Tailored Plan shall comply with the requirements listed above in *Section V.B.1.ii.(i) Ongoing Requirements* to support members transitioning during the Cross-over Period.
 - (b) The BH I/DD Tailored Plan shall implement strategies to minimize the disruption of benefits at BH I/DD Tailored Plan implementation by adhering to additional prior authorization requirements, including resetting the number of visits that do not require prior authorization,

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

- (c) The BH I/DD Tailored Plan shall have the capacity to accept, ingest and utilize claims, encounter, prior authorization data files and care plans from other authorized Department Business Associates related to Crossover activities.
- (d) The BH I/DD Tailored Plan shall participate in Department led implementation preparation activities including but not limited to:
 - (1) Time-limited “stand up” meetings with the Department on a schedule to be determined by the Department;
 - (2) Testing related to data file transfers on a schedule and under a protocol determined by the Department.
 - (3) Time-limited, rapid cycle solutions process related to data transfer issues and member disruption in care.
- (e) The BH I/DD Tailored Plan shall complete and submit crossover status reports and data reconciliation to the Department on a weekly basis.
- (f) The BH I/DD Tailored Plan shall participate in member-specific knowledge transfer sessions known as “Warm Handoffs” for beneficiaries transitioning to the BH I/DD Tailored Plan who were previously receiving services through CCNC or care coordination services through an LME/MCO.
- (g) The BH I/DD Tailored Plan must honor existing and active prior authorizations on file with NC Medicaid Direct, LME/MCOs or Standard Plans for the first ninety (90) days after BH I/DD Tailored Plan implementation to ensure continuity of care for members. For the first sixty (60) days after BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall pay claims and authorize services for Medicaid-eligible nonparticipating/out-of-network providers equal to that of in network providers until end of episode of care or the sixty (60) days after BH I/DD Tailored Plan launch, whichever is less.

iii. Member Engagement

- (i) Members, their families, and caregivers may need support in the initial transition to Medicaid Managed Care and on-going as members in the Medicaid Managed Care program. The BH I/DD Tailored Plan will be responsible, individually and in partnership with the Department and other entities identified by the Department, for assisting members and their families with understanding Medicaid Managed Care, navigating the health care system, improving overall member health through various avenues, including maintaining a Member Services department, conducting member and community outreach, and providing education before, during, and after Medicaid Managed Care implementation. The Department strongly encourages the BH I/DD Tailored Plan to develop innovative approaches, including the use of electronic mechanisms for member education and outreach.
- (ii) The BH I/DD Tailored Plan shall be responsible for engaging with members and their authorized representatives to provide assistance with understanding Medicaid Managed Care and their rights and responsibilities and accessing available benefits and services in-person, by telephone, by mail, and online/electronically. 42 C.F.R. § 438.10(c)(7).
- (iii) The BH I/DD Tailored Plan shall utilize various engagement strategies and communication mediums to engage, educate, and assist members. The engagement strategy shall include the operation of a dedicated Member Services Department which, at a minimum, shall:
 - (a) Maintain a member call center and a member services website;
 - (b) Engage with the Department engagement and customer service offices, as well as local community and county organizations;
 - (c) Provide written and verbal educational materials, activities and programs;

- (d) Collaborate with other entities operating within the Medicaid Managed Care delivery system; and
- (e) Comply with the requirements of *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* if BH I/DD Tailored Plan delegates any of the requirements to a Subcontractor.
- (iv) The BH I/DD Tailored Plan shall use standard managed care terminology in all communications with members and potential members as defined in *Section VII. Attachment L. Managed Care Terminology Provided to BH I/DD Tailored Plans pursuant to 42 C.F.R. § 438.10*.
- (v) Unless otherwise stated, all written communications, call center scripts, websites or other communications directed to Members or potential Members must adhere to the requirements in this Contract and receive prior approval from the Department before the material is communicated. The Department may require changes to previously approved communications, at its sole discretion.
- (vi) Member Services Department
 - (a) The BH I/DD Tailored Plan shall have and implement Member Services policies and procedures that address the needs of potential members, members, those individuals who support and care for members and address all Member Services activities.
 - (b) The BH I/DD Tailored Plan shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication. 42 C.F.R. § 438.10(d).
 - (c) The Member Services staff shall be responsible, at a minimum, for the following functions:
 - (1) Explaining operation of the BH I/DD Tailored Plan, including the role of the PCP and what to do in an emergency, disaster or urgent medical situation;
 - (2) Assisting with arranging non-emergency medical transportation for members;
 - (3) Assisting members in selecting or changing PCP or care manager;
 - (4) Educating and assisting members with obtaining services under Medicaid Managed Care, including out-of-network services;
 - (5) Explaining transition of care requirements and care management services offered by the BH I/DD Tailored Plan;
 - (6) Assisting in the coordination of care and services that address social determinants of health and eliminate barriers to health and wellness including linkages to NCCARE360;
 - (7) Fielding and responding to members' questions and complaints;
 - (8) Clarifying information in the Member Handbook;
 - (9) Advising members of and assisting members with the Appeals, Grievance, and State Fair Hearing processes;
 - (10) Referring members to the Department's Enrollment Broker if an individual requests information regarding how to enroll in or select a BH I/DD Tailored Plan, Standard Plan, or NC Medicaid Direct; and
 - (11) Referring members to and, as applicable, working in partnership with the Department's Ombudsman Program to resolve issues.
 - (d) The BH I/DD Tailored Plan shall operate and maintain the following three (3) member facing Service Lines:
 - (1) Member and Recipient Service Line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*);
 - (2) Behavioral Health Crisis Line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*); and
 - (3) Nurse Line.
 - (e) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its Member Services Department via member surveys and internal audits of departments to ensure member

satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.

- (1) Member surveys shall be made available after each web, call center (with exception of Behavioral Health Crisis Line) or in-person interaction.
- (2) Surveys and internal audits are intended to measure member's overall ability to access needed services, ease of use of telephone, webinar services, convenience, and help function effectiveness.
- (3) Reports, including the results of provider surveys and the BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, must be provided to the Department on a regular basis as determined by the Department, and ad hoc as requested.

(vii) Member Services Website

- (a) The Department encourages the BH I/DD Tailored Plan to utilize processes, procedures and technology to improve the member experience and effectively reduce or ease administrative burdens on the member.
- (b) The BH I/DD Tailored Plan shall develop and maintain a dedicated, interactive North Carolina Medicaid and NC Health Choice member services website that, at a minimum, has the functionality to allow the member to search for in-network providers and search the drug formulary.
- (c) Within two (2) "clicks" from the homepage, the BH I/DD Tailored Plan shall also include on its website at a minimum:
 - (1) An up-to-date copy of the Member Handbook, Innovations Member and Family Handbook, and, if applicable, TBI Handbook;
 - (2) Information on hours of operation;
 - (3) How to contact the Member Services staff and care managers;
 - (4) How to access BH I/DD Tailored Plan services;
 - (5) Appeals, Grievances, and State Fair Hearing policies and processes;
 - (6) Information regarding the Ombudsman program;
 - (7) Health promotion and educational materials;
 - (8) Any specific prevention, population health, or care management programs offered by the BH I/DD Tailored Plan;
 - (9) Information relevant to any disasters or states of emergency affecting the BH I/DD Tailored Plan region; and
 - (10) Other information the BH I/DD Tailored Plan believes would support the member and their families.
- (d) The BH I/DD Tailored Plan shall meet the same literacy standards identified for written materials in any materials made available electronically.
- (e) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines as described in the Contract.
- (f) The BH I/DD Tailored Plan website shall be accessible via mobile devices.
- (g) The BH I/DD Tailored Plan website shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, except for agreed-upon, pre-announced scheduled down-time for maintenance or downtime of the State's Systems that impact the ability for the website to operate correctly.
 - (1) The BH I/DD Tailored Plan shall notify the Department in writing of scheduled downtime at least fourteen (14) Calendar Days in advance and publish on its website at least seven (7) Calendar Days in advance.

- (2) The BH I/DD Tailored Plan shall notify the Department of unscheduled downtime within one (1) hour and include a notice on its website with an estimated time until the website is functioning and alternative methods of communication with the BH I/DD Tailored Plan.

(viii) Communications with Members and Potential Members

- (a) The BH I/DD Tailored Plan shall ensure all contacts with members or authorized representatives are Culturally and Linguistically Competent and provide effective communication to the member, with deference to the method requested by the member, including sign language interpreters, and occur in a timely manner that protects the privacy and independence of the individual with a disability.
- (b) The BH I/DD Tailored Plan shall ensure that members and potential members are provided all information required by 42 C.F.R. § 438.10(e)-(i) and N.C. Gen. Stat. § 58-3-191(b)(5) in a Culturally and Linguistically Competent manner and format that may be easily understood and is readily accessible.
- (c) The BH I/DD Tailored Plan shall address the following in the development of member materials:
 - (1) The population size and geographic/regional needs and differences throughout each of the BH I/DD Tailored Plan's Region;
 - (2) Language proficiencies;
 - (3) Types of disabilities;
 - (4) Literacy levels;
 - (5) Cultural needs of the member population;
 - (6) Age and age-specific or other targeted learning skills or capabilities; and
 - (7) Ability to access and use technology.
- (d) The BH I/DD Tailored Plan shall be permitted to provide information required to be communicated to members and potential members in the following manner:
 - (1) Mailing a printed copy of the information to the member's mailing address is the default absent an explicit preference stated by a member or their authorized representative;
 - (2) Emailing the information, after receiving the member's or potential member's express consent to receive information via email and obtaining a valid, up to date email address;
 - (3) Posting the information on the BH I/DD Tailored Plan's website and advising the member or potential member in paper or electronic form that the information is available on the internet and including the applicable internet address and providing a contact number and means by which a member may request communication accommodations; and
 - (4) Providing the information by any other method that can reasonably be expected to result in the member receiving the information. 42 C.F.R. § 438.10(g)(3).
- (e) The BH I/DD Tailored Plan shall not construe requirement herein to limit or alleviate the BH I/DD Tailored Plan's obligation to communicate directly with the member, a member's authorized representative, parent or guardian, or potential member as required under the Contract or under federal or state law or regulation.
- (f) The BH I/DD Tailored Plan shall provide information in the member's preferred format upon request at no cost (e.g., a member with disabilities who cannot access this information online shall be provided auxiliary aids and services upon request).
- (g) The BH I/DD Tailored Plan shall consult with and comply with practices of the Department's Office of Communications, including Creative Services and the Medicaid Communications Team.

(ix) Written and Verbal Member Materials

- (a) The BH I/DD Tailored Plan shall provide member materials and information in accordance with 42 C.F.R. § 438.10(c)(1), 42 C.F.R. § 438.10(c)(7), 42 C.F.R. § 438.10(f)(3), and 42 C.F.R. § 438.3(i), which address information requirements related to written and verbal information provided to members.

- (b) The BH I/DD Tailored Plan shall provide all written materials to members and potential members consistent with the following:
 - (1) Use easily understood language and format. 42 C.F.R. § 438.10(d)(6)(i).
 - (2) Use a san serif font type and a font size no smaller than 12-point. 42 C.F.R. § 438.10(d)(6)(ii). The font type and size shall be appropriate to the audience.
 - (3) Available, upon request at no cost, in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.
 - (4) Include a large print (i.e., font size no smaller than 18 point) tagline and information on how to request auxiliary aids and services, including materials in alternative formats. 42 C.F.R. § 438.10(d)(6)(iii) & (iv).
 - (5) Written in accordance with Associated Press Style and Department-specific style guide.
 - (6) Accommodates screen readers (e.g., reading order, tags, Alt Text labels, captions).
 - (7) Includes taglines in the top fifteen (15) prevalent non-English languages in North Carolina, as well as large print, explaining the availability of written translation or verbal interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the BH I/DD Tailored Plan's Member Service Call Center line. 42 C.F.R. § 438.10(d)(3). The top fifteen (15) prevalent non-English languages in North Carolina include:
 - i. Spanish,
 - ii. Chinese (Mandarin Simplified),
 - iii. Vietnamese,
 - iv. Korean,
 - v. French,
 - vi. Arabic,
 - vii. Hmong,
 - viii. Russian,
 - ix. Tagalog,
 - x. Gujarati,
 - xi. Mon-Khmer (Cambodia),
 - xii. German,
 - xiii. Hindi,
 - xiv. Laotian, and
 - xv. Japanese.
- (c) The BH I/DD Tailored Plan shall ensure that all audio-reliant materials e.g., videos, webinars, and recorded presentations, have accessible captioning at the time they are made available to members in their original format.
- (d) The BH I/DD Tailored Plan shall ensure that materials available on the internet follow the current release of web content accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973, as amended.
- (e) The BH I/DD Tailored Plan shall ensure that all written materials made available electronically meet the requirements of 42 C.F.R. § 438.10(c)(6) and are accessible on various platforms, such as website and mobile devices.
- (x) Mailing Materials to Members
 - (a) The BH I/DD Tailored Plan shall verify addresses against a United States Postal Service approved product or service on all members enrolled in the BH I/DD Tailored Plan prior to mailing materials, at no additional cost to the Department or the member.

- (1) The BH I/DD Tailored Plan shall make all reasonable attempts to identify the correct mailing address and mail information to the member within applicable timeframes, as required under the Contract.
 - (2) The BH I/DD Tailored Plan shall notify the Department of all non-verifiable addresses in an electronic format and frequency as defined by the Department.
 - (3) The BH I/DD Tailored Plan shall notify the Department of all addresses which are incorrect and provide the corrected address in an electronic format and frequency as defined by the Department.
- (b) The BH I/DD Tailored Plan shall notify the Department, or the local DSS office as directed by the Department, of all returned mail due to incorrect mailing address in an electronic format and frequency as defined by the Department.
 - (c) If the BH I/DD Tailored Plan identifies a new, updated address, the BH I/DD Tailored Plan shall resend only member specific information at no additional cost to the Department or the member.
 - (d) All materials mailed to potential members, members, and, when applicable, authorized representatives, shall be sent via first class mail.
 - (e) The BH I/DD Tailored Plan shall consider cost-effective methods for controlling postage costs when producing member materials for mailing.
 - (f) The BH I/DD Tailored Plan shall develop a Member and Recipient Mailing Policy, subject to Department review and approval. The BH I/DD Tailored Plan shall submit to the Department ninety (90) days after Contract Award.
- (xi) Translation and Interpretation Services
- (a) The BH I/DD Tailored Plan shall make interpretation services available to all potential members and members. This includes verbal interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Verbal interpretation requirements apply to all non-English languages, not just those that the Department identifies as prevalent. 42 C.F.R. § 438.10(d)(4).
 - (b) The BH I/DD Tailored Plan shall notify its members of the availability of interpretation services and inform them of how to access such services, including providing the following information:
 - (1) That verbal information is available for any language and written translation is available in prevalent languages free of charge to each member. 42 C.F.R. § 438.10(d)(4); and
 - (2) That auxiliary aids and services are available upon request and at no cost for members with disabilities. 42 C.F.R. § 438.10(d)(5).
 - (c) The BH I/DD Tailored Plan shall offer qualified interpreter services available for verbal contacts with members and authorized representatives whose primary language is not English.
 - (d) The BH I/DD Tailored Plan shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the member.
 - (e) The BH I/DD Tailored Plan shall provide assistive listening devices, computer assisted real-time captioning, and qualified sign language interpreters during presentations and other events with member audiences.
 - (f) The BH I/DD Tailored Plan shall make interpretation services available free of charge to each member. 42 C.F.R. § 438.10(d)(4).
 - (g) The BH I/DD Tailored Plan shall staff member facing service lines with enough fluent Spanish speakers to converse with members who prefer to speak in Spanish. All other languages may be handled through a language line service at no cost to the member or the Department. Verbal interpretations must be available in all languages as required by regulation or determined by the Department.
 - (h) Translation shall be provided in compliance with Title VI of the Civil Rights Act of 1964, as amended, including:

- (1) Means by which persons with limited English proficiency will be informed of the language services available to them and how to obtain them; and
- (2) Translation of materials into Spanish and up to three (3) additional languages, as required by the Department.
- (i) The BH I/DD Tailored Plan shall notify the Department in writing within five (5) Business Days each time the BH I/DD Tailored Plan or its Subcontractor charges a member, potential member, authorized representative or guardian for interpreter or translation services.
- (j) The BH I/DD Tailored Plan shall notify the Department of any change in the language preference for members in an electronic format and frequency as defined by the Department.
- (xii) Member Welcome Packet
 - (a) The BH I/DD Tailored Plan shall send a Welcome Packet to the member within eight (8) Calendar Days following receipt, from the Department, of the 834 enrollment file, or other standard eligibility and enrollment file as defined by the Department indicating a new enrollment.
 - (b) The BH I/DD Tailored Plan shall include the following in the initial member Welcome Packet and upon redetermination:
 - (1) A welcome letter that notifies the member of their enrollment in the BH I/DD Tailored Plan and provides:
 - i. The effective date from which the BH I/DD Tailored Plan shall assume health coverage for the member;
 - ii. Information on how to access the online provider directory and how to request a hardcopy of the provider directory;
 - iii. Information on how to change to a Standard Plan or NC Medicaid Direct;
 - iv. The toll-free service line numbers which a member may call for the Member and Recipient Service Line, Behavioral Health Crisis Line, and Nurse Line;
 - v. Information on how to inquire about accessing care management services, including background on Tailored Care Management and information on opting out;
 - vi. The role of a PCP in Medicaid Managed Care;
 - a) How to select or change a PCP;
 - b) Why a member might be auto-assigned a PCP;
 - vii. How to arrange for non-emergency medical transportation (NEMT);
 - viii. An offer of assistance in arranging initial visit to his or her PCP; and
 - ix. Contact information for the Ombudsman Program.
 - (2) Member identification card; and
 - (3) A current Member Handbook.
 - (4) The BH I/DD Tailored Plan may opt to send the ID card or handbooks separately from the Welcome Packet, but all documents must be sent within the timeframes defined in the Contract.
 - (c) The BH I/DD Tailored Plan shall submit a sample copy of the contents of its Member Welcome Packet to the Department for review and approval within ninety (90) Calendar Days of Contract Award, and then annually thereafter. The Department may require changes to the Member Welcome Packet and other communications, at its sole discretion.
 - (d) All materials mailed to potential members, and when applicable, authorized representatives, shall be sent via first class mail, unless otherwise approved by the Department or permitted by the Member and Recipient Mailing Policy.
- (xiii) Member Identification Cards
 - (a) The BH I/DD Tailored Plan is required to generate an identification card for each member enrolled in the BH I/DD Tailored Plan with the following printed information:
 - (1) The member's North Carolina Medicaid or NC Health Choice identification number

- i. The member identification number shall be used to identify an individual for Medicaid Managed Care eligibility and enrollment; and
 - ii. The member identification number shall be used by providers, in part, for prior authorization requests, submitting claims and claim reimbursement to the BH I/DD Tailored Plan.
- (2) The BH I/DD Tailored Plan's name, mailing address and Member Portal.
- (3) The member's PCP name, physical address and phone number.
- (4) The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Service Line, and Prescriber Service Line.
- (5) Indicator if Member is NC Medicaid or NC Health Choice.
- (6) The MID, fraud, waste and abuse hotline with the following language:
 - i. If you suspect a doctor, clinic, hospital, home health service or any other kind of health provider is committing Medicaid fraud, report it. Call (919) 881-2320.
- (b) A replacement identification card shall be provided upon request by the member or the member's authorized representative or upon PCP change, at no charge to the member.
- (c) The BH I/DD Tailored Plan shall submit the member identification card to the Department for review and approval ninety (90) days after Contract Award, at the direction of the Department, or when changes are made to the card layout or content.
- (xiv) Member Handbook, Innovations Member and Family Handbook, and TBI Handbook
 - (a) The BH I/DD Tailored Plan shall use the Department's model BH I/DD Tailored Plan Member Handbook as guidance in the development of the BH I/DD Tailored Plan's Member Handbook. 42 C.F.R. § 438.10(c)(4)(ii).
 - (b) Within eight (8) Calendar Days after the BH I/DD Tailored Plan receives notice of the member's enrollment in the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall provide each member a Member Handbook.
 - (c) The BH I/DD Tailored Plan shall provide each existing waiver enrollee an Innovations Member and Family Handbook or a TBI Handbook within seven (7) Calendar Days of BH I/DD Tailored Plan launch and new waiver enrollees their respective waiver handbooks within seven (7) Calendar Days of being awarded a waiver slot (or having an approved level of care form).
 - (d) The BH I/DD Tailored Plan shall ensure that all Member Handbook, Innovations Member and Family Handbook, and TBI Handbook information complies with federal and Department information requirements, including those related to accessibility, reading level, font size, Cultural and Linguistic Competency, and literacy standards.
 - (e) The BH I/DD Tailored Plan shall ensure that the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook includes sufficient information that enables the member to understand how to effectively use Medicaid Managed Care. This information shall include at a minimum:
 - (1) Covered benefits provided by the BH I/DD Tailored Plan, including:
 - i. Waiver services and supports where applicable; and
 - ii. Care management, including how to select and change care managers or care management entities.
 - (2) For BH I/DD Tailored Plans in selected Pilot regions—Information on the Healthy Opportunities Pilot program and how to access its services, including through Tailored Care Management.
 - (3) Member Enrollment and Disenrollment Policy, including Information on the member enrollment and disenrollment consistent with 42 C.F.R. § 438.10(e)(2)(i) and the requirements of this Contract.

- (4) How and where to access any benefits provided by the Department, including carved out services.
- (5) List of counseling or referral services that the BH I/DD Tailored Plan does not cover because of moral or religious objection, instructions for how the member can obtain information from the Department about how to access those services, and notification that the BH I/DD Tailored Plan's failure to cover a service based on moral or religious objection.
- (6) The amount, duration, and scope of benefits available under the BH I/DD Tailored Plan in sufficient detail to ensure that members understand the benefits to which they are entitled.
- (7) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's PCP.
- (8) Information on the EPSDT benefits, for Medicaid Managed Care members under the age of twenty-one (21), including:
 - i. The benefits of preventive health care;
 - ii. Populations eligible for EPSDT;
 - iii. Services available under the EPSDT program and where and how to obtain those services;
 - iv. That EPSDT services are not subject to cost sharing; and
 - v. That BH I/DD Tailored Plan will provide scheduling and transportation assistance for EPSDT services upon request by the member.
- (9) The extent to which, and how, after-hours and emergency coverage are provided, including:
 - i. What constitutes an emergency medical condition and emergency services;
 - ii. The fact that prior authorization is not required for emergency services; and
 - iii. The fact that, subject to 42 C.F.R. § 438.10, the member has a right to use any hospital or other setting for emergency care.
- (10) Any restrictions on the member's freedom of choice among in-network providers and out-of-network providers.
- (11) The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers, including an explanation that the BH I/DD Tailored Plan cannot and shall not require a member to obtain a referral before choosing a family planning provider.
- (12) Cost sharing, if any, imposed on North Carolina Medicaid or NC Health Choice beneficiaries.
- (13) Member rights and responsibilities, including the elements specified in 42 C.F.R. § 438.100 and under the Contract.
- (14) The process of selecting and changing the member's PCP, including, but not limited to:
 - i. Information on the two (2) annual without cause PCP changes; and
 - ii. The with cause reasons for switches beyond the two (2) without cause changes.
- (15) Grievance, Appeal, and State Fair Hearing procedures and timeframes developed or approved by the Department, including information on:
 - i. The right to file Grievances and Appeals;
 - ii. The requirements and timeframes for filing a Grievance or Appeal or State Fair Hearing;
 - iii. The availability of assistance in the filing process;

- iv. The right to request a State Fair Hearing after the BH I/DD Tailored Plan makes a decision on the member's Appeal which is adverse to the member; and
 - v. The fact that, when requested by the member, benefits that the BH I/DD Tailored Plan seeks to reduce or terminate will continue if the member files a request within the timeframes specified for filing and that the member may be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the member.
- (16) How to exercise an Advance Directive.
 - (17) An overview of its continuation of benefits policy and define when, why and how a member or a member's authorized representative may file for a continuation of benefits.
 - (18) How to access auxiliary aids and services, including additional information in alternative formats or languages.
 - (19) The toll-free help line numbers for the Member and Recipient Service Line, Behavioral Health Crisis Line, Nurse Line, Provider Support Service Line, and Prescriber Service Line.
 - (20) Information on how to report suspected fraud, waste or abuse.
 - (21) Information about Opioid Misuse Prevention and Treatment Program and the Tobacco Cessation Program.
 - (22) Information on the BH I/DD Tailored Plan Transition of Care Policy.
 - (23) Information about the BH I/DD Tailored Plan's prevention and population health programs.
 - (24) Contact information for beneficiary support systems, including the Ombudsman Program and the Enrollment Broker.
- (f) The BH I/DD Tailored Plan shall ensure that the Innovations Member and Family Handbook and the TBI Handbook include monitoring requirements and participant responsibilities for the respective waiver and information on the respective waiver advisory group.
 - (g) The BH I/DD Tailored Plan shall provide the Department for review any changes to the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook sixty (60) Calendar Days prior to the intended effective date of the change.
 - (h) The BH I/DD Tailored Plan shall notify each member, using Department-developed templates, of any Significant Change to the Member Handbook, Innovations Member and Family Handbook, and TBI Handbook at least thirty (30) Calendar Days before the intended effective date of the change.
- (xv) Member Education and Outreach
 - (a) The BH I/DD Tailored Plan shall provide education and outreach to members and potential members, including hosting and participating in health awareness events, community events, and health fairs, where representatives from the Department, the Enrollment Broker, Ombudsman Program and/or local health departments may be present.
 - (b) The BH I/DD Tailored Plan shall develop educational materials to be used by the Enrollment Broker to support BH I/DD Tailored Plan, PCP, and care management selection. The materials are subject to review and approval by the Department at least ninety (90) Calendar Days prior to use with members, potential members, and/or authorized representatives.
 - (c) The BH I/DD Tailored Plan shall provide information regarding its planned member education efforts to the Department for review and approval sixty (60) days after Contract Award and annually thereafter.
 - (d) The BH I/DD Tailored Plan shall provide Innovations and TBI waiver education and training for members and families in the manner prescribed in the Innovations and TBI waivers.
 - (e) Any outreach or education related to the proposed Member Incentive Program (as described in *Section V.B.1.iii.(xx) Member Incentive Program*) must be approved by the Department

through the established marketing process. Any activities that are passive in nature and not explicitly aimed at promoting greater member engagement will not be approved.

(xvi) Engagement with Consumers

- (a) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of its members. To that end, the BH I/DD Tailored Plan shall establish and maintain mechanisms to communicate with and obtain advisement from consumer groups.
- (b) Specifically, the BH I/DD Tailored Plan shall establish a Consumer and Family Advisory Committee (CFAC) and comply with applicable provisions of N.C. Gen. Stat. § 122C regarding the composition, meeting schedule, training, and support of the governing board, as outlined in *Section V.A.1.ii. Entity Requirements for Medicaid and State-funded Services*.
- (c) The BH I/DD Tailored Plan shall seek input and advice regarding the BH I/DD Tailored Plan's programs and policies from the CFAC. Topics for discussion and consultation shall include but should not be limited to:
 - (1) Medical, pharmacy, BH, I/DD, and TBI benefits;
 - (2) Healthy Opportunities priority domains;
 - (3) Care management; and
 - (4) Healthy Opportunities Pilots (if applicable).

(xvii) Engagement with Beneficiaries Utilizing Long Term Services and Supports

- (a) The BH I/DD Tailored Plan must have a strong understanding of and capability to meet the needs of beneficiaries utilizing LTSS, including care provided in the home, in community-based settings, or in facilities such as nursing homes. The BH I/DD Tailored Plan shall establish a LTSS Member Advisory Committee that garners stakeholder input and advice regarding the LTSS covered under the BH I/DD Tailored Plan contract, and meets all provisions noted in 42 C.F.R. § 438.110.
- (b) The BH I/DD Tailored Plan shall provide reports to Committee that will enable the Committee to review member experience and quality of care to serve as an early warning system for the BH I/DD Tailored Plan on emerging issues.
- (c) The LTSS Member Advisory Committee shall reflect the LTSS populations covered by the BH I/DD Tailored Plan or their representatives and include:
 - (1) Members accessing LTSS;
 - (2) Representatives of LTSS members (e.g., authorized representatives);
 - (3) LTSS providers;
 - (4) Care managers from AMH+ practices and CMAs serving members with LTSS needs; and
 - (5) BH I/DD Tailored Plan staff involved in the authorization of LTSS and/or care management of LTSS members.
- (d) The BH I/DD Tailored Plan shall consult with the LTSS Member Advisory Committee at least on a quarterly basis.
- (e) The BH I/DD Tailored Plan shall designate a single point of contact who will be responsible for reporting concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to the state's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, Consumer and Family Advisory Committee (CFAC), as applicable.
- (f) The BH I/DD Tailored Plan shall require care managers and other member services and provider relations staff to report concerns related to quality of care delivered to members obtaining institutional and community-based LTSS to a single point of contact designated by the BH I/DD Tailored Plan.
- (g) The BH I/DD Tailored Plan shall help coordinate resolutions to quality of care concerns related to quality of care delivered to members obtaining institutional and community-based LTSS with the member, member's family, the Department's Long-Term Care Ombudsman, Medicaid Managed Care Ombudsman Program, and/or CFAC, as appropriate.

- (xviii) Engagement with Innovations and TBI Waiver Members
 - (a) The BH I/DD Tailored Plan shall develop stakeholder group(s) consisting of Innovations waiver members, families, advocates, and providers to provide recommendations regarding implementation and operation of Innovations waiver services and policies.
 - (1) The BH I/DD Tailored Plan shall meet with this stakeholder group(s) at least on a quarterly basis.
 - (2) The BH I/DD Tailored Plan shall keep meeting minutes and attendance records for each of these stakeholder meetings. BH I/DD Tailored Plan shall make these records available for review by Department and shall report on these efforts at Intra-Departmental Monitoring Team (IMT) meetings.
 - (b) The BH I/DD Tailored Plan shall develop stakeholder group(s) consisting of TBI waiver members, families, advocates, and providers to provide recommendations regarding implementation of TBI waiver services and policies.
 - (1) The BH I/DD Tailored Plan shall meet with this stakeholder group(s) at least on a quarterly basis.
 - (2) The BH I/DD Tailored Plan shall keep meeting minutes and attendance records for each of these stakeholder meetings. BH I/DD Tailored Plan shall make these records available for review by the Department and shall report on these efforts at IMT meetings.
 - (3) This subsection only applies to those BH I/DD Tailored Plans with TBI waiver members.
- (xix) Health Education and Promotion Programs
 - (a) The BH I/DD Tailored Plan shall develop member health education and promotion programs that address prevention, wellness, and early intervention of illness and disease.
 - (b) The health education and promotion programs shall, at a minimum, address the appropriate use of health services, risk reduction and healthy lifestyles, and self-care and management of health conditions.
 - (c) The BH I/DD Tailored Plan shall make the health education and promotion programs available to members through various communication mediums, including, but not limited to electronic (e.g., audiovisual), printed, and in-person educational or training sessions.
 - (d) The Department may select specific educational and health promotion topics for the BH I/DD Tailored Plan to implement that align with the Department's priorities or the annual update to the Quality Strategy.
- (xx) Member Incentive Program
 - (a) The BH I/DD Tailored Plan may offer healthy behavior incentive programs to members, provided that the following criteria are met:
 - (1) The healthy behavior incentive is aligned to the objectives outlined within the Quality Strategy.
 - (2) The healthy behavior incentive shall not be provided in the form of cash or cash-redeemable coupons; and
 - (3) The total monetary value of all health behavior incentives awarded to any one individual in a given fiscal year (July 1- June 30) shall not exceed \$75.00.
 - (b) Subject to federal restrictions, acceptable forms of healthy behavior incentives may include gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used only for health-related purchases, and gym memberships.
 - (c) Prior to implementation, the BH I/DD Tailored Plan shall obtain approval from the Department for its Member Incentive Program. The Program should include objectives, interventions, monitoring plan and metrics, and should demonstrate alignment to the Quality Assurance and Performance Improvement (QAPI).

(xxi) The BH I/DD Tailored Plan shall include in its Member Incentive Program adequate assurances, as assessed by the Department, that: (i) the program meets the requirements of 1112 of the Social Security Act; and (ii) the program meets the criteria determined by the Department.

iv. Marketing

- (i) The Department views BH I/DD Tailored Plan marketing activities as a method to help publicize Medicaid Managed Care and educate potential members about health plan options, while ensuring the protection of members from coercive or misleading practices.
- (ii) The BH I/DD Tailored Plan shall comply with all marketing requirements, including monitoring and overseeing the activities of its Subcontractors and all persons acting for, or on behalf of, the BH I/DD Tailored Plan to ensure that members receive accurate verbal and written information to make an informed decision on whether to enroll or reenroll in the BH I/DD Tailored Plan.
- (iii) The BH I/DD Tailored Plan shall submit its marketing plan to the Department for review and approval on an annual basis.
- (iv) The BH I/DD Tailored Plan shall not market nor distribute any marketing materials without obtaining written approval from the Department. 42 C.F.R. § 438.104(b)(1)(i). Approval is required for marketing materials, marketing target population lists, and any associated algorithms for identifying marketing target populations.
- (v) The BH I/DD Tailored Plan shall ensure that marketing materials are accurate and do not mislead, confuse, or defraud members or the Department. 42 C.F.R. § 438.104(b)(2).
- (vi) The BH I/DD Tailored Plan shall establish and maintain a system of control over the content, form, and method of dissemination of all marketing materials. All marketing materials, regardless by whom written, produced, created, designed or presented, shall be the responsibility of the BH I/DD Tailored Plan.
- (vii) If the BH I/DD Tailored Plan chooses to market, the BH I/DD Tailored Plan shall distribute marketing materials to the entire Region served by the BH I/DD Tailored Plan. 42 C.F.R. 438.104(b)(1)(ii).
- (viii) The BH I/DD Tailored Plan shall ensure that all marketing materials comply with the language, accessibility, and Cultural and Linguistic Competency requirements and the member materials requirements in the Contract, and any applicable federal and North Carolina laws and regulations.
- (ix) The BH I/DD Tailored Plan shall ensure that all marketing materials and marketing strategies shall abide by the BH I/DD Tailored Plan's Non-discrimination Policy. In addition, the BH I/DD Tailored Plan shall not discriminate against members or potential members who may:
 - (a) Live or receive health care in rural or underserved areas; or
 - (b) Experience income disparities.
- (x) The BH I/DD Tailored Plan shall assign a unique marketing code to all marketing materials distributed to members.
- (xi) Marketing Materials and Activities
 - (a) Permissible Marketing Activities
 - (1) The BH I/DD Tailored Plan may use, distribute, display, or otherwise make available written marketing materials (e.g., posters, brochures, leaflets) at community centers, markets, malls, retail establishments, hospitals, pharmacies, other provider sites, schools, health fairs, and public libraries and other state-approved community-based marketing events or locations.
 - (2) The BH I/DD Tailored Plan may participate in community-based marketing events or activities (e.g., health fairs, community events).
 - (3) The BH I/DD Tailored Plan may sponsor outreach activities and events, including as a financial sponsor.
 - (4) The BH I/DD Tailored Plan may conduct media campaigns, including through television, radio, billboards, bus posters, and social media.

- (5) The BH I/DD Tailored Plan may engage in marketing activities in accordance with federal and state regulation, and not otherwise prohibited by this Contract or by the Department.
- (b) Prohibited Statements, Claims, and Activities (Written or Verbal)
- (1) The BH I/DD Tailored Plan shall not assert that a member must enroll in the BH I/DD Tailored Plan to obtain benefits or to not lose benefits. However, the BH I/DD Tailored Plan may inform the member that certain benefits are available only through enrollment in a BH I/DD Tailored Plan (e.g., BH I/DD Tailored Plan-only services, Innovations waiver services, TBI waiver services, and State-funded services) so that the member may make an informed decision. 42 C.F.R. § 438.104(b)(2)(i).
 - (2) The BH I/DD Tailored Plan shall not claim that the BH I/DD Tailored Plan is endorsed by CMS, the federal or State government, or similar entity. 42 C.F.R. § 438.104(b)(2)(ii).
 - (3) The BH I/DD Tailored Plan shall not use the Department or State logo or other proprietary material in marketing.
 - (4) The BH I/DD Tailored Plan shall not use the name of the Department in conjunction with any marketing material and/or activities without prior written approval of the Department.
 - (5) The BH I/DD Tailored Plan shall not reference competing BH I/DD Tailored Plans, Standard Plans, or other contractors of the Department, list or reference providers who are not part of the plan network or include negative information about the Department, Standard Plans, or other BH I/DD Tailored Plans in any of its marketing materials.
 - (6) The BH I/DD Tailored Plan shall not cross-market with a Standard Plan.
 - (7) The BH I/DD Tailored Plan shall not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities including direct mailings and solicitation. 42 C.F.R. § 438.104(b)(1)(v).
 - (8) The BH I/DD Tailored Plan shall not falsely describe covered or available services, enrollment benefits, availability of network providers, or qualifications or skills of network providers.
 - (9) The BH I/DD Tailored Plan shall not market materials or activities that are discriminatory or that target potential members based on health status, geographic residence, location of the provision of possible services or income.
 - (10) The BH I/DD Tailored Plan shall not offer gifts, coupons for products of material value, or incentives to enroll, except as provided in the Contract.
 - (11) The BH I/DD Tailored Plan shall not distribute marketing materials or engage in marketing activities in service areas prohibited by the Department.
 - (12) The BH I/DD Tailored Plan shall not engage in activities that seek to target members currently enrolled in other BH I/DD Tailored Plans, Standard Plans, NC Medicaid Direct, the Tribal Option, or the Statewide Specialized Foster Care Plan.
 - (13) The BH I/DD Tailored Plan shall not offer choice counseling or seek to enroll potential members in the BH I/DD Tailored Plan. This is the sole responsibility of the Department and the Enrollment Broker.
 - (14) The BH I/DD Tailored Plan shall not send Request for Tailored Plan eligibility forms to potential members without prior approval from the Department on the target population and associated algorithms.
 - (15) The BH I/DD Tailored Plan shall not distribute, display, or otherwise conduct marketing activities in health care settings, except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms.
 - (16) The BH I/DD Tailored Plan shall not conduct marketing activities in areas where patients primarily intend to receive health care services. These prohibited areas include, but are

not limited to, emergency rooms, patient hospital rooms, exam rooms, and pharmacy counter areas.

(c) References to Studies and Statistics

- (1) The BH I/DD Tailored Plan shall not use irrelevant facts or inaccurate or misleading statistical information in any marketing materials and shall not imply that statistics are derived from the information that is being marketed unless such is the fact.
- (2) If references to a study or statistics are included in any marketing material, the BH I/DD Tailored Plan shall provide reference information (e.g., publication, date, page number) and information about the BH I/DD Tailored Plan's relationship with the entity that conducted the study or provided the statistics including the funding source either in the text or as a footnote, on the marketing material.

(d) Nominal Gifts

- (1) The BH I/DD Tailored Plan may conduct giveaways and distribute nominal gifts to members and potential members.
- (2) The BH I/DD Tailored Plan shall ensure the following for nominal gifts offered by the BH I/DD Tailored Plan:
 - i. The gifts do not exceed ten dollars (\$10) per person in value when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
 - ii. The gifts are made available to the public and are not in any way connected to enrollment.
 - iii. The gifts are distributed via in-person contacts only (e.g., community events).

(e) Marketing of Multiple Lines of Business

- (1) The BH I/DD Tailored Plan shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance. Private insurance shall not include Qualified Health Plans (QHPs) as defined in 45 C.F.R. § 155.20, 42 C.F.R. § 438.104.
- (2) The BH I/DD Tailored Plan shall be permitted to co-market QHPs and Medicaid products, to the extent the BH I/DD Tailored Plan is participating in both markets in the State and within the scope authorized for BH I/DD Tailored Plans under State law.
- (3) The BH I/DD Tailored Plan shall be permitted to provide information about a QHP to potential members who could enroll in such a plan as an alternative to Medicaid Managed Care due to a loss of Medicaid eligibility.

(xii) Department Approval of Marketing Materials

- (a) The BH I/DD Tailored Plan shall submit marketing materials to the Department for review at least eight (8) weeks before the proposed use of the material.
- (b) If the BH I/DD Tailored Plan makes a Significant Change to marketing materials or marketing target populations that have been previously approved by the Department, the BH I/DD Tailored Plan must resubmit the materials, in accordance with this Section, for Department review and approval.

(xiii) The BH I/DD Tailored Plan may engage in marketing activities beginning eight (8) weeks prior to the start of BH I/DD Tailored Plan launch and shall be permitted to market throughout the term of the Contract, unless the Department has otherwise restricted the BH I/DD Tailored Plan's marketing activities in accordance with *Section VI.A. Contract Violations and Noncompliance for Medicaid and State-funded Services*.

v. Member Rights and Responsibilities

- (i) The Department expects the BH I/DD Tailored Plan to treat members with dignity and respect, to protect members' rights, to inform members of their responsibilities as members of the plan, and ensure each member is not subject to any unlawful discrimination in the course of obtaining or

receiving services from the BH I/DD Tailored Plan or any Network provider of the BH I/DD Tailored Plan.

- (ii) The BH I/DD Tailored Plan shall establish and maintain written policies and procedures that are designed to protect the rights of members and describe the responsibilities of each member. The BH I/DD Tailored Plan shall develop and submit to the Department for review a Member and Recipient Rights and Responsibilities Policy ninety (90) Calendar Days after Contract Award.
 - (iii) The BH I/DD Tailored Plan shall include a written description of the rights and responsibilities of members in the Member Welcome Packet and the Member Handbook.
 - (iv) The BH I/DD Tailored Plan shall provide a copy of its Member and Recipient Rights and Responsibilities Policy to all BH I/DD Tailored Plan employees and network providers.
 - (v) In accordance with 42 C.F.R. § 438.100(b), the BH I/DD Tailored Plan shall ensure its written policies and procedures, at a minimum, afford members the right to:
 - (1) Receive information in accordance with 42 C.F.R. § 438.10;
 - (2) Be treated with respect and with due consideration for his or her dignity and privacy;
 - (3) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
 - (4) Participate in decisions regarding his or her health care, including the right to refuse treatment and Advance Directives under *Section V.A.1.viii. Advance Directives for Medicaid and State-funded Services*;
 - (5) Be free from any form of restraint (e.g., physical or chemical) or seclusion used as a means of coercion, discipline, convenience or retaliation;
 - (6) If the privacy rule, as set forth in 45 C.F.R. parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526; and
 - (7) Be furnished, consistent with the scope of services of this Contract, health care services in accordance with 42 C.F.R. §§ 438.206-438.210.
 - (vi) The BH I/DD Tailored Plan shall not attempt to influence, limit, or otherwise interfere with the member's decision to exercise his or her rights as provided in this Contract.
 - (vii) The BH I/DD Tailored Plan shall ensure that members are free to exercise their rights and that the exercise of those rights does not adversely affect the way the BH I/DD Tailored Plan or its Network providers treat the member. 42 C.F.R. § 438.100(c).
 - (viii) The BH I/DD Tailored Plan shall ensure compliance with the non-discrimination requirements specified in this Contract, as well as any other applicable federal and state laws and regulations prohibiting discrimination against members in the course of obtaining or receiving services from the BH I/DD Tailored Plan or any network provider of the BH I/DD Tailored Plan. 42 C.F.R. § 438.100(d).
 - (ix) The BH I/DD Tailored Plan shall not avoid costs for services covered in its Contract by referring NC Health Choice beneficiaries to publicly supported health care resources. 42 C.F.R. § 457.1201(p).
- vi. Member Grievances and Appeals
- (i) The Department is committed to ensuring that members understand and can freely exercise their Appeal and Grievance rights and resolve issues efficiently with minimal burden to the member or their authorized representative. The BH I/DD Tailored Plan shall educate the member on their rights and provide reasonable assistance with understanding and navigating the Appeals and Grievances processes.
 - (ii) Member Grievances and Appeals General Requirements
 - (a) The BH I/DD Tailored Plan shall establish and maintain a Grievance and Appeals system for reviewing and resolving member Grievances and Appeals. Components of the system shall include a Grievance process, a plan-level Appeal process, and access to a State Fair Hearing. 42 C.F.R. part 438, subpart F. The BH I/DD Tailored Plan shall ensure the Grievance and Appeals

system aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, to the degree a subcontractor relationship applies.

- (b) The BH I/DD Tailored Plan shall, while adhering to the required Utilization Management Program, employ strategies to resolve Grievance and Appeals at lowest level of escalation that meets a member's needs and in a manner that does not discourage members from exercising their rights.
 - (c) The BH I/DD Tailored Plan shall provide members information on the Ombudsman program, its role and contact information to assist if needed with resolution of issues prior to escalation as outlined in *Section V.A.4.iii. Integration with other Department Partners*, *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*, and *Section V.B.1.iii. Member Engagement*.
 - (d) The BH I/DD Tailored Plan shall provide members reasonable assistance in completing forms and taking other procedural steps related to a plan Grievance or Appeal or a State Fair Hearing including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. 42 C.F.R. § 438.406(a).
 - (e) The BH I/DD Tailored Plan shall ensure that the individuals making decisions on Grievances and Appeals:
 - (1) Acknowledge receipt of Grievances and Appeals (including verbal Appeals), unless the member requests expedited resolution 42 C.F.R. §§ 438.406(b)(1) and 438.228(a).
 - (2) Were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. 42 C.F.R. §§ 438.406(b)(2)(i) and 438.228(a).
 - (3) If deciding an Appeal of a denial is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues, are individuals who have the appropriate clinical expertise in treating the member's condition or disease. 42 C.F.R. §§ 438.406(b)(2)(ii)(A)-(C) and 438.228(a).
 - (4) Take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. 42 C.F.R. §§ 438.406(b)(2)(iii) and 438.228(a).
 - (f) The BH I/DD Tailored Plan shall allow an authorized representative (including providers) or legal guardian, with the member's written consent, to request an Appeal or file a Grievance on behalf of a member. 42 C.F.R. § 438.402(c)(ii).
 - (g) The BH I/DD Tailored Plan shall not retaliate if a member, authorized representative, or legal guardian requests an Appeal or files a Grievance.
 - (h) The BH I/DD Tailored Plan shall use Department developed templates for all member notices related to the member Grievance and Appeals processes that meet applicable notification standards, including but not limited to, the notice of adverse benefit determination, the plan Appeal request form, the State Fair Hearing Appeal request form, the Notice of Acknowledgment, the Notice of Extension, and the Notice of Resolution. 42 C.F.R. § 438.10(c)(4)(ii).
 - (i) The BH I/DD Tailored Plan shall define an Appeal, adverse benefit determination, and Grievance the same as the terms are defined in the Contract. 42 C.F.R. § 438.400.
 - (j) The BH I/DD Tailored Plan shall provide the information specified in 42 C.F.R. §§ 438.10(g)(xi) on its Grievance, Appeals, and State Fair Hearing procedures to all providers and applicable subcontractors at the time they enter into a contract. 42 C.F.R. § 438.414.
 - (k) The BH I/DD Tailored Plan shall comply with Chapter 108D of the North Carolina General Statutes for all Appeals and Grievance proceedings.
- (iii) Member Grievance Process

- (a) The BH I/DD Tailored Plan shall develop and submit to the Department for review a Member Grievance Policy one hundred twenty (120) Calendar Days after Contract Award.
 - (b) The BH I/DD Tailored Plan shall allow a member or authorized representative to file a Grievance with the BH I/DD Tailored Plan, verbally or in writing, at any time. 42 C.F.R. §§, 438.408; 438.402(c)(2)(i), and 438.402(c)(3)(i).
 - (c) The BH I/DD Tailored Plan shall use the Department-defined Notice of Acknowledgement of Receipt of Grievance to notify the member of receipt of the Grievance.
 - (d) The BH I/DD Tailored Plan's member Grievance process shall include acknowledgement, in writing, within five (5) Calendar Days of receipt of each Grievance. 42 C.F.R. § 438.406(b)(1).
 - (e) If a Grievance relates to the denial of an expedited Appeal request, the BH I/DD Tailored Plan shall acknowledge receipt of the Grievance, in writing via trackable mail, within twenty-four (24) hours of receipt the Grievance.
 - (f) If a Grievance relates to the denial of an expedited Appeal request, the BH I/DD Tailored Plan shall resolve the Grievance and provide notice to the member and, as applicable, the member's authorized representative within five (5) Calendar Days from the date the BH I/DD Tailored Plan receives the Grievance. 42 C.F.R. § 438.408(b)(1).
 - (g) The BH I/DD Tailored Plan shall provide written notice of resolution of the Grievance to the member and, as applicable, the member's authorized representative within thirty (30) Calendar Days from the date the BH I/DD Tailored Plan receives the Grievance. 42 C.F.R. § 438.408(b)(1).
 - (h) Consistent with 42 C.F.R. § 438.408(c)(1)(i) - (ii), the BH I/DD Tailored Plan may extend the timeframes for resolution of a Grievance by up to fourteen (14) Calendar Days if:
 - (1) The member requests the extension or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest.
 - (2) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - i. Make reasonable efforts to give the member verbal notice of the delay;
 - ii. Within two (2) Calendar Days, provide written notice and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - iii. Resolve the Grievance as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
 - (3) The BH I/DD Tailored Plan shall notify members of their opportunity to submit a complaint with the Department if the member is dissatisfied with the BH I/DD Tailored Plan's resolution of a Grievance.
- (iv) Notice of Adverse Benefit Determination
- (a) The BH I/DD Tailored Plan shall give the member and provider timely and adequate written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 C.F.R. § 438.404.
 - (b) Each notice of adverse action shall conform with 42 C.F.R. § 431.210, contain and explain:
 - (1) The action the BH I/DD Tailored Plan has taken or intends to take. 42 C.F.R. § 438.404(b)(1);
 - (2) The reasons for the action, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse action. 42 C.F.R. § 438.404(b)(2);
 - (3) The member's right to file an Appeal, including information on exhausting the BH I/DD Tailored Plan's one (1) level of Appeal and the right to request a State Fair Hearing if the adverse action is upheld. 42 C.F.R. § 438.404(b)(3); 42 C.F.R. § 438.402(b)-(c);
 - (4) Procedures for exercising member's rights to file a Grievance or Appeal. 42 C.F.R. § 438.404(b)(4);

- (5) Circumstances under which expedited resolution is available and how to request it. 42 C.F.R. § 438.404(b)(5); and
 - (6) The member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these continued benefits. 42 C.F.R. § 438.404(b)(6).
- (c) The BH I/DD Tailored Plan shall use the Department-defined template for the Notice of Adverse Benefit Determination.
 - (d) The BH I/DD Tailored Plan shall provide the member with a Department-developed Appeal request form in conjunction with the Notice of Adverse Benefit Determination.
 - (e) Timing of the Notice of Adverse Benefit Determination.
 - (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the BH I/DD Tailored Plan shall give written notice to the member, and when applicable, an authorized representative at least ten (10) Calendar Days before the date of the adverse benefit determination is to take effect, except as provided in this Section. 42 C.F.R. § 438.404(c)(1).
 - (2) For termination, suspension, or reduction of previously authorized Medicaid-covered services the BH I/DD Tailored Plan shall provide written notice as expeditiously as possible and no later than five (5) Calendar Days before the date of the action if:
 - i. The BH I/DD Tailored Plan has facts indicating that action should be taken because of probable fraud by the member; and
 - ii. The facts have been verified, if possible, through secondary sources. 42 C.F.R. §§ 431.214 and 438.404(c).
 - (3) For termination, suspension, or reduction of previously authorized Medicaid-covered services, the BH I/DD Tailored Plan shall provide written notice no later than by the date of the action when any of the following occurs:
 - i. The BH I/DD Tailored Plan has factual information confirming the death of the member;
 - ii. The BH I/DD Tailored Plan receives a signed, written statement from the member requesting service termination or giving information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
 - iii. The member is admitted to an institution where he or she is ineligible under the plan for further services;
 - iv. The member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
 - v. The BH I/DD Tailored Plan establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction State, territory, or commonwealth; or
 - vi. A change in the level of medical care is prescribed by the member's physician. 42 C.F.R. §§ 431.213 and 438.404(c).
 - (4) For denial of payment, the BH I/DD Tailored Plan shall give written notice to the member and, when applicable, an authorized representative at the time of an action affecting the claim in accordance with the following:
 - i. When the denial of payment of a claim, in whole or in part, by the BH I/DD Tailored Plan does not result in any financial liability for the member for the cost of the service, the BH I/DD Tailored Plan shall not consider this an Adverse Benefit Determination under 42 C.F.R. § 438.400(b)(3) and is not required to send a written notice to the member.

- ii. When the denial of payment of a claim, in whole or in part, by the BH I/DD Tailored Plan results in financial liability for the member for any portion of the cost of the service, the BH I/DD Tailored Plan shall consider this an Adverse Benefit Determination under 42 C.F.R. § 438.400(b)(3) and shall use a Department-developed template to notify the member of the denial. 42 C.F.R. § 438.404(c)(2).
- (5) For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the BH I/DD Tailored Plan shall provide written notice on the date that the timeframes expire. 42 C.F.R. § 438.404(c)(5).
- (6) If the member's address is unknown and mail directed to him/her has no forwarding address, the BH I/DD Tailored Plan shall have a contingency plan to provide an Adverse Benefit Determination notification to the member or legally responsible person regarding termination or reduction of previously authorized Medicaid-covered services no later than the date of the benefit determination
- (f) Internal Plan Appeals
 - (1) The BH I/DD Tailored Plan shall have an established internal member Appeal process for standard and expedited resolution of Appeals requests.
 - (2) The BH I/DD Tailored Plan shall have only one level of Appeal for members. 42 C.F.R. § 438.402(b).
 - (3) The BH I/DD Tailored Plan shall include the member and his or her representative or the legal representative of a deceased member's estate as parties to the Appeal. 42 C.F.R. § 438.406(b)(6).
 - (4) The BH I/DD Tailored Plan shall provide members a reasonable opportunity, by phone, in person, or in writing to present evidence and testimony and make allegations of fact or law in support of the Appeal. For requests for expedited resolution, the BH I/DD Tailored Plan shall inform the member of the limited time available to provide evidence sufficiently in advance of the expedited resolution timeframe. 42 C.F.R. § 438.406(b)(4)
 - (5) The BH I/DD Tailored Plan shall provide members and his or her authorized representative 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 sufficiently in advance of the Appeal resolution timeframe. 42 C.F.R. § 438.406(b)(5).
 - (6) The BH I/DD Tailored Plan shall consider all comments, documents, records, and other information submitted by the member or, his or her authorized representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
 - (7) The BH I/DD Tailored Plan shall require members to exhaust the internal Appeal process before requesting a State Fair Hearing. However, if the BH I/DD Tailored Plan fails to adhere to the notice and timing requirements under 42 C.F.R. § 438.408 and as specified in this Contract, members will be deemed to have exhausted the BH I/DD Tailored Plan's internal Appeal process and can request a State Fair Hearing. 42 C.F.R. § 438.402(c)(1).
 - (8) Request for Plan Appeals
 - i. The BH I/DD Tailored Plan shall allow members, or an authorized representative, sixty (60) Calendar Days from the date on the Notice of Adverse Benefit Determination to file a request, verbally or in writing, for an Appeal with the BH I/DD Tailored Plan. 42 C.F.R. § 438.402(c)(2)(ii) and (3)(ii).

- ii. The BH I/DD Tailored Plan shall use a Department-developed Notice of Acknowledgement of Receipt of Appeal Request template to acknowledge, in writing, receipt of each standard Appeal request, whether received verbally or in writing, within five (5) Calendar Days of receipt of the request. 42 C.F.R. § 438.406(b)(1).
- iii. Standard resolution of Appeals
 - a) The BH I/DD Tailored Plan shall provide written notice of resolution of the Appeal to the member and/or authorized representative as expeditiously as the member's health condition requires and no later than thirty (30) Calendar Days after receipt of a standard Appeal request. 42 C.F.R. § 438.408(b)(2).
 - b) The BH I/DD Tailored Plan shall use a Department-developed template for the written Notice of Standard Appeal Resolution and the State Fair Hearing Appeal request form consistent with. 42 C.F.R. § 438.408(e).
 - c) The BH I/DD Tailored Plan shall do the following if the Member makes an oral appeal request for standard resolution:
 - 1) Require the member to follow up the oral request with a written Appeal Request Form.
 - 2) At the time that the oral request is made, inform the member that the oral request must be followed up by a written Appeal Request Form.
 - i) If the Appeal Request Form is received (postmarked if mailed) within fourteen (14) Calendar Days of the oral appeal request, the BH I/DD Tailored Plan shall count the date of receipt of the oral request as the date of filing.
 - ii) If the Appeal Request form is received (postmarked if mailed) more than fourteen (14) Calendar Days following receipt of the oral request but within the sixty (60) Calendar Days of the date on the Notice of Adverse Benefit Determination, the BH I/DD Tailored Plan shall count the date of receipt of the Appeal Request Form as the date of filing.
 - iii) If the Appeal Request form is received (postmarked if mailed) more than fourteen (14) Calendar Days following receipt of the oral request and more than sixty (60) Calendar Days of the date on the Notice of Adverse Benefit Determination, the BH I/DD Tailored Plan is not required to process the appeal. The BH I/DD Tailored Plan shall notify the member in writing within five (5) Calendar Days of the decision to not process an oral appeal request and provide the reason for the decision.
 - d) Acknowledge, in writing, receipt of the verbal request within five (5) Calendar Days of receipt of the request in accordance with 42 C.F.R. §438.406(b)(1).
 - e) Attempt to contact the member if a signed Appeal Request Form is not received within five (5) Calendar Days of the expiration of the period to Appeal.
 - f) If a verbal Appeal request is made and the member does not submit a signed Appeal Request Form within sixty (60) Calendar Days of the date on the Notice of Adverse Benefit Determination, the BH I/DD Tailored Plan is not required to process the Appeal. The BH I/DD Tailored Plan shall notify the member in writing within five (5) Calendar Days of the decision to not process a verbal Appeal request and provide the reason for the decision.
- iv. Extension of standard resolution of Appeal
 - a) The BH I/DD Tailored Plan may extend the timeframes for standard resolution of an Appeal request by up to fourteen (14) Calendar Days if:

- 1) The member requests the extension, or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest. 42 C.F.R. § 438.408(c)(1)(i)-(ii); 42 C.F.R. § 438.408(b)(1).
 - b) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - 1) Make reasonable efforts to give the Member verbal notice of the delay;
 - 2) Within two (2) Calendar Days, provide written notice using the Department-developed template for Notice of Extension of Timeframe for Standard Appeal Resolution and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - 3) Resolve the Appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2)(i)-(ii).
 - c) The Notice of Extension of Timeframe for Standard Appeal Resolution shall include:
 - 1) The timeframe for extension;
 - 2) The reason for extension;
 - 3) A statement on the member's right to file a Grievance if he or she disagrees with the extension; and
 - 4) A statement regarding the availability of assistance with the Appeals process and the ability to call the BH I/DD Tailored Plan with questions. 42 C.F.R. § 438.10(c)(4)(ii).
 - d) The BH I/DD Tailored Plan shall provide written notice of the resolution of the Appeal, which shall include the date completed and reasons for the determination in easily, understood language. The BH I/DD Tailored Plan shall include a written statement, in simple language, of the clinical rationale for the decision, including how the requesting member may obtain the Utilization Management clinical review or decision-making criteria. 42 C.F.R. § 438.408(d)(2)(i); 42 C.F.R. § 438.10; 42 C.F.R. § 438.408(e)(1)-(2).
- (g) Expedited Resolution of Plan Appeals
- (1) The BH I/DD Tailored Plan shall establish, maintain and communicate to members an expedited Appeal resolution process for plan Appeals for use when there is an immediate need for health services because a standard Appeal could jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. 42 C.F.R. 438.410(a).
 - (2) The BH I/DD Tailored Plan shall allow members or an authorized representative to file an expedited Appeal resolution request either verbally or in writing within sixty (60) Calendar Days of the date on the adverse benefit determination notice.
 - (3) The BH I/DD Tailored Plan shall not require any additional written follow-up for verbal requests for expedited Appeal resolution requests. 42 C.F.R. § 438.406(b)(3).
 - (4) For expedited Appeal requests made by providers on behalf of members, the BH I/DD Tailored Plan shall presume an expedited Appeal resolution is necessary and grant the request for expedited resolution. The BH I/DD Tailored Plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or otherwise supports a member's Appeal. 42 C.F.R. § 438.410(a)-(b).
 - (5) If the BH I/DD Tailored Plan denies the request for an expedited plan Appeal, it shall do the following:

- i. immediately transfer the Appeal to the timeframes for standard resolution timeframe and
 - ii. Make reasonable efforts to give the member or an authorized representative oral notice of the denial and follow up with a written notice, of the denial of the expedited resolution request within seventy-two (72) hours of receipt of the request. 42 C.F.R. 438.410(c) and N.C. Gen. Stat. § 108D-14(b).
- (6) For expedited resolution of Appeals, the BH I/DD Tailored Plan shall make a determination as expeditiously as the member's health condition requires but shall provide written notice, and make reasonable effort to provide verbal notice, of resolution no later than seventy-two (72) hours of receipt of the expedited Appeal request. 42 C.F.R. §§ 438.408(b)(2) and 431.230(b).
- (7) BH I/DD Tailored Plan shall use a Department-developed template for the written Notice of Expedited Appeal Resolution and the State Fair Hearing Appeal request form.
- (8) Extension of expedited Appeal resolution
 - i. The BH I/DD Tailored Plan may extend the timeframes for expedited resolution of an Appeal request by up to fourteen (14) Calendar Days if:
 - a) The member requests the extension, or the BH I/DD Tailored Plan determines that there is a need for additional information and the delay is in the member's interest.
 - b) If the timeframe is extended other than at the member's request, the BH I/DD Tailored Plan shall do the following:
 - 1) Make reasonable efforts to give the member verbal notice of the delay;
 - 2) Within two (2) Calendar Days, provide written notice and inform the member of the right to file a Grievance if he or she disagrees with that decision; and
 - 3) Resolve the Appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 C.F.R. § 438.408(c)(2).
 - ii. The BH I/DD Tailored Plan shall use a Department-developed template for Notice of Extension of Timeframe for Appeal Resolution. The Notice shall include:
 - a) The timeframe for extension;
 - b) The reason for extension;
 - c) A statement on the member's right to file a Grievance if he or she disagrees with the extension; and
 - d) A statement on the availability of assistance with the Appeals process and the ability to call the BH I/DD Tailored Plan with questions. 42 C.F.R. § 438.10(c)(4)(ii).
- (v) Continuation of Benefits
 - (a) Timely Request for Continuation of Benefits: The BH I/DD Tailored Plan shall continue and pay for the member's benefits during the pendency of the plan Appeal and State Fair Hearing if all of the following occur:
 - (1) The member, or the member's authorized representative, files the request for an Appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);
 - (2) The plan Appeal involves the termination, suspension, or reduction of previously authorized services;
 - (3) The services were ordered by an authorized provider;
 - (4) The period covered by the original authorization has not expired; and

- (5) The member timely files for continuation of benefits within ten (10) Calendar Days of the BH I/DD Tailored Plan sending the notice of the adverse benefit determination (or before), or on the intended effective date of the BH I/DD Tailored Plan's proposed adverse benefit determination, whichever comes later. 42 C.F.R. § 438.420(b).
- (b) If the BH I/DD Tailored Plan continues the member's benefits while the Appeal is pending, the benefits must be continued until one (1) of the following occurs:
 - (1) The member withdraws the Appeal or State Fair Hearing request, in writing;
 - (2) The member does not request a State Fair Hearing and continuation of benefits within ten (10) Calendar Days from when the BH I/DD Tailored Plan mails an adverse BH I/DD Tailored Plan decision regarding the member's BH I/DD Tailored Plan Appeal; or
 - (3) A State Fair Hearing decision adverse to the member is made.
- (c) The BH I/DD Tailored Plan shall not allow a provider to request continuation of benefits on behalf of a member. 42 C.F.R. § 438.402(c)(1)(ii).
- (d) Following a request for continuation of benefits, the BH I/DD Tailored Plan shall notify the Department within twenty-four (24) hours of the decision to approve or deny the request.
- (e) Recovery of Costs for Services Furnished during the Pendency of the Appeal Process
 - (1) The BH I/DD Tailored Plan shall be permitted to recover the cost of services furnished to the member during the pendency of the plan Appeal and the State Fair Hearing if:
 - i. The BH I/DD Tailored Plan notified the member of the potential for recovery;
 - ii. The BH I/DD Tailored Plan furnished benefits to the member solely because of the requirement for continuation of benefits; and
 - iii. The final resolution of the plan Appeal or the State Fair Hearing is adverse to the member (i.e., upholds the BH I/DD Tailored Plan's adverse benefit determination). 42 C.F.R. § 438.420(d). For purposes of recovering cost of services furnished during the pendency of the Appeal, the BH I/DD Tailored Plan shall consider a final resolution to be adverse to the member when all the following occur:
 - a) The member timely requests benefits to continue during the plan appeal or the State Fair Hearing;
 - b) The BH I/DD Tailored Plan fully upholds its initial decision in its notice of resolution to the member following the plan appeal; and
 - c) The Office of Administrative Hearings issues a final decision in accordance with N.C. Gen. Stat. § 150B-34 that fully upholds the BH I/DD Tailored Plan's Adverse Benefit Determination that gave rise to the appeal.
 - (2) If the BH I/DD Tailored Plan chooses to seek to recover the cost of services provided to members during the pendency of the plan Appeal or the State Fair Hearing, the BH I/DD Tailored Plan shall do the following:
 - i. Develop a member hardship exemption process; and
 - ii. Obtain prior approval from the Department for each instance in which the BH I/DD Tailored Plan seeks to recover the costs of benefits provided to members under this Section which includes an explanation of the services provided to the member, the amount the BH I/DD Tailored Plan is seeking to recover and a detailed explanation for why the BH I/DD Tailored Plan is seeking recovery.
- (vi) State Fair Hearing Process
 - (a) BH I/DD Tailored Plan shall comply with Chapter 108D and Article 3 of Chapter 150B of the General Statutes for all State Fair Hearing proceedings.
 - (b) The BH I/DD Tailored Plan shall comply with all terms and conditions set forth in any orders and instructions issued by the North Carolina Office of Administrative Hearings (OAH) or an Administrative Law Judge.

- (c) The BH I/DD Tailored Plan shall allow members or, an authorized representative, one hundred and twenty (120) Calendar Days from the date on the Notice of Resolution issued by the BH I/DD Tailored Plan upholding, in whole or in part, the Adverse Benefit Determination to request a State Fair Hearing. 42 C.F.R. § 438.408(f).
- (d) The parties to the State Fair Hearing shall include the BH I/DD Tailored Plan and the member or, when applicable, the member's authorized representative. 42 C.F.R. § 438.408(f)(3).
- (e) The BH I/DD Tailored Plan shall designate a mailing and email address with the OAH for all fair-hearing-related communications from OAH and any party to the State Fair Hearing.
- (f) Mediation
 - (1) The BH I/DD Tailored Plan shall notify members of the right to request a mediation with the Mediation Network of North Carolina and assistance from the Ombudsman Program upon the filing of a request for a State Fair Hearing with OAH.
 - (2) The BH I/DD Tailored Plan shall inform members that mediation is voluntary and that the member is not required to request a mediation to receive a State Fair Hearing with OAH.
 - (3) The BH I/DD Tailored Plan shall attend and participate in mediations and State Fair Hearings as scheduled by the Mediation Network of North Carolina and/or OAH.
- (g) Effectuation of Reversed Appeal Resolutions
 - (1) If the BH I/DD Tailored Plan, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the BH I/DD Tailored Plan shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires and no later than seventy-two (72) hours from the date it receives notice reversing the determination. 42 C.F.R. § 438.424(a).
 - (2) If the BH I/DD Tailored Plan, during the plan Appeal, or the Administrative Law Judge, during the State Fair Hearing, reverses a decision to deny, limit, or delay services and the member received the disputed services while the Appeal was pending, the BH I/DD Tailored Plan shall pay for those services in accordance with the terms of the Contract. 42 C.F.R. § 438.424(b).
- (vii) Appellate Responsibilities
 - (a) The BH I/DD Tailored Plan shall notify the Department within five (5) Calendar Days of being served notice of a member's request for judicial review, or other Appeal, following an adverse ruling in a State Fair Hearing.
 - (b) The BH I/DD Tailored Plan is responsible for responding to the request for judicial review, or other Appeal, as well as BH I/DD Tailored Plan's attorney's fees and costs.
 - (c) If Department is also a party, the Department is responsible for its response to the request for judicial review. The BH I/DD Tailored Plan will cooperate fully with Department in its response and defense. To the extent no conflict of interest exists or arises, the BH I/DD Tailored Plan and Department may agree to joint defense.
 - (d) The BH I/DD Tailored Plan is responsible for satisfying any judgement, including, payment of benefits, that result from a court's ruling or order in favor of the member and against the BH I/DD Tailored Plan. The Department will seek indemnification in accordance with the terms of this Contract for any ruling against the Department.
- (viii) NC Health Choice Beneficiary Grievances and Appeals
 - (a) The BH I/DD Tailored Plan shall allow members who are NC Health Choice beneficiaries enrolled in the BH I/DD Tailored Plan to file Grievances in the same manner as members who are North Carolina Medicaid beneficiaries as specified in this Contract. 42 C.F.R. § 457.1260.
 - (b) In accordance with 42 C.F.R. §§ 457.1260 and 457.1130(b), the BH I/DD Tailored Plan shall allow members who are NC Health Choice beneficiaries enrolled in the plan to file Appeals in the same manner as members who are North Carolina Medicaid beneficiaries as specified in this

Contract, except that the BH I/DD Tailored Plan shall not provide continuation of benefits to members who are NC Health Choice beneficiaries during the pendency of an Appeal. 42 C.F.R. § 457.1260.

- (c) Notwithstanding requirements within this Section, if the sole basis for the BH I/DD Tailored Plan's decision to delay, deny, reduce, suspend, or terminate health services, in whole or in part, is a provision in the NC Health Choice State Plan or in federal or North Carolina law requiring an automatic change in coverage under the health benefits package that affects all members or a group of members without regard to their individual circumstances, the BH I/DD Tailored Plan shall not be required to provide the member with an opportunity for review of the matter. 42 C.F.R. § 457.1130(c).
- (ix) Appeals and Grievances Recordkeeping and Reporting
 - (a) The BH I/DD Tailored Plan shall maintain records of all member Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State's Quality Strategy. 42 C.F.R. § 438.416(a).
 - (b) The record of each Grievance and Appeal shall contain, at a minimum, the following:
 - (1) The name of the person for whom the Appeal or Grievance was filed;
 - (2) A general description of the reason for the Appeal or Grievance;
 - (3) The date received;
 - (4) The date of each review or, if applicable, review meeting;
 - (5) Resolution at each level of the Appeal or Grievance, if applicable;
 - (6) Date of resolution at each level, if applicable;
 - (7) Date of Appeal decision and mail date of Appeal decision;
 - (8) Whether the Appeal was an expedited request, if applicable;
 - (9) Who conducted the review of the Appeal or Grievance and made the determination; and
 - (10) Whether an extension of Appeal resolution timeframe was requested, if applicable. 42 C.F.R. § 438.416(b).
 - (c) The BH I/DD Tailored Plan shall maintain accurate records in a manner accessible to the Department and available upon request to CMS. 42 C.F.R. § 438.416(c).
 - (d) The BH I/DD Tailored Plan shall retain Appeal and Grievance records consistent with the record retention terms of the Contract following the final decision or the close of the Appeal or Grievance. If any litigation, claims negotiation, audit, or other action involving the records has been started before the expiration of the retention period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular period, whichever is later.
 - (e) Appeals and Grievance Reporting
 - (1) In accordance with 42 C.F.R. § 438.416, the Department will monitor the BH I/DD Tailored Plan to ensure compliance with all applicable laws and rules pertaining to member Appeals and Grievances.
 - (2) To support the Department's monitoring efforts, the BH I/DD Tailored Plan shall upload the following to the Appeals Clearinghouse in a manner and frequency specified by the Department:
 - i. Each Notice of Adverse Benefit Determination issued by the BH I/DD Tailored Plan; and
 - ii. Each Notice of Resolution issued by the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall provide a report on all Appeals and Grievances received by the BH I/DD Tailored Plan from members, or an authorized representative, in a form and frequency as described in *Section VII. Attachment J. Reporting Requirements*.
- (x) Due Process Principles under the NC Innovations waiver and TBI waiver: BH I/DD Tailored Plan shall comply with the following due process principles as they relate to members who are participants

in the Innovations waiver or TBI waiver, including but not limited to development of the member's individual budget and ISP:

- (a) NC Innovations Waiver: The BH I/DD Tailored Plan shall utilize a Department-approved template to notify the member or authorized representative of the results of any new Supports Intensity Scale® (SIS®) evaluation and to inform the member or authorized representative in writing of the opportunity and process for raising concerns regarding SIS® evaluations and results. The process for raising concerns shall include an opportunity to discuss the results of the SIS® evaluation with the BH I/DD Tailored Plan and the potential for results to be adjusted if it is determined that particular support needs of the individual were not accurately captured, as well as the opportunity to file a Grievance regarding SIS® evaluations and results. The failure to request a Grievance shall not waive the Innovations waiver member's ability to argue that the results of the SIS® are incorrect in requesting services, or during reconsideration review or the State fair hearing
- (b) If the BH I/DD Tailored Plan authorizes a requested service for a duration less than the duration requested in the ISP, the BH I/DD Tailored Plan shall provide written notice with Appeal rights and clinical reasons for the decision at the time of the limited authorization.
- (c) If the BH I/DD Tailored Plan denies a request for authorization of services by a member, in whole or in part, or authorizes a requested service in a limited manner, including the type, level, or duration of service, BH I/DD Tailored Plan shall, at the time of such denial or limited authorization, provide written notice and due process rights in accordance with 42 CFR § 438.404:
 - (1) An Appeal filed by a member must not prevent any authorized services from being provided pending the outcome of the Appeal. BH I/DD Tailored Plan must not prevent the member from making a new request for services during a pending Appeal.
- (d) The BH I/DD Tailored Plan shall implement procedures and trainings, and utilize trainings provided by the Department, to protect all members from discouragement, coercion, or misinformation regarding the type, amount, and durations of services they may request in their plans of care and their right to Appeal the denial, reduction, or termination of a service. BH I/DD Tailored Plan shall not attempt to influence, limit, or interfere with a member's right or decision to file or pursue a Grievance or request an Appeal.
- (e) ISP: The BH I/DD Tailored Plan shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver or TBI waiver member and that such desires are reflected in the Innovations waiver or TBI waiver member's ISP, including the desired type, amount, and duration of services.
- (f) The BH I/DD Tailored Plan shall attend trainings required by the Department, including but not limited to training on the principles of due process as they apply to the Innovations/TBI waivers and other trainings relevant to due process procedures, whether related to the waiver or otherwise.

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

(i) Advanced Medical Home Contracting

(a) Background and General Requirements

- (1) The majority of primary care practices serving Medicaid beneficiaries are participating in the Advanced Medical Home (AMH) program in Tiers 1-3. All AMH practices additionally receive a Medical Home Fee.
- (2) Under BH I/DD Tailored Plans, AMH practices will act as primary care providers (PCPs) for BH I/DD Tailored Plan members. The BH I/DD Tailored Plan shall pay AMH practices serving as the PCP for members the Medical Home Fee paid to AMH practices. *Section V.B.4.iv.(xvii) Payments of Medical Home Fees to Advanced Medical Homes.*

- (3) Different from Standard Plans, AMH practices ready to take primary responsibility for care management under BH I/DD Tailored Plans must become certified as AMH+ practices as described in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*. The Department will establish a fixed Tailored Care Management payment for AMH+ practices certified to provide Tailored Care Management as described in *Section III.D.36. Payment and Reimbursement*.
 - (4) The BH I/DD Tailored Plan shall incorporate all Department-defined AMH practice standards into each of its contracts with AMH practices as described in *Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members*.
 - (5) The BH I/DD Tailored Plan shall be allowed to incorporate additional standards and contract terms, which are mutually agreed upon by the AMH practice and the BH I/DD Tailored Plan.
 - (6) The BH I/DD Tailored Plan shall incorporate any new Department guidance, policy, operational manuals and other program-specific requirements into BH I/DD Tailored Plan operations and AMH contracts, as applicable, and within Department-specified timelines.
- (b) Advanced Medical Home Quality Metrics
- (1) Based on the common quality measure set for the AMH program, which will be a subset of the overall measure set that the Department will be collecting for BH I/DD Tailored Plans, the BH I/DD Tailored Plan shall compile and calculate each of the AMH quality metrics for each AMH practice and share them with the Department.
 - (2) The BH I/DD Tailored Plan shall provide feedback on quality scoring results to each AMH practice.
 - (3) The Department will provide the BH I/DD Tailored Plan with the AMH measure set and reporting schedule prior to implementation as described in *Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members*.
- (c) For AMH practices that are not certified as AMH+ practices, the BH I/DD Tailored Plan may, but is not required to, develop methodologies for the calculation of AMH Performance Incentive Payments that utilize the AMH metrics.
- (ii) PCP Choice and Assignment
- (a) Consistent with 42 C.F.R. § 438.3(l), the BH I/DD Tailored Plan shall ensure that each member has a choice of PCP.
 - (b) The BH I/DD Tailored Plan shall assign every member to a PCP for general primary care services prior to their assignment to a care management approach as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (c) The BH I/DD Tailored Plan shall, in instances in which a member does not select a PCP at the time of enrollment, assign the member to a PCP within twenty-four (24) hours of effectuation date of enrollment in BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall allow PCPs to set limits on panel size and shall have a process for PCPs to do so.
 - (d) The BH I/DD Tailored Plan's methodology for assigning members to a PCP shall include the following components, in this order, to the extent that such information is available.
 - (1) Prior PCP assignment;
 - (2) Member's claims history;
 - (3) Family member's PCP assignment, as appropriate;
 - (4) Family member's claims history, as appropriate;
 - (5) Geographic proximity;
 - (6) Special medical needs;
 - (7) Language/cultural preference; and
 - (8) AMH+ status

- (9) AMH status (Tiers 2 and 3).
- (e) The Department reserves the right to adjust the PCP methodology for assigning each member to a PCP as defined in this Contract and to audit the BH I/DD Tailored Plan's PCP auto-assignment logic.
- (f) The BH I/DD Tailored Plan shall notify members when they have been assigned to a PCP.
- (g) Members can change their PCP without cause twice per year. Members shall be given thirty (30) days from receipt of notification of their PCP assignment each year to change their PCP without cause (1st instance) and shall be allowed to change their PCP without cause up to one time per year thereafter (2nd instance).
- (h) Members shall be allowed to change their PCP with cause at any time.
- (i) The Department shall consider the following as appropriate "cause" for member PCP changes:
 - (1) The provider has failed to furnish accessible and appropriate medical care, services or supplies to which the member is entitled. This includes, but is not limited to, the failure to:
 - i. Provide primary care services;
 - ii. Arrange for inpatient care, consultations with specialists, or laboratory or radiological services when reasonably necessary;
 - iii. Arrange for consultation appointments;
 - iv. Coordinate and interpret any consultation findings with an emphasis on continuity of medical care;
 - v. Arrange for services with qualified licensed or certified providers;
 - vi. Coordinate the member's overall medical care such as periodic immunizations and diagnosis and treatment of any illness or injury;
 - vii. The member disagrees with a treatment plan;
 - viii. The member and provider are not able to communicate due to a language barrier or other impediment to communication;
 - ix. The provider is not able to reasonably accommodate the member's special needs;
 - x. There is a change in the provider's practice, including but not limited to the following:
 - a) The provider moves to a location that is not convenient for the member;
 - b) There is a Significant Change in the hours the provider is available, and the member cannot reasonably make appointments during the new hours;
 - c) The provider no longer has hospital access.
 - xi. The member and the provider agree that a change would be in the best interest of the member; or
 - xii. The provider leaves the Network.
- (j) The BH I/DD Tailored Plan shall allow PCPs to request removal of a member from their panel and must submit to the Department their process for reviewing and approving such removal requests.
- (k) The BH I/DD Tailored Plan shall allow members with complex conditions or special health care needs to select a specialist as their PCP or otherwise allow such members direct access to a specialist as appropriate to the member's condition or diagnosis. 42 C.F.R. § 438.208(c)(4).

2. Benefits

- i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package
 - (i) Throughout the term of this Contract, the BH I/DD Tailored Plan shall promptly provide, arrange, purchase or otherwise make available all medically necessary services required under this Contract to all its members enrolled in the BH I/DD Tailored Plan. Services shall be delivered within the standard of care and meet Department quality standards and expectations.

- (a) Physical health benefits are inclusive of physical health and State Plan LTSS services, including nursing facility services, home health services, private duty nursing services, personal care services, and hospice services.
 - (b) BH benefits are inclusive of mental health and SUD services.
 - (c) I/DD benefits refer to services targeted towards individuals with an I/DD, including intermediate care facilities for individuals with intellectual disabilities (ICF-IID), Innovations waiver services, and other home and community-based services.
 - (d) TBI benefits refer to services targeted toward individuals with a TBI, including TBI waiver services and other home and community-based services.
- (ii) The BH I/DD Tailored Plan shall:
- (a) Cover all services in the North Carolina Medicaid and NC Health Choice State Plans with the exception of services carved out of Medicaid Managed Care under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract;
 - (b) Use the North Carolina definition of medical necessity, defined in 10A NCAC 25A.0201, in making coverage determinations;
 - (c) Consistent with 42 C.F.R. § 438.210(a)(3)(ii), not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the member's diagnosis, type of illness or condition;
 - (d) Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2);
 - (e) Ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 42 C.F.R. § 438.210(a)(3)(i);
 - (f) Develop a comprehensive Utilization Management Program inclusive of a subset of NC Medicaid Direct clinical coverage policies as defined in this Contract; and
 - (g) Implement and adhere to all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policies and protocols as defined in *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)* for Medicaid members.
- (iii) Covered Medicaid and NC Health Choice services:
- (a) The BH I/DD Tailored Plan shall cover all services as defined in the Medicaid and NC Health Choice State Plans with the exception of services carved out under N.C. Gen. Stat. § 108D-35; as specified in 42 C.F.R. § 438.210; and as otherwise noted within this Contract. A summary of Medicaid and NC Health Choice State Plan covered services are described in *Section VII. Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies* (this table is not meant to be exhaustive and is only a summary of the services included in the Medicaid and NC Health Care State Plan); the BH I/DD Tailored Plan shall not be responsible for providing carved out services to members as defined in *Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care*;
 - (b) Consistent with N.C. Gen. Stat. §§ 108D-60 and 108D-35, the BH I/DD Tailored Plan shall be responsible for covering BH, I/DD and TBI services that are defined as *Section V.B.2. Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans*, including 1915(c) Innovations and TBI waiver services, as well as any services that the Department obtains authority through a SPA or waiver to cover and adds to the BH I/DD Tailored Plan benefit package (e.g., supported employment).
 - (1) A crosswalk of the SUD services covered under the Medicaid and NC Health Choice State Plans to national clinical standards is provided in *Section V.B.2 Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services*.

- (c) The BH I/DD Tailored Plan shall implement changes to covered or carved-out services within thirty (30) Calendar Days after notification by the Department, unless otherwise indicated.

Section V.B.2. Table 1: Services Carved Out of Medicaid Managed Care⁷
Services provided through the Program of All-Inclusive Care for the Elderly (PACE)
Services documented in an Individualized Education Program (IEP), Individual Family Service Plan (IFSP), a Section 504 Accommodation Plan pursuant to 34 C.F.R. § 104.36, an Individual Health Plan (IHP), or a Behavior Intervention Plan (BIP) as appropriate for each covered service and provided or billed by Local Education Agencies (LEAs)
Services provided and billed by Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan
Dental services defined as all services billed as dental using the American Dental Association's Current Dental Terminology (CDT) codes, with the exception of the two CDT codes (D0145 and D1206) associated with the "Into the Mouths of Babes" (IMB)/Physician Fluoride Varnish Program
Services for Medicaid applicants provided prior to the first day of the month in which eligibility is determined in cases where retroactive eligibility is approved (with exception of deemed newborns) unless otherwise defined in the Contract ⁸
Fabrication of eyeglasses, including complete eyeglasses, eyeglasses lenses, and ophthalmic frames

Section V.B.2. Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced BH services are <i>italicized</i>	
State Plan BH and I/DD Services <ul style="list-style-type: none"> • Inpatient BH services • Outpatient BH emergency room services • Outpatient BH services provided by direct-enrolled providers • Psychological services in health departments and school-based health centers sponsored by health departments • Peer supports • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> 	State Plan BH and I/DD Services <ul style="list-style-type: none"> • Residential treatment facility services • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • Psychiatric residential treatment facilities (PRTFs) • <i>Assertive community treatment (ACT)</i> • <i>Community support team (CST)¹⁰</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i>

⁷ N.C. Gen. Stat. § 108D-35.

⁸ The Department is considering pursuing legislative authority to carve these services into managed care.

¹⁰ CST includes tenancy supports.

Section V.B.2. Table 2: Behavioral Health Services Covered in Standard Plans and BH I/DD Tailored Plans	
BH, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	BH, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME/MCOs Prior To Launch)
Enhanced BH services are <i>italicized</i>	
<ul style="list-style-type: none"> • <i>Professional treatment services in facility-based crisis program</i> • <i>Outpatient opioid treatment⁹</i> • <i>Ambulatory detoxification</i> • Research-based BH treatment for Autism Spectrum Disorder (ASD) • Diagnostic assessment • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization</i> • Early and periodic screening, diagnostic and treatment (EPSDT) services 	<ul style="list-style-type: none"> • <i>Substance abuse intensive outpatient program (SAIOP)</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF-IID) <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services

Section V.B.2. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
1	Outpatient services	
2.1	Intensive outpatient services	Substance abuse intensive outpatient program
2.5	Partial hospitalization services	Substance abuse comprehensive outpatient treatment
3.5	Clinically managed high-intensity residential services	Substance abuse non-medical community residential treatment
3.7	Medically monitored intensive inpatient services	Substance abuse medically monitored community residential treatment
N/A		Medically supervised or alcohol and drug abuse treatment center (ADATC) detoxification crisis stabilization
4	Medically managed intensive inpatient services	Inpatient BH services

⁹ BH I/DD Tailored Plans will also be required to cover OBOT services as detailed in *Section VII. Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies.*

Section V.B.2. Table 3: Crosswalk of Covered American Society of Addiction Medicine (ASAM) SUD Services to North Carolina Medicaid Covered SUD Services		
ASAM Level of Care	ASAM Service Title	North Carolina Medicaid Service Title
Office-based opioid treatment	Office-based opioid treatment ¹¹	Office-based opioid treatment
Opioid treatment services	Opioid treatment services	Outpatient opioid treatment and
1-WM	Ambulatory withdrawal management without extended on-site monitoring	Ambulatory detoxification
2-WM	Ambulatory withdrawal management with extended on-site monitoring	
3.7-WM	Medically monitored inpatient withdrawal management	Non-hospital medical detoxification
4-WM	Medically managed intensive inpatient withdrawal	Inpatient BH services

- (d) The Department will allocate a specific number of Innovations and TBI waiver slots to each BH I/DD Tailored Plan. The BH I/DD Tailored Plan shall manage access to its allotted waiver slots, including reserved capacity slots except for Military Transfers, and maintain a Registry of Unmet Needs (waiting list) for members who are determined eligible for waiver funding but for whom funding is not available at the time of their waiver eligibility determination. The BH I/DD Tailored Plan shall report on the status of the use of waiver slots and reserved capacity as required by the Department.
- (e) The BH I/DD Tailored Plan shall cover Innovations and TBI waiver services for beneficiaries enrolled in the waivers as defined in *Section V.B.2. Table 4: Innovations Waiver Services* and *Section V.B.2. Table 5: TBI Waiver Services* (as applicable) pending CMS approval of the 1915(c) waiver renewals and authorization of funding by the General Assembly.

Section V.B.2. Table 4: Innovations Waiver Services¹²	
<ul style="list-style-type: none"> • Assistive Technology • Community Living and Support • Community Navigator¹³ • Community Networking • Community Transition 	<ul style="list-style-type: none"> • Natural Supports Education • Residential Supports • Respite • Supported Employment • Specialized Consultation

¹¹ BH I/DD Tailored Plans will be required to cover OBOT services as detailed in *Section VII. Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies*.

¹² Only BH I/DD Tailored Plan members who are enrolled in the Innovations waiver will have access to these services.

¹³ The Department plans to remove community navigator from the Innovations service array prior to BH I/DD Tailored Plan launch because it is duplicative with Tailored Care Management. Self-directed functions that are currently provided under the community navigator service definition will be incorporated into the financial support services definition.

Section V.B.2. Table 4: Innovations Waiver Services¹²

- | | |
|--|---|
| <ul style="list-style-type: none"> • Crisis Services • Day Supports • Financial Support Services • Home Modifications • Individual Goods and Services | <ul style="list-style-type: none"> • Supported Living • Supported Living - Periodic • Supported Living – Transition • Vehicle Adaptations |
|--|---|

Section V.B.2. Table 5: TBI Waiver Services¹⁴

- | | |
|--|---|
| <ul style="list-style-type: none"> • Adult Day Health • Assistive Technology • Cognitive Rehabilitation • Community Networking • Community Transition • Crisis Support Services • Day Supports • Home Modifications • In Home Intensive Support • Life Skills Training • Natural Supports Education | <ul style="list-style-type: none"> • Occupational Therapy • Personal Care • Physical Therapy • Residential Supports • Respite • Resource Facilitation • Speech Language Therapy • Specialized Consultation • Supported Employment • Vehicle Modifications |
|--|---|

- (f) The Department currently covers a subset of BH services under its 1915(b)(3) waiver, which will sunset upon BH I/DD Tailored Plan launch. The Department plans to seek authority to cover most of the current 1915(b)(3) services through 1915(i) authority. The Department is also considering seeking federal authority to provide Medicaid coverage for select home and community-based services that are currently covered under the state-funded I/DD service array. Prior to BH I/DD Tailored Plan launch, the Department will release additional information on additional services it is seeking to cover through BH I/DD Tailored Plans.
- (g) The BH I/DD Tailored Plan shall contract with publicly-funded local health departments to conduct Refugee Health Assessments outlined in Clinical Coverage Policy 1D-1: Refugee Health Assessments Provided in Health Departments.
- (h) The BH I/DD Tailored Plan shall, in accordance with the federal Women’s Health and Cancer Rights Act of 1998 (WHCRA), provide protections to members who choose to have breast reconstruction relating to a mastectomy, including coverage of:
 - (1) All stages of reconstruction of the breast on which the mastectomy has been performed;
 - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (3) Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.
- (i) The BH I/DD Tailored Plan shall provide LTSS in settings that comply with 42 C.F.R. § 441.301(c)(4) requirements for home and community-based settings. 42 C.F.R. §438.3(o).
- (j) The BH I/DD Tailored Plan shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a member enrolling in the BH I/DD Tailored Plan.
- (k) The BH I/DD Tailored Plan shall encourage primary care providers who serve members under age nineteen (19) to participate in the Vaccines for Children (VFC) program, which allows

¹⁴ Only BH I/DD Tailored Plan members who are enrolled in the TBI waiver will have access to these services.

providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).

- (1) The BH I/DD Tailored Plan shall require that primary care providers administer vaccines consistent with the American Academy of Pediatrics (AAP)/Bright Future periodicity schedule.
 - (2) The BH I/DD Tailored Plan shall only pay for the vaccine administration fee for VFC eligible children.
 - (3) Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.
 - (4) Vaccines provided for children enrolled in NC Health Choice are not covered by the VFC program. The BH I/DD Tailored Plan shall reimburse the provider for both the vaccine and administration fee for NC Health Choice beneficiaries.
 - (5) The BH I/DD Tailored Plan shall adhere to additional VFC requirements as defined in *Section V.B.3.ix. Prevention and Population Health Programs*.
- (l) Pursuant to 42 C.F.R. § 457.410(b)(1), the BH I/DD Tailored Plan shall provide office visits for preventive services (well-child visits) for NC Health Choice children, including:
- (1) Routine physical examinations as recommended and updated by the AAP “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents” including:
 - i. Screening for developmental delay at each visit through the 5th year;
 - ii. Screening for Autistic Spectrum Disorders per AAP guidelines;
 - iii. Comprehensive unclothed physical examination;
 - iv. All appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices;
 - (2) Laboratory tests (including blood lead screening appropriate for age and risk factors) associated with well-child routine physical examinations; and
 - (3) Health education and anticipatory guidance for both the child and caregiver.
- (m) Changes to Covered Benefits
- (1) The BH I/DD Tailored Plan shall cover benefits consistent with any approved State Plan Amendments (SPAs) to the North Carolina Medicaid or NC Health Choice State Plans and consistent with any approved Medicaid waivers, except to the extent the service is carved out of Medicaid Managed Care.
- (n) Institutions for mental disease (IMD) SUD Services
- (1) Under North Carolina’s 1115 waiver authority, the BH I/DD Tailored Plan shall provide coverage for substance use disorder services for members aged twenty-one (21) through sixty-four (64) in an IMD, as well as any other State Plan services for which they may be eligible during their stay in the IMD.
 - (2) The BH I/DD Tailored Plan shall provide the Department with a weekly report on members who are residing or have resided in an IMD for SUD treatment as defined in *Section VII. Attachment J. Reporting Requirements* to support 1115 waiver reporting to CMS. The report shall be submitted to the Department by each Friday and no later than fourteen (14) Calendar Days from the applicable admission or discharge date.
- (o) For members newly enrolled in the BH I/DD Tailored Plan with no immediately prior period of Medicaid Managed Care enrollment or NC Medicaid Direct enrollment with inpatient coverage, the BH I/DD Tailored Plan shall be responsible for any diagnosis-related group based inpatient facility claims if the member’s first day of BH I/DD Tailored Plan enrollment is during the hospital stay.
- (iv) Medical Necessity

- (a) The BH I/DD Tailored Plan shall cover all medically necessary services for its enrolled members in accordance with *Section V.B.2. Benefits*.
 - (b) The BH I/DD Tailored Plan shall provide medically necessary services to all enrolled members under the age of twenty-one (21) beginning at birth, which are necessary to treat or ameliorate defects, physical or BH, and conditions identified by an EPSDT screen, considering the medical necessity criteria specific to EPSDT defined in *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment for Medicaid Members*, 42 U.S.C. § 1396d(r), and 42 C.F.R. § 441.50-62 and the needs of the child.
 - (c) The BH I/DD Tailored Plan may place appropriate limits on a service based on medical necessity, or for utilization control, consistent with *Section V.B.2.i.(v) Utilization Management* below and as permitted by 42 C.F.R. § 438.210(a)(4)(ii), provided the services furnished can be reasonably expected to achieve their purpose.
 - (d) The BH I/DD Tailored Plan shall work with providers to ensure that providers identify an appropriate new level of care for a member who no longer meets the medical necessity criteria for an existing service.
 - (e) The BH I/DD Tailored Plan shall determine whether a service is medically necessary on a case by case basis.
 - (f) For Medicaid Managed Care members under the age of twenty-one (21), the BH I/DD Tailored Plan shall not issue adverse determinations on requests for a medical service coverable under 42 U.S.C. § 1396d(a), (§1905(a) of the Social Security Act) unless the decision is made following a medical necessity review per EPSDT federal standards.
- (v) Utilization Management
- (a) The BH I/DD Tailored Plan shall develop a utilization management (UM) program for medical, BH, I/DD, LTSS, and pharmacy services that is based on nationally-recognized, evidence-based clinical practice guidelines and decision support methodologies to support UM and prior authorization for services not otherwise defined in mandated clinical coverage policies. The BH I/DD Tailored Plan shall ensure the UM program aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, to the degree a subcontractor relationship applies.
 - (b) UM Program Policy
 - (1) The BH I/DD Tailored Plan shall document the UM program, including referral and prior authorization processes, in a written UM Program Policy and submit to the Department for review one hundred fifty (150) Calendar Days after Contract Award.
 - (2) Subject to Department review and approval, the UM Program Policy, consistent with 42 C.F.R. § 438.210(b), shall contain written policies and procedures for, at a minimum, the following:
 - i. Service authorization. Prior and concurrent authorization of services, including the process used to authorize services, criteria used to support authorization of services;
 - ii. Mechanisms to ensure consistent application of review criteria, inter-rater reliability, and when appropriate, consultation with the requesting provider;
 - iii. Mechanisms to assess whether members are receiving the appropriate level of care corresponding to their clinical information;
 - iv. Authorization of State Plan LTSS based on a member's current needs assessment and consistent with the person-centered service plan;
 - v. Evaluation of the consistency with which UM criteria are applied to service authorization decisions;
 - vi. Timeframes for decision making related to service authorizations in accordance with time frames specified in 42 C.F.R. § 438.210(d) and as outlined in the Contract;

- vii. Protecting members from discouragement, coercion, or misinformation about the amounts of services that they may request in their plans of care or their right to Appeal the denial or reduction or termination of a service;
 - viii. Mechanisms for detecting and addressing instances of overutilization, underutilization, and misutilization;
 - ix. Identification of all UM activities delegated to other entities, the delegate's accountability for these activities, and the frequency of reporting to the BH I/DD Tailored Plan;
 - x. Standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to members. Section 1903(i) of the Social Security Act;
 - xi. Dissemination of guidelines to all affected providers and, upon request, to members and potential members; and
 - xii. Consistent with 42 C.F.R. § 438.210(e), ensures that compensation to individuals or entities that conduct UM activities is not structured to provide financial incentives for the individual or entity to deny, limit, or discontinue services to any member.
- (3) The BH I/DD Tailored Plan shall revise the UM Program Policy based on changes requested by the Department and submit to the Department in writing any changes to the UM Program Policy no less than sixty (60) Calendar Days before such changes go into effect.
 - (4) The BH I/DD Tailored Plan shall post the UM Program Policy on their publicly available website for providers and members, or in other forms as requested by the provider or member, at no cost. The BH I/DD Tailored Plan shall include a prominent reference to the web address of the UM Program Policy in both its provider and Member Handbooks, including Innovations and TBI Waiver Handbooks.
 - (5) The BH I/DD Tailored Plan shall provide training and education to providers including prescribers on changes to the UM Program prior to the effective date of the change as part of the Provider Training Plan as described in *Section V.B.4.iii. Provider Relations and Engagement*.
 - (6) The UM Program shall comply with the federal laws and regulations on mental health parity, including Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. §438.3(e)(1)(ii) and 438.910(b)-(d).
 - i. Annually, the BH I/DD Tailored Plan shall submit a completed standardized parity analysis workbook, developed by the Department and provided upon award, to demonstrate compliance.
- (c) The BH I/DD Tailored Plan shall have the option of using the Department's NC Medicaid Direct clinical coverage policies as the basis for the UM program or developing its own for all covered services with the exception of those listed in *Section V.B.2. Table 6: Required Clinical Coverage Policies*.
 - (d) The UM process must support an integrated, holistic look at an enrollee's physical health, LTSS, BH, and I/DD needs, noting that alternative treatments or supports may be appropriate in light of a beneficiary's complete clinical and other support needs.
 - (e) The Clinical Practice Guidelines shall:
 - (1) Be based on valid and reliable clinical evidence or consensus of providers in a particular field;
 - (2) Consider the needs of members;
 - (3) Be adopted in consultation with contracting health professionals;
 - (4) Be reviewed and updated periodically as appropriate; and

- (5) Starting in Contract Year 1, meet the clinical practice guidelines required for Health Plan Accreditation with LTSS distinction set forth by the National Committee for Quality Assurance (NCQA). 42 C.F.R. § 438.236(b).
- (f) The Department will allow “proprietary” UM policies under limited circumstances, with prior approval by the Department.
- (g) A chart of all North Carolina Medicaid and NC Health Choice clinical coverage policies is found in *Section VII. Attachment B. Summary of Medicaid and NC Health Choice Covered Services & Clinical Coverage Policies.*
- (h) For a limited number of services, the BH I/DD Tailored Plan shall incorporate existing NC Medicaid Direct, NC Health Choice, and State-funded clinical coverage policies into the UM Program to maintain services for specific vulnerable populations, maximize federal funding, and comply with State mandates, as described in *Section V.B.2. Table 6: Required Clinical Coverage Policies.*
- (i) The Department reserves the right to require the BH I/DD Tailored Plan to follow additional NC Medicaid Direct clinical coverage policies developed by the Department after the effective date of this Contract based on the rationale listed herein.

Section V.B. Table 6: Required Clinical Coverage Policies	
Service	Scope
<i>BH and I/DD Services</i>	
<i>Medicaid State Plan BH Services</i>	<p><i>8A: Enhanced Mental Health and Substance Abuse Services:</i></p> <ul style="list-style-type: none"> • Ambulatory Detoxification • Child and Adolescent Day Treatment services • Diagnostic Assessment • Intensive In-Home Services • Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization • Mobile Crisis Management • Multi-systemic Therapy Services • Non-hospital Medical Detoxification • Outpatient Opioid Treatment • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis Program • Psychosocial Rehabilitation (PSR) • Substance abuse comprehensive outpatient treatment program (SACOT) • Substance Abuse Non-Medical Community Residential Treatment • Substance Abuse Medically Monitored Residential Treatment • Substance Abuse Intensive Outpatient Program (SAIOP) <p><i>8A-1: Assertive Community Treatment</i> <i>8A-2: Facility-Based Crisis Services for Children and Adolescents</i> <i>8A-6: Community Support Team (CST)</i></p> <p><i>8B: Inpatient Behavioral Health Services</i></p>

Section V.B. Table 6: Required Clinical Coverage Policies	
Service	Scope
	<p><i>8C: Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers</i></p> <p><i>8D-1: Psychiatric Residential Treatment Facilities for Children under the Age of 21</i></p> <p><i>8D-2: Residential Treatment Services</i></p> <p><i>8F: Research-based Intensive Behavioral Health Treatment for Autism Spectrum Disorder</i></p> <p><i>8G: Peer Supports</i></p> <p><i>8I: Psychological Services Provided by Health Departments and School-Based Health Centers to the Under 21 Population</i></p>
<i>Medicaid State Plan I/DD Services</i>	<i>8E: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)</i>
<i>1915(c) Home and Community-Based Services (HCBS) Waivers</i>	<i>8P: North Carolina Innovations</i>
Other Services	
<i>Auditory Implant External Parts</i>	<p><i>13A: Cochlear and Auditory Brainstem Implant External Parts Replacement and Repair</i></p> <p><i>13B: Soft Band and Implantable Bone Conduction Hearing Aid External Parts Replacement and Repair</i></p>
<i>Obstetrics and Gynecology</i>	<i>1E-7: Family Planning Services</i>
<i>Physician Services</i>	<p><i>1A-4: Cochlear and Auditory Brainstem Implants</i></p> <p><i>1A-5: Child Medical Evaluation and Medical Team Conference for Child Maltreatment</i></p> <p><i>1A-23: Physician Fluoride Varnish Services</i></p> <p><i>1A-36: Implantable Bone Conduction Hearing Aids (BAHA)</i></p> <p><i>1A-39: Routine Costs in Clinical Trial Services for Life Threatening Conditions</i></p>
<i>Pharmacy</i>	<i>As defined in Section V.B.2.iii. Pharmacy Benefits</i>

- (j) The BH I/DD Tailored Plan shall make the CMO or designee available to discuss and report on the UM Program, as requested by the Department.

- (k) The BH I/DD Tailored Plan shall use a standardized prior authorization request form developed by the Department.
- (l) The BH I/DD Tailored Plan shall, prior to the decision on a request for prior approval, limit contacts with the requesting provider or member (including telephone and email contacts) to those needed to obtain more information about the service request and/or to provide education about covered services.
 - (1) Providers and members will not be asked to withdraw or modify a request for prior approval of a covered service in order to accept a lesser number of hours, or less intensive type of service, or to modify a SNAP (Supports Needs Assessment Profile) or SIS® score or other clinical assessment.
 - (2) Material misinformation to or intimidation of providers or members who has the foreseeable effect of significantly discouraging request for covered services, continuation of covered services, or the filing or prosecution of OAH Appeals is prohibited. The care management process shall not be used to improperly influence, change or prevent a request for a prior approval.
 - (3) Nothing in this paragraph should be construed to prevent clinical or treatment discussions.
- (m) The BH I/DD Tailored Plan shall not retract a service authorization after the services, supplies, or other items have been provided, except as provided in N.C. Gen. Stat. § 58-3-200(c).
- (n) The BH I/DD Tailored Plan shall not retract a prior authorization for emergency services after the services have been provided, except as provided in N.C. Gen. Stat. § 58-3-190(c).
- (o) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by an individual who has appropriate expertise in addressing the member's medical, BH, I/DD, TBI, or long-term services and supports needs. 42 C.F.R. § 438.210(b)(3).
- (p) As part of the UM program, the BH I/DD Tailored Plan shall adhere to the following prior authorization requirements.
 - (1) To effectively manage the care of its members, the BH I/DD Tailored Plan shall establish and maintain a referral and prior authorization process that is centered on the member's primary care provider (PCP).
 - (2) The BH I/DD Tailored Plan shall conduct prior authorization reviews using current clinical documentation and must consider the comprehensive range of the member's physical health, LTSS, BH, I/DD and TBI needs, noting that alternative treatments or supports may be appropriate in light of a member's complete clinical and other support needs.
 - (3) The BH I/DD Tailored Plan may require a referral for any medical services not provided by the PCP except where specifically prohibited in the Department-BH I/DD Tailored Plan contract and in federal and state statute and regulations.
 - (4) The BH I/DD Tailored Plan shall not require the submission of an Individualized Education Program (IEP) plan as a condition of receiving a prior authorization nor shall evidence of an IEP be grounds for a prior authorization request denial for services that are not required to be provided by the LEA.
 - (5) Consistent with 42 C.F.R. § 438.206, the BH I/DD Tailored Plan shall not require referral or prior authorization on any of the following services, and shall include information on services that do not require a referral or prior authorization in its Member Handbook:
 - i. Emergency services
 - a) In accordance with 42 C.F.R. § 438.114, the BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization before receiving emergency services.

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

- (0) through six (6); The BH I/DD Tailored Plan shall use EPSDT criteria when evaluating requests for services for all children;
- b) Mental Health:
 - 1) Level of Care Utilization System (LOCUS) scores for adults ages eighteen (18) and older
 - 2) Child and Adolescent Level of Care Utilization System (CALOCUS) scores for children and adolescents ages six (6) through seventeen (17)
 - 3) Either the Early Childhood Services Intensity Instrument (ECSII) or Children and Adolescents Needs and Strengths (CANS) for Infants, Toddlers and Pre-Schoolers for children ages zero (0) through five (5) or another validated assessment tool with prior approval by the Department
 - c) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for the first mental health or substance use assessment completed in a twelve (12) month period.
 - d) The BH I/DD Tailored Plan shall make available to all members a complete listing of its participating mental health and SUD providers. The listing should specify which provider groups or practitioners specialize in children’s mental health services.
- iv. Children’s screening services
 - a) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for children’s screening services.
 - b) The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for Local Health Department services.
 - v. Primary care services: the BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for primary care services.
 - vi. School-based clinic services: The BH I/DD Tailored Plan shall not require members to obtain a referral or prior authorization for services rendered at school-based clinics.
- (6) The BH I/DD Tailored Plan shall ensure members have and are aware of having direct access to services for which the Department does not allow the BH I/DD Tailored Plan to require referral or prior authorization, as defined in this Section.
- (q) Service Authorization and Noticing Requirements
- (1) The BH I/DD Tailored Plan shall provide written notice, using the Department-developed template, to members on decisions related to authorization of services. The written notice shall include the following:
 - i. The basis for such decisions; and
 - ii. Sufficient details that inform members of the decision, which will provide them with information necessary to determine if they wish to Appeal as noted in *Section V.B.1.vi. Member Grievances and Appeals*.
 - (2) For standard authorization decisions, the BH I/DD Tailored Plan shall provide notice as expeditiously as the member’s condition requires and no later than fourteen (14) Calendar Days following receipt of the request of services. 42 C.F.R. § 438.210(d)(1).¹⁵

¹⁵ For Standard Plan members transferring to the Behavioral Health I/DD Tailored Plan in order to obtain a service only available through the Behavioral Health I/DD Tailored Plan, the timeline for processing the service authorization period—both for standard and expedited requests—will begin when the Department receives the request to transfer to a Behavioral Health I/DD Tailored Plan.

- (3) The BH I/DD Tailored Plan may receive a possible extension of service authorization decision of up to fourteen (14) Calendar Days if the member requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the member's interest.
 - (4) If the BH I/DD Tailored Plan extends the timeframe beyond fourteen (14) Calendar Days, the BH I/DD Tailored Plan shall provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.
 - (5) For expedited authorization decisions, consistent with 42 C.F.R. § 438.210(d)(2), the BH I/DD Tailored Plan shall provide notice no later than seventy-two (72) hours after receipt of the request for service.¹⁶
 - (6) The BH I/DD Tailored Plan may extend the seventy-two (72) hour time period for service authorization decisions by up to fourteen (14) Calendar Days if the member requests the extension or the BH I/DD Tailored Plan justifies a need for additional information and how the extension is in the member's interest.
 - (7) If the BH I/DD Tailored Plan extends the timeframe beyond seventy-two (72) hours, the BH I/DD Tailored Plan shall provide the member and provider with a written notice of the reason for the decision to extend the timeline and inform the member of the right to file a Grievance if he or she disagrees with that decision.
- (r) UM policy for Innovations and TBI waiver services
- (1) For Innovations waiver members only:
 - i. The BH I/DD Tailored Plan shall use the NC Innovations level of care assessment tool to determine whether a member meets the level of care required by the Innovations waiver.
 - ii. The BH I/DD Tailored Plan shall utilize a NC Medicaid-approved template to notify members enrolled in the Innovations waiver of the results of any new SIS[®] evaluation and to inform members in writing of the opportunity and process for:
 - a) Raising concerns regarding SIS[®] evaluations and results, and
 - b) Filing a Grievance regarding SIS[®] evaluations and results.
 - iii. The process for raising concerns shall include an opportunity to discuss the results of the SIS[®] evaluation with the BH I/DD Tailored Plan and the potential for the results to be adjusted if it is determined that the particular needs of the individual were not accurately captured.
 - iv. The failure to request a Grievance shall not waive the Innovations waiver member's ability to argue that the results of the SIS[®] evaluation are incorrect in requesting of services, or during reconsideration review or the State Fair Hearing.
 - v. The BH I/DD Tailored Plan shall ensure that the SIS[®] is used to guide the development of the ISP, and that the results of the SIS[®], or any other similar evaluation, are not the sole basis for limiting the services requested or approved. The BH I/DD Tailored Plan may use the SIS[®] in conjunction with other information to reduce or deny requested services.
 - (2) The BH I/DD Tailored Plan shall ensure that the TBI waiver level of care tool is used to determine whether a member meets the level of care required for the TBI waiver.

¹⁶ 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.

- (3) The BH I/DD Tailored Plan shall ensure that any request for authorization of services is consistent with and incorporates the desires of the Innovations waiver or TBI waiver member and that such desires are reflected in the Innovations or TBI waiver member's ISP, including the desired type, amount and duration of services. Review of requests for authorization of services shall be made in accordance with 42 C.F.R. § 438.210(d). See *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver* for additional details.
 - i. The member's care manager based in a BH I/DD Tailored Plan, AMH+ or CMA shall discuss with the member the duration of the services expected by the member and shall ensure that proposed ISP request authorization for each service at the duration requested by the member during the contract year.
 - ii. The member's care manager based in a BH I/DD Tailored Plan, AMH+ or CMA shall assist the member in developing an ISP and shall explain options regarding the services available to the member.
 - (4) The BH I/DD Tailored Plan shall inform Innovations and TBI waiver members that they may make a new request for services at any time by requesting an updated ISP.
 - (5) Care managers based in a BH I/DD Tailored Plan, AMH+ or CMA may not exercise prior authorization authority over the ISP.
 - (6) BH I/DD Tailored Plans shall issue prior authorizations for all BH and I/DD services covered under the 1915(c) waivers and any forthcoming 1915(i) SPAs according to the requirements set forth in the service definitions that will be established by the Department.
 - (7) The BH I/DD Tailored Plan may act to terminate a member from participation in the Innovations or TBI waiver based upon the following circumstances:
 - i. The member's or member's personal representative's failure to comply with the requirements set forth in the Innovations or TBI waiver approved by CMS
 - ii. The member no longer meets the Level of Care criteria stipulated in the Innovations or TBI Waiver.
 - iii. For other reasons explicitly authorized in the Innovations or TBI waiver approved by CMS.
 - (8) Prior to the termination of a member from the Innovations or TBI waiver, the BH I/DD Tailored Plan must discuss the termination with the Department. Termination of Innovations or TBI waiver participation is considered an adverse benefit determination.
- (s) UM Policy for DSOHF facilities
- (1) The BH I/DD Tailored Plan shall comply with the authorization and admission requirements for state psychiatric hospitals, ADATCs and developmental centers in accordance in accordance with N.C. Gen. Stat. § 122C-261(f)(4) and *Section VII. Attachment N. Addendum for Division of State Operated Healthcare Facilities*. Prior to authorizing or making a referral for the admission to a state psychiatric hospital, the BH I/DD Tailored Plan shall first make every effort to identify an appropriate alternative treatment location, including referral to community inpatient psychiatric units or other locations providing the necessary level of care. This effort may also include specialized or wrap around services for special populations such as individuals with IDD, TBI or dementia.
 - (2) Prior to referral or authorization of any member known or reasonably believed to have an intellectual disability for admission to a state psychiatric hospital, the BH I/DD Tailored Plan must verify that the referral is in accordance with the requirements of N.C. Gen. Stat.

§ 122C-261 and any other applicable North Carolina law governing the admission of members with intellectual disabilities to a State psychiatric hospital.

- (3) For members who have multiple disorders and medical fragility or have multiple disorders and deafness, the BH I/DD Tailored Plan shall be designated by the Department to determine whether members have a high level of disability that alternative care is inappropriate, consistent with N.C. Gen. Stat. § 122C-261(e)(4).
 - (4) In determining whether members are eligible for referral and/or authorization for admission to a State psychiatric hospital, the BH I/DD Tailored Plan must utilize and complete the I/DD diversion process and tools established and approved by the Department for this purpose in order to determine that any less restrictive and less costly options in the community have been exhausted.
- (vi) Telehealth, Virtual Patient Communications and Remote Patient Monitoring
- (a) The BH I/DD Tailored Plan shall provide services via Telehealth, Virtual Patient Communications and Remote Patient Monitoring to Medicaid and NC Health Choice beneficiaries as an alternative service delivery model where clinically appropriate in compliance with all state and federal laws, including HIPAA and record retention requirements.
 - (b) The services provided via Telehealth, Virtual Patient Communications and Remote Patient Monitoring shall be provided in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the NC Medicaid Direct program. 42 C.F.R. § 438.210(a)(2).
 - (c) The BH I/DD Tailored Plan may use Telehealth, Virtual Patient Communications and Remote Patient Monitoring as tools for facilitating access to needed services in a clinically appropriate manner that are not available within the BH I/DD Tailored Plan's network.
 - (d) The BH I/DD Tailored Plan shall not require a member to seek the services through Telehealth and must allow the member to access an in-person service through an out-of-network provider, if the member requests.
 - (e) As part of the UM Program Policy, the BH I/DD Tailored Plan shall develop and submit a Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy to the Department. The Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy shall include:
 - (1) Eligible providers who may perform Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
 - (2) Modalities covered by the BH I/DD Tailored Plan;
 - (3) Modalities not covered by the BH I/DD Tailored Plan;
 - (4) Requirements for and limitations on coverage;
 - (5) Description of each covered modality, including:
 - i. Compliance with local, state and federal laws, including HIPAA; and
 - ii. Process to ensure security of protected health information.
 - (6) Reimbursement mechanism (i.e. flow of funds from BH I/DD Tailored Plan to all relevant providers and facilities) for each covered modality; and
 - (7) Billing guidance for providers.
 - (f) The BH I/DD Tailored Plan shall submit a revised Telehealth, Virtual Patient Communications and Remote Patient Monitoring Policy to the Department whenever there is a material change to the Policy.
 - (1) The BH I/DD Tailored Plan shall pay at least the in-person rate for the same service delivered via Telehealth (i.e. payment parity).
 - (2) For all services provided through Telehealth, the BH I/DD Tailored Plan shall reimburse for a facility fee at the originating site when the originating site is a Medicaid-enrolled provider.

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

educational materials to reflect the change at least thirty (30) Calendar Days prior to the effective date of the change.

- (d) Value-Added Services will not be included in the calculation of capitation payments. 42 C.F.R. § 438.3(e).
- (ix) Specialized Services under federal Preadmission Screening and Resident Review (PASRR) requirements
 - (a) The BH I/DD Tailored Plan shall work with the Department and the member's nursing facility to coordinate Specialized Services as defined in the federal PASRR regulations at 42 C.F.R. § 483.120 for members admitted to nursing facilities.
 - (b) The BH I/DD Tailored Plan shall ensure the provision of Specialized Services identified by the PASRR process for members admitted to nursing facilities in accordance with the Medicaid benefits and limits covered under this contract as listed in *Section V.B.2.i.(iii) Covered Medicaid and NC Health Choice Services*.
 - (1) The BH I/DD Tailored Plan shall ensure that any approved Specialized Services are part of the nursing facility's plan of care for the member and shall coordinate with the nursing facility and other providers, as relevant, to ensure that such specialized services are delivered.
- (x) Cost Sharing
 - (a) The BH I/DD Tailored Plan shall impose the same cost sharing amounts as specified in North Carolina's Medicaid and NC Health Choice State Plans which are displayed in *Section V.B.2. Table 7 Medicaid Managed Care Cost Sharing* below.
 - (b) The BH I/DD Tailored Plan shall not require members to pay for any covered services other than the copayment amounts required under the State Plans.
 - (c) The BH I/DD Tailored Plan shall not hold members responsible for any of the following:
 - (1) BH I/DD Tailored Plan's debts in the event of BH I/DD Tailored Plan insolvency;
 - (2) Covered services provided to the member for which:
 - i. The Department does not pay the BH I/DD Tailored Plan, or
 - ii. The Department, or BH I/DD Tailored Plan, does not pay the health care provider that furnished the services under a contractual referral or other arrangement.
 - (3) Payments for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the BH I/DD Tailored Plan covered the services directly. 42 C.F.R. § 438.106.
 - (d) The BH I/DD Tailored Plan shall track cost sharing obligations of each member and provide to the Department using the Department developed standardized template.
 - (e) Exceptions for cost sharing:
 - (1) Pursuant to 42 C.F.R. § 457.505(d)(1), all NC Health Choice members receive well-child visits and age-appropriate immunizations at no cost to their families.
 - (2) Consistent with 42 C.F.R. § 447.56, Medicaid cost sharing does not apply to a subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska Natives, BCCCP beneficiaries, foster children, disabled children under Family Opportunity Act, 1915(c) waiver beneficiaries, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
 - (3) The BH I/DD Tailored Plan shall not impose cost sharing on Medicaid and NC Health Choice BH, I/DD and TBI services, as defined by the Department.

Section V.B.2. Table 7: Medicaid Managed Care Cost Sharing			
Income Level	Annual Enrollment Fee	Service	Copay
Medicaid			
<i>All Medicaid beneficiaries</i>	<i>None</i>	Physician services Outpatient services Podiatrists Generic and brand prescriptions Chiropractic services Optical services/supplies Optometrists Non-emergency ER visit	\$3/visit \$3/visit \$3/visit \$3/script \$2/visit \$2/visit \$3/visit \$3/visit
NC Health Choice			
<i>NC Health Choice beneficiaries with family incomes <159% FPL</i>	<i>None</i>	Office visits Generic prescriptions Brand prescriptions when no generics available Brand prescriptions when generics available Over-the-counter medications Non-emergency ER visit	\$0/visit \$1/script \$1/script \$3/script \$1/script \$10/visit
<i>NC Health Choice beneficiaries with family incomes <159% and <211% FPL</i>	<i>\$50 per child or \$100 maximum for two or more children¹⁷</i>	Office visits Outpatient hospital visits Generic prescriptions Brand prescriptions when no generics available Brand prescriptions when generics available Over-the-counter medications Non-emergency ER visit	\$5/visit \$5/visit \$1/script \$1/script \$10/script \$1/script \$25/visit

- (f) Cost Sharing Noticing Requirements
- (1) The BH I/DD Tailored Plan shall provide written notice to members using the Department developed standardized template of any Department-initiated changes to the Medicaid or NC Health Choice benefits package or cost sharing requirements. Notification to members shall be provided at least thirty (30) Calendar Days in advance of the effective date of such change.
 - (2) The Department shall provide written notice to members of the aggregate family limit on cost sharing. The Department shall provide written notice to the BH I/DD Tailored Plan and members when a member incurs out-of-pocket expenses up to the aggregate

¹⁷ The NC Health Choice annual fee is collected by the counties, not by the BH I/DD Tailored Plan.

household limit and individual household members are no longer subject to cost sharing for the remainder of the quarter.

(g) Electronic Verification System Requirements.

- i. The BH I/DD Tailored Plan must utilize an Electronic Visit Verification (EVV) system to verify personal care services, including Medicaid State Plan and all waiver services that provide assistance with ADLs that are provided in the member's home and are not provided as a per diem service, prior to releasing payment.
- ii. The BH I/DD Tailored Plan must utilize an EVV system to collect the following data as required by the federal mandate and other data as required by the state for claims adjudication, as referenced in the 21st Century CURES Act, 114 U.S.C. § 255:
 - a) Type of service performed;
 - b) Individual receiving the service;
 - c) Date of the service;
 - d) Time that the service begins;
 - e) Location of service delivery;
 - f) Individual providing the service; and
 - g) Time that service ends
- iii. If the BH I/DD Tailored Plan utilizes an existing EVV system, usage may continue provided that the system is compliant with state and federal regulations and can deliver to the Department required EVV data in a format and frequency specified by the Department.
- iv. The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for State Plan Personal Care Services, Innovations waiver services, and TBI waiver services is in effect by BH I/DD Tailored Plan launch. The BH I/DD Tailored Plan shall ensure that utilization of an EVV system for Home Health Care Services is in effect by January 1, 2023.
- v. At time of BH I/DD Tailored Plan implementation, the BH I/DD Tailored Plan shall deliver the EVV data elements to the Encounter Processing System (EPS) for personal Care Services or services that provide support with activities of daily living in a member's home that are not daily rate services.
- vi. The BH I/DD Tailored Plan shall permit providers to continue using their existing EVV system provided that the system is compliant with state and federal regulations.

(h) Moral and Religious Objection

- i. The BH I/DD Tailored Plan is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if it objects to the service on moral or religious grounds so long as the information requirements of 42 C.F.R. § 438.102(b) have been met. This provision does not apply to a BH I/DD Plan that is also a governmental entity.
 - ii. If the BH I/DD Tailored Plan elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, the BH I/DD Tailored Plan shall furnish information about the services it does not cover to the Department, and to any other Department partner as directed by the Department, whenever it adopts such a policy during the term of the contract. Section 1932(b)(3)(B)(i) of the SSA; 42 C.F.R § 438.102(b)(1)(i)(A)(2).
- ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members
- (i) The BH I/DD Tailored Plan shall cover services, products, or procedures for a Medicaid member under the age of twenty-one (21) if the service is medically necessary health care to correct or

- ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination. This includes any evaluation by a physician or other licensed practitioner.
- (ii) The BH I/DD Tailored Plan shall ensure EPSDT services are furnished in an amount, duration and scope no less than the amount, duration, and scope for the same services under NC Medicaid Direct and as defined in the Department's EPSDT policies.
 - (iii) The BH I/DD Tailored Plan shall cover regular wellness visits to all children enrolled in Medicaid under the age of twenty-one (21) to allow health care providers to carefully monitor a child's overall health and development and to identify and address health concerns as early as possible.
 - (iv) The BH I/DD Tailored Plan shall clearly document that all EPSDT federal criteria were considered in the course of their service authorization review process for Medicaid members under twenty-one (21) years of age.
 - (v) When adjudicating service authorizations for members under twenty-one (21) years of age, the BH I/DD Tailored Plan shall determine whether a service is medically necessary on a case by case basis, taking into account the medical necessity criteria specific to EPSDT defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and the particular needs of the child, including the application of medical necessity criteria by an appropriately licensed medical professional to the documented, individual clinical condition of the member.
 - (vi) Upon conclusion of an individualized review of medically necessary services, the BH I/DD Tailored Plan shall cover medically necessary services that are included within the categories of mandatory and optional services listed in 42 U.S.C. § 1396d(r), regardless of whether such services are covered under the North Carolina Medicaid State Plan and regardless of whether the request is labeled as such. The BH I/DD Tailored Plan shall refer to and/or arrange for any medical service described in 42 U.S.C. § 1396d(r), when those services are not included within the scope of this Contract. The final determination of medical necessity, per criteria specified in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62, is the responsibility of the BH I/DD Tailored Plan responsible for delivery of the referred service, product, or treatment.
 - (vii) The BH I/DD Tailored Plan may provide medically necessary services in the most economic mode possible, if:
 - (a) The treatment made available is similarly efficacious to the service requested by the member's physician, therapist, or other licensed practitioner;
 - (b) The determination process does not delay the delivery of the needed service; or
 - (c) The determination does not limit the member's right to a free choice of providers within the BH I/DD Tailored Plan's Network.
 - (viii) Specific limits (number of hours, number of visits, or other limitations on scope, amount or frequency, multiple services in the same day, or location of service) in clinical coverage policies, UM policies, service definitions, or billing codes do not apply to Medicaid members who are less than twenty-one (21) years of age when those services are determined to be medically necessary per federal EPSDT criteria. If a service is requested in quantities, frequencies, or at locations or times exceeding policy limits and the request is reviewed and approved to correct or ameliorate a defect, physical or mental illness, it shall be provided. This includes limits on visits to physicians, therapists, dentists, or other licensed, enrolled clinicians. Note that visits to dentists shall not be billed to the BH I/DD Tailored Plan but shall be billed to NC Medicaid Direct.
 - (ix) The BH I/DD Tailored Plan shall:
 - (a) Require all in-network primary care providers to perform, during preventive service visits and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the Department's Oral Health Periodicity Schedule.
 - (b) Require all in-network primary care providers to refer infant Medicaid members to a dentist or a dental professional working under the supervision of a dentist at age one (1), per

requirements of the Department's Oral Health Periodicity Schedule. Note that services provided by a dentist are carved out of Medicaid Managed Care and should be billed to NC Medicaid Direct.

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

long as the BH I/DD Tailored Plan makes clear that the member has the right to request authorization of the services he or she wants to request.

- (a) The BH I/DD Tailored Plan shall not request that providers or members withdraw or modify a request for EPSDT services to accept a fewer number of hours, or less intensive type of service, or to modify a SNAP (Support Needs Assessment Profile) or other clinical assessment.
 - (b) Material misinformation to or intimidation of providers or members who has the foreseeable effect of significantly discouraging a request for EPSDT services or the filing or prosecution of OAH Appeals is prohibited.
 - (c) Nothing in this Section should be construed to prevent clinical or treatment discussions.
- (xx) The BH I/DD Tailored Plan shall offer assistance with scheduling appointments for EPSDT services, upon a member's request.
- (xxi) The BH I/DD Tailored Plan shall make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Crippled Children's Services) for referrals. The BH I/DD Tailored Plan shall also make use of other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC), to ensure an effective child health program.
- (xxii) The BH I/DD Tailored Plan shall develop and maintain an EPSDT Policy. The BH I/DD Tailored Plan shall submit the EPSDT Policy to the Department for review one hundred fifty (150) days after Contract Award and annually thereafter.
- (xxiii) Educational and Training Materials
- (a) The BH I/DD Tailored Plan shall develop written and verbal educational materials on EPSDT, including educational materials for members and any publicly disseminated materials describing the EPSDT benefit, the EPSDT medical necessity review and operational details of the federal EPSDT guarantees.
 - (1) The BH I/DD Tailored Plan shall submit the materials to the Department for review and approval as defined in *Section V.B.1.iii. Member Engagement*.
 - (2) The BH I/DD Tailored Plan may develop additional educational materials related to EPSDT in addition to the required consumer notice requirements defined within the Contract.
 - (b) As part of the Provider Training Plan defined in *Section V.B.4.iii. Provider Relations and Engagement*, the BH I/DD Tailored Plan shall provide training to all Network providers where EPSDT is relevant to the providers' area of practice on an annual basis. Training must include information related to:
 - (1) EPSDT benefits;
 - (2) EPSDT medical necessity review per federal criteria: standards and processes;
 - (3) AAP/Bright Futures Periodicity Schedule;
 - (4) Immunizations;
 - (5) Required components of an EPSDT screening service;
 - (6) Providing or arranging for all required lab screenings;
 - (7) Medical transportation services available to members;
 - (8) Outreach activities related to EPSDT provided by the BH I/DD Tailored Plan;
 - (9) Necessary documentation required for reimbursement of EPSDT services; and
 - (10) Into the Mouths of Babes/Physician Fluoride Varnish Program.

iii. Pharmacy Benefits

- (i) Prescription drugs play a significant and increasing role in maintaining health and treating illnesses, giving members the opportunity to become healthier and improve their quality of life. Through current pharmacy program management strategies, the BH I/DD Tailored Plan shall implement a pharmacy benefit which ensures members and providers access to therapeutically needed medications that will provide the best overall value to members, providers and the Department.

- (ii) The BH I/DD Tailored Plan shall:
 - (a) Cover all covered outpatient drugs for which the manufacturer has a CMS rebate agreement and for which the Department provides coverage. 42 C.F.R. § 438.3(s)(1);
 - (b) Adhere to the Department's defined preferred drug list (PDL); and
 - (c) Furnish covered benefits in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct. 42 C.F.R. § 438.210(a)(2).
- (iii) Drug Formulary and PDL
 - (a) The BH I/DD Tailored Plan shall not be allowed to maintain a closed formulary as defined in N.C. Gen. Stat. § 58-3-221(c)(1).
 - (b) In accordance with N.C. Gen. Stat. § 108D-65(6)b., the BH I/DD Tailored Plan shall use the same drug formulary established by the Department.
 - (c) The drug formulary shall, at minimum, include:
 - (1) All drugs included the North Carolina Medicaid and NC Health Choice PDL as posted on the Department's website. The BH I/DD Tailored Plan shall refer to the Pharmacy Services page on the Department's website, for a current listing of covered drugs on the North Carolina Medicaid and NC Health Choice PDL.
 - (2) All other covered drugs in drug classes not listed on the Department's PDL except for outpatient drugs excluded by state or federal policy, as defined in 42 C.F.R. § 438.3(s)(1).
 - (d) The BH I/DD Tailored Plan may substitute a brand drug with a generic drug when the drug is considered bioequivalent and clinically efficacious unless the brand drug is preferred on the Department's PDL.
 - (e) Beginning in Contract Year 2, the BH I/DD Tailored Plan may submit additional information or requests for the inclusion of additional drug classes in the Department's PDL for the Department's review and approval.
 - (1) The BH I/DD Tailored Plan will adhere to the Department defined uniform review and approval process for requests for the inclusion of additional drug classes in the Department PDL.
 - (2) The BH I/DD Tailored Plan shall use the same drug formulary established by the Department, until provided written approval by the Department.
 - (f) In accordance with 42 C.F.R. § 438.10(h)(4)(i), the BH I/DD Tailored Plan shall make available to members and providers in a machine-readable electronic file and paper format, the following information about the drug formulary:
 - (1) List of all covered drugs (including over the counter, brand name, and generic prescription drugs); and
 - (2) Each covered drug's tier (i.e. PDL preferred, PDL non-preferred, and non-PDL).
 - (g) Drug formulary updates:
 - (1) The BH I/DD Tailored Plan will be provided by the Department's PDL vendor with a weekly national drug code (NDC) file delegating the preferred or non-preferred status of each NDC included on the North Carolina Medicaid and NC Health Choice PDL. The BH I/DD Tailored Plan shall update their pharmacy claim system within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.
 - (2) The BH I/DD Tailored Plan shall implement routine PDL changes within thirty (30) Calendar Days of notification of changes to the PDL by the Department (i.e. annual or quarterly updates based on the Department's routine PDL review).
 - (3) The BH I/DD Tailored Plan shall, at the direction of the Department, perform off-cycle PDL file updates within one (1) Calendar Day of file receipt of the PDL file from Department's PDL vendor.
- (iv) Pharmacy Utilization Management:

- (a) As defined herein, the BH I/DD Tailored Plan shall develop a UM program, inclusive of pharmacy benefits.
- (b) For pharmacy services, the BH I/DD Tailored Plan shall follow the existing NC Medicaid Direct and NC Health Choice Fee-for-Service clinical coverage policies and prior authorization (PA) criteria into the UM program as described in:
 - (1) Clinical Coverage Policies: *Section V.B.2. Table 8: Required Pharmacy Clinical Coverage Policies* below.
 - (2) Prior Authorization Criteria: Drugs and/or drug classes requiring prior approval are available at <https://www.nctracks.nc.gov/content/public/providers/pharmacy/forms.html>.

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

- (c) Consistent with N.C. Gen. Stat. § 108A-68.1, the BH I/DD Tailored Plan shall not require PA for any antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available.
- (d) The UM program shall include PA processes, as defined within Section 1927(d)(5) of the Social Security Act and 42 C.F.R. § 438.3(s)(6), including but not limited to:
 - (1) The BH I/DD Tailored Plan shall process pharmacy PA requests within twenty-four (24) hours from when the request is received.
 - (2) The BH I/DD Tailored Plan shall notify the prescriber of the decision by electronic means within twenty-four (24) hours from when the request was received, unless it is necessary for the PA request to be pended to obtain additional information (in which case, the BH I/DD Tailored Plan shall notify the prescriber of the need for additional information within twenty-four (24) hours from when the request was received, and the BH I/DD Tailored Plan shall have twenty-four (24) additional hours from the receipt of additional information to notify the prescriber of the decision).
 - (3) The BH I/DD Tailored Plan shall allow the satisfying of any PA requirement that mandates prior use of an alternative drug or drugs if the prescribing physician certifies that the member has previously used an alternative drug not requiring PA and/or the alternative drug has been determined detrimental to the member’s health or has been ineffective in treating the same condition and, in the opinion of the prescribing physician, is likely to be detrimental to the member’s health or ineffective in treating the condition again. The BH I/DD Tailored Plan shall not void or refuse to renew a provider contract because the provider has provided a certification for a medically necessary drug.
 - (4) The BH I/DD Tailored Plan shall ensure that if a pharmacist cannot fill a prescription when presented due to a PA requirement in an emergency situation, the BH I/DD Tailored Plan must cover a seventy-two (72)-hour emergency supply of the prescription.

- (5) The BH I/DD Tailored Plan shall not require a pharmacy to dispense a seventy-two (72)-hour supply if the dispensing pharmacist determines that taking the prescribed medication would jeopardize the member's health or safety, and he or she has made good faith efforts to contact the prescriber.
 - (6) The BH I/DD Tailored Plan shall allow the pharmacy to bill consecutive seventy-two (72) hour supplies if the prescriber is unavailable and a decision in response to the prior authorization request has not been made during the initial 72-hour period.
 - (7) The BH I/DD Tailored Plan shall reimburse the pharmacy for dispensing the temporary supply of medication and the pharmacy shall only receive one dispensing fee per month for each medication dispensed.
 - (8) The BH I/DD Tailored Plan shall develop and maintain an Emergency Preparedness Protocol, consistent with Required Pharmacy Clinical Coverage Policy 9: Outpatient Pharmacy, to prevent a significant disruption in medication access during a state of emergency or disaster.
 - (9) The BH I/DD Tailored Plan shall align prior authorization requirements as defined in the Opioid Misuse Prevention and Treatment Program.
 - (10) The BH I/DD Tailored Plan shall honor existing and active pharmacy services prior authorizations on file with the North Carolina Medicaid program, NC Health Choice program, a Standard Plan or another BH I/DD Tailored Plan through the expiration date of the active service authorization.
- (e) The BH I/DD Tailored Plan shall implement PA policies and procedures and pharmacy point of service edits process consistent with the A+KIDS program as part of its UM program to prevent overprescribing and inappropriate prescribing of antipsychotics in members under the age of eighteen (18).
 - (f) As new drugs are approved to the market, the BH I/DD Tailored Plan may require PA for those drugs based on the drug's FDA approved indication(s) and use(s) until the Department determines the need for and establishes clinical coverage and PA criteria.
 - (g) Beginning in Contract Year 2, the BH I/DD Tailored Plan, after consultation with its or its vendor/subcontractor's Pharmacy and Therapeutics Committee consistent with N.C. Gen. Stat. § 58-3-221(a)(1), may submit alternative pharmacy clinical coverage and PA criteria to the Department for review and approval. The BH I/DD Tailored Plan shall:
 - (1) Adhere to the Department-defined uniform review and approval process to request alternative clinical coverage and PA criteria.
 - (2) Seek the Department's approval of alternative prior authorization criteria prior to implementing the alternative criteria.
 - (h) Pharmacy Prior Authorization Process
 - (1) The BH I/DD Tailored Plan shall develop and maintain web-based PA processes, which provides an electronic review system accessible to providers and the Department's staff.
 - (2) The BH I/DD Tailored Plan shall utilize a common PA request form(s), developed by the Department, and accept PA requests via electronic submission, via phone, via fax, or via U.S. mail.
 - (3) The BH I/DD Tailored Plan's pharmacy claim processing system shall have the ability to integrate member pharmacy claims and diagnosis history to automate the adjudication of pharmacy claims requiring PA based on criteria requiring the existence of diagnosis or prior pharmacy claims history.
 - (v) Pharmacy Services Website
 - (a) The BH I/DD Tailored Plan shall maintain its own pharmacy services web page available to providers and members with information regarding the drug formulary and UM Program Policy.
 - (b) The BH I/DD Tailored Plan shall post to their pharmacy services web page, at a minimum:

- (1) The drug formulary;
- (2) UM Policy, including pharmacy clinical coverage and PA criteria; and
- (3) PA request form(s).
- (4) Information about how to access medication during a disaster or emergency
- (c) All additions or changes to the drug formulary, UM Program Policy and PA request form shall be posted thirty (30) Calendar Days prior to the effective date of the requirement or revision.
- (d) If the BH I/DD Tailored Plan utilizes a Pharmacy Benefits Manager (PBM), the BH I/DD Tailored Plan's pharmacy services web page may direct providers and members to their PBM's pharmacy services web page which shall adhere to all the same requirements outlined in this Section.
- (vi) Pharmacy Benefit Managers
 - (a) The BH I/DD Tailored Plan may contract with a pharmacy benefits manager (PBM) to administer the pharmacy benefit as detailed in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
 - (b) If the BH I/DD Tailored Plan utilizes a PBM, the BH I/DD Tailored Plan shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with affiliated pharmacy providers, monitor PBM performance, and ensure the confidentiality of member information and the Department information that is not public.
 - (c) The BH I/DD Tailored Plan shall report all financial arrangements between the BH I/DD Tailored Plan/subcontractors and all drug-related companies to the Department on an annual basis. Drug-related companies include manufacturers, labelers, compounders, and benefit managers in a manner to be specified by the Department.
 - (d) If the PBM is owned wholly or in part by a retail participating pharmacy, chain drug store or pharmaceutical manufacturer, the BH I/DD Tailored Plan shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of member and the Department proprietary information.
 - (e) The PBM shall provide a liaison with whom the Department will communicate with directly. The PBM liaison shall be available for direct communication with pharmacy providers to resolve issues, and to work with the Department to resolve rebate issues resulting from the BH I/DD Tailored Plan's encounter and drug utilization files.
- (vii) Pharmacy Programs:
 - (a) The BH I/DD Tailored Plan shall develop and maintain the following pharmacy programs.
 - (1) Drug Utilization Review
 - i. As required by 42 C.F.R. § 438.3(s)(4), the BH I/DD Tailored Plan shall operate a drug utilization review (DUR) program that includes prospective DUR, retrospective DUR, and an educational program for prescribers and pharmacists. The DUR must comply with 42 C.F.R. part 456, subpart K and Section 1927(g) of the Social Security Act.
 - ii. The prospective DUR program shall:
 - a) Operate at pharmacy point of sale.
 - b) Address, but not be limited to the following:
 - 1) Screening for potential drug therapy problems due to therapeutic duplication;
 - 2) Drug-disease contraindications;
 - 3) Drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs);
 - 4) Incorrect drug dosage or duration of drug treatment, drug-allergy interactions;

- 5) Clinical abuse or misuse; and
 - 6) Include other parameters as appropriate.
- iii. The retrospective DUR program shall, at a minimum:
- a) Address the following:
 - 1) Therapeutic appropriateness;
 - 2) Over- and under-utilization;
 - 3) Use of anti-psychotics in children and youth;
 - 4) Psychotropic polypharmacy in children and youth;
 - 5) Appropriate use of generic products;
 - 6) Therapeutic duplication, drug-disease contraindication;
 - 7) Drug-drug interaction;
 - 8) Incorrect drug dosage;
 - 9) Incorrect duration of drug treatment; and
 - 10) Clinical abuse or misuse.
 - b) Conduct at least a quarterly review of paid drug pharmacy and medical claims utilization data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists, and members; and
 - c) Address other programs and initiatives as directed by the Department.
- iv. The educational program within the DUR for prescribers and pharmacists that includes, at a minimum, the following:
- a) Written, verbal, or electronic reminders containing patient-specific or drug utilization review-specific information (or both) and suggested changes in prescribing or dispensing practices;
 - b) Face-to-face discussions, with follow up discussions when necessary, between health care professionals who are experts in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices;
 - c) Intensified review or monitoring of selected prescribers or pharmacists; and
 - d) Other educational activities as appropriate. 42 C.F.R. 456 subpart K.
- v. The BH I/DD Tailored Plan shall implement DUR programs to address opioid misuse. The Department reserves the right to require the BH I/DD Tailored Plan to develop DUR programs for other targeted populations, drug classes and/or disease states.
- vi. The BH I/DD Tailored Plan shall provide a detailed description of its DUR program activities to the Department on an annual basis. 42 C.F.R. § 438.3(s)(5).
- vii. The BH I/DD Tailored Plan shall report DUR program data to the Department in a format consistent with the Department's reporting format for the CMS annual report no later than ninety (90) Calendar Days prior to the CMS due date.
- (2) Opioid Misuse Prevention and Treatment Program is defined in *Section V.B.3.ix. Prevention and Population Health Programs.*

(viii) Pharmacy Reimbursement

(a) Dispensing Fees

- (1) In accordance with N.C. Gen. Stat. § 108D-65(5)b., the BH I/DD Tailored Plan shall reimburse pharmacies a dispensing fee at a rate established by the Department.
- (2) The pharmacy dispensing fee shall be defined by the North Carolina Medicaid State Plan (Attachment 4.19-B, Section 12, Page 1a).

- i. The BH I/DD Tailored Plan may choose to reimburse based on flat dispensing fee of \$10.24 as defined in the Department's 2015 cost of dispensing (COD) study or the Department's current composite rate utilized in fee-for-service.
 - (3) The Department shall perform a cost of dispensing study every five (5) years to inform the NC Medicaid Direct and NC Health Choice Fee-for-Service dispensing rate and notify the BH I/DD Tailored Plan of any changes to the pharmacy dispensing fee.
 - (4) The calculation used to determine the quarterly generic dispensing rate (GDR) for tiered reimbursement shall be the same used by the Department.
 - (5) A claim level GDR report shall be provided to each pharmacy provider prior to each quarterly dispensing rate adjustment for tiered reimbursement.
 - (b) Ingredient Costs
 - (1) The BH I/DD Tailored Plan shall reimburse pharmacies' ingredient costs at the same rate at the NC Medicaid Direct and NC Health Choice Fee-for-Service rate.
 - (2) The NC Medicaid Direct and NC Health Choice Fee-for-Service rates include, but are not limited to, the Wholesale Acquisition Cost, National Average Drug Acquisition Cost (NADAC), the State Maximum Allowable Cost (SMAC) list, and other financial arrangements established by the Department.
 - (3) Based on lesser of logic methodology, such that the pharmacy is reimbursed the usual and customary cost if it is less than the allowed amount.
 - (c) The BH I/DD Tailored Plan shall update drug ingredient cost reimbursement rates at least weekly and subject to the Department's schedule of updates.
 - (d) Subject to Department review and approval, in Contract Year 2, the BH I/DD Tailored Plan may develop its own pharmacy contracting for ingredient reimbursement if the BH I/DD Tailored Plan can demonstrate that the reimbursement results in overall savings to the Department and does not impact access to care. In submitting an alternative reimbursement schedule, the BH I/DD Tailored Plan must also submit a pharmacy network access monitoring plan.
 - (e) The BH I/DD Tailored Plan shall comply with N.C. Gen. Stat. § 58-51-37(f) in relation to any rebates or marketing incentives offered by the BH I/DD Tailored Plan.
 - (f) Reimbursement Inquiries. The BH I/DD Tailored Plan shall require pharmacies to continue to utilize the Department's SMAC rate reimbursement inquiry process, as long as the SMAC is established by the Department.
- (ix) Drug Rebates
 - (a) The Department shall have sole authority to negotiate rebate agreements for all covered drugs in the Medicaid and NC Health Choice Program. The Department shall not delegate authority to negotiate rebate agreements for covered drugs in the Medicaid or NC Health Choice Program to a BH I/DD Tailored Plan. The BH I/DD Tailored Plan or its Subcontractor shall not negotiate rebates for any covered drugs in the Medicaid and NC Health Choice program. If the BH I/DD Tailored Plan or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid and NC Health Choice covered drug claims, including outpatient pharmacy, outpatient hospital and physician-administered drugs, must be exempt from such rebate agreements.
 - (b) The BH I/DD Tailored Plan shall submit outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims encounter data to the Department or its Encounter Data Processing vendor on a weekly basis, no later than seven (7) Calendar Days following the date on which the BH I/DD Tailored Plan or its Subcontractor adjudicated the claims for drug rebate invoicing as defined in *Section V.B.6.ii. Encounters*.
 - (c) The BH I/DD Tailored Plan shall submit all pharmacy and medical drug encounter data for rebate invoicing in a format determined by the Department or its Drug Rebate vendor. At a

minimum, the data should be at claims level and include the total number of units by strength by NDC of each covered outpatient pharmacy drug, outpatient hospital drug and physician administered drug paid for by the BH I/DD Tailored Plan or its Subcontractor. 42 C.F.R. § 438.3(s)(2).

- (d) The BH I/DD Tailored Plan shall submit drug encounters using a HCPCS/CPT code with the following:
 - (1) An NDC that is appropriate for the HCPCS/CPT code based on the drug description, strength and date of service.
 - (2) HCPCS/CPT units and NDC units reported that represent a medically appropriate dosing and package size.
 - (3) Date of service that is not past the termination date of the drug.
 - (4) An NDC that is from a rebate-eligible manufacturer on the date of service of the claim. 42 C.F.R. § 438.3(s)(2)
- (e) 340B covered entities:
 - (1) The BH I/DD Tailored Plan pharmacy provider contracts shall require 340B covered entities, and the entity's 340B contract pharmacies, to submit national Council for Prescription Drug Programs (NCPDP) code "8" in Basis of Cost Determinations filed 423-DN or in Compound Ingredient Basis of Cost Determination filed 490-UE or a '20' in the submission clarification code field (NCPDP D.0 field 420-DK) at the point of sale to identify claims submitted for drugs purchased through the 340B program.
 - (2) The BH I/DD Tailored Plan pharmacy provider contracts shall require 340B covered entities to identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the Department. 42 C.F.R. § 438.3(s)(3).
 - (3) The BH I/DD Tailored Plan pharmacy provider contracts shall require that 340B covered entities' written agreements with contracted pharmacies specify that contract pharmacies comply with the point of sale identification of drugs purchased through the 340B program. 42 C.F.R. § 438.3(s)(3).
 - (4) The BH I/DD Tailored Plan pharmacy provider contracts shall require contract pharmacies that retroactively identify 340B claims, resubmit the claims with the appropriate NCPDP 340B claims identification codes. 42 C.F.R. § 438.3(s)(3).
 - (5) The BH I/DD Tailored Plan shall report to the Department the commencement, conclusion and final results of all HRSA audits.
 - (6) The BH I/DD Tailored Plan shall review 340B covered entities' HRSA audits and coordinate with the Department to ensure the prevention of duplicate discounts.
- (f) The BH I/DD Tailored Plan shall disclose to the Department all financial terms and arrangements for remuneration of any kind that apply between the BH I/DD Tailored Plan and other entities identified in the BH I/DD Tailored Plan Operating Plan and any drug manufacturer, labeler or PBM including, without limitation, formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and any other fees.
 - (1) The Department shall maintain the confidentiality of information disclosed by the BH I/DD Tailored Plan pursuant to this Section, to the extent that the information is confidential under North Carolina or federal law.
 - (2) The Department may audit financial terms and arrangements for remuneration of any kind that apply between the BH I/DD Tailored Plan and any drug manufacturer or labeler.
- (g) The BH I/DD Tailored Plan shall support the Department with drug rebate dispute resolution processes within the timeframe requested by the Department.

- (1) The BH I/DD Tailored Plan or its Subcontractor shall assign a single point of contact to research any encounters that are denied on submission to the Department or identified as a dispute by the drug manufacturers and within thirty (30) Calendar Days shall resolve.
- (2) The BH I/DD Tailored Plan or its Subcontractor shall provide an explanation of such disputes to the Department at the encounter claim level in a spreadsheet.
- (3) If the encounter claim information is found to be in error, the encounter shall be voided within five (5) Business Days of the determination.

iv. Non-Emergency Medical Transportation

- (i) The BH I/DD Tailored Plan shall provide non-emergency medical transportation (NEMT) services to ensure that members have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid-enrolled providers.
- (ii) The BH I/DD Tailored Plan shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under NC Medicaid Direct and consistent with the Department's Medicaid Managed Care Policy Guidance for Non-Emergency Medical Transportation.
- (iii) The BH I/DD Tailored Plan shall provide NEMT services for all enrolled Medicaid members:
 - (a) By the least expensive mode available and appropriate for the member;
 - (b) To the nearest appropriate medical providers; and
 - (c) For a Medicaid covered service, including services carved out of Medicaid Managed Care provided by a qualified Medicaid provider (enrolled as a North Carolina Medicaid provider).
 - (d) When providing NEMT services, the BH I/DD Tailored Plan shall use the most appropriate form of transportation to meet the needs of the Member.
- (iv) NEMT services shall include:
 - (a) NEMT transportation vendors including public transportation, taxis, van, wheel-chair vans, mini-bus, mountain area transports, or other transportation systems and non-emergency ambulance transportation.
 - (b) Other transportation services including volunteers, family members and friends, attendant expenses, ancillary costs and attendant pay, and non-emergency air travel.
 - (c) Travel related expenses including food, parking, fees/tolls, transportation vouchers (i.e. taxis, ride sharing services, public transit), and mileage.
- (v) The BH I/DD Tailored Plan shall guarantee the following rights to members:
 - (a) To be informed of the availability of Medicaid NEMT;
 - (b) To be informed that there is no cost to the member;
 - (c) To be informed of who may accompany a member without cost;
 - (d) To be informed that a member under the age of eighteen (18) does not have to ride alone;
 - (e) To have the BH I/DD Tailored Plan's NEMT Policy, as defined below, explained including:
 - (1) How to request or cancel a trip;
 - (2) Limitations on transportation;
 - (3) Advanced notice requirements; and
 - (4) Expected member conduct and procedures for no-shows.
 - (f) To be transported to medical appointments if unable to arrange or pay for transportation and by means appropriate to circumstances;
 - (g) To arrive at provider in time for the scheduled appointment; and
 - (h) To request an Appeal, as defined in the Contract, if the request for transportation assistance is denied.
- (vi) The BH I/DD Tailored Plan shall not require members to make transportation requests more than two (2) Business Days in advance.
- (vii) The BH I/DD Tailored Plan shall ensure that an attendant is present with:

- (a) Members under the age of eighteen (18), unless emancipated, at no additional cost to the member or attendant. The attendant may or may not be the parent.
 - (b) Members with special medical, physical or mental impediments, at no additional cost to the member or attendant. The attendant may or may not be the parent.
- (viii) The individuals included in *Section V.B.2. Table 9: Individuals Not Eligible to Receive NEMT Services* are not eligible to receive NEMT services from the BH I/DD Tailored Plan.

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

- (ix) The BH I/DD Tailored Plan shall develop a network of NEMT providers sufficient to fulfill the requirements as outlined in this Section.
- (x) The BH I/DD Tailored Plan shall provide copies of its contract(s) with subcontractor(s) providing NEMT services upon Contract Award or within fourteen (14) days of signing any new agreement or modification with the BH I/DD Tailored Plan's NEMT subcontractor(s).
- (xi) The BH I/DD Tailored Plan shall develop, submit and maintain a NEMT Policy. The BH I/DD Tailored Plan shall submit the Policy one hundred fifty (150) days after Contract Award and annually thereafter, for use with members.
 - (a) The Policy shall include, at a minimum, the following:
 - (1) Transportation options available to members;
 - (2) Methods and process by which to request transportation;
 - (3) Driver and vehicle requirements;
 - (4) Process for transportation assessment;
 - (5) Member rights and responsibilities; and
 - (6) Hours of operation.
- (xii) The NEMT Policy shall adhere to the following:
 - (a) Transportation shall be scheduled so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one (1) hour

after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment;

- (b) Members cannot be required to make transportation requests in person;
- (c) Urgent transportation services are exempt from any advance notice requirement;
- (d) The Department's requirements for written materials; and
- (e) All other requirements defined in this Section.

3. Care Management

i. Overview

- (i) The Department believes that care management is a crucial driver to help achieve key goals of BH I/DD Tailored Plans, including integrated, whole-person care and fostering coordination and collaboration among care team members across disciplines and settings.
- (ii) The Department has developed Tailored Care Management, described in *Section V.B.3.ii. Tailored Care Management*, as the predominant care management model for the BH I/DD Tailored Plan population.
- (iii) The BH I/DD Tailored Plan shall be responsible for implementing the Tailored Care Management model as described in *Section V.B.3.ii. Tailored Care Management* and engaging its members in Tailored Care Management.
- (iv) Beyond Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for delivering care coordination and managing care transitions for all members, regardless of whether they participate in Tailored Care Management, as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*.
- (v) The BH I/DD Tailored must also provide additional care management and care coordination functions as detailed in *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver*, *Section V.B.3.v. Other Care Management Programs*, *Section V.B.3.vii. System of Care*, and *Section V.B.3.viii. In-reach and Transition from Institutional Settings*.
- (vi) The BH I/DD Tailored Plan must also meet the requirements set forth in *Section V.B.3.vi. Care Management Policy*, *Section V.B.3.ix. Prevention and Population Health Program*, *Section V.B.3.x. Health Opportunities*, and *Section V.B.3.xi. Relocation of Members Following Emergency Residential Facility Closures*.

ii. Tailored Care Management

(i) Model Overview and Objectives

- (a) Tailored Care Management is built on the principle that provider- and community-based care management is crucial to the success of fully integrated managed care. The BH I/DD Tailored Plan must ensure that care managers delivering Tailored Care Management coordinate across a member's whole-person needs, including physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.
- (b) The Department is committed to the principle that placing care management as close as possible to the beneficiary and the site of care will drive better health outcomes.
- (c) The BH I/DD Tailored Plan shall ensure that Tailored Care Management is available to all BH I/DD Tailored Plan members, regardless of geography, continuously throughout their enrollment, unless they are receiving duplicative Care Management services as defined in *Section V.B.3.ii.(xix)(g) Duplication of Care Management*.
- (d) Tailored Care Management is also designed to align with the North Carolina System of Care framework. The North Carolina System of Care framework was developed to address the unique needs and challenges of children and youth with BH needs.
- (e) Federal Health Home Structure
 - (1) The Department intends to submit a SPA to add Tailored Care Management as a Health Home State Plan benefit.

- (2) The BH I/DD Tailored Plan shall act as the designated Health Home for its members. In its role as a Health Home, the BH I/DD Tailored Plan shall ensure that members have access to Care Management that meet the requirements of this Section and federal Health Home requirements.
- (3) The BH I/DD Tailored Plan shall cooperate with the Department in the administration of North Carolina's Section Health Home SPA, including implementation, providing reporting and data, and other requirements.

(ii) Delivery of Tailored Care Management

- (a) The BH I/DD Tailored Plan must offer the following three approaches for delivering Tailored Care Management:

- (1) AMH+: To be eligible to become an AMH+, the practice must intend to become a PCP in the BH I/DD Tailored Plan network. Only AMH Tier 3 practices certified as an AMH+ practice may provide Tailored Care Management as defined in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*.
- (2) Care Management Agency (CMA): To be eligible to become a CMA, an organization must, at the time of certification, have as its primary purpose the delivery of NC Medicaid, NC Health Choice, or State-funded Services, other than Care Management, to the BH I/DD Tailored Plan eligible population in North Carolina. Provider organizations must be certified as a CMA to provide Tailored Care Management as defined in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs*.
- (3) BH I/DD Tailored Plan-based care managers: The BH I/DD Tailored Plan may provide Tailored Care Management.

- (b) Provider-based Tailored Care Management

- (1) The Department considers Tailored Care Management delivered by an AMH+ practice or a CMA to be provider-based.
- (2) The BH I/DD Tailored Plan must contract with all organizations in its Region that receive AMH+ or CMA certification to provide Tailored Care Management, with limited exceptions as described in *Section V.B.3.ii.(xviii) Certification of AMH+ Practices and CMAs* and *Section V.B.3.ii.(xix) Oversight*.
- (3) The BH I/DD Tailored Plan shall meet annual requirements established by the Department for the percentage of members actively engaged in Provider-based Tailored Care Management approaches, meaning members who are receiving at least one (1) of the following six (6) core Health Home services in that month:
 - i. Comprehensive care management;
 - ii. Care coordination;
 - iii. Health promotion;
 - iv. Comprehensive transitional care/follow-up;
 - v. Individual and family supports; or
 - vi. Referral to community and social support services.
 - vii. CMS guidance on the core Health Home core service definitions and related activities can be found at the following website: <https://www.medicaid.gov/sites/default/files/2020-02/health-homes-section-2703-faq.pdf>.
 - viii. The percentage shall be calculated as:
 - a. Numerator: Number of members actively engaged in Tailored Care Management provided by care managers based in AMH+ practices or CMAs certified by the Department
 - b. Denominator: Total number of members actively engaged in Tailored Care Management.

- (4) Each year, the Department will divide the amount of Tailored Care Management that was delivered to each BH I/DD Tailored Plan's members by AMH+s and CMAs (and Clinically Integrated Networks (CINs) or Other Partners on their behalf) by the amount of all Tailored Care Management delivered to members of that BH I/DD Tailored Plan. The annual required percentages for Provider-based Care Management delivered to BH I/DD Tailored Plan members are as follows:
 - i. Contract Year 1: 30 percent (30%);
 - ii. Contract Year 2: 45 percent (45%);
 - iii. Contract Year 3: 60 percent (60%); and
 - iv. Contract Year 4: 80 percent (80%).
- (5) The Department will assess compliance with annual required percentages for each Contract Year during the first quarter of subsequent Contract Year.
- (6) The Department may adjust the annual required percentages at its discretion.
- (7) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall provide a plan for supporting development of Provider-based Care Management and oversight of Provider-based Care Management

(iii) Eligibility for Tailored Care Management

- (a) All members, including those enrolled in North Carolina's 1915(c) Innovations and TBI waivers, are eligible for Tailored Care Management, with the following exceptions for members participating in services that are duplicative of Tailored Care Management:
 - (1) Members obtaining Assertive Community Treatment (ACT);
 - (2) Members residing in Intermediate Care Facilities for Individuals for Intellectual Disabilities (ICF-IIDs);
 - (3) Members participating in Care Management for At-Risk Children; and
 - (4) Members participating in the High-Fidelity Wraparound program as described in *Section V.B.3.v.(v) High-Fidelity Wraparound*.
- (b) The Department reserves the right to require BH I/DD Tailored Plans to allow beneficiaries enrolled in NC Medicaid Direct to enroll in Tailored Care Management if they meet the Health Home eligibility criteria that will be specified in the forthcoming Health Home SPA.

(iv) Enrollment in Tailored Care Management

- (a) The BH I/DD Tailored Plan shall auto-enroll all members eligible for Tailored Care Management into Tailored Care Management at BH I/DD Tailored Plan launch.
- (b) The BH I/DD Tailored shall allow members to opt out of Tailored Care Management at any time.
 - (1) The BH I/DD Tailored Plan shall permit members who do not want to participate in Tailored Care Management to opt-out via a Tailored Care Management Opt-out Form, which the BH I/DD Tailored Plan shall submit to the Department for approval as part of its Care Management Policy. The form must include a place to provide the reason for opting out.
 - i. The BH I/DD Tailored Plan shall permit the Tailored Care Management Opt-out Form to be mailed in, completed online, filled out in person with the care manager, or filled out over the telephone with either the BH I/DD Tailored Plan or organization assigned to provide Tailored Care Management.
 - (2) The BH I/DD Tailored Plan shall permit a member who has opted out to opt back into Tailored Care Management at any time by contacting the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall provide care coordination and manage care transitions for members who opt-out of Tailored Care Management as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*.

- i. In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver.
 - (4) The BH I/DD Tailored Plan shall submit a sample care management enrollment packet as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (v) Tailored Care Management Assignment
 - (a) The BH I/DD Tailored Plan shall ensure that all members, including those enrolled in the Innovations or TBI waiver, have a choice of care management approach (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*). To facilitate timely engagement in Tailored Care Management, the BH I/DD Tailored Plan shall make initial Tailored Care Management assignments as described in this Section. The assignment process for Tailored Care Management shall be distinct from the Primary Care Provider (PCP) assignment process described in *Section V.B.1.vii.(ii) PCP Choice and Assignment*.
 - (b) The BH I/DD Tailored Plan must submit to the Department its methodology for assigning eligible members to Tailored Care Management based at an AMH+ practice, a CMA or the BH I/DD Tailored Plan.
 - (c) The BH I/DD Tailored Plan must assign members to a mix of the three Tailored Care Management approaches (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*) according to the factors described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (d) The BH I/DD Tailored Plan shall not assign a disproportionate mix of beneficiaries to any particular care management approach. The BH I/DD Tailored Plan must assign each AMH+ and CMA providing Tailored Care Management a justifiably sized population that allows and incentivizes the AMH+ practice or CMA to substantially engage in the model.
 - (e) The BH I/DD Tailored Plan must ensure that Tailored Care Management assignment aligns with the annual requirements for Provider-based Care Management as described in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*.
 - (f) The BH I/DD Tailored Plan shall consider the following factors when assigning each member to care management at an AMH+ practice or a CMA, or at the BH I/DD Tailored Plan level:
 - (1) For Innovations and TBI waiver enrollees:
 - i. If the member enrolled in the Innovations or TBI waiver has an existing relationship with an LME/MCO care coordinator who meets the Tailored Care Management qualifications and training requirements as described in *Section V.B.3.ii.(xiv) Staffing and Training Requirements* and is employed by the member's BH I/DD Tailored Plan or in the BH I/DD Tailored Plan's network, the BH I/DD Tailored Plan must give the member the option of choosing their previous care coordinator as their Tailored Care Management care manager, to the extent possible.
 - ii. The BH I/DD Tailored Plan shall assign members enrolled in the Innovations or TBI waiver to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) waiver enrollees. 42 C.F.R. § 431.301(c)(1)(vi). The BH I/DD Tailored Plan shall ensure that members do not obtain both 1915(c) waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.
 - (2) For all members:
 - i. Assignment to a Tailored Care Management approach and organization providing Tailored Care Management must occur after the PCP assignment process (outlined in *Section V.B.1.vii.(ii) PCP Choice and Assignment*).

- ii. The BH I/DD Tailored Plan must take into account the member's existing provider relationships at an AMH+ practice or a CMA within the BH I/DD Tailored Plan's network and give preference to that provider when making a Tailored Care Management assignment unless there is a specific cause not to do so, including in instances of conflict of interest for Innovations and TBI waiver enrollees.
 - iii. The BH I/DD Tailored Plan must take into account the member's medical complexity as well as BH and I/DD complexity when making a Tailored Care Management assignment.
 - a) In instances where Children with Medical Complexity are receiving primary care through an AMH+ practice, the BH I/DD Tailored Plan shall give that AMH+ practice preference when assigning the member to a care management approach.
 - iv. The BH I/DD Tailored Plan must take into account the member's geographic location when making a Care Management assignment.
 - v. The BH I/DD Tailored Plan shall ensure capacity at an AMH+ practice or CMA before assigning a Member to the AMH+ practice or CMA. The BH I/DD Tailored Plan must permit AMH+ practices and CMAs to set limits on their panel sizes (i.e., decline assignments based on capacity).
 - a) The BH I/DD Tailored Plan shall monitor care management assignment to ensure that AMH+ practices and CMAs do not select members of their panel based on acuity tier.
- (g) The BH I/DD Tailored Plan shall permit members to change the organization they are assigned to for Tailored Care Management and/or change care managers twice per year without cause and anytime with cause.
- (h) The Department shall consider the following as appropriate cause for changes in care management approach, assigned organization providing Tailored Care Management, and care manager:
- (1) The AMH+, CMA, BH I/DD Tailored Plan or care manager has failed to furnish accessible and appropriate services to which the member is entitled.
 - (2) The AMH+, CMA, BH I/DD Tailored Plan or care manager is not able to reasonably accommodate the member's needs.
 - (3) There is a change in the accessibility of the AMH+, CMA, BH I/DD Tailored Plan or care manager, including but not limited to the following:
 - i. The organization or care manager moves to a location that is not convenient for the member.
 - ii. There is a Significant Change in the hours the AMH+ practice or CMA is open and the member cannot reasonably meet during the new hours.
 - iii. There is a Significant Change in the hours the care manager is available and the member cannot reasonably meet during the new hours.
 - (4) The member and the assigned organization providing Tailored Care Management or the care manager agree that a change would be in the best interest of the member.
 - (5) The member's assigned AMH+ practice or CMA leaves the BH I/DD Tailored Plan's Network or is no longer certified by the Department.
 - (6) The member's assigned AMH+ practice or CMA becomes excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b).
 - (7) The care manager is no longer employed by the AMH+, CMA, or BH I/DD Tailored Plan.
- (i) The BH I/DD Tailored Plan shall educate members on the three different care management approaches and provide unbiased counseling on selecting an approach.

- (j) At least thirty (30) days prior to BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall send members a Tailored Care Management enrollment packet, with information on their Tailored Care Management assignment and options for changing their assignment.
 - (k) After the initial launch of the BH I/DD Tailored Plan, on an ongoing basis the BH I/DD Tailored Plan shall complete Tailored Care Management assignments and send Tailored Care Management enrollment packets to new members within fourteen (14) days of the member's enrollment in the BH I/DD Tailored Plan.
 - (l) The Tailored Care Management enrollment packet must include:
 - (1) Information on The Tailored Care Management program, including services available for those who have opted out of Tailored Care Management
 - (2) The nature of the care manager relationship
 - (3) Information on the member's Tailored Care Management assignment and options for changing their Tailored Care Management assignment
 - (4) Process and options for changing their Tailored Care Management assignment
 - (5) The Tailored Care Management opt-out form
 - (6) Circumstances under which member information will be disclosed to third parties
 - (7) The availability of the Grievance and Appeals process as described in *Section V.B.1.vi. Member Grievances and Appeals*
 - (m) The BH I/DD Tailored Plan must share with each AMH+ practice and CMA, at least monthly, a roster of their assigned members and members' current contact and demographic information in a manner specified by the Department.
 - (n) The BH I/DD Tailored Plan must share with each AMH+ and CMA all data elements specified in *Section V.B.3ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*
 - (o) The BH I/DD Tailored Plan must assign and must ensure that AMH+ practices and CMAs assign the member to a care manager with appropriate qualifications and experience according to the member's needs within thirty (30) days of BH I/DD Tailored Plan enrollment.
 - (p) The BH I/DD Tailored Plan shall submit its policies and procedures for Tailored Care Management assignment as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (vi) Outreach and Engagement
- (a) The BH I/DD Tailored Plan shall require that care managers initiate contact with assigned members who have recently been enrolled in Tailored Care Management to start the care management comprehensive assessment within 30 days of BH I/DD Tailored Plan enrollment (see *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*). The care manager shall educate the member about the benefits of care management and work to engage the member in a care management comprehensive assessment and care planning.
 - (1) Contact for the purpose of starting the care management comprehensive assessment may be telephonic, through two-way real time video and audio conferencing, or in-person.
 - (b) The BH I/DD Tailored Plan shall develop and ensure that AMH+ practices and CMAs also develop, policies for communicating and sharing information with members and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences, including sign language, closed captioning and/or video capture.
 - (c) The BH I/DD Tailored Plan shall submit its policies and procedures for outreach and engagement as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (vii) Care Management Comprehensive Assessment¹⁸
- (a) The care management comprehensive assessment shall serve as the federally required initial care needs screening. 42 CFR 438.208(b)(3).

¹⁸ The care management comprehensive assessment is unrelated to the comprehensive clinical assessment and does not serve as a means to approve services.

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

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

- (18) Justice system involvement (adults) or juvenile justice involvement and/or expulsions or exclusions from school (children and adolescents);
 - (19) Risk factors that indicate an imminent need for LTSS
 - (20) Caregiver's strengths and needs
 - (21) Upcoming life transitions (changing schools, employment, moving, change in caregiver/natural supports, etc.)
 - (22) Self-management and planning skills
 - (23) Receipt of and eligibility for entitlement benefits, such as Social Security and Medicare.
- (o) For members with an I/DD or TBI diagnosis, the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* plus the following:
- (1) Financial resources and money management
 - (2) Alternative guardianship arrangements, as appropriate
- (p) For members ages zero (0) up to age three (3), the care management comprehensive assessment shall address the elements in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment* and incorporate questions related to Early Intervention (EI) services for children, including:
- (1) Whether the child is receiving EI services
 - (2) Member's current EI services
 - (3) Frequency of EI services provided
 - (4) Which local Children's Developmental Service Agency (CDSA) or subcontracted agency is providing the services
 - (5) Contact information for the CDSA service coordinator
- (q) For BH I/DD Tailored Plan members ages three (3) up to twenty-one (21) with a mental health disorder and/or SUD who are receiving BH or substance abuse services, including members with a dual I/DD and mental health or SUD diagnosis, the care management comprehensive assessment shall incorporate a strengths assessment process that promotes the identification of the functional strengths of each youth, family and community.
- (r) The BH I/DD Tailored Plan's assessment practices and requirements shall be informed by and coordinate with federally required MDS 3.0 and OASIS assessments performed by nursing facilities and home health agencies, as appropriate.
- (s) For specific requirements related to care management comprehensive assessments for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.
- (t) The BH I/DD Tailored Plan will be required to send a monthly report listing all members who received the Standardized Unmet Health-Related Resource Needs screening in the form and manner specified by the Department. See *Section VII. Attachment J: Reporting Requirements* for more detail.
- (u) The BH I/DD Tailored Plan shall submit its policies and procedures for Care Management comprehensive assessments as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (viii) Development of Care Plan/Individual Support Plan (ISP)
- (a) Using the results of the care management comprehensive assessment, the assigned organization providing Tailored Care Management shall develop a Care Plan for members with BH needs and an ISP for members with I/DD and TBI needs. 42 C.F.R. § 441.725.
 - (b) The BH I/DD Tailored Plan shall ensure that all Care Plans and ISPs are developed and presented in a manner understandable to the member, including consideration for the member's reading level and alternate formats.

- (c) The BH I/DD Tailored Plan shall ensure that meetings related to the member's Care Plan/ISP are held at a location, date and time convenient to the member and the member's chosen participants.
- (d) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP is individualized and person-centered and is developed using a collaborative approach including member and family participation where appropriate.
- (e) The BH I/DD Tailored Plan shall make best efforts to complete an initial Care Plan or ISP within thirty (30) days of the completion of the care management comprehensive assessment.
 - (1) "Best effort" is defined as including at least three documented strategic follow-up attempts, such as going to the member's home or working with a known provider to meet the member at an appointment, to contact the member if the first attempt is unsuccessful.
- (f) The BH I/DD Tailored Plan shall ensure that development of the Care Plan or ISP does not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a Care Plan/ISP to be developed.
- (g) The BH I/DD Tailored Plan shall ensure that the Care Plan or ISP is regularly updated incorporating input from the member and members of the care team, as part of ongoing care management, and that the Care Plan will be comprehensively updated:
 - (1) At minimum every twelve (12) months
 - (2) When a member's circumstances or needs change significantly
 - (3) At the member's request
 - (4) Within thirty (30) days of (re)assessment
- (h) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP incorporates results of the care management comprehensive assessment (including Unmet Health-Related Resource Needs questions), claims analysis and risk scoring, any available medical records, and screening and/or level of care determination tools, including the following, as appropriate, unless modified by the Department:
 - (1) LOCUS and CALOCUS
 - (2) CANS
 - (3) ASAM criteria
 - (4) For Innovations waiver enrollees: SIS®
 - (5) For TBI waiver enrollees: Rancho Los Amigos Levels of Cognitive Functioning Scale
- (i) The BH I/DD Tailored Plan shall ensure that each Care Plan and ISP contains, at a minimum:
 - (1) Names and contact information of key providers, care team members, family members and others chosen by the member to be involved in planning and service delivery
 - (2) Measurable member goals
 - (3) Clinical needs including, but not limited to, any physical health, BH, I/DD-related, TBI-related, or dental needs
 - (4) Interventions including addressing medication management, including adherence
 - (5) Intended outcomes of interventions and goals
 - (6) Social, educational and other services needed by the member
 - (7) Strategies to increase social interaction, employment and community integration
 - (8) Emergency/natural disaster/crisis plan
 - (9) Strategies to mitigate risks to the health, well-being and safety of the members and of others
 - (10) Information about Advance Directives, including advance instructions for mental health treatment, as appropriate

- (11) A life transitions plan to address instances where the member is changing schools, experiencing a change in caregiver/natural supports, changing employment, moving or entering another life transition
- (12) Strategies to improve self-management and planning skills
- (j) For members with SED, I/DD, or TBI, the care plan or ISP should also include caregiver supports, including connection to respite services, as necessary.
- (k) For members ages three (3) up to age twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance use services, the BH I/DD Tailored Plan shall ensure:
 - (1) A Child and Family Team member is involved in developing the Care Plan/ISP and facilitating the planning process.
 - (2) The assigned organization providing Tailored Care Management uses the strengths assessment described in *Section V.B.3.ii.(vii)(q)* to build strategies included in the Care Plan or ISP that address the critical needs and unique strengths of the youth and family as identified by and in cooperation with the Child and Family Team (CFT). These strategies shall be included in the Care Plan or ISP.
 - (3) The Care Plan or ISP is regularly updated to respond to changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.
- (l) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management monitors for completion of Care Plan/ISPs and review them for quality control.
- (m) The BH I/DD Tailored Plan must conduct regular audits of care management comprehensive assessments, Care Plans, and ISPs to ensure they meet quality expectations.
- (n) The BH I/DD Tailored Plan shall ensure that each Care Plan/ISP is documented and stored and made available to the member and the following representatives within fourteen (14) days of completion of the Care Plan or ISP:
 - (1) Care team members, including the member's PCP, other physical health, BH, I/DD, TBI and LTSS providers
 - (2) Other providers delivering care to the member
 - (3) The member's legal representative (as appropriate)
 - (4) The member's caregiver (as appropriate, with consent)
 - (5) Social service providers (as appropriate, with consent)
 - (6) Other individuals identified and authorized by the member
- (o) For specific requirements related to ISPs for Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.
- (p) The BH I/DD Tailored Plan shall submit its policies and procedures for Care Plan/ISP development with members as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (ix) Care Team Formation
 - (a) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management establishes a multidisciplinary care team for each member based on the member's needs.
 - (b) The BH I/DD Tailored Plan shall ensure that the multidisciplinary care team consists of the following members as applicable depending on member needs:
 - (1) The member
 - (2) Caretaker(s)/legal guardians
 - (3) The member's care manager
 - (4) Supervising care manager

- (5) PCP
 - (6) BH provider(s)
 - (7) I/DD and/or TBI providers
 - (8) Other specialists
 - (9) Nutritionists
 - (10) Pharmacists and pharmacy techs
 - (11) The member's obstetrician/gynecologist (for pregnant women)
 - (12) Peer support specialist
 - (13) In-reach and/or transition staff
 - (14) Other providers, as determined by the care manager and member
- (c) For members ages three (3) up age to twenty-one (21) with a mental health disorder and/or SUD who are receiving mental health or substance abuse services, the BH I/DD Tailored Plan shall ensure that the CFT is incorporated into the care team.
- (1) The CFT shall be built around the youth and family to meet their unique needs, and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the Care Plan.
 - (2) The CFT shall be convened at least once every thirty (30) days.
- (d) The BH I/DD Tailored Plan shall require timely communication across the care team.
- (x) Ongoing Care Management
- (a) The BH I/DD Tailored Plan shall establish policies and procedures to deliver care to, and coordinate services for, members in accordance with 42 C.F.R. § 438.208 and N.C. Gen. Stat. § 122c-115.4, regardless of risk or need.
 - (b) The BH I/DD Tailored Plan shall ensure that each member who is actively engaged in Tailored Care Management receives care management according to their Care Plan or ISP.
 - (c) The BH I/DD Tailored Plan shall ensure that care management includes:
 - (1) Coordinating and providing referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by either BH I/DD Tailored Plans or NC Medicaid Direct:
 - i. Physical health
 - ii. BH
 - iii. I/DD
 - iv. LTSS
 - v. TBI
 - vi. Pharmacy
 - vii. Vision
 - viii. Dental
 - (2) Coordinating and providing referral, information and assistance in obtaining and maintaining State-funded Services managed by the BH I/DD Tailored Plan
 - (3) Coordinating social services provided by community and social providers to address a member's Unmet Health-Related Resource Needs
 - (4) Coordinating Medicare services for members dually eligible for Medicare and Medicaid
 - (5) Coordinating with other care management supports for members dually eligible for Medicare and Medicaid
 - (6) Ensuring that members have scheduled annual physical exams, or well-child visits based on the appropriate age-related frequency
 - (7) Conducting a care management comprehensive assessment at least every twelve (12) months *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment.*

- (8) Conducting continuous monitoring of progress toward goals identified in the Care Plan or ISP through in-person and collateral contacts with the member and the member's supports, including family, informal, and formal caregivers and routine care team reviews
 - (9) Conducting medication management, including regular medication reconciliation (conducted by appropriate care team member; a community pharmacist at the CIN level may assume this role, in coordination with the AMH+ or CMA) and support of medication adherence
 - (10) Supporting the member's adherence to prescribed treatment regimens and wellness activities
 - (11) Communicating and consulting with other providers and the Member and the member's supports, including family, informal, and formal caregivers, as appropriate
 - (12) Following up on referrals
 - (13) Conducting transitional care management as described in *Section V.B.3.ii.(xi) Transitional Care Management*.
 - (14) Facilitating timely communication across the care team, including case conferencing
- (d) For children and youth receiving BH services, ongoing care management shall also include:
- (1) Promotion of family-driven, youth-guided service delivery and development of strategies built on social networks and natural or informal supports.
 - (2) Development of, with families and youth, strategies that maximize the skills and competencies of family members to support youth and caregivers' self-determination and enhance self-sufficiency.
 - (3) Verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs.
 - (4) Development and implementation of proactive and reactive crisis plans in conjunction with the Care Plan/ISP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT shall be provided a copy of the plan.
 - (5) Use family and youth-friendly tools to document and demonstrate for the youth and family their progress over the course of treatment
- (e) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management provides or arranges for coverage for services, consultation or referral, and treatment for emergency medical conditions, including, but not limited to, BH crisis, twenty-four (24) hours per day, seven (7) days per week.
- (f) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management has the ability twenty-four (24) hours per day, seven (7) days per week to (1) share information such as Care Plans/ISPs and Advance Directives, and (2) coordinate care to place the member in the appropriate setting during urgent and emergent events. Automatic referral to the hospital emergency department for services does not satisfy this requirement.
- (g) The BH I/DD Tailored Plan shall ensure that Tailored Care Management incorporates individual and family supports including:
- (1) Training the member in self-management
 - (2) Providing education and guidance on self-advocacy to the member, family members and support members
 - (3) Connecting the member and caregivers to education and training to help the member improve function, develop socialization and adaptive skills, and navigate the service system
 - (4) Providing information and connections to needed services and supports including but not limited to self-help services, peer support services and respite services

- (5) Providing information to the member, family members and support members about the member's rights, protections and responsibilities, including the right to change providers, the Grievance and complaint resolution process, and fair hearing processes
 - (6) Health promotion, including promoting wellness and prevention programs (see *Section V.B.3.ix. Prevention and Population Health Programs*)
 - (7) Providing information on establishing Advance Directives, including advance instructions for mental health treatment, as appropriate, and guardianship options/alternatives, as appropriate
 - (8) Connecting members and family members to resources that support maintaining employment, community integration and success in school, as appropriate
 - (9) For high-risk pregnant women, inquiring about broader family needs and offering guidance on family planning
 - (10) For high-risk pregnant women, beginning discussions about the potential for an Infant Plan of Safe Care
- (h) The BH I/DD Tailored Plan must establish policies and procedures for coordinating with services provided by community and social support providers and submit them as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*). 42 C.F.R. § 438.208(b)(2)(iv).
 - (i) The BH I/DD Tailored Plan shall ensure that Tailored Care Management addresses Unmet Health-Related Resource Needs, including at a minimum:
 - (1) Provision of referral, information, and assistance and follow-up in obtaining and maintaining community-based resources and social support services, including:
 - i. Disability benefits (e.g., SSI/SSDI Outreach, Access, and Recovery (SOAR) caseworkers)
 - ii. Food and income supports
 - iii. Housing
 - iv. Transportation
 - v. Employment services
 - vi. Education
 - vii. Child welfare services
 - viii. Domestic violence services
 - ix. Legal services
 - x. Services for justice-involved populations
 - xi. Other services that help individuals achieve their highest level of function and independence
 - (2) Use NCCARE360, to identify community-based resources, and connect members to such resources and track closed-loop referrals. The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management use NCCARE360, including for the following functionalities:
 - i. Act as their community-based organization and social service agency resource repository to identify local community-based resources;
 - ii. Refer members to the community-based organizations and social service agencies available on NCCARE360; and
 - iii. Track closed-loop referrals.
 - (3) Provision of comprehensive assistance--available either in-person or electronically, at the member's preference and depending on what is the most efficient, effective, and feasible approach--securing key health-related services, including assistance at initial application and renewal with filling out and submitting applications, and gathering and submitting required documentation, at a minimum to:

- i. Food and Nutrition Services
 - ii. Temporary Assistance for Needy Families
 - iii. Child Care Subsidy
 - iv. Low Income Energy Assistance Program
 - v. ABLEnow Accounts (for individuals with disabilities)
 - vi. Women, Infants and Children (WIC) Program
 - vii. Other programs managed by the BH I/DD Tailored Plan that address Unmet Health-Related Resource Needs
- (4) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit its policies for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.
- (j) The BH I/DD Tailored Plan shall ensure that a member has a post-partum visit with a physician within fifty-six (56) days of delivery to assess for signs of postpartum depression. Postpartum care is further described in the *Obstetrics Clinical Coverage Policy 1E-5*.
- (k) The Department will establish a standardized methodology to assign each member to a Tailored Care Management acuity tier (e.g., high, medium, low) and will release additional detail on the methodology prior to BH I/DD Tailored Plan Contract Year 1.
- (1) The BH I/DD Tailored Plan shall use the acuity tiers to guide the intensity of Tailored Care Management for each member according to minimum contact requirements as described in *Section V.B.3.ii.(x) Ongoing Care Management*.
 - (2) The BH I/DD Tailored Plan shall use the acuity tiers to determine payment for Tailored Care Management as described in *Section V.B.4.iv. Provider Payments*.
- (l) The BH I/DD Tailored Plan must ensure that care managers at the assigned organization providing Tailored Care Management meet the minimum contact requirements for members according to their acuity tier as outlined below, unless the member expresses preference for fewer contacts and this preference is documented in the Care Plan/ISP and reviewed with the supervising care manager, or if the member is enrolled in the Innovations waiver (as described in *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver*). In-person contact requirements must be met as described below. Contacts that are not required to be in-person may be telephonic or through two-way real time video and audio conferencing, If the care manager utilizes two-way real time video and audio conferencing, the care manager shall enable applicable encryption and privacy modes and provide notice to the member that the third-party application potentially introduces privacy risks. Public facing video communication applications, such as Facebook Live, Twitch, or TikTok, shall not be used. The administration of the care management comprehensive assessment may count as one of the contacts. The Department intends to release additional guidance on circumstances in which a member’s acuity tier may change.
- (1) Care manager contacts for members with BH needs
 - i. High Acuity: At least four (4) care manager-to-member contacts per month, including at least one (1) in-person contact with the member
 - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
 - iii. Low Acuity: At least two (2) care manager-to-member contacts per month and at least two (2) in-person contacts member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person)

- (2) Care manager contacts for members with an I/DD or TBI
 - i. High Acuity: At least three (3) care manager-to-member contacts per month, including at least two (2) in-person contacts
 - ii. Moderate Acuity: At least three (3) care manager-to-member contacts per month and at least one (1) in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in-person).
 - iii. Low Acuity: At least one (1) telephonic or two-way real time video and audio conferencing, contact per month and at least two (2) in-person care manager-to-member contacts per year, approximately six (6) months apart (includes care management comprehensive assessment if it was conducted in-person).
- (3) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine whether the contact requirements for BH or I/DD conditions apply, based on what is clinically appropriate. .
- (4) For members with I/DD or TBI who have a guardian, telephonic or two-way real time video and audio conferencing contact may be with a guardian in lieu of the member, where appropriate or necessary. In-person contacts must involve the member.
- (m) The BH I/DD Tailored Plan shall ensure that in-person contacts occur at a location, date and time convenient to the member and their chosen participants.
- (n) For specific requirements for ongoing care management related to Innovations/TBI waiver enrollees, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver.*
- (xi) Transitional Care Management
 - (a) Regardless of the organization providing Tailored Care Management, the BH I/DD Tailored Plan shall oversee care transitions for all members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i) and in addition to the requirements in this Section.
 - (b) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management are able to receive notifications of each admission/discharge/transition within a clinically appropriate time period.
 - (c) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management carry out the following transitional care management functions.
 - (1) Ensure that a care manager is assigned to manage the transition.
 - (2) Have a care manager assume coordination responsibility for transition planning.
 - (3) Have a care manager or care team member visit the member during their stay in an institution (e.g., acute, subacute and long-term stay facilities) and be present on the day of discharge.
 - (4) Conduct outreach to the member's providers.
 - (5) Obtain a copy of the discharge plan and review the discharge plan with the member and facility staff.
 - (6) Facilitate clinical handoffs.
 - (7) Refer and assist members in accessing needed social services and supports identified as part of the transitional care management process, including access to housing.
 - (8) Assist the member in obtaining needed medications prior to discharge, ensure an appropriate care team member conducts medication reconciliation/management and support medication adherence.
 - (9) Develop a ninety (90) day post-discharge transition plan prior to discharge from residential or inpatient settings, in consultation with the member, facility staff and the member's care team, that outlines how the member will maintain or access needed

services and supports, transition to the new care setting, and integrate into their community.

- i. The ninety (90) day post-discharge transition plan shall be implemented upon discharge and be an amendment to the Care Plan or ISP
- ii. To the extent feasible, a care management comprehensive assessment should be conducted to inform the ninety (90) day post-discharge transition plan.
- iii. The ninety (90) day post-discharge transition plan must incorporate any needs for training of parents and other caregivers to care for a child with complex medical needs post-discharge from an inpatient setting.
- iv. Development of a ninety (90) day post-discharge transition plan is *not* required for all ED visits, but may be developed according to the care manager's discretion.
- v. The assigned organization providing Tailored Care Management shall communicate with and provide education to the member and the member's caregivers and providers to promote understanding of the ninety (90) day post-discharge transition plan.

(10) Assist with scheduling of transportation, in-home services, and follow-up outpatient visits with appropriate providers within a maximum of seven (7) Calendar Days post-discharge, unless required within a shorter timeframe.

(11) Ensure that the assigned care manager follows up with the member within forty-eight (48) hours of discharge.

(12) Arrange to visit the member in the new care setting after discharge/transition.

(13) Conduct a care management comprehensive assessment within thirty (30) days of the discharge/transition or update the current assessment.

(14) Update the member's Care Plan/ISP in coordination with the member's care team within ninety (90) days of the discharge/transition based on the results of the care management comprehensive assessment.

(d) The BH I/DD Tailored Plan must ensure that for individuals with I/DD or TBI, the assigned organization providing Tailored Care Management conducts relevant transitional care management activities in the following "life transitions":

- (1) Instances where a member is transitioning out of school-related services;
- (2) Instances where a member experiences life changes such as employment, retirement or other life events;
- (3) Instances where a member has experienced the loss of a primary caregiver or a change of primary caregiver; and
- (4) Instances where a member is transitioning out of foster care.

(e) The BH I/DD Tailored Plan shall submit its policies and procedures for transitional care management, including the approach to working with members with LTSS needs, as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*),

(xii) Diversion from Institutional Settings

(a) The BH I/DD Tailored Plan shall ensure that members are identified who are at risk of requiring care in an institutional setting or ACH are provided diversion interventions as described below. The BH I/DD Tailored Plan shall ensure that diversion activities, including identification of eligible members, are the responsibility of the assigned organization providing Tailored Care Management (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*). In the event that a member who is not actively engaged in Tailored Care Management is eligible for diversion, the BH I/DD Tailored Plan shall conduct outreach to engage the member in Tailored Care Management and conduct diversion activities.

- (1) The BH I/DD Tailored Plan must ensure that the assigned organization providing Tailored Care Management consults with BH I/DD Tailored Plan-based medical staff or medical staff based at the organization providing Tailored Care Management to assess the medical needs of the member receiving diversion services.

(b) Eligibility for Diversion

- (1) Members eligible for diversion activities include those meeting the following criteria:

- i. Have transitioned from an institutional or correctional setting, or an ACH for adult members, within the previous six (6) months; or
- ii. Are seeking entry into an institutional setting or ACH; or
- iii. Meet one of the following additional criteria for members with I/DD or TBI:
 - a) Member has an aging caregiver who may be unable to provide the recipient their required interventions; or
 - b) Member's caregiver is in fragile health, which may include but is not limited to member caregivers who have been hospitalized in the previous twelve (12) to eighteen (18) months, diagnosed with a terminal illness, or have an ongoing health issue that is not managed well (e.g., diabetes, heart condition, etc.); or
 - c) Member with two parents or guardians if one of those parents/guardians dies; or
 - d) Any other indications that a member's caregiver may be unable to provide the member their required interventions; or
 - e) Member is a child or youth with complex BH needs.

(c) Diversion Activities

- (1) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management (outlined in *Section V.B.3.ii.(ii) Delivery of Tailored Care Management*) performs the following diversion activities in a timely manner:

- i. Screen and assess the member for eligibility for community-based services.
- ii. Educate the member on the choice to remain in the community and the services that would be available to support that decision.
- iii. Facilitate referral and linkages to community-based and other support services for assistance.
- iv. Determine if the member is eligible for supportive housing, if needed.
- v. For those who choose to remain in the community:
 - a) Develop a Community Integration Plan (CIP) that clearly documents that the member's decision to remain in the community was based on informed choice, and the degree to which the member's decision has been implemented.
 - b) Integrate the member's CIP as an addendum in the member's Care Plan or ISP.
 - c) For members with a CIP, refer and provide linkages to services and supports for which they are eligible, including supportive housing.

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

(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waiver

- (a) Tailored Care Management shall incorporate all Innovations or TBI Waiver care coordination activities, as required in the applicable 1915(c) waivers.
- (b) The BH I/DD Tailored Plan shall auto-enroll new members who obtain an Innovations or TBI waiver slot after BH I/DD Tailored Plan launch into Tailored Care Management if they are not

already enrolled in Tailored Care Management. The BH I/DD Tailored Plan shall send new waiver enrollees information about Tailored Care Management and the option to opt out with the materials informing them of their waiver slot.

- (c) The BH I/DD Tailored Plan must auto-enroll all current Innovations/TBI waiver enrollees in Tailored Care Management.
 - (1) Innovations/TBI waiver enrollees may opt out of Tailored Care Management.
 - (2) Innovations/TBI waiver enrollees who have opted out of Tailored Care Management shall still receive care coordination as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members* and Innovations and TBI waiver care coordination as described in *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver*.
- (d) For members who were enrolled in the Innovations or TBI waiver prior to BH I/DD Tailored Plan launch and engage in Tailored Care Management:
 - (1) If the member's ISP annual update is in the first six (6) months of Year 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment prior to completing the ISP.
 - (2) If the member's annual update is in the second half of Year 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management completes the care management comprehensive assessment according to the timeframes described in *Section V.B.3.ii.(vii) Care Management Comprehensive Assessment*. The BH I/DD Tailored Plan shall ensure that the organization providing Tailored Care Management completes the care management comprehensive assessment prior to the annual update, and in subsequent years, aligns the timing of the reassessment with the ISP annual update.
 - (3) The ISP developed prior to BH I/DD Tailored Plan launch will continue to serve as the ISP under Tailored Care Management in Year 1 of BH I/DD Tailored Plan operation, until updated.
 - (4) The BH I/DD Tailored Plan must ensure that the ISP is aligned with Tailored Care Management requirements at the member's next annual update (during the month before the individual's birth month), after a triggering event or at the member's request.
 - (5) Prior to the annual update, the member's care management comprehensive assessment results may be used to amend the ISP if appropriate, but a full update is not required.
- (e) If the member is enrolled in the Innovations or TBI waiver, when determining required care management contacts, the assigned organization providing Tailored Care Management shall adhere to, whichever is higher in frequency and modality (e.g. number of in-person contacts):
 - (1) The contact requirements found in the 1915(c) waiver, or
 - (2) The contacts noted in *Section V.B.3.ii.(x) Ongoing Care Management*.
- (f) For Innovations waiver enrollees, the BH I/DD Tailored Plan shall ensure that results of the SIS® are shared with the member's care manager in an electronic format to aid completion of the care management comprehensive assessment.

(xiv) Staffing and Training Requirements

- (a) The BH I/DD Tailored Plan shall ensure that each care manager across AMH+ practices, CMAs and the BH I/DD Tailored Plan is supervised by a supervising care manager. One supervising care manager shall not oversee more than eight (8) care managers.
 - (1) Supervisors cannot have a caseload but will provide coverage for vacation and sick leave. They will be responsible for ensuring that all Care Plans/ISPs are complete, reviewing

them for quality control, and providing guidance to care managers on how to meet members' needs.

(b) The BH I/DD Tailored Plan shall ensure that the assigned organization providing Tailored Care Management has access to clinical consultants to provide subject matter expert advice to the care team. The clinical consultants will not be part of the care team for any given member.

- (1) The AMH+ practice or CMA may employ or contract with consultants or do so through a CIN or Other Partner.
- (2) The consultants should be available by phone to staff within AMH+ practices and CMAs to advise on complex clinical issues on an ad hoc basis.
- (3) The following consultants must be available:
 - i. An adult psychiatrist or child and adolescent psychiatrist (depending on the population being served)
 - ii. A neuropsychologist or psychologist
 - iii. A primary care physician appropriate for the population being served, to the extent the member's PCP is not available for consultation

(c) Care Manager Qualifications

(1) The BH I/DD Tailored Plan shall ensure that all care managers providing Tailored Care Management to members have the following minimum qualifications:

- i. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area or licensure as a registered nurse (RN).
 - a) If serving members with BH needs, the care manager must have two (2) years of experience working directly with individuals with BH conditions.
 - b) If serving members with an I/DD or TBI, the care manager must have two (2) years of experience working directly with individuals with I/DD or TBI.
 - c) If serving members with LTSS needs, the care manager shall meet the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, as described above.
 - d) If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall determine the appropriate care manager assignment.

(2) The BH I/DD Tailored Plan shall ensure that all supervising care managers overseeing care managers performing Tailored Care Management have the following minimum qualifications:

- i. For members with BH conditions:
 - a) Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT), or licensure as an RN, and
 - b) Three (3) years of experience providing care management, case management, or care coordination to the population being served
- ii. For members with an I/DD or TBI, have one (1) of the following minimum qualifications:

- a) A Bachelor’s degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and five (5) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI, or
 - b) A Master’s degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human services area, or licensure as an RN; and three (3) years of experience providing care management, case management, or care coordination to complex individuals with I/DD or TBI
- iii. If the member is dually diagnosed with a BH condition and I/DD or TBI, the assigned organization providing Tailored Care Management shall ensure that the supervising care manager is qualified to oversee the member’s care manager.
- (d) The BH I/DD Tailored Plan shall ensure all care managers and supervising care managers serving its members, whether based at the BH I/DD Tailored Plan, AMH+ or CMA, are trained on all the topics described in this Section.
 - (e) The BH I/DD Tailored Plan shall develop and implement a care management training curriculum that includes the following domains at a minimum in addition to any training requirements specified in N.C. General Statute § 122c-115.4:
 - (1) BH I/DD Tailored Plan eligibility and services
 - i. BH I/DD Tailored Plan eligibility criteria, services available through BH I/DD Tailored Plans, and differences between Standard Plan and BH I/DD Tailored Plan benefit packages
 - ii. Principles of integrated and coordinated physical and BH care and I/DD and TBI services
 - iii. BH crisis response
 - iv. Knowledge of Innovations and TBI waiver eligibility criteria
 - (2) Whole-person health and unmet resource needs
 - i. Understanding and addressing ACEs, trauma, and trauma-informed care
 - ii. Understanding and addressing Unmet Health-Related Resource Needs, including identifying, utilizing, and helping the member navigate available social supports and resources at the member’s local level
 - iii. Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, nonwhite populations, and forms of bias that may affect BH I/DD Tailored Plan members
 - (3) Community integration
 - i. Independent living skills
 - ii. Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities
 - iii. Knowledge of supportive housing, tenancy supports and other programs that establish resiliency and permanency in housing in the community
 - iv. Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration
 - (4) Components of Health Home care management

- i. Health Home overview, including but not limited to Health Homes' purpose, target population, and services, in addition to members and their families' role in care planning
- ii. Working effectively with a multidisciplinary care team, scheduling team meetings, planning agendas and facilitating meetings

(5) Health promotion

- i. Common physical comorbidities of BH I/DD Tailored Plan populations
- ii. Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease)
- iii. Common environmental risk factors including but not limited to the health effects of exposure to second and third-hand tobacco smoke; and e-cigarette aerosols and liquids and their effects on family and children,
- iv. Standard of care tobacco treatment, including both counseling and FDA approved tobacco treatment medications
- v. Self-management and self-help recovery resources (including substance use recovery)
- vi. Brief tobacco use intervention and referral to treatment roles and responsibilities for medication management
- vii. Use of IT in care management comprehensive assessments, care planning, and ongoing care coordination and management, including the use of NCCARE360

(6) Other care management skills

- i. Transitional care management best practices
- ii. Supporting health behavior change, including motivational interviewing
- iii. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs
- iv. Preparing members for and assisting them during emergencies and natural disasters
- v. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings.
- vi. General understanding of virtual (e.g., Telehealth) applications in order to assist members in using the tools
- vii. Understanding needs of the justice-involved population
- viii. Understanding and navigating the Medicare program, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible members, such as PACE

(7) Additional trainings for care managers and supervisors serving members with I/DD or TBI

- i. Understanding various I/DD and TBI diagnoses and their impact on the individual's functional abilities, physical health and BH (i.e., co-occurring mental health or SUD diagnosis), as well as their impact on the individual's family/caregivers
- ii. Understanding HCBS, related planning, and 1915(c) services and requirements
- iii. Accessing and using assistive technologies to support individuals with I/DD and TBI
- iv. Understanding the changing needs of individuals with I/DD and TBI as they age, including when individuals transition from primary school to secondary school and age out of school-related services
- v. Educating members with I/DD and TBI about consenting to physical contact and sex

(8) Additional trainings for care managers and supervisors serving children

- i. Child- and family-centered teams
 - ii. Understanding of the “System of Care” approach (see *Section V.B.3.vii. System of Care*), including knowledge of child welfare, school, and juvenile justice systems
 - iii. Methods for effectively coordinating with school-related programming and transition-planning activities
- (9) Additional training for care managers and supervisors serving the children with complex needs
 - i. Specialized training in addressing co-occurring mental health disorders and I/DDs
- (10) Additional trainings for care managers and supervisors serving pregnant and postpartum women with SUD or with SUD history
 - i. Best practices for addressing the needs of pregnant and postpartum women with SUD or with SUD history, such as general knowledge about pregnancy, medication-assisted treatment, SUD and breastfeeding, and infant opioid withdrawal
- (11) Additional trainings for care managers and supervisors serving members with LTSS needs
 - i. Methods for coordinating with supported employment resources available through the Department, the Division for Vocational Rehabilitation and other general employment resources such as the Employment Securities Commission
- (f) As a best practice, the BH I/DD Tailored Plan may collaborate with other BH I/DD Tailored Plans on Tailored Care Management curriculum development.
- (g) The BH I/DD Tailored Plan shall allow care managers and supervisors, regardless of the organization in which they provide care management, to waive components of the required training if the care manager or supervisor can verify that they have previously completed and demonstrated competency in a specific training domain.
 - (1) The BH I/DD Tailored Plan must document and get approval for their approach to waiving components of the required training in their Care Management Policy. (*Section V.B.3.vi. Care Management Policy*).
- (h) The BH I/DD Tailored Plan must provide annual refresher courses on training topics, based on needs determined by care manager supervisors.
- (i) The BH I/DD Tailored Plan shall provide additional targeted trainings and continuing education opportunities for care managers and supervisors upon request.
- (j) The BH I/DD Tailored Plan shall identify core modules that care managers must complete before being deployed to serve members; care managers must complete the remaining training modules within thirty (30) days of being deployed to serve members.
- (k) Current Innovations waiver care coordinators who are transitioning to care managers under Tailored Care Management will have additional time to complete these trainings, not to exceed six (6) months after launch.
- (l) The BH I/DD Tailored Plan shall provide training to its Network providers about Tailored Care Management.
- (m) The BH I/DD Tailored Plan shall not require care managers and supervisors working in multiple BH I/DD Tailored Plan regions to complete and pass each required domain of the Tailored Care Management training curriculum more than once. Care managers and supervisors should complete and pass the training in the region where they serve the most members.
 - (1) The BH I/DD Tailored Plan may require care managers and supervisors to complete additional training, beyond the required domains, specific to their region or the populations they serve.

- (n) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall submit to the Department its Tailored Care Management training plan for approval:
- (1) Policies and procedures for training and qualification of care managers and other multidisciplinary team members
 - (2) Training modalities (e.g., in-person versus online)
 - (3) Approach to tracking and verifying that care managers have completed trainings
 - (4) Process for addressing noncompliance with trainings
 - (5) Timing/frequency of trainings
 - (6) Summary of curriculum
 - (7) Approach for assessing competencies
 - (8) Approach for annual refreshers and ongoing continuing education
 - (9) Approach for waiving specific training domains for care managers and supervisors
- (xv) Data System Requirements, Data Sharing, and Risk Stratification
- (a) Tailored Care Management Data System Requirements
- (1) The BH I/DD Tailored Plan shall have a sophisticated IT infrastructure and data analytic capabilities to support the Department's vision for care management, including the capabilities to:
 - i. Consume and use physical health, BH, I/DD and TBI claims, pharmacy and encounter data, clinical data, ADT data, risk stratification information and/or Unmet Health-Related Resource Needs data
 - ii. Share and transmit data with AMH+ practices and CMAs
 - (2) The BH I/DD Tailored Plan shall have a single care management data system across Medicaid and State-funded Services.
 - (3) The BH I/DD Tailored Plan shall ensure all organizations providing Tailored Care Management have care management data systems that have the ability to:
 - i. Maintain up-to-date documentation of members enrolled in Tailored Care Management and assignments of individual members to care managers
 - ii. Electronically document and store the care management comprehensive assessment and re-assessment
 - iii. Electronically document and store Care Plans and ISPs
 - iv. Consume claims and encounter data
 - v. Provide role-based access to members of the multidisciplinary care team
 - vi. Electronically and securely transmit (at minimum) the care management comprehensive assessment, Care Plan or ISP and reports/summaries of care to each member of the multidisciplinary care team to support case conferences
 - vii. Track care management encounters electronically, including date and time of each attempted encounter, method of attempt (in-person, telephonic), personnel involved, and whether the attempt was successful
 - viii. Track referrals
 - ix. Allow care managers to:
 - a) Identify risk factors for individual members
 - b) Develop actionable Care Plans and ISPs
 - c) Monitor and quickly respond to changes in a member's health status
 - d) Track a beneficiary's referrals and provide alerts where care gaps occur
 - e) Monitor a beneficiary's medication adherence

- f) Transmit and share reports and summary of care records with care team members
- g) Support data analytics and performance
- h) Transmit quality measures (where applicable)
- x. Helping schedule and prepare members (via, e.g., reminders and transportation) for appointments
- xi. The BH I/DD Tailored Plan shall submit a description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

(b) Data Sharing in Support of Tailored Care Management

- (1) The BH I/DD Tailored Plan shall provide data to AMH+ practices and CMAs to support Tailored Care Management. The BH I/DD Tailored Plan shall submit its proposed methodology and schedule for sharing data with AMH+ practices and CMAs as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (2) The BH I/DD Tailored Plan shall have the capability to consume clinical and care management comprehensive assessment data shared by AMH+s and CMAs.
- (3) In cases where the Department establishes a standard file format for data-sharing reports, the BH I/DD Tailored Plan shall utilize the file format specified by the Department.
- (4) In order to support care management activities, the BH I/DD Tailored Plan shall provide the following information to all AMH+ practices, CMAs, and CINs or Other Partners in a machine-readable format or other format that may be specified by the Department for the members assigned to them for Tailored Care Management:
 - i. Clinically relevant and available enrollment/eligibility data
 - ii. Member assignment files, including:
 - a) Point-in-time assignment information on at least a monthly basis;
 - b) Projected assignment information for the following month (to the extent information is available);
 - c) Information about newly assigned members to the BH I/DD Tailored Plan, within seven (7) Business Days of enrollment; and
 - d) Notifications of any ad hoc changes in assignment as they occur, within seven (7) Business Days of each change.
 - iii. Acuity tiering and risk stratification information, including:
 - a) The BH I/DD Tailored Plan shall share acuity tiering results for every assigned member and shall share any changes to a member's acuity tier assignment within seven (7) Business Days of each update.
 - b) The BH I/DD Tailored Plan shall share any additional BH I/DD Tailored Plan-furnished risk scoring results for every assigned member, including (where possible and relevant) member-level information about cost and utilization outliers.
 - c) The BH I/DD Tailored Plan is encouraged to share types or categories of risk stratification model inputs (e.g., frequent hospital utilization) and any clinically relevant information identified through the risk score development process that can inform specific actions by the AMH+ practice or CMA.
 - iv. Quality measure performance information at the practice level
 - a) The BH I/DD Tailored Plan shall provide quality scoring results on both an annual and an interim basis as specified by the Department, and in a format to be defined by the Department. These will include:

- 1) Practice-specific numerators and denominators for each measure.
- 2) An exhibit comparing the practice's performance on each measure to its contracted benchmarks, and to the performance of other practices contracting with the BH I/DD Tailored Plan.
- 3) Practice-specific gap reports identifying members who are in the measure denominator but do not meet numerator criteria.
- 4) Sufficient information on lags in encounter data, member (re) assignment, and other elements contributing to data quality that the practice can interpret the completeness and timeliness of the data included in the performance report.

v. Encounter data

- a) The BH I/DD Tailored Plan shall provide the following encounter and/or claims data directly to AMH+ practices and CMAs, or their designated CINs or Other Partners, as appropriate:
 - 1) Encounter and/or claims data for physical health, BH, I/DD, TBI, NEMT or LTSS services, where the first delivery should include all available data dating back twenty-four (24) months, with new data delivered at least monthly thereafter.
 - 2) Pharmacy encounter and/or claims data, where the first delivery should include all available data dating back twenty-four (24) months, with new data delivered at least weekly thereafter.
- b) Data flows from the BH I/DD Tailored Plan to AMH+ practices, CMAs, and CINs or Other Partners shall include only members assigned to the receiving practices or groups of practices.

vi. Other data

- a) Prior authorization data
 - b) Pharmacy lock-in data
- (5) The BH I/DD Tailored Plan shall also provide other available data or information that may be used to support Tailored Care Management (e.g., previously established care plans, historical member clinical information, ADT data) to all AMH+ practices and CMAs in a format agreed to by the BH I/DD Tailored Plan and AMH+ or CMA.
 - (6) The BH I/DD Tailored Plan shall consume, integrate, and use available Medicare data to advance the whole-person care management activities and functions for members who are Dually-Eligible for Medicare and Medicaid as described in this Contract to the extent possible and applicable.
 - (7) The BH I/DD Tailored Plan shall participate in a Department-led advisory committee addressing data sharing and infrastructure to support Tailored Care Management.
 - (8) The BH I/DD Tailored Plan shall adopt standardized data-sharing formats and protocols as they are developed by the Advisory Committee.
 - (9) The BH I/DD Tailored Plan shall develop a strategy to share data with members, in a format that is secure, takes into account varying levels of health literacy and promotes member engagement in care

(c) Risk Stratification

- (1) As part of its approach to population health management, the BH I/DD Tailored Plan may choose to establish a risk stratification methodology in addition to the Department's acuity tiering methodology. Any such methodology may be used to support Tailored Care Management assignment and segmentation of the population to target interventions to

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

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

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

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

(d) ADT Feeds for Organizations Providing Tailored Care Management

- (1) The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management have access to an ADT data source that correctly identifies when members are admitted, discharged or transferred to/from an ED or hospital in real time or near-real time.
- (2) As part of transitional care management, the BH I/DD Tailored Plan shall ensure that there is a systematic, clinically appropriate process with designated staffing for care managers responding to certain high-risk ADT alerts, including:
 - i. Real-time (within minutes/hours) response to notifications of ED visits, for example by contacting the ED to arrange rapid follow-up
 - ii. Same-day or next-day outreach for designated high-risk subsets of the population
 - iii. Additional outreach within several days after the alert to address outpatient needs or prevent future problems for patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post-discharge)

(xvi) Tailored Care Management Payments

- (a) The BH I/DD Tailored Plan shall make payments for Tailored Care Management according to the requirements in *Section V.B.4.iv. Provider Payments*.
- (xvii) Technical Assistance to AMH+ Practices and CMAs
- (a) The BH I/DD Tailored Plan shall provide ongoing technical assistance to practices going through the certification process and already certified AMH+ practices and CMAs to enable them to become high-performing providers of Tailored Care Management.
 - (1) Areas of technical assistance shall include, but are not limited to, health IT and data analytics capabilities to support the Department’s vision for Tailored Care Management; population health; quality measurement and performance; and integration of physical health, behavioral health, and I/DD services for care management purposes.
 - (2) The BH I/DD Tailored Plan shall submit a description of its approach for providing technical assistance as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- (xviii) Certification of AMH+ Practices and CMAs
- (a) The Department will implement a direct process to certify provider organizations to deliver provider-based Care Management under this model as AMH+ practices or CMAs, further described in *Section VII. Attachment M.3. AMH+ Practice and CMA Certification Policy* and <https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd-tailored-plan>.
 - (b) The Department will be responsible for certification of AMH+ practices and CMAs prior to BH I/DD Tailored Plan launch. From the start of BH I/DD Tailored Plan implementation onwards, BH I/DD Tailored Plans will be responsible for certification of any new organizations seeking certification as AMH+ practices or CMAs, with oversight from the Department. The Department will release additional guidance prior to BH I/DD Tailored Plan launch to describe the parameters for certification by BH I/DD Tailored Plans. Providers applying for certification as an AMH+ and CMA that are denied certification may appeal to the Department.
 - (c) As stated above in *Section V.B.3.ii.(ii)(b) Provider-based Tailored Care Management*, the BH I/DD Tailored Plan shall contract for Tailored Care Management with all certified AMH+ practices and CMAs operating in its Region. For Contract Year 1, the Department will be responsible for providing BH I/DD Tailored Plans with the list of certified providers in each Region. The only permitted exceptions to this contracting requirement are the following:
 - (1) The AMH+ practice or CMA notifies the Department that it elects to withdraw from certification. The Department will provide guidance to providers for how to give such notification.
 - (2) During Readiness Review, if the BH I/DD Tailored Plan determines that the AMH+ practice or CMA (or CIN or Other Partner on behalf of such organizations) is not ready to meet the requirements of the Tailored Care Management model. In this situation, the BH I/DD Tailored Plan shall provide detailed reasons to the Department why it proposes to decline to contract with that AMH+ practice, CMA or CIN or Other Partner, inclusive of technical assistance provided and why the AMH+ practice, CMA or CIN or Other Partner is inadequate. For the purposes of calculating compliance with the requirement to contract with all certified AMH+ practices and CMAs, the Department reserves the right not to remove an AMH+ practice or CMA from the denominator of the calculation, if it deems the BH I/DD Tailored Plan’s reasons for not contracting to be unsatisfactory.
 - (3) After BH I/DD Tailored Plan launch, if the BH I/DD Tailored Plan finds the AMH+ practice or CMA to be out of compliance with the requirements of the Tailored Care Management model, then the BH I/DD Tailored Plan follows its documented process, as described in *Section V.B.3ii.(xix) Oversight* to terminate the contract with the AMH+ practice or CMA.

- (d) AMH practices other than those certified as AMH+ practices are not required to meet the Tailored Care Management requirements within this Section; however, in their capacity as assigned PCPs for BH I/DD Tailored Plan members, they shall meet the requirements for AMH practices contained in *Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members*.
- (e) The BH I/DD Tailored Plan shall submit its policies and procedures for certification and recertification of AMH+ practices and CMAs as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).

(xix) Oversight

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

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

- (m) The BH I/DD Tailored Plan shall not terminate its contract with an AMH+, CMA or CIN or Other Partner under this provision until at least ninety (90) days after BH I/DD Tailored Plan launch.
- (n) In the event of underperformance by an AMH+ practice, CMA or CIN or Other Partner relative to the requirements for Tailored Care Management contained in this Section:
 - (1) The BH I/DD Tailored Plan shall send a notice of underperformance to the AMH+ practice/CMA within fourteen (14) days of identifying the underperformance, with a copy to the Department.
 - (2) The BH I/DD Tailored Plan shall provide the AMH+ practice, CMA or CIN or Other Partner with the opportunity to remediate any identified issues through a Corrective Action Plan (CAP), and a copy of the CAP shall be sent to the Department.
 - (3) The BH I/DD Tailored Plan shall ensure that a minimum of thirty (30) Calendar Days is provided for remediation of the identified underperformance addressed by the CAP, although the parties may establish longer remediation periods by mutual agreement.
- (o) In the event of continued underperformance by an AMH+ practice, a CMA or a CIN or Other Partner that is not corrected after the time limit set forth on the CAP, and the BH I/DD Tailored Plan terminates its contract with the AMH+ practice, CMA, CIN, or other entity, then the BH I/DD Tailored Plan shall notify the Department within seven (7) days that it will no longer be contracting with the AMH+ practice, CMA or CIN or Other Partner for Tailored Care Management. The Department reserves the right to specify the timing and format of this notification.
- (p) In the event of underperformance by an AMH+ practice, a CMA or a CIN or Other Partner for Tailored Care Management, the BH I/DD Tailored Plan shall ensure that there are no gaps in care management functions for members assigned to the AMH+ practice or CMA.
- (q) As part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall have a documented process for how it will oversee AMH+ practices, CMAs and CINs or Other Partners that meet all the requirements above. This process must:
 - (1) Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner.
 - (2) Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance.
 - (3) Describe how, in the event that the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with AMH+ practice, CMA, or CIN or Other Partner, the BH I/DD Tailored Plan would reassign members who were obtaining care management from that organization, taking member preferences into account and using the process described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (4) Describe how, in the event that the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to:
 - i. Provide Tailored Care Management without contracting with a CIN or Other Partner, which would require the AMH+ practice or CMA to enter a direct contract with the BH I/DD Tailored Plan for Tailored Care Management, or
 - ii. Contract with another CIN or Other Partner that in turn will contract with the BH I/DD Tailored Plan.

iii. Care Coordination and Care Transitions for all Members

- (i) The BH I/DD Tailored Plan shall be responsible for care coordination and care transitions for all members in accordance with 42 C.F.R. § 438.208, regardless of whether a member opts out of

Tailored Care Management, does not engage in Tailored Care Management, or is ineligible for Tailored Care Management.

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

- iv. I/DD and/or TBI related needs
 - v. Risk of requiring LTSS
 - vi. Detailed medication history—a list of all medicines, including over-the-counter medication and medication that has been prescribed, dispensed, or administered – and known allergies;
 - vii. Other factors or conditions (e.g., pregnancy) about which the BH I/DD Tailored Plan would need to be aware to arrange available interventions for the member
- (3) The BH I/DD Tailored Plan shall include standardized Unmet Health-Related Resource Needs questions to be provided by the Department for use in all care needs screenings, covering four (4) priority domains:
- i. Housing
 - ii. Food
 - iii. Transportation
 - iv. Interpersonal Violence/Toxic Stress
- (4) The BH I/DD Tailored Plan must attempt a care needs screening at least annually for enrolled members who have opted out of Tailored Care Management.
- (d) The BH I/DD Tailored Plan shall make member referrals to appropriate 1915(c) waiver programs using all information available to it, including member self-referrals.
- (e) The BH I/DD Tailored Plan shall connect members to programs and resources that can assist in securing employment, supported employment (such as through the Individual Placement and Support-Supported Employment (IPS-SE) program), apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activity that support community integration, as appropriate.

(viii) Care Transitions

- (a) The BH I/DD Tailored Plan shall oversee care transitions for all members, including those who opt out of or never engage in Tailored Care Management, who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes. 42 C.F.R. § 438.208(b)(2)(i).
- (b) The BH I/DD Tailored Plan shall refer and assist all members in accessing needed social services and supports identified as part of the care transitions, including access to housing.
- (c) The BH I/DD Tailored Plan must ensure that its contracts with institutions in the BH I/DD Tailored Plan provider network (hospitals, residential settings, rehabilitation settings, State Operated Health Care Facilities, ICF-IIDs, other facility-based treatment settings and LTSS providers) establish policies and procedures for care transitions that require the institution to:
- (1) Permit transition staff (as described further in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*), including the care manager, in-reach specialist or peer support specialist, and/or transition coordinator to engage in and help coordinate the discharge planning process.
 - (2) Notify the BH I/DD Tailored Plan of member admissions/pending discharges and contact the assigned organization providing Tailored Care Management (if applicable) to integrate the organization into the discharge/transition planning process.
 - (3) Share relevant information (including the member's current Care Plan/ISP, initial and final discharge plans, and medical information when applicable) among transition/discharge planning team members and the member's care team if applicable.
 - (4) Establish relationships with AMH+ practices and CMAs to facilitate care transitions.
- (d) The BH I/DD Tailored Plan shall develop a methodology for identifying members in transition who are at risk of readmissions and other poor outcomes. This methodology shall take into account:

- (1) Frequency, duration, and acuity of inpatient, skilled nursing facility (SNF), and LTSS admissions or ED visits
 - (2) Discharges from inpatient, crisis, other facility-based, and residential treatment settings
 - (3) NICU discharges
 - (4) Identification of patients by severity of condition, medications, risk score, Unmet Health-Related Resource Needs and other factors the BH I/DD Tailored Plan may prioritize
- (e) For members transitioning out of an ACH, a state psychiatric facility, a state developmental center, ICF-IID, PRTF, or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2, the BH I/DD Tailored Plan shall also meet the requirements described in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*
- (ix) The BH I/DD Tailored Plan shall submit its policies and procedures for care coordination and care transitions for all members as part of its Care Management Policy (*Section V.B.3.vi. Care Management Policy*).
- iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver
- (i) In cases where a member enrolled in the Innovations or TBI waiver opts out of Tailored Care Management, the BH I/DD Tailored Plan must provide the Innovations or TBI waiver care coordination services as stipulated by the applicable 1915(c) waiver.
 - (a) The BH I/DD Tailored Plan shall ensure that Innovations and TBI waiver care coordination services are performed by a care manager meeting the following qualifications:
 - i. Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area;
 - ii. Two (2) years of experience working directly with individuals with I/DD or TBI; and
 - iii. Two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience.
 - (b) The Department will not make a Tailored Care Management payment to the BH I/DD Tailored Plan for members who opt out of Tailored Care Management.
 - (ii) For all members enrolled in the Innovations or TBI waiver, regardless of whether they engage in Tailored Care Management, the BH I/DD Tailored Plan shall ensure that waiver care coordination includes:
 - (a) Guiding the development and submission of the ISP, based on assessed need and living arrangements, at least annually:
 - (1) The BH I/DD Tailored Plan shall ensure that the member's care manager convenes a person-centered planning meeting and completes the ISP. This is done after the member is administered the SIS[®] and the level of care determination for initial plans of care.
 - (2) If applicable, the BH I/DD Tailored Plan shall ensure that the member's AMH+ practice or CMA (if applicable) reviews and submits the ISP to the BH I/DD Tailored Plan.
 - (3) The BH I/DD Tailored Plan shall review ISP for waiver compliance, medical necessity, and the member's health and safety needs.
 - (4) The BH I/DD Tailored Plan shall approve or deny the ISP within standard service authorization periods except for in the case of initial plans which must be received within sixty (60) days of level of care determination. In the case where services are needed more immediately, an interim plan of care may be completed so that services may be approved with the full ISP being completed afterwards and within the 60 days of level of care determination.
 - (5) The BH I/DD Tailored Plan shall ensure that waiver services begin within forty-five (45) days of ISP approval.
 - (b) Monitoring and contact requirements found in the 1915(c) waiver.

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

v. Other Care Management Programs

- (i) Overview
 - (a) While Tailored Care Management will be the predominant care management model for the BH I/DD Tailored Plan population, the BH I/DD Tailored Plan must offer additional care management sections targeted towards special populations, as detailed in this Section.
- (ii) Local Health Departments

- (a) The BH I/DD Tailored Plan shall be required to contract with local health departments (LHDs) during a transitional period that will align with the transitional period established for Standard Plans. Accordingly, in Contract Year 1, the BH I/DD Tailored Plan shall be required to offer a right of first refusal with each LHD in its Region to provide Care Management for At-Risk Children (CMARC) to children already enrolled in that program at the time of BH I/DD Tailored Plan launch and to provide Care Management for High Risk Pregnancy (CMHRP).
- (b) The BH I/DD Tailored Plan shall work with LHDs for the temporary continuation of CMARC to members already enrolled in CMARC, as follows:
 - (1) In Contract Year 1, the BH I/DD Tailored Plan shall offer the right of first refusal to each LHD in its Region to provide CMARC to any members ages zero (0) up to age five (5) who are already enrolled in CMARC at the time of BH I/DD Tailored Plan launch. Such children will not be eligible for Tailored Care Management while enrolled in CMARC because the two (2) programs provide duplicative services. At the conclusion of CMARC for a child enrolled in the BH I/DD Tailored Plan, the BH I/DD Tailored Plan shall enroll the child into Tailored Care Management.
 - (2) If an LHD in the BH I/DD Tailored Plan's Region chooses not to continue to provide CMARC for currently-enrolled children enrolled in BH I/DD Tailored Plans, the BH I/DD Tailored Plan shall be responsible for ensuring that CMARC services are provided as part of Tailored Care Management.
 - (3) For all contracts developed with LHDs for CMARC, the BH I/DD Tailored Plan shall use standard contract language provided by the Department. The BH I/DD Tailored Plan shall be allowed to incorporate additional standards and contract terms which are mutually agreed upon by the LHD and the BH I/DD Tailored Plan.
 - (4) The BH I/DD Tailored Plan shall incorporate all Department-defined care management practice standards for CMARC into each of its contracts with LHDs, as noted in *Section VII. Attachment M.4. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members*.
 - (5) After the launch of BH I/DD Tailored Plans, the BH I/DD Tailored Plan shall not enroll any further children into CMARC and shall instead enroll all children into Tailored Care Management.
 - (6) At the conclusion of Contract Year 1, the BH I/DD Tailored Plan shall have the option to transition all children from CMARC into Tailored Care Management, or to continue to contract with LHDs for any children remaining in CMARC at that time.
- (c) The BH I/DD Tailored Plan shall work with LHDs for the provision of CMHRP to high-risk pregnant women who are BH I/DD Tailored Plan members as follows:
 - (1) In Contract Year 1, the BH I/DD Tailored Plan shall offer the right of first refusal to each LHD in its Region to provide CMHRP to any members eligible for CMHRP.
 - (2) The BH I/DD Tailored Plan shall identify high-risk pregnancies for referral to CMHRP through one or more of the following mechanisms:
 - i. Standardized risk screening tool conducted by providers
 - ii. Risk stratification by the BH I/DD Tailored Plan
 - iii. Direct referral by providers, members or families.
 - (3) The BH I/DD Tailored Plan shall send all screening information to the applicable LHDs to provide CMHRP within one (1) Business Day of the member's referral.
 - (4) In Contract Year 1, the BH I/DD Tailored Plan shall make best efforts to engage members participating in CMHRP into Tailored Care Management and shall assign them to care management according to *Section V.B.3.v. Tailored Care Management Assignment*. Care managers providing Tailored Care Management will address other needs that are not included in the LHD model. A member can receive CMHRP and Tailored Care Management simultaneously.

- (5) For women enrolled in CMHRP as well as Tailored Care Management simultaneously, the BH I/DD Tailored Plan shall be responsible for ensuring that the assigned organization providing Tailored Care Management coordinates with LHD care managers to ensure all the members' needs are met, pertinent information is shared, and services are not duplicated between the two programs.
 - (6) For all contracts developed with LHDs for CMHRP, the BH I/DD Tailored Plan shall use standard contract language provided by the Department, to ensure that CMHRP services include (but are not limited to):
 - i. Outreach;
 - ii. Motivational interviewing;
 - iii. Development of person-centered Care Plans;
 - iv. Identification of community resources available to meet the specific needs of the population; and
 - v. Referrals to childbirth education, oral health, BH or other needed services reimbursed by Medicaid.
 - (7) The BH I/DD Tailored Plan shall be allowed to incorporate additional standards and contract terms that are mutually agreed upon by the LHD and the BH I/DD Tailored Plan.
 - (8) The BH I/DD Tailored Plan shall incorporate all Department-defined care management practice standards for CMHRP into each of its contracts with LHDs, as noted in *Section VII. Attachment M.4. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members.*
 - (9) At the conclusion of Contract Year 1, the BH I/DD Tailored Plan shall have the option to continue to contract with LHDs for CMHRP; or to include CMHRP services within Tailored Care Management for members experiencing high risk pregnancy (whether provided by the organization responsible for Tailored Care Management or by another organization under contract with the BH I/DD Tailored Plan).
- (d) In the event of underperformance by an LHD, the BH I/DD Tailored Plan shall follow standard procedures specified by the Department. In the event of continued underperformance by an LHD that is not corrected, the BH I/DD Tailored Plan shall be permitted to terminate the contract with that LHD and the LHD shall have the right to appeal the termination. The BH I/DD Tailored Plan shall notify the Department of underperformance by or contract termination of an LHD. The Department reserves the right to specify the timing and format of this notification.
 - (e) The BH I/DD Tailored Plan must participate in Department-led meetings involving the CMHRP and CMARC programs, including requiring attendance by appropriate clinical and operational leadership at meetings.
 - (f) The BH I/DD Tailored Plan must incorporate new guidance, policy, operational manuals and other program-specific requirements regarding CMARC and CMHRP into BH I/DD Tailored Plan operations and LHD contracts, as applicable, and within Department-specified timelines.
- (iii) Pregnancy Management Program
- (a) Pregnancy Management Program (PMP) in Coordination with Care Management for High-Risk Pregnant Women
 - (1) The BH I/DD Tailored Plan shall be required to participate in Department-led meetings involving the PMP program, including requiring attendance by appropriate clinical and operational leadership at meetings.
 - (2) The BH I/DD Tailored Plan shall be required to incorporate new guidance, policy, operational manuals and other program-specific requirements into BH I/DD Tailored Plan operations and PMP contracts, as applicable, and within Department-specified timelines.
 - (3) The BH I/DD Tailored Plan shall adopt the PMP standardized screening tool currently used in practices, with modifications, as determined by the Department.

- (4) The BH I/DD Tailored Plan shall be responsible for receiving standardized screening tool results from PMP providers and for arranging enrollment into CMHRP based on referrals by PMP providers.
 - (5) During Contract Year 1, when a high-risk pregnancy is referred to the BH I/DD Tailored Plan by a PMP provider, member, family or another entity, the BH I/DD Tailored Plan shall be responsible for arranging enrollment of the member into CMHRP and shall inform the member's PMP provider that the member has entered the program.
- (iv) HIV Case Management Providers
- (a) The BH I/DD Tailored Plan may contract with existing HIV case management providers, at their discretion.
 - (b) The BH I/DD Tailored Plan shall coordinate with local Ryan White HIV case management programs and providers.
- (v) High-Fidelity Wraparound
- (a) Overview of High-Fidelity Wraparound
 - (1) The Department recognizes that High-Fidelity Wraparound, an evidence-based intervention targeted toward youth ages three (3) to twenty (20) years old with serious emotional disturbance, has produced cost savings as compared with psychiatric residential treatment facility services and Level III/IV group home services.
 - (2) The Department is committed to expanding access to High-Fidelity Wraparound with the launch of BH I/DD Tailored Plans.
 - (3) The Department intends to submit a SPA to add High-Fidelity Wraparound as a Health Home State Plan service. The High-Fidelity Wraparound Health Home benefit will be distinct from the Tailored Care Management Health Home benefit.
 - i. If approved by CMS, the BH I/DD Tailored Plan shall cooperate with the Department in the administration of this Health Home SPA, including implementation, providing reporting and data, and other requirements.
 - (4) Provider organizations may choose to seek certification to offer High-Fidelity Wraparound to children with serious emotional disturbance who meet eligibility criteria that will be documented in the Department's forthcoming High-Fidelity Wraparound Policy. Only providers that meet requirements as described in this Section (*Section V.B.3.v.(v)*) may offer High-Fidelity Wraparound.
 - (5) The BH I/DD Tailored Plan shall ensure that High-Fidelity Wraparound providers meet all data sharing requirements described in *Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification*.
 - (6) The BH I/DD Tailored Plan shall ensure that the High-Fidelity Wraparound program is subject to requirements for facilitating timely communication across the care team as described in *Section V.B.3.ii.(x) Ongoing Care Management*
 - (7) The BH I/DD Tailored Plan shall ensure that it has sufficient providers in its Network to meet the needs of members who are eligible for the services, as defined below in *Section V.B.3.v.(v)(b) Eligibility and Assignment to High-Fidelity Wraparound*.
 - (b) Eligibility and Assignment to High-Fidelity Wraparound
 - (1) Youth ages three (3) through twenty (20) are eligible for High-Fidelity Wraparound if they meet the criteria documented in the Department's High-Fidelity Wraparound Policy.
 - (2) On an ongoing basis, the BH I/DD Tailored Plan shall identify members who may meet the High-Fidelity Wraparound eligibility criteria and would benefit from the program. The BH I/DD Tailored Plan shall also accept referrals from Network providers for members who may be eligible for and benefit from High-Fidelity Wraparound.

- (3) If the BH I/DD Tailored Plan identifies that a member may meet the High-Fidelity Wraparound eligibility criteria, the BH I/DD Tailored Plan shall contact the member and their caretaker/legal guardian (if applicable) to determine interest in High-Fidelity Wraparound.
 - (4) If the member and their caretaker/legal guardian indicate interest in High-Fidelity Wraparound, the BH I/DD Tailored Plan shall determine whether the member meets the High-Fidelity Wraparound eligibility criteria, as specified in the Department's forthcoming High-Fidelity Wraparound Policy.
 - (5) If the BH I/DD Tailored Plan determines that the member meets the High-Fidelity Wraparound eligibility criteria, the BH I/DD Tailored Plan shall refer the member to a provider that offers High-Fidelity Wraparound for Care Management.
 - (6) If the member meets the High-Fidelity Wraparound eligibility criteria and elects to participate in the intervention, the member will be transitioned from Tailored Care Management to High-Fidelity Wraparound. The assigned organization providing Tailored Care Management shall facilitate a Warm Handoff to the High-Fidelity Wraparound Team.
 - i. The BH I/DD Tailored Plan shall disenroll the member from Tailored Care Management at the time of the Warm Handoff.
- (c) High-Fidelity Wraparound Services and Fidelity Monitoring
- (1) The BH I/DD Tailored Plan must contract with the single vendor selected by the Department to conduct training and fidelity monitoring for providers offering High-Fidelity Wraparound.
 - (2) The BH I/DD Tailored Plan shall ensure that all providers offering High-Fidelity Wraparound meet fidelity requirements, as assessed by the vendor performing fidelity monitoring.
 - (3) The BH I/DD Tailored Plan must ensure that providers offering High-Fidelity Wraparound meet all requirements documented in the Department's High-Fidelity Wraparound Policy, including requirements for staffing, qualifications and training.
- (d) Transitions from High-Fidelity Wraparound
- (1) When a member has completed the High-Fidelity Wraparound intervention, the BH I/DD Tailored Plan must assign the member to an AMH+, a CMA or the BH I/DD Tailored Plan for Tailored Care Management as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*, unless the member opts out of Tailored Care Management. The BH I/DD Tailored Plan must give preference to the provider that delivered High-Fidelity Wraparound if that provider is certified as a CMA and has the capacity to serve that member.
 - (2) The BH I/DD Tailored Plan shall require a Warm Handoff between the High-Fidelity Wraparound team and the assigned organization providing Tailored Care Management.
- (vi) Members Obtaining ACT or Residing in an ICF-IID
- (a) The BH I/DD Tailored Plan must implement the following protocols for members obtaining ACT or services in an ICF-IID:
 - (1) Ensure that the member receives transitional care management, as described in *Section V.B.3.ii.(xi) Transitional Care Management*, in the first and last months of obtaining ACT.
 - (2) Ensure that the member receives transitional care management, as described in *Section V.B.3.ii.(xi) Transitional Care Management* in the first and last months of obtaining services in an ICF-IID.
 - (3) Suspend enrollment in Tailored Care Management effective the month following initial receipt of ACT or ICF-IID services and report the suspension to the Department. The Department will cease making Tailored Care Management payments to the BH I/DD

Tailored Plan for the member, except in the first and last months that the member receives ACT or ICF-IID services.

- (4) Ensure that when a member begins obtaining ACT or services through an ICF-IID, the member's care manager for Tailored Care Management shares the member's Care Plan/ISP with the ACT or ICF-IID case manager, with consent.

(vii) Coordination with Children's Developmental Service Agencies

- (a) The BH I/DD Tailored Plan shall coordinate with every Early Intervention (EI) Program Children's Developmental Service Agency (CDSA) in the Region in which it operates.
- (b) The BH I/DD Tailored Plan shall establish reciprocal information-sharing agreements with CDSAs that reflect parental consent requirements and are compliant with HIPAA and the Family Educational Rights and Privacy Act (FERPA).
- (c) For children who are actively engaged in Tailored Care Management:
 - (1) The care manager providing Tailored Care Management shall coordinate with the CDSA service coordinator, to the maximum extent possible, in order to facilitate information sharing and coordination between the BH I/DD Tailored Plan and the CDSAs.
 - (2) For any child ages zero (0) to three (3) identified as receiving EI services through the needs assessment, the organization providing Tailored Care Management shall:
 - i. Incorporate the child's Individualized Family Service Plan (IFSP) into the Care Plan or ISP.
 - ii. Update the child's BH I/DD Tailored Plan Care Plan or ISP to reflect any changes to the IFSP on an ongoing basis.
 - iii. Request that the CDSA service coordinator take part in the child's Tailored Care Management case conferences, upon consent of the parent/legally responsible person.
 - iv. Partner with the CDSA service coordinator to identify Unmet Health-Related Resource Needs and connect the family to appropriate social and community-based services, as needed.
 - (3) For any child age zero (0) up to age three (3) who is not receiving EI services, but whose developmental assessment demonstrates evidence of developmental delay, the organization providing Tailored Care Management shall provide referral information to the parents for an EI evaluation, facilitate a Warm Handoff to the appropriate CDSA, and follow up on the results of the referral and whether an EI evaluation was conducted.
- (d) The BH I/DD Tailored Plan shall ensure that appropriate staff, such as member services staff and care managers, are generally knowledgeable about EI services and provide referrals to the appropriate local CDSA to assist and consult with enrollees concerning EI services.
- (e) In its Care Management Policy (*Section V.B.3.vi. Care Management Policy*), the BH I/DD Tailored Plan shall detail the plan to ensure referral and coordination for all children who receive service coordination through a CDSA during Contract Year 1, or a time otherwise defined by the Department, and annually thereafter.

(viii) Care Management through the Indian Health Service or EBCI

- (a) At the request of the Department, the BH I/DD Tailored Plan shall enter into a contract with EBCI to perform care management or other functions for tribal members and IHS-eligibles as prescribed by the Department, in consultation with EBCI.

vi. Care Management Policy

- (i) The BH I/DD Tailored Plan shall submit its Care Management Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award. The BH I/DD Tailored Plan

must submit an updated version of the Care Management Policy sixty (60) days prior to BH I/DD Tailored Plan launch and at the beginning of each Contract Year.

- (ii) The Care Management Policy shall include the BH I/DD Tailored Plan's:
 - (a) Plan for supporting development of provider-based Care Management and oversight of Provider-based Care Management (including, but not limited to CAP procedures);
 - (b) Sample Tailored Care Management enrollment packet and opt-out form
 - (c) Policies and procedures for Tailored Care Management assignment, including methodology for assigning eligible members, as defined in *Section V.B.3.ii.(iii) Eligibility for Tailored Care Management*, to Tailored Care Management based at an AMH+ practice, a CMA or the BH I/DD Tailored Plan.
 - (d) Policies and procedures for outreach and engagement
 - (e) Process for how members are notified of the name of their assigned care manager and how to contact them.
 - (1) Process for how the care manager is made aware of Grievances and Appeals filed by members or by providers (when providers file an Appeal based on a denial of service).
 - (2) Strategies to outreach to and engage members who are hard to contact/locate (because of, for example, incorrect address information, a missing or incorrect phone number, or homelessness).
 - (3) Strategies that shall be used to document attempted contacts; "robocalls" and automated telephone calls that deliver recorded messages can be part of the outreach strategy, but will not solely be an acceptable form of contacting members.
 - (4) Strategies to re-engage members who did not engage previously in Tailored Care Management.
 - (f) Policies and procedures for care management comprehensive assessments, including but not limited to:
 - (1) Strategies to comply with federal care needs screening requirements (42 CFR § 438.208(b)(3))
 - (2) Assessment tools/questions used
 - (3) Variation in care management comprehensive assessment based on population (including LTSS)
 - (4) Expected volume of care management comprehensive assessments monthly and annually
 - (5) Method of conducting the care management comprehensive assessment based on member needs or other factors
 - (6) Audits of care management comprehensive assessments to ensure they meet quality expectations.
 - (g) Policies and procedures for Care Plan/ISP development with members, including:
 - (1) Approach for involving multidisciplinary care team
 - (2) Approach for ensuring that Care Plans/ISPs are individualized and person-centered and that the member and the member's family, advocates, caregivers, and/or legal guardians are actively involved
 - (3) Process for and frequency of Care Plan/ISP updates
 - (4) Approach for ISP development for members enrolled in the Innovations or TBI waivers
 - (5) Audits of care plan/ISP to ensure they meet quality expectations
 - (h) Policies and procedures for transitional care management, including the approach to working with members with LTSS needs
 - (i) Policies and procedures for linkages with community resources for all members as needed, including for those identified as having Unmet Health-Related Resource Needs

- (j) Policies and procedures for providing Members with information about social service providers in their community, referring individuals to such providers, and tracking closed-loop referrals, including through the use of NCCARE360.
- (k) Approach to providing technical assistance to AMH+ practices and CMAs
- (l) Training plan, including:
 - (1) Policies and procedures for training and qualification of care managers and other multidisciplinary team members
 - (2) Training modalities (e.g., in person versus online)
 - (3) Approach to tracking and verifying that care managers have completed trainings
 - (4) Process for addressing noncompliance with trainings
 - (5) Timing/frequency of trainings
 - (6) Summary of curriculum and training modalities (e.g., in person versus online)
 - (7) Approach for assessing competencies
 - (8) Approach for annual refreshers and ongoing continuing education
 - (9) Approach for permitting care managers and supervisors to waive specific training domains if they have previously obtained comparable training
- (m) Policies and procedures for population health management, including any risk scoring and stratification approach in addition to acuity tiering
- (n) Description of requisite health IT infrastructure, data analytic capabilities, and data privacy and security policies
- (o) Proposed methodology and schedule for sharing data with AMH+ practices and CMAs
- (p) Proposed methodology for calculating costs and outcomes of the care management program
- (q) Risk stratification methodology, if the BH I/DD Tailored Plan adopts its own methodology in addition to acuity tiering
- (r) Policies and procedures for certification and recertification of AMH+ practices and CMAs
- (s) Policies and procedures for conflict-free care management
- (t) Policies and procedures for ensuring members do not receive duplicative care management from multiple sources
- (u) Process for overseeing AMH+ practices, CMAs, and CINs or Other Partners, as described in *Section V.B.3.ii.(xix) Oversight*. This process must:
 - (1) Describe how a CAP may be applied to an individual AMH+ practice or CMA as well as how a CAP may be applied to a CIN or Other Partner.
 - (2) Provide the details of how it would cease to make Tailored Care Management payments and terminate its contract with the AMH+ practice, CMA or CIN or Other Partner, in the event of continued underperformance.
 - (3) Describe how, in the event that the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with AMH+ practice, CMA or CIN or Other Partner, the BH I/DD Tailored Plan would reassign members who were obtaining care management through that organization, taking member preferences into account and using the process described in *Section V.B.3.ii.(v) Tailored Care Management Assignment*.
 - (4) Describe how, in the event that the BH I/DD Tailored Plan terminates its contract for Tailored Care Management with a CIN or Other Partner, the certified AMH+ practices and/or CMAs that had contracted with the CIN or Other Partner will be provided with options to continue serving as AMH+ practices and CMAs. Such options may include the option to contract directly with the BH I/DD Tailored Plan or the option to contract with another CIN or Other Partner that in turn will contract with the BH I/DD Tailored Plan.
 - (5) Policies and procedures for care coordination and care transitions for all members, including:
 - i. Ensuring the member has an ongoing source of care
 - ii. Coordination across settings of care

- iii. Coordination during member transitions (including transitions from a Standard Plan to a BH I/DD Tailored Plan, from NC Medicaid Direct/LME/MCO into a BH I/DD Tailored Plan, among PHPs, among payers, and between community and social support providers)
 - (v) Specialized care management strategies that address the medical and psychosocial needs of infants who are substance affected; address the needs of the infant's mother/caregiver, including parental/caregiver education on the potential psychosocial development of an infant who is substance affected; and establish coordination with the mother's care manager to ensure that care management services for the infant and the mother are aligned
 - (w) Care management strategies to manage the needs of pregnant and postpartum women with SUD diagnoses/history or mental health diagnoses/history, including strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes, and addiction and recovery treatment approaches
 - (x) Policies and procedures for referral and coordination for all children who receive service coordination through a CDSA
 - (y) Strategy for building and managing the High-Fidelity Wraparound provider network
 - (z) Protocols for ensuring that individuals moving between the following services and the Tailored Care Management model experience smooth transitions:
 - (1) ACT;
 - (2) ICF-IIDs;
 - (3) Care Management for At-Risk Children; and
 - (4) High-Fidelity Wraparound program
- (iii) The BH I/DD Tailored Plan shall modify the Care Management Policy based on EQRO review, Department review, or care management improvement activities as part of the QAPI.

vii. System of Care

- (i) System of Care Background
 - (a) The North Carolina System of Care is the framework through which the State delivers public BH services to children and youth. The objective of North Carolina's System of Care is to provide evidence-based, trauma-informed/resiliency developed BH services to all children, youth and their families.
 - (b) The BH I/DD Tailored Plan shall use a System of Care approach, including use of specific strategies and protocols described in the BH I/DD Tailored Plan System of Care Policy (*Section V.B.3.vii.(iii) System of Care Policy*) for all members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving mental health or substance use services, including special populations such as youth with a dual I/DD and mental health disorder at risk of out-of-home placement or unable to return from out-of-home placement; youth with dual physical and mental health or SUD diagnoses with or without the risk of out-of-home placement; youth and young adults transitioning from child service systems into adult service systems; and youth involved in the child welfare and/or the juvenile justice system.
 - (c) The System of Care's core elements are:
 - (1) Family-driven, youth-guided services;
 - (2) Interagency collaboration;
 - (3) Service coordination through a single facilitator;
 - (4) Individualized, strength-based, trauma-informed/resilience development approach;
 - (5) Culturally and Linguistically Competent care;
 - (6) Evidence-based or informed services provided in a home or community setting; and
 - (7) Family and youth involvement in regional and state policy development, implementation, and evaluation.

(ii) System of Care Staffing Requirements

- (a) The BH I/DD Tailored Plan shall employ or contract with the following dedicated System of Care staff:
- (1) At least one (1) System of Care Coordinator per three (3) counties for the Region in which it operates; and
 - (2) At least one (1) Family Partner per three (3) counties for the Region in which it operates.
- (b) BH I/DD Tailored Plan System of Care Coordinators and Family Partners shall be responsible for comprehensive System of Care planning, implementation, coordination, and training related to required core functions within the Region in which it operates. System of Care Coordinators and Family Partners shall develop, facilitate, and evaluate the following required System of Care functions and responsibilities throughout the Region in which the BH I/DD Tailored Plan operates:
- (1) Serve as staff to each city or county local community collaborative in the Region in which the BH I/DD Tailored Plan operates and shall recruit and maintain membership that includes family members and youth who are receiving or have received public BH services, child-serving agencies and a variety of community partners.
 - (2) Work with Community Collaboratives to:
 - i. Influence the development of a broad and appropriate service array to meet the range of BH needs of children being serviced under the System of Care framework.
 - ii. Develop the capacity of the community collaborative to gather and use data for System of Care decision making.
 - iii. Support BH workforce development through systems partners jointly developing training plans and sharing resources to implement those plans.
 - iv. Develop and implement a strategic communication plan that promotes access to and utilization of BH services, deepens local leadership's understanding of the System of Care framework, and builds public support for local Systems of Care.
 - (3) Foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, work with care managers to ensure that youth and families are leading their person-centered planning processes, and provide and support leadership opportunities for youth and families.
 - (4) Work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of System of Care principles and processes, and provide or facilitate regular consultation, technical assistance and training to provider agencies in System of Care implementation fidelity.
 - (5) Work with community agencies in identifying and responding to community needs, network adequacy and service accessibility needs; participate in interagency efforts in support of the BH system; and provide information and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and substance abuse disorder treatment and recovery services.
 - (6) Regularly identify and respond to consultation, technical assistance and training needs of the Community Collaboratives, provider agencies, families and BH I/DD Tailored Plan staff, and either directly provide such System of Care consultation, technical assistance, and training or facilitate the provision of such activities.
 - (7) Take an active role in promoting BH I/DD Tailored Plan and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.

- (8) Complete and submit BH I/DD Tailored Plan System of Care reports to the Department. These reports shall be submitted to the Department in accordance with the Department's requirements.
 - (9) Regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits in order to support a high level of statewide coordination, networking, monitoring, and evaluation for and with System of Care Coordinators and staff.
- (c) The BH I/DD Tailored Plan shall ensure System of Care Coordinators and Family Partners are trained on all the topics described in this Section.
 - (d) The BH I/DD Tailored Plan shall implement the State System of Care training curriculum for System of Care Coordinators and Family Partners that includes the following:
 - (1) Identifying and addressing barriers to care including strategies to improve the Cultural and Linguistic Competency of the BH service delivery system;
 - (2) Partnering with families and youth in Care Plan development, implementation, and evaluation process.
 - (3) Engaging with a diverse set of public, private, and natural supports stakeholders to ensure that Care Plans are comprehensive, and implementation is shared across sectors;
 - (4) Developing, supporting and expanding relationships among systems;
 - (5) Identifying and addressing racial, ethnic, cultural disparities in the access, availability, and quality of service delivery; and
 - (6) Child and family team care management and High-Fidelity Wraparound.
- (iii) System of Care Policy
- (a) The BH I/DD Tailored Plan shall submit a System of Care Policy for review and approval by the Department within one hundred fifty (150) days after Contract Award and annually thereafter.
 - (b) The scope of this policy includes BH I/DD Tailored Plan members ages three (3) up to age eighteen (18) with a mental health disorder and/or SUD who are receiving BH or substance abuse services.
 - (c) The System of Care Policy shall include a brief description of the BH I/DD Tailored Plan's history and experience coordinating with members' care under the System of Care framework, including examples of specific successes and challenges to date in meeting the needs of children with BH needs.
 - (d) The System of Care Policy shall include the BH I/DD Tailored Plan's policies and processes for implementing the System of Care as required in the *Section V.B.3.vii.(iii) System of Care Policy* and:
 - (1) Integrating into the System of Care framework and applying the System of Care core elements into its approach for covering services for child and youth members with BH needs and their families.
 - (2) Ensuring that the BH I/DD Tailored Plan is an active partner within a member's System of Care.
 - (3) Supporting coordinated multi-system care delivery through:
 - i. Conducting a review of local policies and working with local partners to identify barriers to accessing services and service gaps;
 - ii. Conducting outreach to families to ensure they are engaged as partners in the service delivery process, and are incorporated into advisory bodies addressing System of Care-related training, workforce development, and development of service array, including Community Collaboratives;
 - iii. Instituting effective and timely cross-system communication, including for children in crisis; and
 - iv. Collaborating with system partners to ensure that children receive needed services in the least restrictive setting.

- (4) Describing how the BH I/DD Tailored Plan will work with local and State public agency partners to:
 - i. Reduce the number and length of out-of-home placements for children receiving public BH services;
 - ii. Ensure timely access to an appropriate service array of evidenced based home- and community-based care for children receiving Medicaid and state-funded public BH services;
 - iii. Reduce the number of children receiving public BH services prescribed multiple psychotropic medications; and,
 - iv. Reduce disparities in access to services and supports, availability and quality and completion rates based on race, ethnicity, gender, sexual orientation, and geography.
- (5) Describing how the BH I/DD Tailored Plan will develop capacity to strengthen existing and build new relationships with local and State public agency partners youth and/or family members with lived experience with a child in the BH system and local child and family support education and/or advocacy groups, including but not limited to:
 - i. Local school systems;
 - ii. County government;
 - iii. Juvenile justice system;
 - iv. Child welfare system;
 - v. Public health system;
 - vi. Private and local community-based providers;
 - vii. Child and Family Advisory Committees;
 - viii. Community Collaboratives; and
 - ix. The DMH/DD/SAS System of Care Coordinator.

viii. In-Reach and Transition from Institutional Settings

(i) In-Reach and Transition Overview

- (a) The BH I/DD Tailored Plan shall assume primary responsibility for the in-reach and transition activities described in this Section.
 - (1) In-reach activities shall be conducted with the goal of identifying and engaging members receiving care in a setting described in *Section V.B.3.viii(ii) Eligibility for In-Reach and Transition Services* and *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State* who may be able to have their needs safely met in a community setting.
 - (2) Transition activities shall be conducted with the goal of facilitating the relocation of a member receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services* and *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State* to a community setting, while ensuring the appropriate level of services and supports that member requires.
- (b) The BH I/DD Tailored Plan shall ensure all in-reach and transition activities are documented and stored and made available to the Department for review upon request.
- (c) The BH I/DD Tailored Plan shall provide the in-reach and transition reports in the form and frequency as described in *Section VII. Attachment J. Reporting Requirements*.

(ii) Eligibility for In-Reach and Transition Services

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

- (2) ACHs (members with SMI only),
 - (3) State developmental centers,
 - (4) PRTFs, and
 - (5) Residential Treatment Levels II/Program Type, III, and IV as defined in the Department's Clinical Coverage Policy 8-D-2.
- (b) The BH I/DD Tailored Plan shall also provide in-reach and transition services to members residing in ICF-IIDs not operated by the state as described in *Section V.B.3.viii.(viii) In-Reach and Transition for Members Residing in an ICF-IID Not Operated by the State*.
- (iii) The BH I/DD Tailored Plan shall ensure the individuals as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements* perform the following in-reach activities for members receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services*, beginning within seven (7) days of admission and occurring on a regular basis until the member is referred for transition services described in *Section V.B.3.viii.(iv)*:
- (a) Identify candidates for in-reach services. The BH I/DD Tailored Plan, shall use, at a minimum, the following information and data sources to identify candidates for in-reach services:
 - (1) Claims and enrollment data;
 - (2) Facility referrals;
 - (3) Stakeholder and family/guardian referrals; and
 - (4) Automatic in-reach trigger points the BH I/DD Tailored Plan shall establish.
 - (b) Provide age and developmentally appropriate education, including linkages to peer support services when appropriate and available, and ensure the member and the member's family members and/or guardians are accurately and fully informed about community-based options available.
 - (c) Facilitate and accompany the member and their family members and/or guardians on visits to community-based services.
 - (d) Identify and attempt to address barriers to relocation to a more integrated setting, including barriers related to housing.
 - (e) To the maximum extent possible, explore and address the concerns of the member and/or their family members or guardians who decline the opportunity to transition or are ambivalent about transitioning despite qualifying for supportive housing or other community services. Arrange for peer-to-peer meetings when appropriate to address concerns.
 - (1) For members who decline the opportunity to transition, the BH I/DD Tailored Plan shall:
 - i. Continue to engage the member and/or their family members or guardians about the opportunity to transition to a more integrated setting. Minimum frequency for ongoing in-reach engagement will be determined by the Department.
 - ii. Clearly document that the member's decision to not transition was based on informed choice. Documentation shall describe steps taken to fully inform the member of available community services, including supportive housing.
 - (f) Provide the member and/or the member's family members or guardians opportunities to meet with other individuals with SMI, SED, I/DD or TBI (as relevant to the member) who are living, working and receiving services in integrated settings.
 - (g) Identify any specific training that facility staff may benefit from to support smooth transitions, such as the type and availability of community services and supports that allow individuals with SMI, SED, I/DD or TBI to live in their home/community.
 - (h) For all members who have previously opted out of Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for providing information on the opportunity and process for opting back in.

- (i) For members residing in an ACH or state developmental center, and members age 18 and over residing in a state psychiatric hospital and who have been identified for transition, refer the member to a BH I/DD Tailored Plan transition coordinator, the member's care manager in the Tailored Care Management model, or DSOHF Admission Through Discharge Manager for transition services (see *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*) and ensure a timely, Warm Handoff to the transition staff or care manager in the Tailored Care Management model that the BH I/DD Tailored Plan assigns to the member.
- (j) For members age 18 and above admitted to a state psychiatric hospital, BH I/DD Tailored Plan-based peer support specialists shall coordinate with the member's care manager in the Tailored Care Management model on in-reach activities, if applicable.
- (k) Additional required activities for members who may be eligible for supportive housing:
 - (1) Ensure the member and their family members and/or guardians are accurately and fully informed about all available supportive housing options.
 - (2) Facilitate and accompany the member and their family members and/or guardians on visits to supportive housing settings.
- (iv) The BH I/DD Tailored Plan shall ensure the individual as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements* performs the following transition activities for members receiving services in a setting described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services*:
 - (a) Initiate and assume primary responsibility for ongoing planning for effective and timely transition and continuity of care upon referral from the BH I/DD Tailored Plan in-reach staff as designated in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*.
 - (b) Collaborate with the following individuals, specialists, and provider types as applicable depending on the member's needs, participating in all transition meetings, either by phone or in person to ensure effective and timely discharge and transition to community:
 - (1) The member and/or the member's family or guardian
 - (2) Facility providers
 - (3) Facility discharge planners
 - (4) The member's care manager
 - (5) The member's community-based PCP once selected
 - (6) Peer support specialist or other individuals determined to have appropriate shared lived experience
 - (7) Educational specialists
 - (8) Other community providers and specialists as appropriate in the transition planning process, including physical health providers, BH providers, and I/DD and/or TBI providers.
 - (c) Engage the member's community PCP and other providers as appropriate so that they are actively engaged in the transition planning process prior to member's discharge.
 - (d) Assist the member, prior to discharge, either by phone or in person, to select a qualified community PCP and clinical specialists as needed, including by assisting the member and/or their family members or guardians in developing interview questions to ask potential community providers when they are selecting providers.
 - (e) Collaborate with the member and/or the member's family members or guardians, Peer Support Specialists when available, facility providers, and other relevant community service providers to make arrangements for individualized supports and services needed to be in place upon discharge.
 - (f) Collaborate with the member and/or the member's family members or guardians, the facility provider, and selected community provider(s) prior to the member's discharge to identify and prioritize the most critical services necessary to address the member's specific needs, including complex BH, primary care and medical needs.

- (g) Schedule post-discharge appointments for critical services to occur in a timely manner based upon the member's identified needs and no later than seven (7) Calendar Days following discharge.
- (h) When applicable, collaborate with the facility to make a referral to NC START, or other applicable crisis prevention services, prior to discharge.
- (i) Assist the member and/or the member's family members or guardians in initiating selected community service options including but not limited to BH services.
- (j) Work with receiving providers and/or agencies if applicable, to identify if any specific training is needed by the receiving providers and/or agencies to ensure a seamless transition.
- (k) Address any identified barriers to discharge planning to the least restrictive and most integrated setting possible including but not limited to, network adequacy issues, transportation, housing assessment (including for risk of interpersonal violence), resource identification and referrals to qualified providers and care manager, and training of family or guardians and natural supports prior to the member's discharge.
 - (1) Assess settings that the member is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.
- (l) Explore and secure appropriate and available funding options and work through any potential funding needs with community providers such as managing spend downs, if needed, prior to discharge.
- (m) When applicable, work cooperatively with the facility provider to develop the necessary discharge service orders for post-discharge services required to meet the member's individual needs. Within three (3) Business Days of receipt of discharge service orders from the facility provider, make best efforts to secure authorization and/or denial of services requested to begin upon discharge.
 - (1) If services included in the discharge service order are not authorized or a community provider is not available, submit to the facility provider a written request for any necessary revisions to the discharge service order and/or identify alternative community providers within three (3) Business Days of receipt of discharge service order. Promptly provide additional information necessary to support the revised service order prior to the member's discharge.
 - (2) Make best efforts to ensure that the information contained in the discharge service order, the ninety (90)-day transition plan and the discharge summary are made available to the community providers who will be serving the member after discharge.
 - (3) Ensure the discharge service order, the transition plan and the discharge summary are made available to the organization providing Tailored Care Management if the member is eligible for Tailored Care Management.
- (n) For members residing in a state psychiatric facility whose Medicaid eligibility is in suspended status, work with the Department to ensure Medicaid eligibility is active upon or soon after discharge.
- (o) For members transitioning into an Innovations Waiver slot, ensure level of care assessment and the ISP are completed prior to discharge in accordance with Innovations Waiver requirements.
- (p) For members residing in state developmental centers: If needed, request an extension of Memorandum of Agreement in writing to the DSOHF Developmental Center Director prior to the discharge date outlining the reasons for the extension and anticipated length of extension needed.
- (q) DSOHF Admission Through Discharge Managers shall coordinate with BH I/DD Tailored Plan In-Reach Specialists, Transition Coordinators, System of Care Coordinator, and other relevant community service providers as determined needed by the DSOHF Admission Through Discharge Managers in cases involving members with complex needs or severe symptoms.
- (r) On the day of discharge:

- (1) Obtain a copy of the discharge plan and review the discharge plan with the member and/or the member's family members or guardians and facility staff.
 - (2) Assist the member in obtaining needed medications and ensure an appropriate care team member or facility staff conducts medication reconciliation/management and supports medication adherence.
- (s) Ensure effective and timely discharge and transition to appropriate community providers, in accordance with applicable laws, program requirements, and applicable policies and protocols established by the Department for the distinct member population served, and the discharge and transition responsibilities included in the Department contract including those set forth in this Section.
- (t) Following discharge, ensure the transition coordinator performs the following activities:
- (1) Ensure member is receiving needed transition-related services.
 - (2) Coordinate and facilitate thirty (30)-day post-discharge meetings with the member and the member's family members or guardians, the member's care manager and/or Child and Family Team (if applicable), and community provider(s) including NC START (if applicable) to promptly address any areas of concern identified following transition of the member from the facility to the community.
 - (3) Convene follow-up post-discharge meetings no less than every thirty (30) days until any issues or areas of concern are addressed.
- (u) Additional required activities for members who may be eligible for supportive housing:
- (1) Collaborate with the BH I/DD Tailored Plan's housing specialist to make arrangements for individualized supports and services needed to be in place upon discharge.
 - (2) Assist the member and/or the member's family members or guardians in initiating housing-related services and supports including but not limited to: locating and securing housing; ensuring the home environment is safe and move-in ready; and other ongoing tenancy supports that enable the member to maintain housing.
 - (3) Ensure the transition is completed within ninety (90) days of receiving a housing slot.
- (v) Additional required activities for members residing in a PRTF or Residential Treatment Levels II/Program Type, III, and IV, and members under age 18 residing in a state psychiatric hospital:
- (1) Convene the member's Child and Family Team and work with team, including the member's care manager, if applicable, to add new team members as needed to ensure an effective and timely transition.
 - (2) Engage the member's Child and Family Team through the entire transition planning process.
 - (3) Ensure PRTF Family Peer Partner is included in transition planning for members in a PRTF, when applicable.
 - (4) As required as part of Tailored Care Management (see *Section V.B.3.ii.(x) Ongoing Care Management*):
 - i. Provide the member and their family or guardian linkages to relevant state agencies and systems that support the development and well-being of children, including local school systems and child welfare systems.
 - ii. Provide the member and the member's family or guardian with linkages to community-based services and supports that address Unmet Health Related Resource Needs, including:
 - a) Disability benefits;
 - b) Food and income supports;
 - c) Transportation;
 - d) Education; and

- e) Services for justice-involved populations.
- (5) Collaborate with the member and their family or guardian and all relevant service providers to ensure needed individualized supports and services—including any school-related services, recreational and pro-social activities, supervision plans, and family supports—are in place upon discharge.
- (6) Work with the member and their family or guardian to assess and prepare the member's home so that it provides the member with a safe and appropriate community setting.
 - i. Assess settings that the member is transitioning to, using the checklist developed by the BH I/DD Tailored Plan and approved by the Department as described in *Section V.B.3.viii.(xiii) In-Reach and Transition Policy*.
- (7) Identify and address any barriers to active engagement of a member's family or guardian in transition planning.
- (8) Educate and train the member and the member's family or guardians on resource availability, and how to independently access resources to maintain self-sufficiency in caring for the member in the community.
- (9) If the member has no permanent family or guardian, work with supervising care manager to request that a Department of Social Services (DSS) guardian locate a permanent placement for the member and escalate to DSS supervising staff if permanent placement is not being pursued.
- (w) For members not already engaged in Tailored Care Management, the BH I/DD Tailored Plan shall assign members transitioning out of a facility to Tailored Care Management as described in *Section V.B.3.ii.(v) Tailored Care Management Assignment* upon referral from the transition coordinator and/or DSOHF Admission Through Discharge Manager prior to discharge unless the member is transitioning to another ICF-IID or is authorized for ACT or High-Fidelity Wraparound.
 - (1) The BH I/DD Tailored Plan shall ensure a Warm Handoff from a member's transition coordinator or DSOHF Admission Through Discharge Manager to the member's assigned care manager, ACT team, High-Fidelity Wraparound provider, or other entity providing care management.
 - (2) The Warm Handoff to the care manager providing Tailored Care Management shall take place upon discharge.
 - (3) The transition coordinator and DSOHF Admission Through Discharge Manager shall ensure the care manager providing Tailored Care Management meets with the member and/or the member's family members or guardians prior to discharge.
 - (4) The transition coordinator shall remain a part of the member's care team following the Warm Handoff until ninety (90) days post-discharge. During this time the transition coordinator shall remain available to the care manager providing Tailored Care Management for consultation.
 - (5) For specific requirements related to members transitioning into Innovations/TBI waivers, see *Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members enrolled in the Innovations or TBI Waiver*.
- (x) The BH I/DD Tailored Plan shall assign a member of the BH I/DD Tailored Plan clinical leadership (i.e., clinical Director-level or above) to attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm.
- (v) Staffing Requirements
 - (a) In-Reach Staffing Requirements

- (1) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the following parties are responsible for in-reach activities:
 - i. For members admitted to a PRTF or Residential Treatment Levels II/Program Type, III, and IV as defined in the Department’s Clinical Coverage Policy 8-D-2, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by the member’s care manager as part of the Tailored Care Management model.
 - ii. For members under age 18 admitted to a state psychiatric hospital, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by the member’s care manager as part of the Tailored Care Management model.
 - iii. For members admitted to an ACH and members age 18 and above admitted to a state psychiatric hospital, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based peer support specialist.
 - iv. For members admitted to a state developmental center, in-reach activities described in *Section V.B.3.viii.(iii)* shall be coordinated and/or performed by a BH I/DD Tailored Plan-based in-reach specialist.

- (b) Transition Staffing Requirements
 - (1) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the transition coordinator is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii.(iv)* for the following populations:
 - i. Members transitioning from a state psychiatric hospital to supportive housing, including members under age twenty-one (21),
 - ii. Members transitioning from an ACH into supportive housing, and
 - iii. Members transitioning from a state developmental center.

 - (2) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that the DSOHF Admission Through Discharge Manager is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii.(iv)* for members age twenty-one (21) and above transitioning from a state psychiatric hospital who are not transitioning to supportive housing.

 - (3) As described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, the BH I/DD Tailored Plan shall ensure that a member’s care manager is responsible for coordinating and/or performing transition activities described in *Section V.B.3.viii. (iv)* for the following populations:
 - i. Members transitioning from an ACH who are not transitioning into supportive housing,
 - ii. Members transitioning from a PRTF,
 - iii. Members transitioning from Residential Treatment Levels II/Program Type, III, and IV as defined in the Department’s Clinical Coverage Policy 8-D-2, and
 - iv. Members under age twenty-one (21) transitioning from a state psychiatric hospital who are not transitioning to supportive housing.

Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements

	Setting	Individual Responsible for Conducting In-Reach Activities	Individual Responsible for Conducting Transition Activities
1.	DSOHF Psychiatric Hospital	<p><i>Members Under Age 18:</i> Member’s Care Manager in Tailored Care Management model</p> <p><i>Members Age 18 and Above:</i> BH I/DD Tailored Plan-Based Peer Support Specialist</p>	<p><i>All Members Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based Transition Coordinator</p> <p><i>Members Under Age 21 Not Transitioning to Supportive Housing:</i> Member’s Care Manager in Tailored Care Management model</p> <p><i>Members Age 21 and Above Not Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based DSOHF Admission Through Discharge Manager</p>
2.	ACH	BH I/DD Tailored Plan-Based Peer Support Specialist	<p><i>Members Transitioning to Supportive Housing:</i> BH I/DD Tailored Plan-based Transition Coordinator</p> <p><i>Members <u>Not</u> Transitioning to Supportive Housing:</i> Member’s Care Manager in Tailored Care Management model</p>
3.	DSOHF Developmental Center	BH I/DD Tailored Plan-Based In-Reach Specialist	BH I/DD Tailored Plan-based Transition Coordinator
5.	PRTF	Member’s Care Manager in Tailored Care Management model	Member’s Care Manager in Tailored Care Management model
6.	Residential Treatment Levels II/Program Type, III, and IV	Member’s Care Manager in Tailored Care Management model	Member’s Care Manager in Tailored Care Management model

(c) Transition Supervisor Requirements

- (1) The BH I/DD Tailored Plan shall ensure that all BH I/DD Tailored Plan-based in-reach and transition staff working with members who are in or transitioning out of an institutional setting or ACH are supervised by a transition supervisor.

- (2) The BH I/DD Tailored Plan shall ensure transition supervisors have no caseload but will provide coverage for other in-reach and transition staff's vacation and sick leave.
- (3) The BH I/DD Tailored Plan shall ensure transition supervisors are responsible for providing guidance to Peer Support Specialists, In-Reach Specialists, Transition Coordinators, DSOHF Admission Through Discharge Managers, and care managers under the Tailored Care Management model working with individuals transitioning out of an institutional setting or an ACH.
- (4) The BH I/DD Tailored Plan shall ensure transition supervisors attend and participate in case discussions and transition planning for members with complex needs identified by facility clinical leadership, such as members with co-occurring disorders or a history of aggression and/or serious self-harm.
- (d) Additional Staffing Requirements for DSOHF Facilities
 - (1) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager to each DSOHF psychiatric hospital associated with the BH I/DD Tailored Plan's region.
 - (2) The BH I/DD Tailored Plan shall assign at least one (1) full-time DSOHF Admission Through Discharge Manager who will be responsible for serving its members across all DSOHF developmental centers.
 - (3) The BH I/DD Tailored Plan shall ensure that the total number of DSOHF Admission Through Discharge Managers is sufficient for fulfilling transition responsibilities for its members at DSOHF facilities.
- (e) For members for whom in-reach and transition activities are coordinated and/or performed by the member's care manager as part of the Tailored Care Management model as described in *Section V.B.3.h.v. Table 1. In-Reach and Transition Staffing Requirements*, but who have previously opted out of Tailored Care Management, the BH I/DD Tailored Plan shall be responsible for coordinating and/or performing in-reach and transition activities.
- (f) The BH I/DD Tailored Plan shall ensure all individuals responsible for conducting in-reach and transition activities report potential rights violations of Members residing in ACHs in accordance with General Statute 131D.
- (vi) In-Reach and Transition Staff Qualifications
 - (a) The BH I/DD Tailored Plan shall ensure that Peer Support Specialists serving members residing in an ACH or state psychiatric hospital have the following minimum qualifications:
 - (1) NC Certified Peer Support Specialist Program Certification, and
 - (2) Specific background and expertise working with people with SMI and their families or guardians, and
 - (3) Must be knowledgeable about community services and supports, including supportive housing.
 - (b) The BH I/DD Tailored Plan shall ensure that In-Reach Specialists serving members residing in a state developmental center have the following minimum qualifications:
 - (1) Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant human services area.
 - (2) Must be knowledgeable about community services and supports, including supportive housing.
 - (3) Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.
 - (c) The BH I/DD Tailored Plan shall ensure that DSOHF Admission Through Discharge Manager serving residents of DSOHF psychiatric hospitals have the following minimum qualifications:
 - (1) Master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), or bachelor's-

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

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

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

- (b) The scope of this policy includes all BH I/DD Tailored Plan members eligible for in-reach and transition services as described in *Section V.B.3.viii.(ii) Eligibility for In-Reach and Transition Services* and members residing in ICF-IIDs not operated by the state.
 - (c) The In-Reach and Transition Policy shall include the BH I/DD Tailored Plan’s policies and processes for implementing in-reach and transition requirements described in *Section V.B.3.viii. In-Reach and Transition from Institutional Settings*, including:
 - (1) Policies and procedures for outreach and engagement of members eligible to receive in-reach and/or transition services.
 - (2) Training plan for individuals responsible for conducting in-reach and transition activities.
 - (3) Approach for identifying and using available resources to address barriers to transitions to a more integrated setting and to support member transitions to more integrated settings.
 - (4) Additional required policies and processes for members residing in ICF-IIDs not operated by the state:
 - a) Staffing model for conducting in-reach and transition activities for members residing in ICF-IIDs not operated by the state. The model shall address supervision and oversight, minimum qualifications, training requirements, and caseload requirements for all in-reach and transition staff.
 - b) Approach for identifying, engaging, and collaborating with stakeholders on providing in-reach and transition services to members residing in ICF-IIDs not operated by the state.
 - c) Approach to expanding opportunities for community inclusion for members residing in ICF-IIDs not operated by the state.
 - (d) The In-Reach and Transition Policy shall include a checklist that individuals responsible for conducting transition activities will use to assess the safety and appropriateness of settings that BH I/DD Tailored Plan members will transition to when leaving an institutional setting or ACH. The Department will review and approve such checklists. This review process will ensure that assessments meet appropriate quality standards and are consistent across BH I/DD Tailored Plans.
- ix. Prevention and Population Health Programs
- (i) Roles and Responsibilities
 - (a) The BH I/DD Tailored Plan must take a population-based approach to improving the overall health of Medicaid members and work collaboratively with community partners on targeted public health initiatives (e.g., opioid crisis, infant mortality, mental health awareness, nicotine use prevention/cessation).
 - (b) The BH I/DD Tailored Plan shall establish prevention and population health programs aligned with the Department’s larger public health goals and Quality Strategy. 19 The Department will provide population-level measures to the BH I/DD Tailored Plan, such as measures related to infant and maternal mortality, that are intended to inform the BH I/DD Tailored Plan about regional trends and assist the BH I/DD Tailored Plan in performance improvement efforts.
 - (c) The BH I/DD Tailored Plan shall implement initiatives to increase access to medication-assisted treatment, including initiatives to increase the number of providers offering this treatment.
 - (d) The BH I/DD Tailored Plan shall ensure that AMH+ practices and CMAs, as well as care managers employed or contracted with the BH I/DD Tailored Plan, promote wellness and prevention by educating members about and referring them to BH I/DD Tailored Plan prevention and population health management programs and/or other programs addressing exercise,

¹⁹ North Carolina Medicaid Division of Health Benefits Quality Management and Improvement: <https://medicaid.ncdhhs.gov/quality-management-and-improvement>

nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, suicide prevention, tobacco cessation and self-help recovery, and other wellness services based on the member's needs and preferences.

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

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

- vi. Support programs focused on the treatment and transport to alternative sites of care for people with substance/opioid use disorder (e.g., community paramedicine)
 - vii. Plan to meet network adequacy for medication-assisted treatment for opioid use disorders as determined by the Department, including the standards laid out in the Attachment F. BH I/DD Tailored Plan Network Adequacy Standards for office based opioid treatment (OBOT), SA Comprehensive Outpatient (adult), SA Intensive Outpatient Program (adults and children), and Opioid treatment (adult).
 - viii. Provide non-emergency medical transportation for members to substance use disorder treatment, in alignment with *Section V.B.2.iv. Non-Emergency Medical Transportation*.
- (2) The program shall incorporate requirements in the Strengthen Opioid Misuse Prevention (STOP) Act²⁰ including quantity limits, mandatory electronic prescribing, utilization of the Controlled Substances Reporting System and reporting.
 - (3) The program shall use analytics to identify outlier opioid analgesic prescribers for education, coaching, and/or fraud investigation, as approved by the Department.
 - (4) Include secure storage initiatives such as prescription drug lockboxes and chemical medication disposal kits. Encourage and improve access to information about permanent medication drop box sites, take back days and other places to safely dispose of medications.
 - (5) The program shall describe goals and metrics as specified by the Department to report progress toward goals on at least a biannual basis. Required metrics to be finalized by the Department.
 - (6) The BH I/DD Tailored Plan shall develop an Opioid Misuse Prevention and Treatment Program Policy and submit it to the Department ninety (90) days after the Contract Award. The Opioid Misuse and Prevention Program is subject to Department review and approval, and the department may require changes. The Policy shall be made available on a public website and in the BH I/DD Tailored Plan's Provider Manual.
 - (7) Member lock-in program
 - i. The BH I/DD Tailored Plan's lock-in program criteria shall comply with the Department lock-in program criteria as defined in NC Gen. Stat. § 108A-68.2.
 - ii. The BH I/DD Tailored Plan shall not require members to be enrolled in the lock-in period for more than two (2) years without reassessing for continued eligibility in the program.
 - iii. The BH I/DD Tailored Plan shall report lock-in program outcomes, including but not limited to reduced ED visits and reduced opioid misuse, in a format to be developed by the Department.
 - iv. The BH I/DD Tailored Plan shall accept and enroll all individuals enrolled in NC Medicaid Direct or another BH I/DD Tailored Plan lock-in program in the BH I/DD Tailored Plan's lock-in program for the remaining duration of the lock-in period.
 - (iv) Additional Prevention and Population Health Programs
 - (a) The BH I/DD Tailored Plan shall actively participate in and support the Department's public health initiatives and coordinate with all existing public health and human services programs, including reporting, education and care management activities. That includes coordination with the following:
 - (1) Women, Infants and Children (WIC) Program

²⁰ The STOP Act, Session Law 2017-74, <https://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf>, was enacted by the NC General Assembly on June 29, 2017.

- i. The BH I/DD Tailored Plan shall identify members potentially eligible for the WIC program based on the following criteria, make referrals to the WIC program, and provide comprehensive application assistance to help members access the WIC program (as described in *Section V.B.3.ii. Tailored Care Management*) as needed:
 - a) Pregnant women;
 - b) Women up to six (6) months postpartum;
 - c) Breastfeeding women up to one (1) year postpartum;
 - d) Infants; and
 - e) Children under age five (5)
 - ii. The BH I/DD Tailored Plan shall establish relationships with the WIC entities.
 - iii. The BH I/DD Tailored Plan shall collaborate with the office of the state WIC director to establish a plan to coordinate these activities and share data as needed to accomplish joint program goals.
- (2) Newborn Screening Programs
- i. Consistent with NC Gen. Stat. §§ 130A-125 and 130A-130.2, the BH I/DD Tailored Plan shall comply with state law and regulatory requirements governing the Newborn Metabolic Screening and Follow-up Program and shall ensure that all lab testing for samples drawn for newborn screening under this statute be sent to the NC State Lab for processing.
 - ii. The BH I/DD Tailored Plan shall coordinate with the Department on the Management of Inborn Errors of Metabolism (IEM) Program and coverage of metabolic formula as defined in *Section VII. Attachment M.8. Management of Inborn Errors of Metabolism Policy for Medicaid and NC Health Choice Members*.
 - iii. The BH I/DD Tailored Plan shall establish a joint plan with the Department to implement reporting, education and care management activities regarding children who screen positive for hereditary and congenital disorders, including sickle cell anemia, during Contract Year 1 or a time period otherwise defined by the Department.
- (3) Newborn Hearing Screening Program
- i. Consistent with NC Gen. Stat. § 130A-125 and 10A NCAC 43F, the BH I/DD Tailored Plan shall comply with state law and regulatory requirements governing the Newborn Hearing Screening Program, including reporting to the Early Hearing Detection and Intervention (EHDI) Program at <https://wcs.ncpublichealth.com>.
 - ii. The BH I/DD Tailored Plan shall establish a joint plan with the Department to implement the requirements of hearing screening by one (1) month of age, diagnostic evaluation by three (3) months of age, and intervention by six (6) months of age during Contract Year 1 or a time period otherwise defined by the Department.
- (4) Vaccines for Children (VFC) Program and NC Immunization Registry
- i. Pursuant to Section 317(j) of the Public Health Service Act, 42 U.S.C. § 247b(j), the BH I/DD Tailored Plan shall provide education to providers on the VFC program and refer providers to the NCDPH Immunization Branch for enrollment requests and additional information.
 - ii. The BH I/DD Tailored Plan shall educate providers on the use of the NC Immunization Registry.
- (b) The BH I/DD Tailored Plan shall engage in public awareness campaigns, including federally and state-supported campaigns designed to reduce the stigma associated with BH, I/DD and TBI needs, promote prevention, wellness, healthy behavior and wellness campaigns.

- (c) The BH I/DD Tailored Plan shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, e-cigarettes, and other drugs) by members and to improve the emotional health and well-being of their members
- (d) The BH I/DD Tailored Plan will submit a plan annually for Departmental approval, as an appendix to its QAPI, which details how the BH I/DD Tailored Plan will ensure Hepatitis C and HIV screenings occur for members in accordance with Centers for Disease Control and Prevention (CDC) guidelines. See *Section V.B.5.i. Quality Management and Quality Improvement*.
- (v) Informing and Educating Members and Providers
 - (a) Members
 - (1) The BH I/DD Tailored Plan shall inform all members through the Member Handbook and through other mechanisms of the availability and accessibility of Prevention and Population Health Programs, including the use of program services.
 - (2) The BH I/DD Tailored Plan shall provide members with information regarding their participation eligibility, how to self-refer, and how to opt into or opt out of a program.
 - (3) The BH I/DD Tailored Plan shall have the option to notify the member's PCP and CMA (if applicable) of the member's participation in a Prevention and Population Health Program.
 - (b) Providers
 - (1) As part of the Provider Training Plan, the BH I/DD Tailored Plan is responsible for educating providers regarding the operation and objectives of all Prevention and Population Health programs. The BH I/DD Tailored Plan shall give providers instructions on how to access specific services and benefits.
 - (2) For those members receiving Prevention and Population Health Program support, the BH I/DD Tailored Plan will notify their PCP and CMA (if applicable) by letter, email, fax or secure web portal of their patient's involvement, unless the member notified the BH I/DD Tailored Plan not to inform their PCP and CMA (if applicable) as described above.
- x. Healthy Opportunities
 - (i) Working collaboratively with its BH I/DD Tailored Plans, the Department envisions establishing North Carolina as a national leader in optimizing the health and well-being for all by effectively stewarding resources that bridge our communities and our health care system to address all factors that impact health.
 - (ii) The Department has identified four (4) priority domains to address members' Unmet Health-Related Resource Needs: housing, food, transportation and interpersonal violence/toxic stress.
 - (iii) The BH I/DD Tailored Plan shall address these priority Healthy Opportunities domains and any other identified Unmet Health-Related Resource Needs to the maximum extent practical and appropriate in the context of Medicaid Managed Care, including with respect to:
 - (a) Tailored Care Management: The BH I/DD Tailored Plan shall establish care management competencies, workforce and procedures that enable the care team to comprehensively address members' identified Unmet Health-Related Resource Needs, including assessing and addressing such needs; referral, and navigation, and follow-up support to connect with community-based resources and social support services; comprehensive application assistance for the programs listed in *Section V.B.3.ii.(ix) Care Team Formation* for which the member is eligible; select health-related programs, including food assistance; and assistance connecting to resources related to housing, medical-legal partnerships, and employment opportunities and to medical-legal partnerships for legal issues adversely affecting health, subject to availability and capacity of medical-legal assistance providers. For full Tailored Care Management requirements, see *Section V.B.3.ii. Tailored Care Management*.

- (b) Quality: The BH I/DD Tailored Plan shall report on rates of completed screenings for Unmet Health-Related Resource Needs; conduct at least one (1) non-clinical performance improvement project annually; and incorporate a description of its contributions to health-related resources in its QAPI Plan. For full quality requirements, see *Section V.B.5.i. Quality Management and Quality Improvement*.
 - (c) VBP: As part of its Value-Based Payment (VBP) Strategy, the BH I/DD Tailored Plan shall submit a written plan to the Department that indicates how it will incorporate addressing Unmet Health-Related Resource Needs into its overall VBP strategy to align financial incentives and accountability around total cost of care and overall health outcomes. For full VBP requirements, see *Section V.B.5.ii. Value-Based Payments (VBP)*.
 - (d) Stakeholder Engagement: The BH I/DD Tailored Plan shall partner with community organizations, counties, the Department and other stakeholders to understand, support and connect members with resources available in the communities it serves, including those that address members' Unmet Health-Related Resource Needs. The BH I/DD Tailored Plan shall also play an integral role in the State's supportive housing approach, including by collaborating with other public and private agencies and Department housing staff. See *Section V.A.4. Stakeholder Engagement and Community Partnerships* for full requirements.
 - (e) In Lieu of Services: The BH I/DD Tailored Plan is encouraged to use In Lieu of Services to offer services that improve health through connecting members with or providing resources, social services and other supports upon receipt of the Department approval. For full In Lieu of Services requirements, see *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package*.
 - (f) Value-Added Services: The BH I/DD Tailored Plan is encouraged to use Value-Added Services to offer services that improve health through connecting members with or providing resources, social services and other supports upon receipt of the Department approval. For full Value-Added Services requirements, see *Section V.B.2.i. Physical Health, Behavioral Health, I/DD and TBI Benefits Package*.
 - (g) Contributions to Health-Related Resources: The BH I/DD Tailored Plan is encouraged to make contributions to health-related resources that help to address members' and their communities' Unmet Health-Related Resource Needs. See *Section V.B.7.ii. Medical Loss Ratio* and below in this Section for full requirements.
 - (h) Healthy Opportunities Pilot Program: BH I/DD Tailored Plans operating in a Pilot program Region shall implement the program for its Pilot-eligible enrollees, as described below in this Section.
- (iv) The BH I/DD Tailored Plan shall use North Carolina-developed tools to address the four (4) priority domains for Healthy Opportunities including:
- (a) Standardized Unmet Health-Related Resource Needs Questions: As part of Tailored Care Management, the BH I/DD Tailored Plan shall undertake best efforts to conduct a care management comprehensive assessment of every member eligible for Tailored Care Management, and a care needs screening for those members who actively opt out of care management or who are excluded from Tailored Care Management based on participation in a duplicative service, as defined in as described in *Section V.B.3.iii. Care Coordination and Care Transitions for all Members*. The comprehensive assessment and care needs screening shall include a set of Department-defined standardized questions to identify Unmet Health-Related Resource Needs in the priority Healthy Opportunities domains.
 - (b) NCCARE360: The BH I/DD Tailored Plan shall ensure that organizations providing Tailored Care Management use NCCARE360, once certified as fully functional, as described in *Section V.B.3.ii.(x) Ongoing Care Management*, to:

- (1) Act as their community-based organization and social service agency resource repository to identify local community-based resources.
 - (2) Identify community-based resources available on NCCARE360 and connect members to such resources; and
 - (3) Track closed loop referrals.
- (c) The BH I/DD Tailored Plan shall participate in regular meetings with the Department regarding their use of NCCARE360 during the implementation, onboarding, and training process to discuss progress, challenges, and best practices. The Department may release additional guidance on NCCARE360-related topics such as consent, privacy/security/confidentiality, reporting, and licensure.
- (d) North Carolina “Hot Spot” Map: The NC “Hot Spot” Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state. The BH I/DD Tailored Plan may use this tool to strategically guide contributions to health-related resources in the communities it serves. (The “Hot Spot” map is available at: <http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b>)
- (v) Contributions to Health-Related Resources:
- (a) The Department encourages the BH I/DD Tailored Plan to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the communities it serves.
 - (b) The BH I/DD Tailored Plan that voluntarily contributes to health-related resources may count the contributions towards the numerator of its Medical Loss Ratio (MLR), as described in *Section V.B.7.ii. Medical Loss Ratio*.
 - (c) The BH I/DD Tailored Plan is encouraged to identify opportunities to contribute to health-related resources in the QAPI plan. See *Section V.B.5.i. Quality Management and Quality Improvement*.
- (vi) Healthy Opportunities Pilots to Address Unmet Health-Related Resource Needs
- (a) Background
 - (1) CMS has authorized an Enhanced Case Management and Other Services Pilot, the “Healthy Opportunities Pilot program,” for a five (5)-year period, from November 1, 2019, through October 31, 2024, as a part of North Carolina’s Section 1115 Medicaid Demonstration waiver.
 - (2) Through the Healthy Opportunities Pilot program, the Department will systematically test, on a population level, how evidence-based interventions in each of the four (4) Healthy Opportunities priority domains (housing, food, transportation, and interpersonal violence/toxic stress) can be delivered effectively to Medicaid members and, through robust evaluation, study the effects on health outcomes and cost of care. The goal of the Pilot program is to learn which evidence-based interventions and processes are most effective to improve health, lower health care costs for specific populations, and to inform health care delivery statewide.
 - (3) Through a competitive procurement process, the Department will procure up to three (3) Lead Pilot Entities and define Healthy Opportunities Pilot Regions in the State to provide a subset of Medicaid beneficiaries with services, interventions and benefits targeted to measurably improve health and lower costs.
 - (4) A local Pilot Region may include a subset of counties within a BH I/DD Tailored Plan Region, and may cross BH I/DD Tailored Plan Region boundaries.
 - (5) The Lead Pilot Entity’s primary role is to develop, contract with and manage a network of Human Service Organizations (HSOs) to deliver the evidence-based Pilot interventions

across each of the four (4) Healthy Opportunities priority domains for Medicaid members within the Pilot Regions.

- (b) BH I/DD Tailored Plan Pilot Program Responsibilities. Any BH I/DD Tailored Plan operating in a local Pilot Region shall implement the Pilot program for its Pilot-eligible members, contingent on the availability of state and federal funding, in accordance with the roles and responsibilities enumerated below and in any additional requirements and guidance issued by the Department:
- (1) Receive payments from the Department up to a specific capped allotment to fund Pilot services, based on the anticipated cost and volume of specified services authorized for the BH I/DD Tailored Plan's eligible members, and recognizing the overall cap on federal funds under the 1115 waiver. This allotment will be in addition to and not included in the Medicaid Managed Care capitation payments.
 - (2) Manage total Pilot funding against allocations for eligible populations and Pilot services.
 - i. The Department may provide further requirements and/or guidance to ensure that Pilot services are targeted to the Pilot-eligible Medicaid members for whom Pilot services may most efficiently improve outcomes and/or reduce costs and that Pilot participants receive the least costly, most necessary and appropriate Pilot services.
 - (3) Make payments to other Pilot-participating entities for executing Pilot responsibilities and for delivering Pilot services from the Pilot allocations, consistent with guidance to be developed by the Department.
 - (4) Determine eligibility for and authorize Pilot program enrollment and specific Pilot services for members, based on guidelines to be developed by the Department.
 - i. Pilot program eligibility criteria include, at a minimum, physical and BH qualifying conditions and social risk factors as defined in the 1115 waiver. Each Pilot service may also have specific eligibility criteria determined by the Department.
 - (5) Ensure that Pilot services do not displace nor duplicate other services, resources or programs for which the member is eligible, including Medicaid State Plan services, Medicaid waiver services, State-funded Services provided by the BH I/DD Tailored Plan, or other resources or programs available to the member, including those provided by the BH I/DD Tailored Plan.
 - i. The Department shall provide guidance to BH I/DD Tailored Plans regarding which services, resources and programs have been identified by the Department as duplicative with Pilot program services. The BH I/DD Tailored Plan may add to the Department's list of potentially duplicative or displaceable services, resources and programs as part of the Pilot authorization approach, based on its knowledge and experience. The BH I/DD Tailored Plan shall provide this list to the Department upon request.
 - ii. The BH I/DD Tailored Plan shall define and implement policies and procedures for authorizing Pilot services as part of its UM program, consistent with *Section V.B.2.i.(v) Utilization Management*, that provide for:
 - a) Validation that no identified other service, resource or program, including those managed by the BH I/DD Tailored Plan, would meet the member's Pilot service needs is available to the member at the time of Pilot service authorization, consistent with Department guidance.
 - b) Validation that the member's Pilot service needs cannot be fully addressed through an identified, available federal, State or local program (e.g., the Supplemental Nutrition Assistance Program), consistent with Department guidance, at the time of Pilot service authorization.

- c) If a federal, State or local program is available that could address the member's Pilot service needs in full or in part, the authorization process must ensure that Tailored Care Management requirements, as outlined in *Section V.B.3.ii. Tailored Care Management*, that require connecting the member with those services, including in some cases through comprehensive application assistance, have been fulfilled.
 - d) The BH I/DD Tailored Plan's Pilot service authorization process must include verification of connection to and/or the provision of comprehensive application assistance to relevant available programs, where applicable.
 - e) The BH I/DD Tailored Plan may not authorize Pilot services once the member is receiving services from another federal, state or local program, if that program fully meets the member's Pilot service need.
 - f) Training for staff conducting Pilot service authorization specific to preventing duplication and displacement of BH I/DD Tailored Plan-managed and other available services, resources and programs with Pilot services.
 - g) Regular, at least monthly, audits of Pilot service authorization procedures and outcomes to prevent duplication or displacement of BH I/DD Tailored Plan-managed and other available services, resources and programs with Pilot services.
- iii. The BH I/DD Tailored Plan shall:
- a) Make Pilot service authorization policies and procedures available to the Department upon request.
 - b) Retain documentation of member-level Pilot service authorization determinations, including validation that no identified duplicative or displaceable service, resource or program, including those managed by the BH I/DD Tailored Plan, that could meet the member's Pilot service need was available to the member at the time of Pilot service authorization for the time period specified in *Section III.C.39: Records Retention*.
 - c) Make member-level Pilot service authorization documentation available to the Department upon request, including for monitoring and audits, in accordance with *Section III.D.40. Response To State Inquires And Request For Information*.
- (6) Contract with any Lead Pilot Entity operating within the BH I/DD Tailored Plan Region for the use of the Lead Pilot Entity's HSO network for delivery of Pilot services to eligible members residing in the local Pilot Region.
- (7) Submit data and reports to support the Department's efforts to oversee and evaluate the Pilot program, as described in *Section V.B.3.x.(vi) Healthy Opportunities Pilots to Address Unmet Health-Related Resource Needs: Reporting Requirements* and *Section VII. Attachment J. Reporting Requirements*.
- (8) Participate in learning collaboratives with the Department and other Pilot-participating entities to share best practices and improve Pilot program policies and practices.
- (9) Support the Department's efforts to evaluate the effectiveness of the Pilot program by reporting on a range of metrics in a form and frequency to be determined by the Department, and as described in *Section VII. Attachment J. Reporting Requirements* including but not limited to reports on:
- i. Pilot enrollment;
 - ii. Pilot service utilization;
 - iii. Pilot expenditures;
 - iv. Pilot-participating member health outcomes;

- v. Pilot-participating member cost and utilization metrics; and
 - vi. Expenditures on and utilization of services and other resources managed by the BH I/DD Tailored Plan that may be duplicated or displaced by Pilot services, as identified in guidance to be developed by the Department, by members residing in local Pilot Region counties.
- (c) Care Manager Pilot Program Responsibilities. The BH I/DD Tailored Plan shall utilize care managers to execute key Pilot program functions. Care managers with Pilot program responsibilities may be employed by or under contract with the BH I/DD Tailored Plan, or an AMH+, CMA, Local Health Department (for some members excluded from Tailored Care Management) or High-Fidelity Wraparound (for some members excluded from Tailored Care Management). The BH I/DD Tailored Plan shall ensure that care managers assigned to members residing in Pilot program Regions:
- (1) Evaluate members using a forthcoming Department-developed Pilot Program Eligibility and Assessment form to assess whether they meet baseline Pilot eligibility criteria.
 - (2) Integrate a member's need for, authorization of, referral to and status of Pilot services into the member's Care Plan or ISP.
 - (3) Secure determination of Pilot program enrollment and authorization of Pilot services from the BH I/DD Tailored Plan.
 - (4) Obtain authorized members' Pilot program participation consent, including related to enrollment, Pilot services and information sharing, based on guidance to be developed by the Department.
 - (5) Communicates approved Pilot enrollment determination and service authorization to members.
 - (6) Refer members approved for Pilot program enrollment and specific Pilot services to HSOs in the Lead Pilot Entity's network for approved Pilot services and track Pilot services delivered to Pilot participants by conducting "closed-loop referrals," using the NCCARE360 platform.
 - (7) Conduct a reassessment of:
 - i. Eligibility for specific Pilot services no less frequently than every three (3) months, or earlier if a member experiences a change in eligibility for an identified service, resource or program that can meet the member's Pilot service need, including those managed directly by BH I/DD Tailored Plans; and,
 - ii. Eligibility for the Pilot program and services no less frequently than every six (6) months.
 - (8) Support the Department's Pilot program oversight and evaluation efforts by providing information and data on Pilot participants and Pilot program operations in accordance with guidance to be developed by the Department.
 - (9) Meet any other Pilot-related requirements outlined by the Department.
- (d) For members excluded from Tailored Care Management and residing in Pilot program Regions, the BH I/DD Tailored Plan shall:
- (1) Conduct the above Pilot-related care manager responsibilities directly for those members obtaining ACT services;
 - (2) Require that the above Pilot-related care manager responsibilities are conducted by the LHD for members receiving CMARC and excluded from Tailored Care Management; and
 - (3) Require that the above Pilot-related care manager responsibilities are conducted by the High-fidelity Wraparound team for members receiving High-fidelity Wraparound services.
 - (4) Exclude individuals receiving ICF-IID services from Pilot program eligibility, following Pilot eligibility and enrollment procedures to be defined in Department guidance.

- xi. Relocation of Members Following Emergency Residential Care Facility Closures
 - (i) The Department understands that the safe and prompt relocation of members residing in licensed residential care facilities that suddenly close requires coordination across multiple Divisions, local services agencies and BH I/DD Tailored Plans.
 - (ii) The BH I/DD Tailored Plan shall assist the transition of care and relocation of members in licensed residential care facilities subject to Emergency Closure in accordance with the Department’s Operational Guide for a Coordinated Response to a Sudden Closure of an Adult Residential Care Facility, or as otherwise defined by the Department.²¹
 - (iii) Emergency Closures of Adult Care Homes:
 - (a) The Department has developed an intra-Departmental Emergency Closures “Adult Care Home (ACH) Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of ACHs in order to safely relocate displaced residents and includes Department divisions—DHSR, DAAS and DMH/DD/SAS—BH I/DD Tailored Plans, Standard Plans, county DSS and the Regional Long Term Care Ombudsman Program these are housed within the Area Authorities on Aging).
 - (b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closures “Adult Care Response Hub” upon notification of an Emergency Closures of a licensed group home where members reside.
 - (c) The BH I/DD Tailored Plan shall be responsible for relocating members following Emergency Closures of adult care homes and coordinating with the local DSS on the following activities:
 - (1) Conduct a site visit of the ACH that is closing;
 - (2) Identify members who are residents;
 - (3) Meet with members and/or guardians;
 - (4) Implement a relocation plan for members;
 - (5) Link members to services as appropriate;
 - (6) Review member medication needs and manage personal items;
 - (7) Participate in daily morning situation calls;
 - (8) Submit discharge information to local DSS contact person;
 - (9) Follow up with relocated members; and
 - (10) Participate in debrief conference call after the closure.
 - (iv) Emergency Closures of Group Homes
 - (a) The Department has developed an intra-Departmental Emergency Closures “Group Home Response Hub” that is activated on an ad-hoc basis to respond to Emergency Closures of group homes in order to safely relocate displaced residents. The “Group Home Response Hub” is comprised of the following Divisional partners: DHSR, DMH/DD/SAS, DHB and DAAS.
 - (b) The BH I/DD Tailored Plan shall coordinate with the Department’s Emergency Closure “Group Home Response Hub” upon notification of an Emergency Closure of a licensed group home where members reside.
 - (c) The BH I/DD Tailored Plan shall be responsible for relocating members following Emergency Closures of group homes including:
 - (1) Conduct a site visit of group home that is closing;
 - (2) Identify members who are residents;
 - (3) Meet with members and/or guardians;
 - (4) Implement relocation plan for members;
 - (5) Link members to services as appropriate;

²¹ The Department’s Operational Guide for a Coordinated Response to the Sudden Closure of an Adult Residential Care Facility is available here: https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/acrf_operational_guide.pdf

- (6) Review member medication needs and manage personal items;
- (7) Participate in daily morning situation calls;
- (8) Submit discharge information to the Department;
- (9) Follow up with relocated members; and
- (10) Participate in debrief conference call after the closure.

4. Providers

i. Provider Network

- (i) Providers are the backbone of North Carolina’s Medicaid and NC Health Choice Program and the Department has a rich tradition of partnering with the provider community to support the Department’s overall vision of creating a healthier North Carolina. The Department seeks BH I/DD Tailored Plans that share and support that tradition.
- (ii) The Department seeks a BH I/DD Tailored Plan with a robust Network to meet the medical, BH, I/DD, TBI, LTSS, and pharmacy needs of all members within its Region, including those with limited English proficiency, physical disability, or BH I/DD needs. The BH I/DD Tailored Plan shall demonstrate that its Network meets Department’s availability, access, quality goals, and requirements and is willing to act to continuously improve its delivery of health care services to members.
- (iii) Availability of Services (42 C.F.R. § 438.206)
 - (a) The BH I/DD Tailored Plan shall establish and maintain a Network that is sufficient to ensure that all services covered under the Contract are available and accessible to all members in a timely manner, including those members with limited English proficiency or physical or mental disabilities. The BH I/DD Tailored Plan shall enter into a written contract with each Network provider, the terms of which are further specified herein.
 - (b) The BH I/DD Tailored Plan shall meet all federal and state provisions for availability, including:
 - (1) Providing for a second opinion from a Network provider or arrange for the member to obtain an opinion from an out-of-network provider at no cost to the member if requested by the member, provided that the out-of-network provider is not excluded from participation in federal health care programs and subject to the UM program requirements if applicable. The BH I/DD Tailored Plan shall clearly state its procedure for obtaining a second opinion in its Member Handbook.
 - (2) Adequately and timely covering services out-of-network for a member if the BH I/DD Tailored Plan’s network is unable to provide the covered service within its current Network, taking into account the urgency of the need for services. BH I/DD Tailored Plan shall cover the member’s out-of-network services for the duration of the Network’s inability to provide them in network.
 - (3) Ensuring that no incentive is given to providers, monetary or otherwise, for withholding medically necessary services.
 - (4) Coordinating payment for services to out-of-network providers and ensuring the cost to the member is not greater than it would be if the services were furnished by a Network provider.
 - (5) Ensuring there are sufficient family planning providers to ensure timely access to covered services.
 - (6) Providing female members with direct access to a women’s health specialist within the Network for covered care necessary to provide women’s routine and preventive health care services; this shall be in addition to the member’s designated provider of primary care if that provider is not a women’s health specialist.
 - (c) Tribal Member Services and Indian Health Care Providers (42 C.F.R. § 438.14)

- (1) The BH I/DD Tailored Plan shall make good faith efforts to contract with Indian Health Care Providers (IHCPs) and demonstrate that a sufficient number of IHCPs are participating in its network to ensure timely access to contracted services for the members of federally recognized tribes and other individuals eligible to receive services at IHS facilities.
 - (2) The BH I/DD Tailored Plan shall allow any members eligible to receive services from an IHCP to choose the IHCP, without contract, as the member's PCP if the IHCP has the capacity to provide PCP services. The BH I/DD Tailored Plan shall consider any referral from such IHCP acting as the member's PCP to a Network provider as satisfying any coordination of care or referral requirement of the Contract, as described in *Section V.A.4.i. Engagement with Tribes for Medicaid Only*.
 - (3) The BH I/DD Tailored Plan shall provide members eligible to receive covered services from an IHCP with direct access, defined as no referral or prior authorization required, to the IHCP.
 - (4) The BH I/DD Tailored Plan shall permit members to obtain services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.
 - (5) If the BH I/DD Tailored Plan cannot provide timely access to necessary services in state and/or in-network for Tribal members, the BH I/DD Tailored Plan must provide access to out-of-state and/or out-of-network IHCPs.
 - (6) The BH I/DD Tailored Plan must refer Tribal members to IHCPs and other sources of Culturally and Linguistically Competent care as determined by the Department. The BH I/DD Tailored Plan enrolling Tribal populations shall provide training for Culturally and Linguistically Competent care to all of its Network providers.
 - (7) The BH I/DD Tailored Plan shall permit out-of-network IHCPs to make referrals to Network providers for any of its members without prior authorization or a referral from a Network provider.
 - (8) The BH I/DD Tailored Plan shall permit IHCPs to refer its member to any provider within the IHCP Purchased and Referred Care network, even if the provider is not a Network provider, without having to obtain prior authorization or a referral from a Network provider.
 - (9) The BH I/DD Tailored Plan shall not impose any enrollment fee, premium, deductible, copayment, or similar cost sharing on any member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization, or through referral under contracted health services.
- (d) Outpatient Commitment
- (1) The BH I/DD Tailored Plan shall ensure the availability of qualified providers of services provided under Outpatient Commitment to members who are respondents to Outpatient Commitment proceedings and meet the criteria for Outpatient Commitment.
 - (2) Consistent with the requirements in N.C. Gen. Stat. § 122C-263, the BH I/DD Tailored Plan shall be able to accept a copy of the Outpatient Commitment order for members who are served by Network outpatient treatment physicians and centers.
 - (3) The BH I/DD Tailored Plan shall require network providers of services provided under Outpatient Commitment to a member to notify the BH I/DD Tailored Plan of the Outpatient Commitment order upon receipt.
 - (4) Once the BH I/DD Tailored Plan is notified of a member's Outpatient Commitment order, the BH I/DD Tailored Plan shall provide care management services for its members who are under an Outpatient Commitment order in accordance with *Section V.C.3. Care Management and Prevention*.
- (e) Pharmacy Services

- (1) The BH I/DD Tailored Plan shall ensure its pharmacy Network meets the time or distance standards defined in *Section VII. Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*, as amended by the Department from time to time.
 - (2) The BH I/DD Tailored Plan shall maintain a Pharmacy Provider Network Audit Program. The BH I/DD Tailored Plan shall submit the program to Department for approval ninety (90) days after Contract Award and annually thereafter.
 - (3) The BH I/DD Tailored Plan shall not require members to accept mail order pharmacy services unless mail order is the only dispensing channel for a drug. The BH I/DD Tailored Plan may allow members to choose to receive prescribed drugs through mail order pharmacy services.
 - (4) The BH I/DD Tailored Plan shall submit its Mail Order Program Policy, including a sample of all member mail order-related correspondence, to the Department for approval ninety (90) days after Contract Award and annually thereafter. The BH I/DD Tailored Plan shall specifically identify any pharmacy service where mail order is the only dispensing channel for a drug.
 - i. The request for approval must be submitted in accordance with the Implementation Plan.
 - ii. The BH I/DD Tailored Plan must submit any Significant Changes to its mail order program to Department for approval at least ninety (90) Calendar Days before implementation target date of the change.
 - (5) The BH I/DD Tailored Plan may contract with a limited specialty pharmacy network if the BH I/DD Tailored Plan demonstrates that:
 - i. A specialty drug is only available through a limited network of pharmacies; and
 - ii. The specialty pharmacy has clinical and care coordination programs that improve medication adherence and drug therapy outcomes.
 - (6) BH I/DD Tailored Plan may contract with 340B covered entities. Drugs purchased through the 340B program shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus dispensing fee as defined in *Section V.B.2.iii. Pharmacy Benefits*.
- (f) Telehealth, Virtual Patient Communications and Remote Patient Monitoring Services
- (1) The BH I/DD Tailored Plan may use Telehealth, Virtual Patient Communications and Remote Patient Monitoring as tools for facilitating access to needed services in a clinically appropriate manner that are not available from providers in the Network and in accordance with the BH I/DD Tailored Plan's Telehealth, Virtual Patient Communications and Remote Patient Monitoring Coverage Policy, as per *Section V.B.2.Benefits*.
 - (2) The BH I/DD Tailored Plan shall be permitted to leverage Telehealth in its Request for Exception to the Department's BH I/DD Tailored Plan Network adequacy standards, as clinically appropriate.
 - (3) The BH I/DD Tailored Plan shall not require a member to receive services from Telehealth, Virtual Patient Communications and Remote Patient Monitoring and must allow the member to access an in-person service from an out-of-network provider, if the member requests.
 - (4) Access to Telehealth providers does not count toward meeting Network adequacy standards, unless approved as part of an exception to Network requirements.
- (g) Innovations and Traumatic Brain Injury Waiver Services
- (1) The BH I/DD Tailored Plan shall ensure that Innovations providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and requirements set forth by the Department.

- (2) The BH I/DD Tailored Plan shall ensure that TBI waiver providers comply with HCBS standards as set forth in 42 CFR 441.301(c)(4) and requirements set forth by the Department.
 - (3) Provider agencies shall comply with the applicable provider specifications for services set forth in the TBI and the Innovations waivers.
 - (4) For Beneficiaries enrolled in the Tribal Option for primary care case management who also receive services through the Innovations waiver, Innovations waiver services shall be provided by the BH I/DD Tailored Plan operating in Region 1. The BH I/DD Tailored Plan shall coordinate with the Tribal Option to ensure the receipt and coordination of appropriate services
 - (5) National accreditation is required of most providers of Innovations and TBI waiver services per the NC Innovations and TBI waivers. Upon contracting with the BH I/DD Tailored Plan, the organization must have achieved national accreditation with at least one of the designated accrediting agencies if required by the waiver(s). The organization must be established as a legally constituted entity capable of meeting all of the requirements of the BH I/DD Tailored Plan.
- (h) SUD Residential Treatment Services
- (1) BH I/DD Tailored Plans shall comply with the SUD residential treatment provider provisions for provider contracts found in *Section VII. Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*.
 - (2) The Department will establish network adequacy standards for SUD residential treatment services prior to BH I/DD Tailored Plan launch.
- (iv) Furnishing of Services (42 C.F.R. § 438.206(c))
- (a) The BH I/DD Tailored Plan shall meet the network time or travel distance, and appointment wait time standards established by the Department as described in *Section VII. Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*, unless otherwise approved by the Department in accordance with the requirements herein.
 - (1) The BH I/DD Tailored Plan shall monitor Network providers regularly to determine compliance with the timely access requirements.
 - (2) The BH I/DD Tailored Plan shall take corrective action if it, or its Network providers, fail to comply with the timely access requirements.
 - (3) The Department is studying the application of provider-patient ratios and may implement ratios by Region. The Department shall provide the BH I/DD Tailored Plan one hundred twenty (120) Calendar Days prior notice of the ratio requirements.
 - (4) The Department may amend the network time or travel distance, appointment wait time, or other adequacy standards from time-to-time. BH I/DD Tailored Plan shall comply with the new standards as directed, but with no less than a ninety (90) Calendar Day prior notice.
 - (b) The BH I/DD Tailored Plan shall meet and require its Network providers meet the Department standards for timely access to care and services, taking into account the urgency of need for services.
 - (c) The BH I/DD Tailored Plan shall ensure that Network providers offer hours of operation that are not less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service, if the provider serves only Medicaid or NC Health Choice.
 - (1) The Department may require after hours and weekend hours to address the needs of the member.
 - (d) The BH I/DD Tailored Plan shall ensure that covered services are available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

- (e) The BH I/DD Tailored Plan shall ensure that Network providers provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for all members with physical disabilities or BH I/DD needs.
- (f) The BH I/DD Tailored Plan shall promote the delivery of services by Network providers in a Culturally and Linguistically Competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, deafness and who are deaf or hard of hearing, and regardless of gender, sexual orientation or gender identity.
 - (1) The BH I/DD Tailored Plan shall assist providers with meeting these requirements, including educating providers on the availability of the Cultural and Linguistic Competency resources, accessing the resource, and responsibility in providing access to interpreter services and having sufficient interpreter capacity.
 - (2) The BH I/DD Tailored Plan shall be prohibited from using any State or federal funds to pay for reparative/conversion therapy for non-heterosexual sexual orientations in accordance with North Carolina Executive Order No. 97 and clinical coverage policies.
 - (3) The BH I/DD Tailored Plan shall ensure that Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) members who obtain covered services are not subject to treatment that does not affirm their orientation.
- (g) the BH I/DD Tailored Plan is encouraged to contract with providers outside of the BH I/DD Tailored Plan's Region to ensure services to meet member's accessibility needs.
 - (1) An individual member's accessibility and BH I/DD Tailored Plan's network adequacy may be satisfied, in part, by contracting with providers across a regional border where appropriate.
- (v) Essential Providers
 - (a) The BH I/DD Tailored Plan shall include all Essential Providers located in the BH I/DD Tailored Plan's Region in its Network unless an alternative arrangement for securing the types of services offered by the Essential Providers is approved by the Department in accordance with the requirements herein.
 - (1) Essential Providers include federally qualified health centers, rural health centers, free clinics, local health departments, and any other providers as designated by the Department. N.C. Gen. Stat. § 108D-22(b),
 - (2) Except for a Veterans Home, a BH I/DD Tailored Plan must submit a request for an alternative arrangement relating to any Essential Provider with whom the BH I/DD Tailored Plan has failed to contract.
 - (3) The BH I/DD Tailored Plan shall contract with newly identified Essential Providers within 90 calendar days of notification of the addition of a new Essential Provider. If at the end of the 90 days a contract with the Essential Provider has not been established, the BH I/DD Tailored Plan shall submit a request for an alternative arrangement relating to the Essential Provider.
 - (b) At such time the BH I/DD Tailored Plan is notified by the Department that a member is determined eligible for and transferred for treatment to a Department of Military and Veterans Affairs (DMVA)-operated Veterans Home, the BH I/DD Tailored Plan shall include the Veterans Home operated by the DMVA in its Network as an Essential Provider and shall reimburse the veterans home at the rates established by the Department until such time as the member is disenrolled as provided in the Contract.
- (vi) Exceptions to Network Requirements
 - (a) Network adequacy measures ensure the BH I/DD Tailored Plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, and all health care services included under the terms of the Contract. Recognizing that there are circumstances which cannot be remedied by the BH I/DD Tailored

Plan alone (e.g., not all counties in North Carolina have a hospital), the Department will permit exceptions to network requirements in a time-limited manner.

- (b) The BH I/DD Tailored Plan may request approval for an alternative arrangement in contracting with an Essential Provider by submitting a written request to the Department with a copy of the request provided to the Essential Provider prior to implementing any alternative arrangement and prior to notifying an Essential Provider of an adverse contracting decision. An alternative arrangement request must:
 - (1) Be made for each Essential Provider that the BH I/DD Tailored Plan is proposing to not contract with;
 - (2) Describe efforts to negotiate in good faith;
 - (3) Include justification for the alternative arrangement with a description of how the alternative arrangement will meet member needs; and
 - (4) Include the BH I/DD Tailored Plan's approach to address member needs and remedy the need for the alternative arrangement including a suggested time line for implementation.
 - (c) In accordance with 42 C.F.R. § 438.68(d)(1), the BH I/DD Tailored Plan may request Department approval for an exception to meeting the Department's BH I/DD Tailored Plan network adequacy standards in a specific Region for a specific provider type. Requests must:
 - (1) Be made in writing;
 - (2) Describe efforts to negotiate in good faith;
 - (3) Include justification for the exception and a description of how member needs for the specific Region and provider type will be met; and
 - (4) Include the BH I/DD Tailored Plan's plan to address member needs and remedy the network deficiency, including an estimated time line to close the network gap.
 - (d) The Department's approval of an exception request to the BH I/DD Tailored Plan network adequacy standards or an Essential Provider alternative arrangement will be limited to specific time frame. Forty-five (45) Calendar Days before an exception/alternative arrangement is set to expire, the BH I/DD Tailored Plan shall submit a new request for the exception or alternative arrangement or inform the Department the exception and alternative arrangement is no longer needed.
 - (e) The Department is not required to approve a request for an alternative arrangement with an Essential Provider or exception to meeting the Department's BH I/DD Tailored Plan network adequacy standards and may deem a BH I/DD Tailored Plan to be out of compliance.
- (vii) Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)
- (a) The BH I/DD Tailored Plan shall develop a Network Access Plan and provide documentation that demonstrates that it has the capacity to serve the expected enrollment in its entire Region in accordance with the Department's BH I/DD Tailored Plan Network adequacy standards (as found *Section VII. Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid*), state and federal law, and the terms of this Contract.
 - (1) The BH I/DD Tailored Plan's Network Access Plan must:
 - i. Demonstrate compliance, or submit plans for compliance before launch of BH I/DD Tailored Plans, with all the following components:
 - a) Offers an appropriate range of preventive, primary care, specialty, BH I/DD, TBI, LTSS, and pharmacy services that is adequate for the anticipated number of members for the Region.
 - b) Maintains a Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the Region, including Tribal members.
 - ii. Include procedures to address the following:

- a) Referrals;
- b) Disclosures and notices to members of BH I/DD Tailored Plan services and features;
- iii. Coordination and continuity of care; and
- iv. Transition of Care that complies with Department requirements set forth in *Section V.B.1.iv. Transition of Care*.
- v. Demonstrate the BH I/DD Tailored Plan's efforts to:
 - a) Address the needs of all members, including those with limited English proficiency or illiteracy;
 - b) Address the needs of Historically Marginalized Populations;
 - c) Ensure that Network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities;
 - d) Assist the Department, as directed, to assess the capacity of select providers to ensure that members residing in these facilities have access to remote communication options and devices to be used for communication with family and providers, including Telehealth and telephonic options, in cases of emergencies, where in-person visitation is restricted. Select providers include:
 - 1) Nursing homes licensed under 10A NCAC 13D
 - 2) Community ICF-IIDs licensed under 10A NCAC 27G .2100
 - 3) Behavioral health residential treatment facilities licensed under 10A NCAC 27G .1300, .1700, .3100, 3200, .3400, .4100, .4300, .5600
 - 4) Adult care homes licensed under 10A NCAC 13F and 13G
 - e) Support and sustain providers, including hospitals, in rural and other traditionally underserved areas, as well as providers representative of Historically Marginalized Populations; and
 - f) Reach agreements with local education agencies that are responsible for providing the education within child and adolescent day treatment programs. This may include, but is not limited to, the list of school districts with which the BH I/DD Tailored Plan has an agreement for day treatment and how these agreements provide adequate coverage.
- vi. Include the BH I/DD Tailored Plan's:
 - a) Efforts to establish a Network that meets the Department's BH I/DD Tailored Plan Network adequacy standards.
 - b) Quantifiable and measurable process for monitoring and assuring the sufficiency of the Network to meet the health care needs of all members on an ongoing basis, including the frequency of the monitoring. The frequency of monitoring shall be at least once a month.
 - c) Factors used to build the Network, including a description of the Network and how the BH I/DD Tailored Plan uses the Medicaid Enrolled Provider Data supplied by the Department or the Department's vendor in its network development and provider contracting process and how the BH I/DD Tailored Plan makes network contacting decisions on providers of BH, I/DD, and TBI services.
 - d) Process and methodology to understand the distribution of member health care needs against available providers and provider capacity to serve those needs.
 - e) Plan to provide timely access to the tribal population to contracted services from a sufficient number of IHCPs.

- f) Plan to provide access to contracted services for Non-emergency Medical Transportation in accordance with *Section V.B.2.iv. Non-Emergency Medical Transportation*.
- g) Plan to provide in-network access, compliant with the Department's BH I/DD Tailored Plan network adequacy standards, to children to the full range of age-appropriate health care providers, subspecialists and facilities, including:
- h) Method for ensuring children's physical health, BH, and I/DD needs will be met using appropriate child-focused specialty services that include supports and services from in-network providers who have special training in pediatrics or in child health and development and approach to assure children's access to child psychologists, child and adolescent psychiatrists (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomate status as a child/adolescent psychiatrist), pediatric occupational, physical and speech therapists, pediatric neurologists, and pediatric surgeons; and
- i) Report annually to Department on the number of members under age eighteen (18) who are prescribed an antipsychotic medication and the proportion who have been assessed at least once in the preceding twelve (12) months in the outpatient setting by a child/adolescent psychiatrist (defined as having completed ACGME accredited child/adolescent psychiatry fellowship and/or have board diplomat status as a child/adolescent psychiatrist).
- j) Approach to assure members residing in CASPs that are outside of the BH I/DD Tailored Plan's Region have access to physical health providers (e.g., primary care, specialty care, etc.), including through collaboration with the BH I/DD Tailored Plan that covers the Region where the CASP is located.
- k) Quality assurance standards, consistent with the Department's Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care.
- l) Geographical location of providers in the Network in relation to where members reside.
- m) The BH I/DD Tailored Plan shall describe how it will address Cultural and Linguistic Competency for specific populations, such as people with TBIs, people with disabilities, people who are blind or visually impaired, people who are deaf or hard of hearing, members who are in the Armed Services, veterans and their families, pregnant women with SUD, people who identify themselves as LGBTQ, people who are in jails or prisons, youth in the juvenile justice system, justice-involved populations more broadly, Historically Marginalized Populations, and other vulnerable populations.
- n) Strategies to ensure access and availability of services and build sufficient provider capacity, including but not limited to addressing Department priorities to increase clinically appropriate access to and utilization of:
 - i) Electroconvulsive therapy (ECT) for indicated conditions, including how the BH I/DD Tailored Plan shall ensure appropriate Regional availability of both inpatient and outpatient ECT, develop clinical practice guidelines related to appropriate utilization of ECT and educate and train network providers on appropriate utilization of ECT consistent with these clinical guidelines;

- ii) Clozapine for the treatment of chronic psychotic disorders, including how the BH I/DD Tailored Plan shall:
 - iii) Analyze and monitor clozapine utilization, including how the target population for clozapine use would be defined, baseline current utilization for the BH I/DD Tailored Plan current estimated target population, and goal targets for future utilization with timelines to achieve the targets;
 - iv) Develop clinical practice guideline(s) related to appropriate utilization of clozapine and educate and train network providers on clozapine utilization consistent with these clinical guidelines; and
 - v) Pursue other efforts to enhance access and develop provider capacity for clozapine prescribing (e.g. leverage Telehealth, organize learning collaboratives, support infrastructure for required medical/lab monitoring).
- o) First episode psychosis programs (FEP), including how the BH I/DD Tailored Plan shall: analyze and monitor utilization of FEPs, develop clinical practice guideline(s) related to appropriate utilization of FEP and education and training of providers, and pursue efforts to enhance access and develop FEP capacity with a focus on members between fifteen (15) and thirty (30) years old who have or are at high risk of psychosis (e.g., build new programs, connect individuals to existing programs, conduct active surveillance of those at-risk).
- (2) The Network Access Plan must be provided as follows:
- i. Thirty (30) days after Contract Award;
 - ii. As specified by the Department;
 - iii. Annually; and
 - iv. Within thirty (30) days of a Significant Change, including merger or county disengagement.
- (3) Network Access Plan shall demonstrate that the BH I/DD Tailored Plan has the capacity to serve the expected enrollment on a regional basis.
- (4) The Department shall supply to the BH I/DD Tailored Plan member eligibility information, including zip codes for the Medicaid and NC Health Choice beneficiaries that are in the BH I/DD Tailored Plan-eligible population as of the date of the Department's report. The information will be provided to the BH I/DD Tailored Plan no later than sixty (60) Calendar Days after Contract Award, at a date to be defined by the Department for purposes of demonstrating compliance with the time or distance standards found in *Section VII. Attachment F.1. BH I/DD Tailored Plan Network Adequacy Standards for Medicaid* during the Readiness Review, and as other times as needed as part of the network adequacy oversight.
- (5) The Network Access Plan shall be subject to Department review and approval. The BH I/DD Tailored Plan shall amend the Network Access Plan as directed by the Department.
- (b) The BH I/DD Tailored Plan and its Network providers shall comply and cooperate with EQRO network adequacy validations and activities including:
- (1) Annual validation of BH I/DD Tailored Plan's network adequacy and compliance with state and federal network requirements.; and
 - (2) Telephone surveys of Network providers to verify accuracy of reported data or other aspects of program requirements or performance.
- (c) The BH I/DD Tailored Plan shall provide the Department with Network data files quarterly and anytime there is Significant Change that impacts network adequacy and the ability to provide

services. The Department shall prescribe the standardized file format and content. The standardized detailed file layout must include, but is not limited to, the following data elements:

- (1) Provider names (first, middle, last);
 - (2) Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - (3) Street address(es) of service location(s);
 - (4) County(ies) of service location(s);
 - (5) Telephone number(s) at each location;
 - (6) Provider specialty;
 - (7) Provider NPI or API;
 - (8) NPI type (individual or organization/facility providers);
 - (9) Taxonomy(ies);
 - (10) Whether provider is accepting new members and the conditions if applicable;
 - (11) Identification as an IHCP;
 - (12) Identification as an Essential Provider;
 - (13) Identification as an Advanced Medical Home/Primary Care Provider;
 - (14) Identification of limitations on age of members seen by provider;
 - (15) Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office;
 - (16) Whether provider has completed Cultural and Linguistic Competency training; and
 - (17) Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment.
- (d) Ongoing Monitoring and Significant Changes in the Provider Network
- (1) At least once a month, the BH I/DD Tailored Plan shall monitor its Provider Network for a Significant Change that would affect the adequacy or capability or services and compliance with the time/distance and appointment wait time standards established by the Department as described in *Section VII. Attachment F. BH I/DD Tailored Plan Network Adequacy Standards*.
 - (2) Within five (5) Business Days of identifying a Significant Change that impacts network adequacy and the ability to provide services, the BH I/DD Tailored Plan shall provide notice to the Department in a format and manner as determined by the Department.
 - (3) Within thirty (30) Calendar Days of submission of the notice of a Significant Change, the BH I/DD Tailored Plan shall submit to the Department:
 - i. An updated Network Access Plan, including an updated attestation of compliance with the time/ distance and appointment wait time standards established by the Department;
 - ii. An updated Network data file as required under *Section V.B.4.i. Provider Network*; and
 - iii. Any new or updated requests for an exception to a network adequacy standard and/or an alternative arrangement for an Essential Provider, as appropriate.
- ii. Provider Network Management
- (i) The BH I/DD Tailored Plan shall manage its Network to meet availability, accessibility, and quality goals and requirements.
 - (a) In developing its network for physical health and pharmacy services, the Department expects the BH I/DD Tailored Plan to negotiate with any willing provider in good faith regardless of provider or BH I/DD Tailored Plan affiliation.
 - (b) In developing its network for BH, I/DD, and TBI services, the Department expects the BH I/DD Tailored Plan to ensure network adequacy and the BH I/DD Tailored Plan has the authority to

maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23. Pending legislative change, the BH I/DD Tailored Plan shall include all essential providers for BH, I/DD, and TBI services located in the BH I/DD Tailored Plan's Region in its Network regardless of closed network requirements.

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

- c) Any change to a provision that is not required by the Contract may be made if the change does not conflict with any requirements in this Contract, or state or federal law.
 - ii. The BH I/DD Tailored Plan may only make changes to the provisions required in Section 3. of *Section VII. Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*, when directed to do so by the Department.
- (c) The BH I/DD Tailored Plan shall not include any provider (including ordering, prescribing, or referring only providers) in its Medicaid Managed Care Network that is not enrolled in North Carolina Medicaid.
 - (1) The BH I/DD Tailored Plan shall validate the enrollment status of a provider in North Carolina Medicaid before adding a new provider, or a new location for a contracted provider, to an existing provider contract. This validation should be done monthly thereafter.
- (d) The BH I/DD Tailored Plan shall not employ or contract with any provider appearing on one of the Exclusion Lists.
- (e) In accordance with N.C. Gen. Stat. § 108D-22, except as otherwise allowed under the Contract, the BH I/DD Tailored Plan shall not exclude eligible providers from its physical health network except under the following circumstances:
 - (1) When a provider fails to meet the Department’s applicable Objective Quality Standards for participation as a Medicaid Enrolled provider; or
 - (2) When a provide refuses to accept network rates (which shall not be less than any applicable rate floors).
- (f) Require as part of objectivity quality standards that contracted facilities, with the exception of the residential provider facilities noted below, implement a tobacco-free policy covering any portion of the property on which the participating provider operates that is under its control as owner or lessee, to include buildings, grounds, and vehicles. A tobacco-free policy includes a prohibition on smoking combustible tobacco products and the use of non-combustible tobacco products, including electronic cigarettes, as well as prohibiting participating providers from purchasing, accepting as donations, and/or distributing tobacco products (combustible and non-combustible products including electronic cigarettes) to the clients they serve. However, contracted facilities that are owned or controlled by the provider and which provide ICF-ID services or residential services that are subject to the HCBS final rule are exempt from this requirement. In these settings:
 - (1) Indoor use of tobacco products shall be prohibited in all provider owned/operated contracted settings.
 - (2) For outdoor areas of campus, providers shall:
 - i. Ensure access to common outdoor space(s) that are free from exposure to tobacco products/use; and
 - ii. Prohibit staff/employees from using tobacco products anywhere on campus.
- (g) The BH I/DD Tailored Plan shall not deny a pharmacy the opportunity to participate in its network as required by N.C. Gen. Stat. § 58-51-37(c)(2). Nothing in this subsection shall require the BH I/DD Tailored Plan to contract with a pharmacy when the pharmacy fails to meet the Department’s applicable Objective Quality Standards.
- (h) The BH I/DD Tailored Plan shall offer to contract with a provider in writing.
 - (1) All offers shall include the standard provisions for provider contracts found in *Section VII. Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*, including the prescribed provisions located therein.

- (2) If within thirty (30) Calendar Days the potential network provider rejects the request or fails to respond either verbally or in writing, the BH I/DD Tailored Plan may consider the request for inclusion in the Medicaid Managed Care network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the BH I/DD Tailored Plan shall not consider the request rejected.
 - (3) The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall not include exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan.
- (i) The BH I/DD Tailored Plan shall not require individual practitioners, as a condition of contracting with BH I/DD Tailored Plan, to agree to participate or accept other products offered by the BH I/DD Tailored Plan nor shall the BH I/DD Tailored Plan automatically enroll the provider in any other product offered by BH I/DD Tailored Plan. This requirement shall not apply to facility providers. This requirement shall not preclude the BH I/DD Tailored Plan from requiring individual practitioners, as a condition of contracting with the BH I/DD Tailored Plan, to provide State-funded Services.
 - (j) The BH I/DD Tailored Plan shall give written notice to any provider with whom it declines to contract within five (5) Business Days after the BH I/DD Tailored Plan's final decision. The notice shall include the reason for the BH I/DD Tailored Plan's decision, the Provider's right to Appeal that decision, and how to request an Appeal. 42 C.F.R. § 438.12(a)(1).
 - (k) The BH I/DD Tailored Plan shall monitor the Department website and other Department communication mechanisms daily for changes to the NC Medicaid Direct rates to ensure compliance with the provider payment requirements herein. For provider payment requirements that refer to Medicaid Direct rates:
 - (1) The BH I/DD Tailored Plan shall make retroactive payment adjustments to the effective date of the NC Medicaid Direct rate change as prescribed by the Department.
 - (2) The BH I/DD Tailored Plan shall implement applicable rate changes within timelines prescribed by the Department. Payments made to providers outside the prescribed timeline will be subject to interest and liquidated damages payments to the applicable provider.
 - (l) The BH I/DD Tailored Plan shall, with regard to payment to any provider or Subcontractor that is "related to" the BH I/DD Tailored Plan, comply with the requirements in *Section V.A.1.iv. BH I/DD Third Party (Subcontractor) Contractual Relationships* and *Section V.B.7.ii. Medical Loss Ratio*.
 - (m) The BH I/DD Tailored Plan shall include a provision in the provider contract regarding a provider's right to file a Grievance or Appeal (as described in *Section V.B.4.v. Provider Grievances and Appeals*) in its contract with providers. The BH I/DD Tailored Plan shall include a notice in all provider contracts that the internal Appeal process with the BH I/DD Tailored Plan must be exhausted before seeking other legal or administrative remedies under state or federal law.
 - (n) The BH I/DD Tailored Plan shall not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding:
 - (1) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - (2) Any information the member needs to decide among all relevant treatment options.
 - (3) The risks, benefits, and consequences of treatment or non-treatment.

- (4) The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 42 C.F.R. § 438.102(a)(1)(i)-(iv).
- (o) The BH I/DD Tailored Plan shall include a provision in the provider contract that requires all in-network PCPs to perform EPSDT screenings for members less than twenty-one (21) years of age in accordance with *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Medicaid Members.*
- (p) The BH I/DD Tailored Plan shall include a provision in the provider contract that requires providers notify the BH I/DD Tailored Plan when a member in a high acuity clinical setting is being discharged.
- (q) The BH I/DD Tailored Plan may utilize evergreen contracts, i.e. a contract that automatically renews, with Medicaid Managed Care providers on the condition that the contract also includes provisions regarding how the contract may be terminated or non-renewed.
- (r) The BH I/DD Tailored Plan shall not include any provider contract provisions prohibited by N.C. Gen. Stat. § 58-50-295.
- (s) In contracting with providers, the BH I/DD Tailored Plan shall comply with all applicable Chapter 58 statutes in accordance with *Section VII. Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid.*
- (t) The BH I/DD Tailored Plan shall include in provider contracts that participating providers shall not submit claim or encounter data for services covered by Medicaid Managed Care and BH I/DD Tailored Plans directly to the Department.
- (u) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall contract with each LHD in its Region to provide Care Management for At-Risk Children and Care Management for High Risk Pregnant Women, to the extent that each LHD chooses to provide these services.
- (v) DSOHF Facilities
- (1) The BH I/DD Tailored Plan shall contract with the following Division of State-Operated Healthcare Facilities' alcohol and drug treatment centers, psychiatric hospitals, developmental centers, and children's residential facilities for inpatient and outpatient services for all levels and types of services provided or offered by the DSOHF facilities:
 - i. Julian F Keith ADATC,
 - ii. R.J. Blackley ADATC,
 - iii. Lakeside
 - iv. Woodsite Treatment Center (State funded)
 - v. Cherry Hospital,
 - vi. Broughton Hospital,
 - vii. Central Regional Hospital,
 - viii. Caswell Developmental Center,
 - ix. J. Iverson Riddle Developmental Center,
 - x. Murdoch Developmental Center,
 - xi. Whitaker Psychiatric Residential Treatment Facility, and
 - (2) The BH I/DD Tailored Plan shall consider these DSOHF facilities to have met the BH I/DD Tailored Plan's Quality Determination based on the DSOHF facility's successful completion of the State's Centralized Credentialing and Re-credentialing Process (CCRP) and valid enrollment as a provider in the NC Medicaid program.
 - (3) The BH I/DD Tailored Plan shall use a Department-developed contract template to contract with these DSOHF facilities, to be delivered by the Department after award.

- (w) The BH I/DD Tailored Plan shall contract with all Cross-Area Service Programs (CASPs) located throughout the state that will be listed in a forthcoming Department guidance. The BH I/DD Tailored Plan shall use a standard contract for all providers who are CASPs.
 - (x) The Department may at its discretion require the BH I/DD Tailored Plan to use a Department-developed contract template of other state-owned providers.
 - (y) For any provider subject to a rate floor as outlined in *Section V.B.4.iv. Provider Payments*, a BH I/DD Tailored Plan may include a provision in the provider's contract that the BH I/DD Tailored Plan will pay the lesser of billed charges or the rate floor only if the provider and the BH I/DD Tailored Plan have mutually agreed to an alternative reimbursement amount or methodology which includes a "lesser than" provision. A BH I/DD Tailored Plan shall not consider a provider who is subject to a rate floor to have refused to contract based upon the provider's refusal to agree to a "lesser than" provision.
- (iv) Provider Preventable Conditions
- (a) The BH I/DD Tailored Plan shall comply with 42 C.F.R. § 438.3(g), which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. The BH I/DD Tailored Plan shall provide a report on all identified provider preventable conditions in a form or frequency as described in *Section VII. Attachment J. Reporting Requirements*.
 - (b) The BH I/DD Tailored Plan shall include a provision in all provider contracts that requires the provider to comply with 42 C.F.R. § 438.3(g). At a minimum, this shall mean non-payment of provider-preventable conditions as well as appropriate reporting as required by the BH I/DD Tailored Plan.
- (v) Critical Incident Reporting
- (a) The BH I/DD Tailored Plan shall establish a process for timely identification, response, reporting, and follow-up to member incidents.
 - (b) The BH I/DD Tailored Plan shall require Network providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System.
 - (c) The BH I/DD Tailored Plan shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of members.
 - (d) The BH I/DD Tailored Plan shall report information on incidents and deaths in accordance with Department procedures.
 - (e) The BH I/DD Tailored Plan shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations in accordance with *Section VII. Attachment G.1. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid*.
 - (f) The BH I/DD Tailored Plan shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence, and provide this information to the Department as requested.
 - (g) The BH I/DD Tailored Plan shall adhere to the critical event reporting requirements for members obtaining services in DSOHF facilities as detailed in *Section VII. Attachment N. Addendum for Division of State Operated Healthcare Facilities Providers*
- (vi) Indian Health Care Providers
- (a) The BH I/DD Tailored Plan shall use the Medicaid Managed Care Addendum for IHCPs when contracting with IHCPs as described in *Section VII. Attachment H. Addendum for Indian Health Care Providers* and adhere to the Tribal Payment Policy (*Section VII.M.11. Tribal Payment Policy*).

- (b) The BH I/DD Tailored Plan shall not include any additional special terms and conditions to the IHCP Addendum or Tribal Payment Policy (*Section VII. Attachment M.11. Tribal Payment Policy*) when contracting directly with IHCPs without mutual consent of both BH I/DD Tailored Plan and the IHCP. For any mutually agreed upon additional special terms and conditions, the BH I/DD Tailored Plan shall:
 - (1) Within thirty (30) Calendar Days of contracting with the IHCP, submit a copy of additional special terms and conditions to the Department Tribal Liaison with a written statement that both parties have agreed to such additional special terms and conditions.
 - (2) Recognize that the IHCP Addendum provisions supersedes any conflicting terms of the contract between BH I/DD Tailored Plan and IHCP.
 - (c) The BH I/DD Tailored Plan must ensure that its contracted IHCPs are subject to medical quality assurance requirements specified in Section 805 of the Indian Health Care Improvement Act. 25 U.S.C. Chapter 18, Section 805: PL No.111-148. IHCPs are not subject to licensure and credentialing of the Department.
 - (d) The BH/IDD TPs shall honor all NC Medicaid EPSDT approved services under NC Medicaid Direct or In-Lieu of services such as but not limited to the Tribal Integrated Classroom, Family Safety, Tribal Therapeutic Foster Care, Tribal Peer Support.
- (vii) Program Integrity
- (a) The BH I/DD Tailored Plan shall develop policies and procedures to perform monitoring and auditing of provider payments. The BH I/DD Tailored Plan shall provide those policies and procedures to the Department upon request for review or as otherwise required by this Contract.
 - (b) The BH I/DD Tailored Plan shall require Network providers and Subcontractors to have compliance program that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.
 - (c) The BH I/DD Tailored Plan shall require Network providers and out-of-network providers to have policies and procedures that recognize and agree that Medicaid as “the payer of last resort,” except in the instances that a member is also accessing State-funded services where State-funded services are “the payer of last resort.”
 - (d) The BH I/DD Tailored Plan shall prohibit providers and referral providers from billing members for covered services any amount greater than would be owed if the provider or referral provider provided the service directly as provided in 42 C.F.R. §§ 438.106(c) and 438.108.
 - (e) The BH I/DD Tailored Plan shall not impose a monetary advantage or penalty that would affect a member’s choice of pharmacy in accordance with N.C. Gen. Stat. § 58-51-37(c)(4) or any other provider.
- (viii) Credentialing and Re-credentialing Process
- (a) The BH I/DD Tailored Plan shall develop a Credentialing and Re-credentialing Policy consistent with the Department requirements and its associated policies and subject to Department approval.
 - (1) The BH I/DD Tailored Plan shall develop, maintain, and implement procedures consistent with its Credentialing and Re-credentialing Policy.
 - (b) The BH I/DD Tailored Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department’s written prior approval. The BH I/DD Tailored Plan is not prohibited from collecting other information from providers necessary for the BH I/DD Tailored Plan’s contracting process.
 - (1) The BH I/DD Tailored Plan shall make timely referrals to the Provider Network Participation Committee, as defined in *Section VII. Attachment M.7. Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-*

funded Providers, of providers who have been identified as potential network providers. The referral shall include all credentialing and verified information pertaining to the provider as provided by the Department.

- (c) The BH I/DD Tailored Plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in *Section V.B.4. Providers*.
- (d) The BH I/DD Tailored Plan is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.
- (e) Re-credentialing:
 - (1) During the Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall apply the Department's applicable Objective Quality Standards, *as defined in Section III.A. Definitions*, for participation as a Medicaid enrolled provider to contracted providers as a provider is re-enrolled through the Provider Enrollment process.
 - (2) After the Provider Credentialing Transition Period, the BH I/DD Tailored Plan shall apply the Department's applicable Objective Quality Standards for participation as a Medicaid enrolled provider to contracted providers every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
- (f) Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all BH I/DD Tailored Plan Network providers as Medicaid providers. 42 C.F.R. § 438.602(b)(1).
 - (1) The BH I/DD Tailored Plan may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, for up to one hundred twenty (120) days but must terminate a Network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected members. 42 C.F.R. § 438.602(b)(2).
- (g) The BH I/DD Tailored Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.
- (h) Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to *Section III.C.5. Availability of Funds*, DHHS shall indemnify, defend, and hold harmless the BH I/DD Tailored Plan, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the BH I/DD Tailored Plan by the Department, Contract Verification Organization, or other Vendor providing such information to the BH I/DD Tailored Plan and relied upon by the BH I/DD Tailored Plan in credentialing a provider for participation in the BH I/DD Tailored Plan's Network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The BH I/DD Tailored Plan shall have the option to participate at its own expense in the defense of such claims or actions filed and the BH I/DD Tailored Plan shall be responsible for its own litigation expenses if it exercises this option. In no event shall the BH I/DD Tailored Plan be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The BH I/DD Tailored Plan shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the BH I/DD Tailored Plan's use of and reliance on such credentialing information.
- (ix) Network Provider System Requirements
 - (a) The BH I/DD Tailored Plan shall accurately and timely load into the BH I/DD Tailored Plan's claim adjudication and payment systems new provider contracts, provider demographic information,

changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory.

- (b) Unless otherwise written in the contract, the BH I/DD Tailored Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a member and billed to the BH I/DD Tailored Plan by the provider:
 - (1) New Medicaid Enrolled provider within ten (10) Business Days after completing contracting;
 - (2) New Medicaid Enrolled hospital or facility provider within fifteen (15) Business Days after completing contracting;
 - (3) New Medicaid Enrolled provider attached to an existing contract within five (5) Business Days after completing contracting;
 - (4) Changes for a re-enrolled Medicaid provider, hospital, or facility attached to an existing contract within five (5) Business Days after completing receipt of notification of the change through the Medicaid Enrolled Provider data from the Department;
 - (5) Change to existing contract terms within ten (10) Business Days of the effective date after the change; and
 - (6) Changes to a provider's service location or demographic data or other information related to a member's access to services must be updated no later than thirty (30) Calendar Days after the BH I/DD Tailored Plan receives updated provider information.
- (c) Payment should be made to the provider for previously rendered services on the next payment cycle following the requirement outlined above.
- (d) In no case shall a provider be used as a PCP or loaded into the Provider Directory during a timeframe in which the provider cannot receive payment in accordance with the BH I/DD Tailored Plan current payment cycle.
- (x) Network Provider Credentialing and Re-credentialing Policy
 - (a) The BH I/DD Tailored Plan shall establish and follow written policies and procedures for network provider selection and retention. 42 C.F.R. § 438.12(a)(2). BH I/DD Tailored Plan shall apply these criteria consistently to all providers. The BH I/DD Tailored Plan shall develop and maintain a Network Provider Credentialing and Re-credentialing Policy as defined in *Section VII. Attachment M.7. Uniform Credentialing and Re-credentialing Policy for Medicaid, NC Health Choice, and State-funded Providers.*
 - (b) The BH I/DD Tailored Plan shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) days after the Contract Award. The Policy must be approved by the Department at least sixty (60) days prior to BH I/DD Tailored Plan executing contracts with providers.
 - (1) The BH I/DD Tailored Plan may utilize the draft Credentialing and Re-credentialing Policy submitted as part of the *Section VIII. Applicant's Response and Completed Attachments* prior to approval by the Department with notification to the provider that the Credentialing and Re-credentialing Policy is subject to amendment based upon Department review and approval.
 - (c) BH I/DD Tailored Plan shall submit any significant policy changes to the Policy to the Department for review and approval at least sixty (60) Calendar Days prior to implementing such changes.
 - (d) Provider Network Participation Committee
 - (1) The BH I/DD Tailored Plan shall establish and maintain a Provider Network Participation Committee to make network contracting decisions in accordance with the BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy.

- (2) The BH I/DD Tailored Plan's Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.
 - (3) BH I/DD Tailored Plan shall make network contracting decisions within the following timeframes:
 - i. For ninety percent (90%) of providers within thirty (30) Calendar Days of the Provider Network Participation Committee's receipt of complete information for consideration:
 - a) For providers of physical health and pharmacy services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor; and
 - b) For providers of BH, I/DD, and TBI services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor and complete information requested by the BH I/DD Tailored Plan for network contracting decisions for providers of BH, I/DD, and TBI services for consideration.
 - ii. For one hundred percent (100%) of providers within forty-five (45) Calendar Days of the Provider Network Participation Committee's receipt of complete information for consideration"
 - a) For providers of physical health and pharmacy services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor; and
 - b) For providers of BH, I/DD, and TBI services, this comprises complete Medicaid Enrolled Provider data from the Department or the Department's vendor and complete information requested by the BH I/DD Tailored Plan for network contracting decisions for providers of BH, I/DD, and TBI services for consideration.
 - (4) The BH I/DD Tailored Plan shall provide written notice of network contracting decisions to providers within five (5) Business Days of the Provider Network Participation Committee's determination.
- (e) Provider Disenrollment and Termination
- (1) Payment Suspension at Re-Credentialing:
 - 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 for dates of services after the effective date provided by the Department in its notice to BH I/DD Tailored Plan that payment must be suspended for the provider's failure to submit re-credentialing documentation to the Department or otherwise failing to meet Department requirements.
 - ii. The BH I/DD Tailored Plan shall reinstate payment to the provider upon notice from the Department that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days of suspension, the Department will terminate the provider from Medicaid.
 - iii. The BH I/DD Tailored Plan shall not be liable for interests or liquidated damages for payment suspension when directed by the Department.
 - iv. The BH I/DD Tailored Plan shall address payment suspension at re-credentialing in its Network Provider Credentialing and Re-credentialing Policy.
 - (2) Termination as a Medicaid Provider by the Department:

- i. The BH I/DD Tailored Plan shall remove any provider from claims payment system, and terminate the provider's contract consistent within one (1) Business Day of receipt of a notice from the Department that the provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.
 - ii. If the BH I/DD Tailored Plan suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the BH I/DD Tailored Plan shall release applicable claims and deny payment for dates of service after the date of termination from Medicaid.
- (3) BH I/DD Tailored Plan Provider Termination
- i. The BH I/DD Tailored Plan may terminate a provider from its Network with cause. Any decision to terminate must comply with the requirements of the Contract.
 - ii. The BH I/DD Tailored Plan shall comply with the Program Integrity Provider Termination Requirements outlined in *Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services*.
 - iii. The BH I/DD Tailored Plan must provide written notice to the Network provider of the decision to terminate to the provider. The notice, at a minimum, must include:
 - a) The reason for the BH I/DD Tailored Plan's decision;
 - b) The effective date of termination;
 - c) The provider's right to Appeal the decision; and
 - d) How to request an Appeal.
 - iv. The BH I/DD Tailored Plan shall provide a report on the number of providers terminated by provider type in a form and frequency as described in *Section VII. Attachment J. Reporting Requirements for Medicaid*. If a waiver provider has been terminated due to HCBS issues, the BH I/DD Tailored Plan shall notify Department waiver administrators.
- (f) Member Notice of Provider Disenrollment/Termination
- (1) The BH I/DD Tailored Plan shall notify each member who, at a minimum, received his or her primary care from, or was seen in the previous twelve (12) months by a terminated provider, of the provider's termination from the Network. BH I/DD Tailored Plan shall:
 - i. Make a good faith effort to provide written notice within fifteen (15) Calendar Days after receipt of a notice of termination by the Department or issuance of termination notice to the provider by the BH I/DD Tailored Plan. 42 C.F.R. 438.10(f)(1).
 - ii. Include in the notice information about selecting or being auto-assigned a new PCP.
 - iii. Describe the BH I/DD Tailored Plan's efforts to support transition of care for the member to the new provider.
 - iv. If the terminated provider was a specialist, assist impacted members with transition of care.
- (g) Provider Directory
- (1) The BH I/DD Tailored Plan shall develop a consumer-facing provider Network Directory of all Network providers including the required information for all such providers, except providers of types which the Department has permitted the BH I/DD Tailored Plan to suppress based upon industry practices or provider characteristics.
 - (2) The Network Directory must be available in both paper and electronic formats, easy to understand, and meet language and format requirements in accordance with 42 C.F.R. § 438.10, the Contract, and as specified by Department.
 - (3) The BH I/DD Tailored Plan shall ensure that the Network Directory:
 - i. Be in a format that is machine-readable and readily accessible;

- ii. Is placed in a location on the BH I/DD Tailored Plan’s website that is prominent and readily accessible by members;
 - iii. Includes accurate and updated provider information consistent with Contract requirements;
 - iv. Is provided in an electronic form which can be electronically retained and printed; and
 - v. Is available in paper form without charge upon member request and if requested, is provided within five (5) Business Days.
- (4) In accordance with 42 C.F.R. § 438.10(h)(3):
- i. The BH I/DD Tailored Plan shall update the paper directory at least monthly and clearly identify the date of the update.
 - ii. The BH I/DD Tailored Plan shall update the electronic version of the Network Directory no later than ten (10) Business Days after the BH I/DD Tailored Plan receives updated provider information and clearly identify the date of the update.
- (5) The BH I/DD Tailored Plan shall provide the Department with a copy of both the electronic and paper versions of the Network Directory as follows:
- i. At the request of the Department during the Readiness Review;
 - ii. Annually; and
 - iii. Any time there has been a Significant Change in BH I/DD Tailored Plan operations that impacts the content of the directory.
- (6) All provider directories must comply with 42 C.F.R. § 438.10(h)(1). The full provider file, also known as the BH I/DD Tailored Plan Network File, delivered to the Enrollment Broker as described in *Section V.B.8. Technical Specifications* shall include the following information, at a minimum:
- i. Provider name;
 - ii. Provider demographics (first, middle, and last name, gender);
 - iii. Providers 3-digit Location Code;
 - iv. Provider DBA Name;
 - v. Provider Service Location Name;
 - vi. Provider mailing address;
 - vii. Provider type (PCP, etc.);
 - viii. Provider type effective date;
 - ix. Group affiliation(s) (i.e., organization or facility name(s), if applicable);
 - x. Street address(as) of service location(s);
 - xi. County(ies) of service location(s);
 - xii. Telephone number(s) at each location;
 - xiii. After hours telephone number(s) at each location;
 - xiv. Provider specialty (Taxonomy Codes) by location;
 - xv. Whether provider is accepting new beneficiaries and whether provider serves Medicaid and NC Health Choice beneficiaries;
 - xvi. Whether BH provider is serving children and adolescents;
 - xvii. Provider’s linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider’s office;
 - xviii. Whether provider has completed Cultural and Linguistic Competency training;
 - xix. Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment;

- xx. A telephone number at the BH I/DD Tailored Plan where a member can call to confirm the information in the directory;
 - xxi. Excluded provider indicator;
 - xxii. Essential provider indicator;
 - xxiii. IHCP indicator; and
 - xxiv. Contract start/end date.
- (h) 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.
- (i) The BH I/DD Tailored Plan shall provide the provider directory to NCTracks for inclusion in the Consolidated Provider Directory made available the Enrolment Broker as described in *Section V.B.8. Technical Specifications*.
- (j) For purposes of BH I/DD Tailored Plan's consumer-facing provider directories referenced in *Section V.B.4.ii.(x)(g)(1)*, the directories shall include, at a minimum, all of the fields listed in *Section V.B.4.ii.(x)(g)(6)*, except for subsections *iii., vi., viii., xxi., and xxiii. of Section V.B.4.ii.(x)(g)(6)*. For purposes of *Section V.B.4.ii.(x)(g)(6).xiv.*, consumer-facing directories shall include the description of the respective provider specialty by location in place of the taxonomy code.
- iii. Provider Relations and Engagement
- (i) Providers are critical partners in ensuring that the goals and objectives for the Medicaid Managed Care Quality Strategy are achieved and services are readily accessible to members. The Department seeks a BH I/DD Tailored Plan that will engage and support providers through a call center and provider web portal as well as provide training and education on the Medicaid program and their rights within the program.
- (ii) Provider Relations: Service Line; Provider Web Portal; Provider Welcome Packet
- (a) The BH I/DD Tailored Plan shall operate a Provider Relations function, that includes a Provider Support Service Line consistent with the applicable standards found in *Section V.A.2. Program Operations*. The Provider Support Service Line should comply with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships* if BH I/DD Tailored Plan utilizes a Subcontractor to provide or operate the service line (see *Section V.A.2.i. Service Lines for Medicaid and State-funded Services*).
- (b) Be staffed with personnel specifically trained on the requirements, policies and procedures of the BH I/DD Tailored Plan operating in North Carolina and are able to respond to all areas within the Provider Manual, including resolving claims payment inquires, in "one-touch."
- (c) The BH I/DD Tailored Plan shall provide and maintain a provider web portal that provides access to program and provider specific information as defined by the Contract. The provider web portal may include access to the Provider Manual.
- (d) The BH I/DD Tailored Plan shall send a Provider Welcome Packet and enrollment notice to providers within five (5) days of executing a contract with the provider for participation within its Medicaid Managed Care network. The Provider Welcome Packet must include orientation information and instructions on how to access the BH I/DD Tailored Plan's Provider Manual.
- (e) The BH I/DD Tailored Plan shall develop and maintain a Provider Support Plan as described in *Section V.B.5.i. Quality Management and Quality Improvement* and make it available to Department upon request.
- (iii) Provider Education and Training
- (a) The BH I/DD Tailored Plan shall provide education, specific to the Medicaid Managed Care requirements, policies, including the Department's Managed Care Provider Billing Guide, and procedures, training and technical assistance on all BH I/DD Tailored Plan-specific

administrative and clinical practices, procedures, policies, programs, and requirements to Network providers.

- (b) The BH I/DD Tailored Plan shall communicate with Network providers, or include in its training and technical assistance, information as requested by Department.
 - (c) The BH I/DD Tailored Plan shall provide training to Network providers within thirty (30) days of provider joining the Network. Additional training will be provided as determined by the BH I/DD Tailored Plan and as requested by Department.
 - (d) The BH I/DD Tailored Plan shall make training materials available on the provider Web portal as determined appropriate by the BH I/DD Tailored Plan and upon request by network providers or Department.
 - (e) The BH I/DD Tailored Plan shall develop a Provider Training Plan that outlines training topics and dates. The BH I/DD Tailored Plan Provider Training Plan shall reference and acknowledge the broader role the BH I/DD Tailored Plan has in supporting Department initiatives. Training must include:
 - (1) Annual EPSDT, where EPSDT is relevant to the provider's area of practice;
 - (2) BH I/DD Tailored Plan prevention and population health management programs;
 - (3) Into the Mouth of Babes (IMB) program training (required before being permitted to receive reimbursement for IMB program);
 - (4) Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training members on proper practices, particularly for members receiving care in the home or community settings, or as members transition across care settings; and
 - (5) Any other training topics required under this Contract.
 - (f) The BH I/DD Tailored Plan shall submit the Provider Training Plan to the Department as follows:
 - (1) Upon award of the Contract;
 - (2) When material changes are made to the Training Plan; and
 - (3) Annually.
- (iv) Provider Manual
- (a) The BH I/DD Tailored Plan shall develop, maintain, and distribute a Provider Manual that offers information and education to providers about the BH I/DD Tailored Plan and Medicaid Managed Care. At a minimum, the Provider Manual must cover the following subject matter:
 - (1) Clinical practice standards and UM Program;
 - (2) Covered services, additional benefits and carved-out services;
 - (3) Provider responsibilities;
 - (4) PCP responsibilities;
 - (5) Network requirements, including nondiscrimination, Cultural and Linguistic Competency expectations, on-call coverage, credentialing, re-credentialing, access requirements, no-reject requirements, notification of changes in address, licensure requirements, insurance requirements, and required availability;
 - (6) Telehealth, Virtual Patient Communications and Remote Patient Monitoring;
 - (7) Network adequacy and access standards;
 - (8) Billing, claim editing, SNIP editing and clearinghouse requirements;
 - (9) Cultural and Linguistic Competency and accessibility requirements;
 - (10) Authorization, utilization review, and care management requirements;
 - (11) Care coordination and discharge planning requirements;
 - (12) Department-required documentation requirements;
 - (13) Provider Appeals and Grievance process;
 - (14) Complaint or Grievance investigation and resolution procedures;

- (15) Notification of the availability of the Department's provider Ombudsman service where a provider may submit a complaint about a BH I/DD Tailored Plan. The manual shall include instructions on how to submit the complaint;
 - (16) Performance improvement procedures including member satisfaction surveys, clinical studies, incident reporting, and outcomes requirements;
 - (17) Compensation and claims processing requirements, including required electronic formats, mandated timelines, transition of care obligations, and coordination of benefits requirements;
 - (18) Interest and penalty provisions for late or under-payment by the BH I/DD Tailored Plan;
 - (19) North Carolina Medicaid payer of last resort requirements;
 - (20) Member rights and responsibilities;
 - (21) Member cost sharing requirements; and
 - (22) Provider Program Integrity requirements that address how to report suspected fraud, waste and abuse, and compliance with other federal and state requirements.
- (b) The BH I/DD Tailored Plan shall also include in the Provider Manual providers' obligations to:
 - (1) Monitor and audit provider's own activities to ensure compliance and prevent and detect fraud, waste and abuse;
 - (2) Monitor and report on provider preventable conditions;
 - (3) Retain patient records for the mandated period;
 - (4) Ensure that all documentation regarding services provided is timely, accurate, and complete;
 - (5) Ensure BH I/DD Tailored Plan is the payer of last resort; and
 - (6) To report and promptly return overpayments within sixty (60) days of identifying the overpayment.
 - (c) The BH I/DD Tailored Plan shall include standardized language in the Provider Manual as requested by the Department.
 - (d) The BH I/DD Tailored Plan shall submit the Provider Manual to Department for approval thirty (30) days after Contract Award. The BH I/DD Tailored Plan shall not use or distribute the Provider Manual prior to approval by Department.
 - (e) The BH I/DD Tailored Plan shall regularly review and update the Provider Manual to reflect changes to applicable federal and state laws, rules and regulations, Department or BH I/DD Tailored Plan policies, procedures, bulletins, guidelines or manuals, or BH I/DD Tailored Plan business processes as necessary.
 - (f) The BH I/DD Tailored Plan shall submit the Provider Manual to Department for approval within fifteen (15) Calendar Days of making substantive updates or revisions.
 - (g) The BH I/DD Tailored Plan shall correct errors in the electronic version of the Provider Manual or make revisions as requested by the Department within fifteen (15) Calendar Days of notification or request by Department. Corrections or revisions to the printed version must be included in the next printing.
 - (h) The BH I/DD Tailored Plan shall make the Provider Manual available in an electronic version accessible via a website or the provider web portal, and in writing upon request of a contracted provider.
 - (v) Provider Survey
 - (a) The BH I/DD Tailored Plan shall conduct ongoing quality assurance of its provider relations staff via standardized provider surveys and internal audits of departments to ensure provider satisfaction and compliance with applicable performance standard metrics as specified in the Contract and take corrective action as necessary.
 - (1) Provider surveys shall be made available after each web, call center or in-person interaction;

- (2) Conduct surveys and internal audits intended to measure provider's overall ability to submit claims, receive timely service authorization requests, receive timely payment, and call center/website convenience and effectiveness; and,
- (3) Provide reports, including the results of provider surveys and BH I/DD Tailored Plan's evaluation of survey results and recommendations for engagement/education approach adjustments, to the Department on a regular basis as determined by the Department, and ad hoc as requested.

iv. Provider Payments

- (i) Provider payment requirements are established to comply with State law, encourage continued provider participation in the Medicaid program to ensure member access, and support safety-net providers by sustaining current reimbursement levels using mechanisms that mitigate the risk of BH I/DD Tailored Plan steerage to other providers.
- (ii) The BH I/DD Tailored Plan shall support the Department in complying with all federal laws, state laws, State Plans, waivers, PI or audit requirements, investigations, findings or corrective action plans related to provider payments.
- (iii) The Department plans to take advantage of the flexibility allotted to states under 42 C.F.R. § 438.6(c) to define qualified directed payments. These payment arrangements are described in the program standards below and are subject to CMS approval. The Department will provide specific reimbursement amounts at a later date. Final capitation payments will reflect required reimbursement levels.
- (iv) Physician and Physician Extender Payments
 - (a) The BH I/DD Tailored Plan shall reimburse all in-network primary and specialty care physicians, as well as physician extenders (e.g., nurse practitioners and physician assistants) no less than one hundred percent (100%) of their respective Medicaid Fee for Service Fee Schedule rate or bundle, as set by the Department, unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
 - (b) The BH I/DD Tailored Plan shall reimburse all in-network physicians and physician extenders providing obstetric services no less than one hundred percent (100%) of the Medicaid Fee for Service rate for obstetrics services, which includes an enhanced rate for all vaginal deliveries (equal to the Medicaid Fee for Service rate for caesarian deliveries) unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
 - (1) This includes reimbursement for the pregnancy risk screening and post-partum visit as defined in the Department's Clinical Coverage Policy 1E-6.
 - (c) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school as prescribed by the Department and as outlined below in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.
 - (d) The BH I/DD Tailored Plan shall not refuse to reimburse for a covered service provided by a physician assistant in accordance with N.C. Gen. Stat. § 58-50-26.
- (v) Hospital Payments (Excluding BH Claims)
 - (a) The BH I/DD Tailored Plan shall reimburse all in-network hospitals no less than the applicable Medicaid Fee for Service rate specified below for inpatient and outpatient services (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(A)) and utilize the applicable Medicaid Fee for Service payment methodology, unless the BH I/DD Tailored Plan and hospital have mutually agreed to an alternative reimbursement amount or methodology.
 - (b) The applicable rate floor and methodology for inpatient hospital services shall be one hundred percent (100%) of the hospital specific Medicaid Fee for Service rate using the Medicaid Fee for Service case weights and outlier methodology.

- (c) The applicable rate floor and methodology for outpatient hospital services, including emergency department, shall be the hospital charges multiplied by the hospital-specific Medicaid cost-to-charge ratio published on the Department's website.
- (d) The hospital rate floors shall apply for the following defined time periods, after which the BH I/DD Tailored Plan will have flexibility to negotiate reimbursement arrangements with the hospitals:
 - (1) The first four (4) contract years for critical access hospitals and hospitals in economically depressed counties defined as Tier 1 or Tier 2 counties as designated by the North Carolina Department of Commerce for 2019 (https://files.nc.gov/nccommerce/documents/files/2019-Tiers-memo_asPublished.pdf).
 - (2) The first two (2) contract years for all other hospitals.
- (e) The BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network hospitals owned by UNC Health Care or Vidant Medical Center as described in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*
- (f) The Department shall reimburse hospitals directly for any graduate medical education payments due under the State Plan (as allowed under 42 C.F.R. § 438.60).
- (g) The Department shall reimburse hospitals directly for Disproportionate Share Hospital Payments.
- (vi) Hospital Payments for BH Claims
 - (a) The BH I/DD Tailored Plan shall negotiate inpatient and outpatient hospital rates with hospitals for BH claims to be defined by the Department.
- (vii) Federally-Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs) Payments
 - (a) The BH I/DD Tailored Plan shall reimburse FQHCs and RHCs for covered services at no less than the following rates:
 - (1) All ancillary services (i.e. radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
 - (2) All core services shall be based on each FQHC's or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T-1015 code.
 - (b) The BH I/DD Tailored Plan shall provide the necessary data to the Department to enable the Department's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by the Department on a schedule to be defined by the Department.
- (viii) Indian Health Care Provider (IHCP) Payments
 - (a) In accordance with 42 C.F.R. § 438.14(c) and consistent with 42 C.F.R. § 438.14(b), the BH I/DD Tailored Plan shall reimburse IHCPs as follows:
 - (1) Those IHCPs that are not enrolled as an FQHC, regardless of whether they participate in the BH I/DD Tailored Plan's Network;
 - (2) The applicable encounter rate published annually in the Federal Register by the Indian Health Service; or
 - (3) The Medicaid Fee for Service rate for services that do not have an applicable encounter rate.
 - (4) Those IHCPs that are enrolled as FQHCs, but do not participate in the BH I/DD Tailored Plan's network, an amount equal to the amount the BH I/DD Tailored Plan would pay a network FQHC that is not an IHCP.
 - (b) The BH I/DD Tailored Plan shall not reduce payments owed to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through cost sharing or other similar charges levied on the Tribal member.
- (ix) Local Health Department (LHD) Payments

- (a) The BH I/DD Tailored Plan shall reimburse in-network LHDs no lower than base rates specified in the North Carolina Medicaid LHD Fee Schedule. The BH I/DD Tailored Plan shall reimburse the LHDs in accordance with this schedule for EPSDT well child exams, low-risk family planning and obstetrical services or sexually transmitted disease (STD) exams provided by enhanced role nurses.
 - (b) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for At-Risk Children services an amount substantially similar to or no less than the amount paid in NC Medicaid Direct (Fee for Service) prior to the start of the BH I/DD Tailored Plan contract (\$4.56 PMPM for all enrolled children ages zero (0) to five (5)).
 - (c) For Contract Year 1 or until June 2023, whichever is earlier, the BH I/DD Tailored Plan shall pay in-network LHDs for Care Management for High Risk Pregnant Women services an amount substantially similar to or no less than the amount paid in Medicaid Fee-for-Service prior to the start of the BH I/DD Tailored Plan contract (\$4.96 PMPM for all enrolled women, ages fourteen (14) to forty-four (44)).
 - (d) The BH I/DD Tailored Plan shall negotiate base reimbursement amounts to in-network LHDs that are no lower than rates paid to non-public providers for similar services.
 - (e) In addition to base reimbursements, the BH I/DD Tailored Plan shall make additional, utilization-based, directed payments to in-network LHDs as defined by the Department and as outlined below in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.
 - (f) The BH I/DD Tailored Plan shall reimburse in-network LHDs providing lab services, as defined by the Department's Laboratory Fee Schedule, at no less than 100% of the Medicare Fee Schedule (as allowed under 42 C.F.R. § 438.6(c)), unless the BH I/DD Tailored Plan and LHD have mutually agreed to an alternative reimbursement arrangement.
- (x) Public Ambulance Provider Payments
 - (a) The BH I/DD Tailored Plan shall negotiate base reimbursement amounts to in-network public ambulance providers no lower than rates paid to non-public providers for similar services.
 - (b) In addition to base reimbursements, the BH I/DD Tailored Plan shall make additional utilization-based payments to in-network public ambulance providers for Medicaid members only, (not NC Health Choice beneficiaries) as defined by the Department and as outlined below in *Section V.B.4.iv.(xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))*.
 - (c) The BH I/DD Tailored Plan shall pay the negotiated base reimbursement to in-network public ambulance providers, which will serve as payment in full for NC Health Choice.
 - (xi) State Owned and Operated Facilities Payments
 - (a) The BH I/DD Tailored Plan shall reimburse facilities that are state-owned and operated by the Department's Division of State Operated Healthcare Facilities (DSOHF) according to the rates established by the Department (as allowed under 42 C.F.R. § 438.6(c)).
 - (b) At such time that the BH I/DD Tailored Plan is required to cover services provided by Veterans Homes operated by the DMVA, the BH I/DD Tailored Plan shall reimburse Veterans Homes according to the rates established by the Department in collaboration with DMVA (as allowed under 42 C.F.R. § 438.6(c)).
 - (xii) Additional Directed Payments for Certain Providers (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B))
 - (a) The BH I/DD Tailored Plan shall make additional directed payments as determined by the Department to certain in-network providers. This includes, but may not be limited to, LHDs, public ambulance providers, certain faculty physicians affiliated with the teaching hospitals for each University of North Carolina medical school, and hospitals owned by UNC Health Care or Vidant Medical Center.

- (b) Additional directed payments will be prescribed by the Department and approved by CMS. Types of payments may include but may not be limited to payment based on utilization of certain services multiplied by a Department-defined specific dollar amount or a percentage of the base payment.
 - (c) The BH I/DD Tailored Plan shall include the Department defined additional directed payments in its contracts with applicable providers.
 - (d) The BH I/DD Tailored Plan shall determine a due date for providers to submit claims for a given quarter to receive the additional directed payment in a timely manner.
 - (e) The BH I/DD Tailored Plan shall be financially obligated to pay the additional directed payments to the applicable providers within five (5) Calendar Days of receiving the payment from the State.
 - (f) The BH I/DD Tailored Plan shall submit the data to substantiate additional directed payments to the Department and each applicable provider quarterly in a format to be defined by the Department.
 - (g) The Department shall reconcile the data to the BH I/DD Tailored Plan's encounter submissions. The BH I/DD Tailored Plan shall support the reconciliation process upon request from the Department.
 - (h) The BH I/DD Tailored Plan shall adhere to the directed payment service unit encounter requirements as described in *Section V.B.6.ii. Encounters*.
- (xiii) Nursing Facility Payments
- (a) For Contract Year 1, the BH I/DD Tailored Plan shall reimburse in-network nursing facilities (excluding those owned and operated by the State) a rate that is no less than the Medicaid Fee for Service rate in effect the first day of each quarter (e.g., January 1, April 1, July 1 and October 1), unless the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement.
- (xiv) Hospice Payments
- (a) The BH I/DD Tailored Plan shall reimburse for hospice services in accordance with section 1902(a)(13)(B) of the Social Security Act and state requirements, including but not limited to the following:
 - (1) Rates shall be no less than the annual federal Medicaid hospice rates (updated each federal fiscal year (FFY)).
 - (2) For hospice services provided to members residing in nursing facilities, the BH I/DD Tailored Plan shall reimburse the hospice provider:
 - i. Hospice rate, and
 - ii. Ninety-five percent (95%) of the Medicaid Fee-for-Service nursing home room and board rate in effect at the time of service.
- (xv) Pharmacy Payments
- (a) The BH I/DD Tailored Plan shall adhere to the pharmacy claims payments requirements as described in *Section V.B.2.iii. Pharmacy Benefits*.
- (xvi) Payments to Certified Advanced Medical Home Plus (AMH+) Practices and Care Management Agencies (CMAs) for Tailored Care Management
- (a) For Tailored Care Management, the BH I/DD Tailored Plan shall pay AMH+ practices and CMAs each of the following components:
 - (1) Tailored Care Management payment for each month in which the AMH+ practice or CMA performed Tailored Care Management for each member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity-tiered. These fixed rates shall apply for both Medicaid and CHIP members. This Tailored Care Management payment shall not be placed at risk. The BH I/DD Tailored Plan shall pay Tailored Care

- Management payment for any month in which the member is assigned to the AMH+/CMA and engaged in care management.
- (2) Performance incentive payment, if earned by the AMH+ or CMA. The performance incentive payment shall be based on the metrics included as the AMH+ and CMA metrics in the Department’s Technical Specifications Manual, once released.
- (xvii) Payments of Medical Home Fees to Advanced Medical Homes
- (a) In addition to the payment for services provided, the BH I/DD Tailored Plan shall pay all AMH practices a Medical Home Fee. “AMH practices” means all practices participating in the AMH program for the purposes of contracting with Standard Plans and BH I/DD Tailored Plans, including, but not limited to, AMH practices also certified as AMH+ practices for the purposes of Tailored Care Management.
- (b) The BH I/DD Tailored Plan shall pay Medical Home Fees to AMH Tiers 1 – 3 practices for any month in which the member is assigned to that AMH practice as their PCP. Medical Home Fees for AMH Tiers 1 –3 practices may be prorated for partial months and shall be no less than the following amounts for Contract Years 1 and 2:
- i. \$1.00 PMPM for Tier 1 practices (consistent with Carolina ACCESS I in the Medicaid Fee for Service program) (Tier 1 shall continue to exist only for the first year of BH I/DD Tailored Plan, or until the end of contract year two (2) of Standard Plans, whichever is sooner);
 - ii. \$5.00 PMPM for all BH I/DD Tailored Plan members in Tier 2 and 3 practices (consistent with Age, Blind, and Disabled (ABD) beneficiaries under Carolina ACCESS II in the Medicaid Fee for Service program, and increasing the level of PMPM to \$5.00 for every BH I/DD Tailored Plan member, regardless of ABD status).
- (xviii) Payment Limitations
- (a) Upon request by the Department, the BH I/DD Tailored Plan shall submit information on payments to related providers and Subcontractors and provide a demonstration of how payment levels for related providers and Subcontractors are not more than equivalent payment levels for non-related providers and subcontractors in cases where there are Value-Based Payment arrangements in place.
- (xix) Out-of-Network Provider Payments (Excluding Emergency Services and Post-Stabilization Services)
- (a) With the exception of out-of-network emergency services, post-stabilization services and services provided during transitions in coverage, the BH I/DD Tailored Plan shall be prohibited from reimbursing an out-of-network provider more than ninety percent (90%) of the Medicaid Fee for Service rate if the BH I/DD Tailored Plan has made a good faith effort to contract with the provider but the provider has refused that contract.
- (b) The BH I/DD Tailored Plan shall develop Good Faith Provider Contracting Policy that includes a description of how the BH I/DD Tailored Plan will conclude that a “good faith” contracting effort has been made. The BH I/DD Tailored Plan shall submit the policy to the Department for review ninety (90) days after Contract Award.
- (1) The BH I/DD Tailored Plan shall consider all facts and circumstances surrounding a provider’s willingness to contract before determining that the provider has refused the plan’s “good faith” contracting effort.
- (c) The BH I/DD Tailored Plan shall reimburse an out-of-network provider who is providing services to a member in accordance with the Transition of Care requirements of the Contract at one hundred percent (100%) of the Medicaid Fee for Service rate.
- (d) Unless an agreement has been negotiated, the BH I/DD Tailored Plan shall reimburse an out-of-network provider at one hundred percent (100%) of the Medicaid Fee for Service rate for:

- (1) Physical health and pharmacy services when the BH I/DD Tailored Plan has not made a “good faith” effort to contract with the provider in accordance with the BH I/DD Tailored Plan’s Good Faith Provider Contracting Policy; and
 - (2) BH, I/DD, and TBI services when the BH I/DD Tailored Plan has not made a “good faith” effort to contract with the provider in accordance with the BH I/DD Tailored Plan’s Good Faith Provider Contracting Policy or the BH I/DD Tailored Plan has exercised its authority to maintain a closed network for these services as set forth in N.C. Gen. Stat. § 108D-23.
- (e) The BH I/DD Tailored Plan shall reimburse out-of-state providers (that are also out-of-network) for medically necessary services according to the Medicaid Fee for Service rates specified in SPAs 4.19-A and 4.19-B (Medicaid) and Amendments 7.2.2 and 8.4.3 (NC Health Choice) when the services meet any of the following criteria:
- (1) Are more reasonably available than can be provided by an in-state Network provider; or
 - (2) The care and services are provided in any one of the following situations:
 - i. In response to an Emergency Medical Condition;
 - ii. The health of the member would be endangered if the care and services were postponed until the member returns to North Carolina; or
 - iii. The health of the member would be endangered if travel were undertaken to return to North Carolina.
- (f) In accordance with 42 C.F.R. § 438.206(b)(5), the BH I/DD Tailored Plan shall coordinate payment with the out-of-network provider to ensure that the cost to the member is no greater than it would be if services were provided by a provider in the Network.
- (xx) Out-of-Network Emergency Services and Post-Stabilization Services Payments
- (a) In accordance with 42 C.F.R. § 438.114, the BH I/DD Tailored Plan shall be subject to the following requirements:
- (1) The BH I/DD Tailored Plan shall cover and pay for emergency services without regard to prior authorization or whether the provider that furnishes the service has a contract with the BH I/DD Tailored Plan.
 - (2) The BH I/DD Tailored Plan shall not deny payment for treatment obtained due to an Emergency Medical Condition or as a result of the member having been instructed by a representative of the BH I/DD Tailored Plan to seek emergency services.
 - (3) Likewise, the BH I/DD Tailored Plan shall not hold a member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - (4) The BH I/DD Tailored Plan shall provide coverage and payment of services until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge. The determination of the attending emergency physician, or the provider actually treating the member, of when the member is sufficiently stabilized for transfer or discharge is binding on the BH I/DD Tailored Plan.
- (b) In accordance with SSA 1932(b)(2)(D), the BH I/DD Tailored Plan shall pay out-of-network providers who provide emergency services or post-stabilization services to a member no more than the applicable Medicaid Fee for Service rates.
- (c) The BH I/DD Tailored Plan shall reimburse out-of-state hospitals that are also out-of-network for emergency and post-stabilization care services according to the applicable Medicaid Fee for Service rates.
- (d) In accordance with 42 C.F.R. § 422.113(c), the BH I/DD Tailored Plan shall be subject to following requirements:

- (1) The BH I/DD Tailored Plan shall be required to reimburse for out-of-network post-stabilization care services that are pre-approved by a BH I/DD Tailored Plan representative.
 - (2) The BH I/DD Tailored Plan shall be financially responsible for post-stabilization care services that are not pre-approved but are administered to maintain the member's stabilized condition within one (1) hour of a request to the BH I/DD Tailored Plan for pre-approval of further post-stabilization care services.
 - (3) Additionally, the BH I/DD Tailored Plan shall be required to reimburse for post-stabilization care services that are not pre-approved but are administered to maintain, improve, or resolve the member's stabilized condition in the following instances:
 - i. If the BH I/DD Tailored Plan cannot be contacted;
 - ii. If the BH I/DD Tailored Plan does not respond to request for pre-approval within one (1) hour;
 - iii. If the BH I/DD Tailored Plan representative and the treating physician cannot reach an agreement concerning the member's care and a BH I/DD Tailored Plan physician is not available for consultation.
 - iv. If the BH I/DD Tailored Plan representative and treating physician cannot reach an agreement concerning the member's care and a BH I/DD Tailored Plan physician is not available for consultation, the BH I/DD Tailored Plan shall give the treating physician the opportunity to consult with a BH I/DD Tailored Plan physician and the treating physician may continue with the care of the member until the BH I/DD Tailored Plan physician is reached or one of the other post-stabilization care services criteria is met.
 - (4) The BH I/DD Tailored Plan shall no longer bear financial responsibility for post-stabilization care services it has not pre-approved in the following instances:
 - i. Once a Network physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. Once a Network physician assumes responsibility for the member's care through transfer;
 - iii. Once a BH I/DD Tailored Plan representative and the treating physician reach an agreement regarding the member's care; or
 - iv. Once the member is discharged.
 - (5) The BH I/DD Tailored Plan shall limit charges to members for post-stabilization care services to an amount no greater than what the BH I/DD Tailored Plan would charge the member if he or she obtained the services through the BH I/DD Tailored Plan in-network provider.
- (xxi) Payments under Locum Tenens Arrangements
- (a) The BH I/DD Tailored Plan shall recognize locum tenens arrangements as provided in N.C. Gen. Stat. § 58-3-231 to the extent that the locum tenens providers are a Medicaid enrolled provider in accordance with 45 C.F.R. § 455.410(b).
 - (b) The BH I/DD Tailored Plan shall establish and maintain a Locum Tenens Policy to comply with the requirements of N.C. Gen. Stat. § 58-3-231(b) and (c) and shall submit the Locum Tenens Policy to the Department for review ninety (90) days after Contract Award.
- (xxii) The BH I/DD Tailored Plan shall develop and maintain a Reimbursement Policy consistent with N.C. Gen. Stat. § 58-3-227(a)(5). The BH I/DD Tailored Plan shall provide the Reimbursement Policy to the Department upon request, for review.
- (xxiii) North Carolina State Laboratory of Public Health

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

v. Provider Grievances and Appeals

- (i) The BH I/DD Tailored Plan shall handle provider Appeals and Grievances promptly, consistently, fairly, and in compliance with State and federal law and Department requirements. The BH I/DD Tailored Plan shall have in place a provider Appeals and Grievance system, distinct from that offered to members, that includes a Grievance process for providers to bring issues to the BH I/DD Tailored Plan, an Appeals process for providers to challenge certain BH I/DD Tailored Plan decisions, and information regarding access to a state level review through the North Carolina Office of Administrative Hearings. The BH I/DD Tailored Plan shall be transparent with providers regarding its Appeals and Grievance processes and procedures. The BH I/DD Tailored Plan shall ensure the Grievance and Appeals system comply with *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan has contracted with a Subcontractor for the Grievance and Appeals system.
- (ii) The BH I/DD Tailored Plan shall submit the BH I/DD Tailored Plan Provider Grievances and Appeals Policy to the Department for review one hundred twenty (120) days after Contract Award. The BH I/DD Tailored Plan shall submit any significant policy changes to the Department for review at least sixty (60) Calendar Days before implementing the changes.
- (iii) The BH I/DD Tailored Plan shall have a process to and staff capable of reviewing provider Grievance and Appeal outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience.
- (iv) The BH I/DD Tailored Plan shall not discriminate against or retaliate against any provider based on any action taken by the provider under Provider Grievances and Appeals Section of the Contract (*Section V.B.4.v.*) or under Member Grievances and Appeals Section of the Contract (*Section V.B.1.vi.*) taken on behalf of a member.
- (v) Grievances
 - (a) The BH I/DD Tailored Plan shall have a process in place to receive and resolve Grievances with providers where remedial action is not requested. Grievances must be resolved in a timely manner.
 - (b) The BH I/DD Tailored Plan shall accept and resolve provider Grievances regarding the BH I/DD Tailored Plan referred from the Department.
 - (c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit Grievances through the BH I/DD Tailored Plan provider web portal.
 - (d) The BH I/DD Tailored Plan shall provide a report on provider Grievances in a form and frequency as described in *Section VII. Attachment J. Reporting Requirements* and upon request.
- (vi) Appeals
 - (a) The BH I/DD Tailored Plan shall offer providers Appeal rights as described in *Section VII. Attachment I. Provider Appeals for Medicaid, NC Health Choice and State-funded Providers*.
 - (b) The BH I/DD Tailored Plan shall provide written notice of provider's right to Appeal with the notice of decision giving rise to the provider's right to Appeal.
 - (c) The BH I/DD Tailored Plan shall have a method of allowing providers to submit Appeals through the BH I/DD Tailored Plan provider web portal.
 - (d) The BH I/DD Tailored Plan shall accept a written request for an Appeal from the provider within thirty (30) Calendar Days on which:

- (1) Provider receives written notice from the BH I/DD Tailored Plan of the decision giving rise to the right to Appeal; or
 - (2) BH I/DD Tailored Plan should have taken a required action and failed to take such actions.
- (e) The BH I/DD Tailored Plan shall acknowledge receipt of each Appeal request within five (5) Calendar Days of receipt of the request.
- (f) The BH I/DD Tailored Plan shall extend the timeframe by thirty (30) Calendar Days for providers to request an Appeal for good-cause shown as determined by the BH I/DD Tailored Plan.
 - (1) BH I/DD Tailored Plan shall document in its Grievance and Appeal Policy its policy and procedure for extending the timeframe for submission of an Appeal request.
 - (2) BH I/DD Tailored Plan shall consider the voluminous nature of required evidence/supporting documentation, as good-cause reasons to extend the timeframe.
- (g) The BH I/DD Tailored Plan shall provide information regarding provider Appeals to Department upon request.
- (h) The BH I/DD Tailored Plan Grievances and Appeals Policy shall provide that a provider must exhaust the BH I/DD Tailored Plan internal Appeals process before seeking recourse under any other process permitted by contract or law.
- (vii) Resolution of Appeal
 - (a) The BH I/DD Tailored Plan shall establish a committee to review and make decisions on provider Appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to Appeal.
 - (b) The BH I/DD Tailored Plan shall provide written notice of decision of the Appeal within thirty (30) Calendar Days of receiving a complete Appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all the evidence is submitted to the BH I/DD Tailored Plan. Notice shall include information regarding further Appeal rights, if any.
 - (c) The BH I/DD Tailored Plan shall allow providers to be represented by an attorney during the Appeals process.
- (viii) Appeals of Suspension or Withhold of Provider Payment
 - (a) The BH I/DD Tailored Plan shall limit the issue on Appeal in cases of suspension or withhold or provider payment to whether the BH I/DD Tailored Plan had good-cause to commence the withhold or suspension of provider payment. BH I/DD Tailored Plan shall not address whether the provider has or has not committed fraud or abuse.
 - (b) The BH I/DD Tailored Plan shall notify the Department within ten (10) Business Days of a suspension or withhold of provider payment.
 - (c) The BH I/DD Tailored Plan shall offer the provider an in person or telephone hearing when provider is Appealing whether BH I/DD Tailored Plan has good cause to withhold or suspend payment to the provider.
 - (d) The BH I/DD Tailored Plan shall schedule the hearing and issue a written decision regarding whether BH I/DD Tailored Plan had good cause to suspend or withhold payment within fifteen (15) Business Days of receiving the provider's Appeal. Upon a finding that BH I/DD Tailored Plan did not have good-cause to suspend or withhold payment, BH I/DD Tailored Plan shall reinstate any payments that were withheld or suspended within five (5) Business Days.
 - (e) The BH I/DD Tailored Plan shall pay interest and liquidated damages for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original date of payment, suspension, withhold or denial.
- (ix) Notice to Department
 - (a) The BH I/DD Tailored Plan shall provide notice to the Department of any provider Appeal regarding the suspension or withhold of payment, finding or recovery of an overpayment by BH I/DD Tailored Plan, or any action related to a finding of fraud, waste, or abuse. Such notice must be provided within five (5) Business Days of the Appeal.

- (b) The BH I/DD Tailored Plan shall notify Department if a provider has sued BH I/DD Tailored Plan in any administrative or general court of justice for actions related to Medicaid Managed Care. Such notice must be provided within five (5) Business Days of being served.

5. Quality and Value

i. Quality Management and Quality Improvement

- (i) The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health. For BH I/DD Tailored Plans, which are tasked with caring for North Carolinians with complex BH, I/DD, and TBI needs, the Department intends to incorporate additional standards and opportunities related to the unique aspects of the BH I/DD Tailored Plan population, while maintaining standards relevant to the Standard Plans. The Department intends to promote the highest quality of care for physical health, BH, I/DD, TBI and LTSS needs and to promote integration among physical and BH service providers and providers of LTSS and I/DD care.
- (ii) The Department's Quality Strategy details Medicaid Managed Care aims, goals, and objectives for quality management and improvement and details specific quality improvement (QI) initiatives that are priorities for the Department. For the populations served by BH I/DD Tailored Plans, the Department will emphasize integration between care delivery for physical health needs and care delivery for BH needs, as well as care specific to the needs of individuals with I/DD and TBI.
- (iii) As North Carolina transitions to Medicaid Managed Care, the Department will work with the BH I/DD Tailored Plan to develop a data-driven, outcomes-based continuous QI process. The QI process builds upon the Department's experience in NC Medicaid Direct and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards BH I/DD Tailored Plans and, in turn, providers for advancing quality goals and health outcomes.
- (iv) The BH I/DD Tailored Plan shall have an IT infrastructure and data analytic capabilities to support the Department's vision in quality management, measurement and improvement, including the capability to stratify and report quality measures at a regional level and across different provider types and patient populations. The BH I/DD Tailored Plan shall engage with the Department and its designees to share quality data reported by the BH I/DD Tailored Plan and receive quality data calculated by the BH I/DD Tailored Plan or its designees.
- (v) The BH I/DD Tailored Plan shall have a Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan, and comply with the quality management and quality improvement assurances and other requirements contained in North Carolina's federal Medicaid waivers (e.g., Section 1115, Section 1915(c), and other active waivers relevant for the BH I/DD Tailored Plan).
 - (a) Quality Assessment and Performance Improvement (QAPI) Plan (42 C.F.R. § 438.330)
 - (1) The BH I/DD Tailored Plan shall submit an annual QAPI Plan, delineating the BH I/DD Tailored Plan's plans for performance improvement programs and other quality improvement efforts as part of the QAPI Plan.
 - (2) The BH I/DD Tailored Plan shall address any Department concerns regarding performance against quality measures directly through the QAPI Plan, and, as applicable, build specific programs to improve quality performance into the QAPI Plan.
 - (3) The QAPI Plan shall include the following elements:
 - i. Completion of PIPs specified by the Department;
 - ii. Collection and submission of all quality performance measurement data required by the Department;

- iii. Mechanisms to detect both underutilization and overutilization of services;
 - iv. Mechanisms to assess the quality and appropriateness of care for members' special health care needs;
 - v. Mechanisms to assess the quality and appropriateness of care provided to members needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan;
 - vi. Mechanisms to assess for and a process for identifying interventions to reduce quality outcome disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS);
 - vii. Mechanisms to incorporate population health programs targeted to improve outcome measures;
 - viii. Participation in efforts by the Department to prevent, detect, and remediate critical incidents including LTSS services and programs;
 - ix. Mechanisms to assess and address health disparities, including findings from the disparity report that BH I/DD Tailored Plans are required to develop; and
 - x. The BH I/DD Tailored Plan's contributions to Health-Related Resources that can support or align with broader improvement in particular health outcomes outlined in the Quality Strategy, for example through engagement with the Department around understanding state performance on the Behavioral Risk Factor Surveillance System survey.
- (vi) The BH I/DD Tailored Plan shall participate in monthly BH I/DD Tailored Plan Quality Director Meetings.
- (vii) The BH I/DD Tailored Plan shall develop a process to evaluate the impact and effectiveness of the QAPI program; this process must be approved by the Department and the results must be provided to the Department annually.
- (viii) The BH I/DD Tailored Plan shall modify its proposed process to evaluate the impact and effectiveness of its QAPI program as part of each BH I/DD Tailored Plan's overall QAPI program design as directed by the Department.
- (ix) Quality Measures
- (a) The BH I/DD Tailored Plan will be held accountable for performance on all measures listed in *Section VII. Attachment E. BH I/DD Tailored Plan Quality Metrics* that are meant to provide the Department with a complete picture of the BH I/DD Tailored Plan's processes and performance. The BH I/DD Tailored Plan's accountability may include: public reporting of measure performance by the Department, requirements to engage with Department staff around measure performance, and, beginning in Contract Year 2, financial accountability for a select set of measures to be specified by the Department.
 - (b) The BH I/DD Tailored Plan shall calculate and report on those measures identified by the Department as the "Priority Set" that require claims or encounter data or clinical data. Priority measures are indicated in *Section VII. Attachment E. BH I/DD Tailored Plan Quality Metrics*. The Department will monitor other measures that are not designated as Priority Set measures, and may elect to report performance on these measures or engage with BH I/DD Tailored Plans around these performance reports. The Department reserves the right to add and remove measures from the Priority Set.
 - (c) The BH I/DD Tailored Plan shall submit to the Department all data necessary for the Department to calculate the BH I/DD Tailored Plan's performance on Priority Set measures.

- (d) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plans prior to launch and annually thereafter.
 - (e) The BH I/DD Tailored Plan shall incorporate elements of the Department-identified Priority Set into the BH I/DD Tailored Plan's QAPI and quality improvement activities.
 - (f) Beginning in Contract Year 2, the Department may implement a quality withhold/incentive program based on quality measures used to administer a BH I/DD Tailored Plan. A subset of the Priority Set may be included in the Withhold/Incentive Program. The Department reserves the right to add and remove measures from the priority set that may be subject to future withholds.
 - (g) The Department intends to monitor CMS's development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register.
- (x) Measurement of Outcomes
- (a) The Department's goal is to advance to measurement of outcomes. The Department intends to measure outcomes in the areas of quality of life, functional status and member satisfaction. This measurement may involve the use of surveys that may be administered by providers or third-party contractors, and may involve the development and piloting of novel survey instruments.
 - (b) The BH I/DD Tailored Plan shall support the administration of surveys as requested by the Department. This support may include conducting outreach to members and providers, incorporating in provider contracting requirements related to survey administration, and conducting analysis of internal data to support survey piloting.
 - (c) The BH I/DD Tailored Plan shall ensure administration of the NC-TOPPS interview tool to members in a form and manner specified by the Department.
 - (d) The Department is also exploring administrative data from other State agencies to support measurement of outcomes outside of the health care system for Medicaid beneficiaries.
- (xi) Disparities Reporting and Tracking
- (a) The BH I/DD Tailored Plan shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures.
 - (1) Detailed specifications around interim and annual measure reporting, stratification, and data submission will be supplied to the BH I/DD Tailored Plan after Contract Award and annually thereafter.
 - (b) The BH I/DD Tailored Plan shall address inequalities as determined by the Department during review of the BH I/DD Tailored Plan's stratified performance on measures identified by the Department as relevant to disparities in health outcomes.
 - (1) The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.
- (xii) Public Health Reporting and Tracking
- (a) The BH I/DD Tailored Plan shall work with the Department to target areas of collaboration and develop programs as part of QI efforts that can:
 - (1) Remove barriers (e.g., benefit coverage, implementation challenges, member education);
 - (2) Align incentives by targeting withholds for measures that will affect public health priorities; and
 - (3) Require select quality initiatives to be embedded in QAPIs, including PIPs and contributions to health-related resources.

- (b) The BH I/DD Tailored Plan shall be an active partner in Healthy NC 2030 (<https://nciom.org/healthy-north-carolina-2030/>) goals planning by participating at a minimum as follows:
 - (1) Joining planning meetings;
 - (2) Designating a senior level clinical staff person to engage in public health issue discussions; and
 - (3) Aligning QI activities to support Healthy NC 2030 goals.
- (xiii) Performance Improvement Projects (PIPs) (42 C.F.R. § 438.330)
 - (a) The BH I/DD Tailored Plan shall include no less than three (3) PIPs as part of the annual QAPI program. 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) The BH I/DD Tailored Plan shall develop a PIP that is:
 - (1) Designed to achieve significant improvement in health outcomes as part of the annual BH I/DD Tailored Plan QAPI program review; and
 - (2) Includes measurement of performance using quality indicators as part of the annual BH I/DD Tailored Plan QAPI program review.
 - (c) Each PIP shall include both the planning and initiation of activities for increasing or sustaining improvement and implementation of interventions to achieve improvement in the access to and quality of care.
 - (d) The BH I/DD Tailored Plan shall conduct at least one (1) non-clinical PIP on an annual basis that is aligned to the aims, goals, objectives, and interventions outlined within the Department's Quality Strategy.
 - (e) The BH I/DD Tailored Plan shall be required to develop and execute one (1) clinical performance improvement projects annually that must be related to one or more of the following areas:
 - (1) Maternal health;
 - (2) Tobacco cessation;
 - (3) Diabetes prevention;
 - (4) Birth outcomes;
 - (5) Early childhood health and development;
 - (6) Hypertension; and
 - (7) Behavioral-physical health integration
 - (f) All BH I/DD Tailored Plans shall be required to develop and execute one (1) clinical performance improvement project annually that is related to diversion, in-reach and/or transition for populations in or at risk of entrance into institutional or ACH settings.
 - (g) the BH I/DD Tailored Plan performs below seventy-five percent (75%) for overall CMS 416 rates for EPSDT screening, the BH I/DD Tailored Plan shall submit one (1) PIP on EPSDT screening and community outreach plans in addition to the three (3) required clinical and non-clinical PIPs annually.
- (xiv) External Quality Review (42 C.F.R. § 438.3(s)(1))
 - (a) The BH I/DD Tailored Plan shall comply with the annual external quality review performed by the EQRO on the timeline defined by the EQRO and agreed upon by the Department and EQRO. This may include a consolidated approach assessing both Medicaid and state-funded services.
 - (b) The BH I/DD Tailored Plan shall participate in the annual Consumer Assessment of Healthcare Providers and Systems Plan Survey (CAHPS), CAHPS-ECHO and Provider Survey conducted by the EQRO, and other surveys as required by the Department.
 - (c) The BH I/DD Tailored Plan shall comply with validation and research activities related to surveys, including survey instruments under development, that are required by the Department.

- (xv) Quality Improvement - Provider Supports
 - (a) The BH I/DD Tailored Plan shall provide support to providers tailored to advance State interventions and ensure providers' ability to achieve the goals outlined in the Quality Strategy.
 - (b) The supports offered will assist providers in clinical transformation and care improvement efforts at a regional and practice level.
 - (c) The BH I/DD Tailored Plan shall develop and maintain a BH I/DD Tailored Plan Provider Support Plan, which must be updated on an annual basis. The Department shall review and approve the BH I/DD Tailored Plan Provider Support Plan.
 - (d) The Provider Support Plan shall be developed as a component part of the QAPI and provider support activities should relate to improvement in specific health outcomes.
 - (e) The BH I/DD Tailored Plan Provider Support Plan shall include:
 - (1) All planned technical support activities;
 - (2) Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy; and
 - (3) An overview of which metrics the BH I/DD Tailored Plan will use to evaluate its provider engagement progress over time.
 - (f) The BH I/DD Tailored Plan shall provide QI support to Network providers during the initiation and implementation of the interventions for Quality and Population Health outcomes as outlined in the Quality Strategy and as otherwise specified by the Department, including:
 - (1) The Opioid Misuse Prevention and Treatment Program;
 - (2) Healthy Opportunities interventions, including but not limited to interventions delivered through the Healthy Opportunities Pilots;
 - (3) The Tailored Care Management model;
 - (4) BH integration;
 - (5) VBP;
 - (6) Pregnancy management/Pregnancy Management Program;
 - (7) Tobacco Cessation Plan;
 - (8) Activities to support at-risk children;
 - (9) The CDC 6|18 initiative; and
 - (10) Support for other activities such as response to or recovery from COVID-19, or future resilience efforts, as indicated by the Department.
- ii. Value-Based Payments (VBP)
 - (i) To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, integration of physical and BH, appropriateness of care and other measures related to value included in the BH I/DD Tailored Plan Quality Strategy, the Department is requiring adoption of VBP arrangements between the BH I/DD Tailored Plan and providers. The Department will issue additional guidance and details on VBP requirements for BH I/DD Tailored Plans.
 - (ii) The Department defines VBP arrangements as payment arrangements between the BH I/DD Tailored Plan and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>. The Department reserves the right to narrow the definition of VBP and the range of acceptable BH I/DD Tailored Plan VBP arrangements with providers in the future.
 - (a) Payments to AMH+ and CMA providers will be considered VBP only when these contracts include a performance incentive payment, as described in *Section V.B.4.iv. Provider Payments*.
 - (b) All VBP arrangements must be aligned with the BH I/DD Tailored Plan Quality Strategy and related measures.

- (iii) The Department will set minimum targets for VBP contracting starting in Contract Year 2, and implement withholds associated with these targets. Targets will be published at least six (6) months prior to Contract Year 1.
- (iv) The BH I/DD Tailored Plan shall have IT infrastructure and data analytic capabilities to support the Department's vision in moving toward VBP, including having systems that can support alternative payment arrangement models which require data-sharing across different provider types, care settings and locations. These systems must have mechanisms to measure quality and costs across attributed populations, share actionable administrative and clinical data with providers in these VBP arrangements, and process payments to providers based on the terms of the contract.
- (v) The BH I/DD Tailored Plan shall complete a VBP Assessment based on the categories developed by HCP-LAN, as described in *Section VII. Attachment J. Reporting Requirements*. The Department will provide specifications on the assessment methodology following Contract Award.
 - (a) The Department shall use the VBP Assessment to demonstrate the number of VBP contracts with providers in HCP-LAN Levels 1 through 4, and the amount of total medical expenditures and covered lives under these VBP payment arrangements, and compare documented progress to the BH I/DD Tailored Plan's final VBP Strategy on an annual basis.
 - (b) The BH I/DD Tailored Plan shall report the initial results of its VBP Assessment focused on VBP contracts in place to date within six (6) months of Contract Award.
 - (c) The BH I/DD Tailored Plan shall update the VBP Assessment on an annual basis, within ninety (90) days of the end of each contract year.
- (vi) To ensure the BH I/DD Tailored Plan's response aligns with the Department's strategy and goals, the BH I/DD Tailored Plan shall develop a BH I/DD Tailored Plan VBP Strategy for Contract Years 1 -3, in alignment with the Department's short- and long-term goals to shift from a fee for service system to VBP.
 - (a) The BH I/DD Tailored Plan VBP Strategy must be submitted to the Department within six (6) months of notice by the Department it is due.
 - (b) All sections of the BH I/DD Tailored Plan VBP Strategy must be updated on an annual basis, within ninety (90) days of the end of each Contract Year.
 - (c) The VBP Strategy shall contain the following elements:
 - (1) A narrative description addressing:
 - i. The BH I/DD Tailored Plan's goals, strategies and interventions for moving providers into VBP arrangements and then into higher levels of the HCP-LAN framework, including a description of how the BH I/DD Tailored Plan will involve BH and intellectual and developmental disability providers in its VBP arrangements.
 - ii. A description of the VBP model(s) that will be pursued by the BH I/DD Tailored Plan and its providers and their HCP-LAN classification, including a description of the required performance incentive programs for AMH+ practices and CMAs, which must be consistent with requirements for Tailored Care Management payment, and a description of VBP arrangements offered to non-AMH+/CMA providers.
 - iii. An explanation of how the BH I/DD Tailored Plan will ensure that physical, BH, and I/DD services are integrated under its VBP arrangements.
 - iv. The BH I/DD Tailored Plan's plan for measurement of outcomes and ROI related to VBP by year.
 - v. The BH I/DD Tailored Plan's approach to address Unmet Health-Related Resource Needs as part of its VBP strategy, including to align financial incentives and accountability around total cost of care and overall health outcomes. For full Healthy Opportunities requirements, see *Section V.B.3.x. Healthy Opportunities*.

- vi. A description of the BH I/DD Tailored Plan's IT capabilities, including specific systems, data sharing and data analytic capabilities currently in place versus those planned that will support the BH I/DD Tailored Plan VBP programs. Specific functionalities to address include:
 - a) Risk adjustment;
 - b) Receiving administrative, clinical, and claims/encounter data and sharing such data with providers;
 - c) Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - d) Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - e) Reporting capabilities; and
 - f) Payment functions.

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

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

6. Claims and Encounter Management

i. Claims

- (i) In order to incentivize successful Medicaid Managed Care and increase provider participation, the BH I/DD Tailored Plan shall pay all providers on a timely basis upon receipt of any Clean Claims for covered services rendered to members who are enrolled with the BH I/DD Tailored Plan in accordance with State and Federal statutes. To maximize Federal match and ensure accurate reporting, the BH I/DD Tailored Plan shall comply with the Department's Managed Care Provider Billing Guide or as otherwise directed by the Department.
- (ii) Incorrect claim payment or inappropriate claim denial result in increased administrative costs to both the provider and the BH I/DD Tailored Plan and by extension, increase the program costs of Medicaid Managed Care. Therefore, the BH I/DD Tailored Plan shall develop, maintain and operate a claims payment, review and Program Integrity process which minimizes incorrect claim payments and inappropriate claim denials.
- (iii) Claims Processing and Reprocessing Standards
 - (a) The BH I/DD Tailored Plan shall have the automated capability to identify, process, and reprocess claims as required by this Contract, and within the timeframes referenced or otherwise stated below. Automated capabilities may include, but are not limited to, reprocessing claims as directed by the Department, or when the Department decisions are made that would warrant reprocessing (i.e., member retrospective eligibility determinations or plan enrollment changes).
 - (b) In addition to processing claims for all Medicaid Managed Care covered services, the BH I/DD Tailored Plan shall have the operational and administrative capability to process ILOS, Value-Added Services, value-based services and qualifying EPSDT services which may be otherwise non-covered.
 - (c) The BH I/DD Tailored Plan shall process and reimburse providers in accordance with the Department's prompt payment standards, regardless of provider contracting status.

- (1) Prior to paying a claim, the BH I/DD Tailored Plan shall validate that the provider is eligible to be paid by North Carolina Medicaid regardless of provider contracting status.
 - (2) For the purposes of this requirement, the provider is deemed eligible to be paid if they are currently enrolled as a provider in the North Carolina Medicaid and NC Health Choice programs, are subject to an out-of-state exception, or the Department or other investigatory agencies have not initiated a payment suspension or withhold.
- (d) The BH I/DD Tailored Plan shall adhere to the following specifications when reimbursing medical and pharmacy claims, except for specific standards specified:
- (1) The BH I/DD Tailored Plan shall process claims in accordance with requirements set forth by the N.C. Gen. Stat. § 58-3-225.
 - (2) The BH I/DD Tailored Plan shall transmit and process data using ASC X12 standards, support provider payments, comply with data reporting requirements as specified pursuant to the Contract, and be of sufficient capacity to expand as needed to accommodate member enrollment or program changes.
 - (3) The BH I/DD Tailored Plan shall capture and retain the IP address/location and the user login/user name for all claims submitted via an on-line portal.
- (e) In instances where a provider submits an adjustment to a previously adjudicated claim, the BH I/DD Tailored Plan shall adjudicate the adjusted claim within the same timeframes as required for the initial Clean Claim.
- (f) The BH I/DD Tailored Plan shall provide an Electronic Remittance Advice or Standard Remittance Advice to the provider as explanation of the adjudication results and reimbursement of each claim.
- (g) The BH I/DD Tailored Plan shall ensure the claim processes align with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if BH I/DD Tailored Plan has delegated claims processing to a Subcontractor.
- (iv) Prompt Payment Standards
- (a) The BH I/DD Tailored Plan shall promptly pay Clean Claims, regardless of provider contracting status. The BH I/DD Tailored Plan shall reimburse providers in a timely and accurate manner when a clean medical or pharmacy claim is received.
 - (1) Medical Claims
 - i. The BH I/DD Tailored Plan shall, within eighteen (18) Calendar Days of receiving a medical claim, notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to timely process the claim.
 - ii. The BH I/DD Tailored Plan shall pay or deny a medical Clean Claim at lesser of thirty (30) Calendar Days of receipt of the Clean Claim or the first scheduled provider reimbursement cycle following adjudication.
 - iii. A medical pended claim shall be paid or denied within thirty (30) Calendar Days of receipt of the requested additional information.
 - (2) Pharmacy Claims
 - i. The BH I/DD Tailored Plan shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a pharmacy Clean Claim or pend the claim and request from the provider all additional information needed to timely process the claim.
 - ii. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.
 - (3) If the requested additional information on a medical or pharmacy pended Claim is not submitted within ninety (90) Calendar Days of the notice requesting the required

additional information, the BH I/DD Tailored Plan may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).

- (b) The BH I/DD Tailored Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this Section (including interest and penalties if applicable).
- (c) Pursuant to N.C. Gen. Stat. § 58-3-225(f), the BH I/DD Tailored Plan may require that claims be submitted within one hundred eighty (180) Calendar Days after the date of the provision of care to the member by the health care provider and, in the case of health care provider facility claims, within one hundred eighty (180) Calendar Days after the date of the member's discharge from the facility. However, the BH I/DD Tailored Plan may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days. Unless otherwise agreed to by the BH I/DD Tailored Plan and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.
- (d) Interest and Penalties
 - (1) The BH I/DD Tailored Plan shall pay interest on late payments to the provider, including, but not limited to, AMH+ practices and CMAs, at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid as specified in the Contract.
 - (2) In addition to the interest on late payments required by this Section, the BH I/DD Tailored Plan shall pay the provider, including, but not limited to, AMH+ practices and CMAs, a penalty equal to one percent (1%) of the claim for each Calendar Day following the date that the claim should have been paid as specified in the Contract.
 - (3) The BH I/DD Tailored Plan shall not be subject to interest or penalty payments under circumstances specified in N.C. Gen. Stat. § 58-3-225(k).
- (e) The BH I/DD Tailored Plan shall maintain written or electronic records of its activities under this Section in accordance with N.C. Gen. Stat. § 58-3-225(i).
- (f) For purposes of actions which must be taken by a BH I/DD Tailored Plan as found in *Section V.B.6.i.(iv) Prompt Payment Standards*, if the referenced Calendar Day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.
- (g) The PHP shall comply with the Department's Tribal Payment Policy, to be provided by the Department upon Contract Award.
- (v) Overpayment or Underpayment Recovery
 - (a) The BH I/DD Tailored Plan, or Subcontractor to the extent that the Subcontractor is delegated responsibility by the BH I/DD Tailored Plan for coverage of services and payment of claims under the Contract, shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. 42 C.F.R. § 438.608(a)(2).
 - (b) In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with N.C. Gen. Stat. § 58-3-225(h).
 - (c) The BH I/DD Tailored Plan shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.
- (vi) System Standards
 - (a) The BH I/DD Tailored Plan shall have a Claims Processing and Management Information System (MIS) capable of meeting Medicaid Managed Care requirements and maintaining compliance throughout the term of the Contract.

- (b) The BH I/DD Tailored Plan shall have a real-time claims reimbursement calculator that will allow providers to see the estimated contract reimbursement for a service provided to a member.
- (vii) Mass Adjustment
 - (a) The BH I/DD Tailored Plan shall have the capability to complete mass adjustments of adjudicated claims by provider types, claim types, and time period.
 - (b) The BH I/DD Tailored Plan shall comply with the Department's policies and procedures on mass adjustment.
- ii. Encounters
 - (i) The Department collects and uses provider service encounter data for many purposes including, but not limited to, Federal reporting, drug rebates, budgeting, rate setting, capitation payments and risk adjustment, qualified directed payments, services verification, Medicaid Managed Care quality improvement activity, fraud, waste, and abuse monitoring, measurement of utilization patterns and access to care, hospital assessment updates, and research studies.
 - (ii) The Department and its vendors, subcontractors, providers and other stakeholders rely on accurate, complete and timely encounter data to support the administration, clinical operations, care management, administrative policies, and financial responsibilities and objectives associated with Medicaid Managed Care.
 - (iii) Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, penalties and liquidated damages paid or recovered, incentive payments paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated services, third-party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the BH I/DD Tailored Plan, its delegees or Subcontractors.
 - (iv) Encounter data does not include rejected claims, where a rejected claim is defined as an EDI/HIPPA rejection and not a denied claim or claim line.
 - (v) Submission Standards and Frequency
 - (a) The BH I/DD Tailored Plan shall ensure that all HIPAA transactions adhere to the Department Encounter Companion Guide and Encounter Data Submission Guide developed by the Department or its vendor(s) to be provided at Contract Award.
 - (b) The BH I/DD Tailored Plan shall establish connectivity to the relevant Department encounter systems in accordance with policies, standards and/or regulations defined in the terms of the State System Use Agreement.
 - (c) The BH I/DD Tailored Plan shall submit encounter data to the Department at a frequency and level of detail specified in the Contract or in the Department's Encounter Companion Guide and Encounter Data Submission Guide.
 - (d) Encounter data submissions must contain adjustments made by BH I/DD Tailored Plan due to payment errors and/or provider adjusted claims.
 - (e) The BH I/DD Tailored Plan shall submit a monthly certification from the BH I/DD Tailored Plan Chief Executive Officer (CEO), Chief Financial Officer (CFO), or other designee that the complete encounter data set has been submitted for a designated month.
 - (f) The BH I/DD Tailored Plan is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. For atypical providers, who do not have an NPI, encounters shall contain an active Administrative Provider Identification (API) number (if one has been issued by the Department).
 - (g) Specifications
 - (1) Encounter data submissions to the Department must be created according to the guidelines outlined in the most current versions of Department's two publications, Encounter Companion Guide and Encounter Data Submission Guide.
 - (2) Encounters are defined in two (2) groups:

- i. BH, I/DD, TBI, ILOS, Value-Added services, value-based services, and ECM pilot services.
 - ii. Pharmacy, including outpatient pharmacy (point-of-sale), physician-administered (professional) and outpatient hospital (institutional) drug claims.
- (3) The BH I/DD Tailored Plan shall adhere to specifications for submitting medical encounter data to the Department in standardized Accredited Standards Committee (ASC) X12N 837 formats.
 - i. The BH I/DD Tailored Plan shall have the capability to submit to the Department encounter data from:
 - a) Professional claims that meet standardized X12 EDI Transaction Standard: 837P - Professional claims; and
 - b) Institutional claims that meet standardized X12 EDI Transaction Standard: 837I - Institutional Claims.
- (4) The BH I/DD Tailored Plan shall adhere to specifications for submitting pharmacy encounter data to the Department in standardized National Council for Prescription Drug Programs (NCPDP) formats.
- (5) The BH I/DD Tailored Plan, and its contracted PBM (as applicable), shall provide the exact amount paid to pharmacies for purposes of encounter data submitted to the Department.
- (6) The BH I/DD Tailored Plan shall reference the same edit codes as the Department's system, which are defined in the Department Encounter Submission Companion Guide, and Encounter Data Manual.
- (h) The BH I/DD Tailored Plan shall submit encounter file(s) to the Department that contain all available claims adjudication outcomes and claim adjustments since the last time that the BH I/DD Tailored Plan submitted an encounter data file.
- (i) Each encounter data file submitted to the Department shall adhere to the Department's benchmarks for data timeliness, completeness, and accuracy.
 - (1) Timeliness
 - i. Encounter data for medical claims, including those required to support reimbursement for additional utilization-based payments to certain providers as required under the Contract, shall be submitted no later than thirty (30) Calendar Days from the claim adjudication date.
 - ii. Encounter data for all pharmacy claims shall be submitted at least weekly and no more than seven (7) Calendar Days from the claim adjudication date.
 - (2) Completeness
 - i. The BH I/DD Tailored Plan shall submit all claims processed as encounters, as defined in this Section.
 - ii. The BH I/DD Tailored Plan encounter data submissions shall meet or exceed a monthly data acceptance rate of ninety-eight percent (98%) as compared to the BH I/DD Tailored Plan's monthly certification.
 - iii. Encounter data completeness shall be measured as the number of unique transactions submitted divided by the number of unique transactions which should have been submitted to the Department as an encounter.
 - iv. If the BH I/DD Tailored Plan encounter submission rate is less than one hundred percent (100%), the BH I/DD Tailored Plan shall submit one hundred percent (100%) of omitted encounters from the initial encounter submission date.
 - (3) Accuracy

- i. BH I/DD Tailored Plan encounter data submissions shall meet or exceed a monthly encounter data submission approval acceptance rate of ninety-eight percent (98%) for all services.
 - ii. Encounter data accuracy shall be defined as a paid claim submitted as an encounter which passes all validation edits (SNIP level 1-7 and State specific validations) and is accepted by the Department.
- (j) Initial Encounter Data at Medicaid Managed Care Launch
 - (1) The BH I/DD Tailored Plan shall include encounter data for medical claims which have a date of service on or after the Medicaid Managed Care launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.
 - (2) The BH I/DD Tailored Plan shall include encounter data for pharmacy claims which have a date of service on or after the Medicaid Managed Care Launch date on which the BH I/DD Tailored Plan becomes responsible for the administration of services.
- (k) To support the Department achieving efficient encounter data processing, the BH I/DD Tailored Plan shall ensure that Duplicate Records as defined by the Department are not submitted in encounter data submissions.
- (l) In the event the BH I/DD Tailored Plan enters into a sub-capitated or other VBP reimbursement arrangement with a provider, the BH I/DD Tailored Plan shall be responsible for submitting all encounters to the Department, containing all the required data fields.
- (m) The BH I/DD Tailored Plan shall limit the encounter data file so as to prevent the total transactions submitted on a single file from exceeding five thousand (5,000) transactions. A transaction shall be defined as an adjudicated claim which may contain one or more detail lines submitted as an encounter.
- (vi) Encounter Data Resubmission Standards
 - (a) Following the Department's validation and processing of encounter data submissions, the BH I/DD Tailored Plan shall receive notification of encounter records which fail edits. Encounter records that fail the Department's editing require remediation of the identified errors and resubmission to the Department and adherence to the resubmission standards.
 - (b) The Department has the discretion to retroactively deny any encounter for a period up to three (3) years after the initial date of service.
 - (1) The BH I/DD Tailored Plan shall work with the provider to correct claim submissions and shall waive timely filing requirements for corrected claims.
 - (2) The Department will work with a BH I/DD Tailored Plan for any retroactive encounter denial longer than three (3) years after the initial date of service.
 - (c) Timeliness
 - (1) The BH I/DD Tailored Plan will receive notification of encounter data errors requiring correction and resubmission within thirty (30) Calendar Days of the BH I/DD Tailored Plan's initial encounter data submission date.
 - i. BH I/DD Tailored Plan shall, where the BH I/DD Tailored Plan submits an 837 (I) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.
 - ii. BH I/DD Tailored Plan shall, where BH I/DD Tailored Plan submits an 837 (P) which triggers a Department negative 999 response, correct and resubmit the 837 to the Department no more than five (5) Business Days following the date that the negative 999 response is generated.

- (2) Within thirty (30) days after a pharmacy encounter fails NCPDP edits, X12 (EDI) edits or NC MMIS system edits, the BH I/DD Tailored Plan or its subcontractor shall correct and resubmit each pharmacy encounter for which errors can be remedied.
- (d) Completeness and Accuracy. Unless otherwise directed by the Department, the BH I/DD Tailored Plan shall correct and successfully resubmit:
 - (1) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of fifty percent (50%) of the errors corrected within fifteen (15) Calendar Days from the date the 277 was generated;
 - (2) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety percent (90%) of the errors corrected within thirty (30) Calendar Days from the date the 277 was generated;
 - (3) Ninety-nine percent (99%) of encounter transactions represented on an X12 277 Health Care Information Status Notification as requiring data correction in the increment of ninety-nine percent (99%) of reported errors within sixty (60) Calendar Days from the date the 277 was generated.
- (e) The BH I/DD Tailored Plan or its subcontractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP pharmacy encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) Calendar Days of the respective action.
- (vii) Data Validation and Processing
 - (a) The BH I/DD Tailored Plan shall have the capability to access sufficient enrollment information to perform member and service provider matching on all claim and/or encounter transactions, if necessary.
 - (b) The Department shall utilize data validation protocols on encounter data files to assess BH I/DD Tailored Plan encounter submissions for accuracy (e.g., SNIP Level 1 through 7 edits).
 - (c) The BH I/DD Tailored Plan shall perform testing with the Department prior to system changes when medical or pharmacy clinical policy changes that may impact operational transactions (i.e. encounter submissions) are identified by BH I/DD Tailored Plan or by Department. The BH I/DD Tailored Plan shall not implement any system changes until testing is approved by the Department.
 - (d) The BH I/DD Tailored Plan shall adhere to any structural changes to encounter data submission file formats as determined and communicated by the Department.
 - (e) The BH I/DD Tailored Plan shall, in instances where the BH I/DD Tailored Plan is required to make structural changes to the EDI files that are submitted to the Department, schedule with the Department sufficient time to test and successfully submit the modifications into the specified Department test environment no less than sixty (60) days prior to the date the modified file will be submitted to the Department production environment.
 - (f) The BH I/DD Tailored Plan shall make changes or corrections to any systems, processes, or data transmission formats within a mutually agreed upon timeframe with the Department to comply with data quality standards as defined within this Contract.
 - (g) At the discretion of the Department, the BH I/DD Tailored Plan may be prohibited from submitted a specific encounter type to the Department's Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the BH I/DD Tailored Plan. In addition, if the BH I/DD Tailored Plan's access to the Production Encounter Processing System is revoked, the BH I/DD Tailored Plan must actively test with the

Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any liquidated damages incurred by the BH I/DD Tailored Plan because of the loss of production access are the responsibility of the BH I/DD Tailored Plan.

(viii) Denied Claims Submitted as Encounters

- (a) The BH I/DD Tailored Plan shall submit denied claims as encounters to support denial trend analysis.
- (b) BH I/DD Tailored Plan submissions of denied claims as encounters must adhere to data quality editing and limited program editing.
- (c) On denied claims submitted as encounters, the BH I/DD Tailored Plan shall include the primary and any corresponding secondary denial reason code(s) on the 837 (I) or 837 (P) transactions.
- (d) Denied claims submitted as encounters must also include the same data content, including provider, member and service details, as a paid claim submitted as an encounter, except when the original claim was denied because it was submitted with insufficient information.
- (e) The BH I/DD Tailored Plan shall submit files that represent paid, denied, and adjusted claims submitted as encounters using the ASC X12 837 transaction or the Department designated pharmacy encounter format.

(ix) Communication and Oversight

- (a) If the BH I/DD Tailored Plan experiences a technical issue preventing encounter data submission, the BH I/DD Tailored Plan shall notify the Department via the approved communication method within the predefined timeline.
- (b) The BH I/DD Tailored Plan shall propose a plan for resolution, including the estimated timeline, to the Department for approval via the approved communication method when there is an issue within the BH I/DD Tailored Plan's system(s) or process(es) that prevents the BH I/DD Tailored Plan from submitting encounter data files as scheduled.
- (c) The BH I/DD Tailored Plan shall attend recurring quarterly and ad hoc encounter management meetings with the Department.
- (d) The BH I/DD Tailored Plan shall have a Department approved method to request ad hoc discussion sessions with the Department to address encounter data submission topics should the need arise outside of the Department reoccurring meeting schedule.

(x) Testing

- (a) The BH I/DD Tailored Plan will be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Department will provide a testing environment and adequate testing time for the BH I/DD Tailored Plan to validate all encounter types including encounters that trigger as many or all of the State's edits as possible. The BH I/DD Tailored Plan shall pass the testing phase for all encounter claim type submissions at a time specified by the Department
- (b) The BH I/DD Tailored Plan shall submit the test encounters to the Department electronically according to the specifications included in the Department's Encounter Submission Companion Guide and Encounter Data Manual.

(xi) In the event of Contract termination or non-renewal, the BH I/DD Tailored Plan shall continue to submit encounter data, in the method defined by the Contract, for ninety (90) Calendar Days following the Contract termination effective date for adjudicated claims with the date of service (DOS) on or before the Contract termination or non-renewal effective date.

(xii) In instances where the Contract has been terminated for greater than ninety (90) Calendar Days from the contract termination effective date, the BH I/DD Tailored Plan shall submit encounter data in agreed upon intervals when the claim DOS is on or before the effective date of Contract termination.

7. Financial Requirements

i. Capitation Payments

- (i) Capitation rates will be set by the Department and developed in an actuarially sound manner, reflecting the contractual requirements and expectations of BH I/DD Tailored Plans. Capitation payments include monthly PMPM payments, maternity event payments and payments for additional directed payments to certain providers as required under the Contract. This solicitation includes the Medicaid Tailored Plan Draft Rate Book which is intended to include sufficient information to support entities in making business decisions related to responding to the RFA. Final rates will reflect the more recent historical experience and changes to program requirements not reflected in the Medicaid Tailored Plan Draft Rate Book.
- (ii) The Department shall set capitation rates in accordance with actuarially sound principles and practices and submit said rates to CMS for approval in advance of rate effective dates. More information on rate setting can be found in the Medicaid Tailored Plan Draft Rate Book. Further details will be provided after Contract Award.
- (iii) The Department shall set BH I/DD Tailored Plan capitation rates on a periodic basis, typically annually, using the most recent data available deemed appropriate for rate development by the Department and its actuary. Rates may be revised within a rating period based on program changes or at the discretion of the Department.
- (iv) The rating period shall generally be defined as the period from July 1st of one year through June 30th of the following year to align with the State Fiscal Year. Shorter rating periods may apply but will be contained within the State Fiscal Year unless otherwise specified by the Department.
- (v) The BH I/DD Tailored Plan shall supply, certify, and validate data to support rate setting, risk adjustment (applicable to Standard Plan PHPs) and the risk corridor program (as applicable), and qualified directed payments based on schedules to be provided by the Department after Contract Award.
- (vi) The Department has established a separate maternity event payment. This payment will be made to the BH I/DD Tailored Plan after the BH I/DD Tailored Plan submits required documentation of a successful delivery event, defined as a qualifying birth, to the Department. The required documentation and process for submission will be finalized prior to Contract Year 1 effective date, and annually thereafter, and included in an Amendment.
- (vii) The Department has established a separate payment outside of the capitation rate for Tailored Care Management for members enrolled in Medicaid. This payment will be made to the BH I/DD Tailored Plan for any month in which the member is engaged in Tailored Care Management. For members enrolled in NC Health Choice, the cost of Tailored Care Management is incorporated in the capitation rate, and the Department will not make separate payments for Tailored Care Management for these members.
- (viii) The Department will reimburse BH I/DD Tailored Plan for additional directed payments to providers as required under *Section V.B.4.iv. Provider Payments* (as allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B)). The BH I/DD Tailored Plan is required to make these payments to certain providers but the payments are explicitly excluded from the prospective PMPM and maternity event capitation payments. The BH I/DD Tailored Plan shall provide the necessary data to support this process in a format and frequency to be defined by the Department.
- (ix) The Department will make capitation payments in accordance in with the Payment and Reimbursement term in *Section III.C.36. Payment and Reimbursement*.

ii. Medical Loss Ratio

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

- (ii) The BH I/DD Tailored Plan shall calculate and report aggregate MLR on an annual basis aligned to the rating year on two (2) bases as follows:
 - (a) The BH I/DD Tailored Plan shall calculate the CMS-defined MLR experienced in a MLR reporting year as defined in 42 C.F.R. § 438.8 and 42 C.F.R § 457.1203(c)-(f).
 - 1. The numerator of the BH I/DD Tailored Plan’s CMS-defined MLR for a MLR reporting year shall be defined as the sum of the BH I/DD Tailored Plan’s incurred claims, expenditures for activities that improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries as defined in 42 C.F.R. § 438.8(e).
 - 2. The denominator of the BH I/DD Tailored Plan’s CMS-defined MLR for a MLR reporting year shall equal the BH I/DD Tailored Plan’s adjusted premium revenue. The adjusted premium revenue shall be defined as the BH I/DD Tailored Plan’s premium revenue minus the BH I/DD Tailored Plan’s federal, state, and local taxes and licensing and regulatory fees as defined in 42 C.F.R. § 438.8(f).
 - (b) The BH I/DD Tailored Plan shall calculate the Department-defined MLR experienced in a MLR reporting year as the ratio of the numerator and denominator.
 - (1) The numerator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustments:
 - i. The BH I/DD Tailored Plan is permitted to include expenditures made for voluntary contributions to health-related resources that align with the Department’s Quality Strategy and meet the following conditions:
 - a) Meet standards established in the Department’s Quality Strategy that such contributions reflect meaningful engagement with local communities and are non-discriminatory with respect to individual members and North Carolina geographic areas, including rural areas.
 - b) Meet standards established in the Department’s Quality Strategy that the expenditures are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.
 - ii. The BH I/DD Tailored Plan is prohibited from including in the Department-defined MLR numerator any of the following expenditures:
 - a) Required additional directed payments to providers as required in the Contract and allowed under 42 C.F.R. § 438.6(c)(1)(iii)(B), that are reimbursed by the Department separate from the prospective PMPM capitation and maternity event payments.
 - b) Payments to related providers that violate the Payment Limitations as required in the Contract.
 - iii. The denominator of the Department-defined MLR shall be calculated in a manner similar to the CMS-defined MLR with the following adjustment:
 - a) Payments from the Department to reimburse for required additional directed payments to providers shall be subtracted from the denominator along with any associated taxes and fees.
- (iii) The following requirements apply to both the CMS-defined MLR and the Department-defined MLR:
 - (a) The BH I/DD Tailored Plan’s classification of activities that improve health care quality 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 liquidated damages assessed by the Department or other regulatory authorities;
 - (3) Rebates paid to the Department if the BH I/DD Tailored Plan exceeds the minimum MLR threshold for a prior year;
 - (4) Voluntary contributions to health-related resources made in lieu of rebates paid to the Department if the BH I/DD Tailored Plan exceeds the minimum MLR threshold for a prior year; and
 - (5) The BH I/DD Tailored Plan shall exclude from the MLR numerator any non-claims costs defined in 42 C.F.R. § 438.8(e)(2)(v)(A), PBM fees and spread pricing, marketing or branding material, related party administrative payments and margin, and administrative costs not allowed as health care quality improvement including corporate allocations.
- (c) The BH I/DD Tailored Plan shall aggregate data for all Medicaid eligibility groups covered under the Contract for purposes of calculating both the CMS-defined MLR and the Department-defined MLR.
 - (d) The BH I/DD Tailored Plan shall use a credibility adjustment, as defined in 42 C.F.R. § 438.8(h)(1)-(3), for plans with less than 380,000 member months in a MLR reporting year.
 - (e) Payments related to the Healthy Opportunities Pilot Program shall not be incorporated into the capitation payment nor into the MLR, unless otherwise required by CMS.
 - (f) All revenue, payments to providers and Tailored Plan expenditures related to Tailored Care Management shall be incorporated into the MLR except as otherwise excluded in Section V.B.7.b.iii.b.
 - (g) The BH I/DD Tailored Plan shall comply with the MLR calculation requirements outlined in the MLR templates and associated instructions to be provided by the Department.
- (iv) If the BH I/DD Tailored Plan's Department-defined MLR is less than the minimum MLR threshold, the BH I/DD Tailored Plan shall do one of the following:
 - (a) Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
 - (b) Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Regions and communities it serves, as described in *Section V.B.3.x. Healthy Opportunities*; a proposal for contributions must align with the Department's Quality Strategy and be reviewed and approved by the Department;
 - (c) Allocate a portion of the total obligation to contributions to health-related resources and the remaining portion to a rebate to the Department, with amounts for each at the discretion of the BH I/DD Tailored Plan.
 - (v) The minimum MLR threshold for the BH I/DD Tailored Plan 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.
 - (vi) The BH I/DD Tailored Plan must attest to the accuracy of the calculation of the CMS-defined and Department-defined MLR in accordance with the MLR standards within the Contract when submitting the required MLR reports in accordance with 42 C.F.R. § 438.8(n).
 - (vii) The BH I/DD Tailored Plan shall require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the BH I/DD Tailored Plan within one hundred eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the BH I/DD Tailored Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).

- (viii) In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the BH I/DD Tailored Plan shall:
- (a) Re-calculate the MLR for all MLR reporting years affected by the change, and
 - (b) Submit a new MLR report meeting the applicable requirements in accordance with 42 C.F.R. § 438.8(m).
- iii. Financial Management
- (i) The Department's financial management requirements were developed to monitor and promote program sustainability. The Department expects, and will rely upon, the BH I/DD Tailored Plan to be a good steward of Medicaid Managed Care resources, focusing expenditures on services and benefits that improve member health. The Department will pay the BH I/DD Tailored Plan a capitation payment that is set in an actuarially sound manner. The BH I/DD Tailored Plan is expected to manage BH I/DD Tailored Plan expenditures within the capitation payments and have access to sufficient capital to cover any losses the BH I/DD Tailored Plan experiences.
 - (ii) The BH I/DD Tailored Plan shall closely track and report their revenue and expenditures to demonstrate value to the Department as well as compliance with medical loss ratio standards. The Department will monitor BH I/DD Tailored Plan expenditures to evaluate program performance relative to benchmarks and support capitation rate setting, compliance reviews, and other functions necessary to operate the program.
 - (iii) Any financial arrangements between BH I/DD Tailored Plans and third parties should align with the parameters outlined in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*.
 - (iv) Managing and Monitoring Cost Growth
 - (a) The BH I/DD Tailored Plan shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations.
 - (b) Pursuant to N.C. Gen. Stat. § 108D-65(6)a., risk-adjusted cost growth for the BH I/DD Tailored Plan's members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."
 - (c) The Department shall monitor annual cost growth of BH I/DD Tailored Plan expenditures by Region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid.
 - (d) The BH I/DD Tailored Plan shall provide reports as requested, and in the format prescribed, by the Department to demonstrate annual cost growth as outlined in *Section VII. Attachment J. Reporting Requirements*. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.
 - (v) Pharmacy Savings
 - (a) N.C. Gen. Stat. § 108D-65(6)b., requires that BH I/DD Tailored Plan spending for prescribed drugs, net of rebates, ensures the Department realizes a net savings for the spending on prescription drugs. To ensure net savings, the Department shall monitor BH I/DD Tailored Plan compliance with the Department's Preferred Drug List and compliance with pharmacy claims encounter reporting.
 - (b) The BH I/DD Tailored Plan shall provide reports as requested, and in a format prescribed, by the Department to demonstrate net pharmacy savings as outlined in *Section VII. Attachment J. Reporting Requirements*.
 - (vi) Reinsurance
 - (a) The BH I/DD Tailored Plan shall have and maintain at all times an adequate plan for protection against insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C. Any reinsurance or alternative arrangement proposed by the BH I/DD Tailored Plan is subject to

review and approval by the Department. The agreement must provide that the Department will be notified no less than 60 days prior to cancellation or reduction of coverage.

- (b) The BH I/DD Tailored Plan shall purchase reinsurance to protect against the financial risk of high-cost individuals and shall submit to the Department proof of purchase or a proposal for an alternative mechanism for managing financial risk. The Department shall review the reinsurance arrangement or any such proposed alternative mechanism and shall notify the BH I/DD Tailored Plan of any required changes to the proposed reinsurance arrangement or alternative mechanism. The BH I/DD Tailored Plan shall maintain the reinsurance arrangement or alternative mechanism and submit any proposed changes to the Department for review and approval.
 - (c) The BH I/DD Tailored Plan shall provide the Department with a copy of the reinsurance policy specifying the costs and coverage terms or the documentation related to the approved alternative method of financial protection. The Department may require additional protections and documentation at any time.
 - (d) The Department reserves the right to revisit reinsurance requirements annually and to modify or establish the deductible threshold and coverage levels required by the Department, if, upon review of financial and encounter data or other information, fiscal concerns arise that a specific threshold is deemed warranted by the Department.
 - (e) The Department shall provide claims experience data or summaries providing a distribution of per Member per year claim spend to a BH I/DD Tailored Plan or its reinsurer within forty-five (45) calendar days of the request by the BH I/DD Tailored Plan.
 - (f) The BH I/DD Tailored Plan shall remain ultimately liable for the services rendered under the Contract. In the event of termination of the reinsurance agreement due to insolvency of the BH I/DD Tailored Plan or the reinsurance carrier, the BH I/DD Tailored Plan shall be fully responsible for all pending and unpaid claims.
 - (g) Any reinsurance agreements which cover expenses to be paid for continued benefits in the event of insolvency shall include Medicaid Managed Care Members as a covered class.
 - (h) The BH I/DD Tailored Plan shall notify the Department when the BH I/DD Tailored Plan incurs a claim against the reinsurance policy.
- (vii) Financial Viability
- (a) The BH I/DD Tailored Plan must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of this contract and N.C. Gen. Stat. § 122C.
 - (b) The BH I/DD Tailored Plan must, by Day 1 of BH I/DD Tailored Plan launch, fully fund BH I/DD Tailored Plan capital reserves at twelve and a half percent (12.5%)²² of total expected annual BH I/DD Tailored Plan Medicaid capitation.
 - (1) If a BH I/DD Tailored Plan fails to meet the Medicaid twelve and a half percent (12.5%) reserves requirement outlined in *Section V.B.7.iii.(vii) Financial Viability* by Day 1 of BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan must submit a viable plan outlining how the BH I/DD Tailored Plan will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements outlined in *Section V.A.1. vi. Readiness Reviews*.
 - (2) For a Tailored Plan to be considered viable at the time of readiness review and subsequently have their solvency plan evaluated, a BH I/DD Tailored Plan must document capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation by Day 1 of BH I/DD Tailored Plan launch.

²² 12.5% of expected annual BH I/DD Tailored Plan capitation is used as a proxy for appropriate Risk Based Capital (RBC) solvency standards. 300% RBC is approximately equal to 1.5 months of claims, or approximately 12.5%.

- (c) The BH I/DD Tailored Plan shall maintain capital reserves of at least 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation as determined from the monthly, quarterly, and annual financial reporting schedules.
 - (1) If a BH I/DD Tailored Plan's capital reserves fall below 9.0% of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline in capital reserves, proposed corrective action to increase capital reserves, and projections of the impact of the corrective actions on the capital reserve levels.
 - (2) If a BH I/DD Tailored Plan's capital reserves fall below 6.25 % of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the BH I/DD Tailored Plan must submit a report to the Department as described in *Section V.B.7.iii.(vii)(c)(1)* for Department review. The Department reserves the right to stipulate required corrective action for the BH I/DD Tailored Plan.
 - (3) If a BH I/DD Tailored Plan capital reserves fall below 4.0 % of total expected annual BH I/DD Tailored Plan Medicaid Capitation in any quarterly statement, the Department reserves the right to place the BH I/DD Tailored Plan under the control of the regulator or initiate actions outlined in *Section V.B.7.iii.(vii)(c)(2)*.
- (d) The Department will provide expected annual BH I/DD Tailored Plan Medicaid Capitation revenue for use in these calculations. Medicaid capitation revenue will include monthly PMPM capitation payments and maternity event payments, but exclude all other managed care payments defined in *Section 5.a of the Terms and Conditions* (i.e. Tailored Care Management payments, monthly single stream allocations, additional directed payments to certain providers, and any Healthy Opportunity Pilot program payments.)
- (e) For purposes of the capital requirements, capital reserves are defined as unobligated assets net of liabilities.
- (f) The BH I/DD Tailored Plan must, at least ninety days (90) before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the North Carolina Department of Insurance (DOI), as outlined in N.C. Gen. Stat. § 58-93-110, contingent upon legislative authority.
- (g) The BH I/DD Tailored Plan shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current Assets include any short-term investments that can be converted to cash within five (5) Business Days without significant penalty. Significant penalty is a penalty greater than twenty percent (20%).
 - (1) If a BH I/DD Tailored Plan's Current Ratio falls below 1.0 at any point in time, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.
- (h) The BH I/DD Tailored Plan shall maintain a Defensive Interval Ratio above thirty (30) Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the period measured in days.
 - (1) If a BH I/DD Tailored Plan's Defense Interval Ratio falls below 30 days at any point in time, the BH I/DD Tailored Plan must submit a report to the Department that describes the reason for the decline, proposed corrective action to increase the ratio, and projections of the impact of the corrective actions.
- (i) The BH I/DD Tailored Plan shall comply with financial viability standards related to liquidity to pay Medicaid Managed Care claims established by the Department.
- (j) The Department may, at its discretion, implement a risk corridor program to provide additional protection to the BH I/DD Tailored Plan and the Department to address any uncertainty

associated with pricing or enrollment. In the event the Department implements such a program, additional details of the program will be included in an amendment to this Contract.

(viii) Financial Accounting and Audit

- (a) The BH I/DD Tailored Plans accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations (FAR), Generally Accepted Accounting Principles (GAAP), and this Contract. The Department will not recognize or pay services that cannot be properly substantiated by the BH I/DD Tailored Plan and verified by the Department. The BH I/DD Tailored Plan shall:
 - (1) Maintain accounting records for this Contract separate and apart from other corporate accounting records;
 - (2) Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
 - (3) Ensure and provide access to the Department and/or its auditors or agents to the detailed records and supporting documentation for all costs incurred by the BH I/DD Tailored Plan. The BH I/DD Tailored Plan must ensure such access to its Subcontractors, including Affiliates, for any costs billed to or passed to the BH I/DD Tailored Plan;
 - (4) Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts;
 - (5) Provide copies of the most recent annual audit within thirty (30) calendar days of certification, to verify the BH I/DD Tailored Plan's financial status, solvency, and viability; and
 - (6) Provide copies of the BH I/DD Tailored Plan's annual cost allocation plan for the Department's review at least sixty (60) calendar days prior to the start of the state fiscal year.
- (b) The annual financial audit and cost allocation plans shall be subject to annual independent verification and audit by the Department or a firm(s) of the Department's choosing, in accordance with the Office of Management and Budget (OMB) Circular A-133 and OMB Circular A-87. All such audits shall be arranged to occur at dates and times that are mutually agreeable, and the BH I/DD Tailored Plan shall be provided with reasonable notice of the Department's intent to perform, or cause to be performed, any such audits. The costs for such audits shall be the responsibility of the Department.
- (c) The BH I/DD Tailored Plan shall reimburse the Department, if reimbursement is sought, for reasonable costs incurred by the Department to perform examinations, investigations, audits, or other types of attestations the Department reasonably determines are necessary to ensure BH I/DD Tailored Plan compliance with this Contract. The use and selection of any external parties to conduct examinations, investigations, audits, or other types of attestations as well as the scope of work of examinations, investigations, audits, or other types of attestations are at the Department's sole discretion.
- (d) If, as a result of an audit or review of payments made to the BH I/DD Tailored Plan, the Department discovers a payment error or overcharge, the Department will notify the BH I/DD Tailored Plan of such error or overcharge. The Department will be entitled to recover such funds as an offset to future payments to the BH I/DD Tailored Plan, or to collect such funds directly from the BH I/DD Tailored Plan.
 - (1) The BH I/DD Tailored Plan must return funds owed to the Department within thirty (30) days after receiving notice of the error or overcharge, or interest will accrue on the amount due.

- (2) The Department will calculate interest at twelve percent (12%) per annum, compounded daily. In the event that an audit reveals that errors in reporting by the BH I/DD Tailored Plan have resulted in errors in payments to the BH I/DD Tailored Plan, the BH I/DD Tailored Plan will indemnify the Department for any losses resulting from such errors, including the cost of audit.

8. Technical Specifications

i. Data Exchange Model

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

No.	Data Exchange Description – For Informational Purposes
1.	<p>The BH I/DD Tailored Plan will send the Department or its Vendors the following data:</p> <ul style="list-style-type: none"> a. Encounter Data – Medical and pharmacy encounter data b. AMH+/CMA Assignment Data c. PCP Assignment Data d. Lock-in Data – Member lock-in data (including pharmacy and prescriber) e. Provider Network Data f. Member Insurance Data g. Member Enrollment – On request the BH I/DD Tailored Plan will send the Department its current, complete roster of members
2.	<p>The Department will send the BH I/DD Tailored Plan the following data:</p> <ul style="list-style-type: none"> a. Enrollment Data – The Department will send a daily 834 transaction with new, modified, and terminated member records b. Capitation Payment Information c. Member Reconciliation Date – The Department will send weekly 834 files to be used by the BH I/DD Tailored Plan for reconciliation purposes
3.	<p>The Department will send the Enrollment Broker the following data:</p> <ul style="list-style-type: none"> a. NC Medicaid Direct Providers – The Department will send the Enrollment Broker its NC Medicaid Direct provider roster for inclusion in the Consolidated Provider Directory.
4a.	<p>The Department will send to its Provider Data Contractor (PDC) its roster of Managed Care Medicaid Providers on a daily basis. This will be a full file.</p>
4b.	<p>The PDC will add supplementary data to the Departments Provider data and make available to the BH I/DD Tailored Plan via a secure FTP site. This data is the Department's Provider data to be used by the BH I/DD Tailored Plan for contracting and Provider reconciliation. This will be a full file.</p>
5.	<p>The BH I/DD Tailored Plan will send the Enrollment Broker the following data:</p> <ul style="list-style-type: none"> a. All Contracted Providers – The BH I/DD Tailored Plan will send to the Enrollment Broker its directory of contracted providers for inclusion in the Consolidated Provider Directory

No.	Data Exchange Description – For Informational Purposes
6.	The BH I/DD Tailored Plan will send data to the AMH+s/CMAA or CINs or Other Partners on their behalf as described in <i>Section V.B.3.ii.(xv) Data System Requirements, Data Sharing, and Risk Stratification</i> .
7.	The BH I/DD Tailored Plan and the Provider will exchange the following data: <ul style="list-style-type: none"> <li data-bbox="358 386 1421 443">a. Claims Data – The Contracted Providers will send claims data for payment to the BH I/DD Tailored Plan <li data-bbox="358 449 1421 470">b. Payment Data – The BH I/DD Tailored Plan will send payments to the provider

ii. Electronic Data Submission

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

- (a) Integrations between the BH I/DD Tailored Plan, the Department, and Department vendors will be required to facilitate the exchange of data and information necessary to operate the program. The Department has provided high level information on these exchanges; however, additional specific details of these integrations will be provided upon Contract Award. To the extent possible all integrations will follow industry standard formats, protocols, and connectivity methods.
- (b) The BH I/DD Tailored Plan shall not transmit protected health information (PHI) or any other sensitive data as defined by the Department over unsecure or open communication channels unless the information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 142.308(d).
- (c) If the BH I/DD Tailored Plan stores, transmits, or maintains data or information in an encrypted format, the BH I/DD Tailored Plan will, at the Department’s request, provide the Department with the software keys or passwords to unlock such information within seventy-two (72) hours.
- (d) The BH I/DD Tailored Plan will work with the Department or its designated Vendor to establish and manage all integration.
- (e) Failures in data exchanges and interfaces that are not resolved immediately through normal operations must be reported to the Department within twenty-four (24) hours. If the failure impacts the BH I/DD Tailored Plan’s ability to deliver member services, it must be reported immediately. The BH I/DD Tailored Plan will provide a root cause analysis (RCA) which details the causes, impacts, downtime, and remediations required to resolve the issue no more than seventy-two (72) hours after the resolution of the failure. The Department may require additional information if the initial RCA does not include adequate information. The Department at its discretion will track issues reported by the BH I/DD Tailored Plan and may require a more comprehensive corrective action plan if the Department identifies trends in the BH I/DD Tailored Plan’s performance.

(ii) Retransmissions

- (a) If the BH I/DD Tailored Plan receives an unintelligible transmission from the Department or Department vendor, the BH I/DD Tailored Plan will immediately notify the Department and the Department shall retransmit as soon as the errors are remediated.
- (b) If the BH I/DD Tailored Plan is notified by the Department or the Department’s vendor of the receipt of an unintelligible transmission, the BH I/DD Tailored Plan shall retransmit as soon as the errors are remediated.
- (c) For the purposes of this Section, an unintelligible file shall be defined as any file that does not conform with the format of the data exchange or interface, is not readable by the target systems due to a malformed file (i.e. corrupt data, unparseable xml, etc.), or is incomplete.

(iii) Test Data Transmission

- (a) The BH I/DD Tailored Plan will be required to test all data transmissions with the Department and the Department's agents and vendors to validate connectivity, format, and data including those required for member enrollment prior to open enrollment as well as those needed for daily operations. This may include data exchanges between the Department and the BH I/DD Tailored Plan, or between the BH I/DD Tailored Plan and other Department vendors such as the Enrollment Broker or Provider Data Contractor. The Department will oversee any testing and review results. If the testing is not successful, the Department will define an appropriate remediation period if not defined in other sections of the Contract.
- iii. Enrollment and Reconciliation
- (i) Member Enrollment and Reconciliation
 - (a) Enrollment:
 - (1) The BH I/DD Tailored Plan shall accept an 834 eligibility file daily from the Department with new, modified, and terminated member records.
 - (2) The BH I/DD Tailored Plan shall add, modify, or terminate members daily based on 834 eligibility file.
 - (3) The BH I/DD Tailored Plan shall send a daily pharmacy lock-in file to the Department, or entity designated by the Department.
 - (b) Reconciliation:
 - (1) The Department will provide to the BH I/DD Tailored Plan a weekly 834 eligibility file, including all members who were added, modified, and terminated for the period.
 - (2) The BH I/DD Tailored Plan at a minimum shall reconcile membership data with the Department using the weekly 834 eligibility file.
 - (3) At the Department's request, the BH I/DD Tailored Plan shall provide a full roster of members currently enrolled in their BH I/DD Tailored Plan in the Department's preferred format within seventy-two (72) hours.
 - (4) The BH I/DD Tailored Plan is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.
 - (5) The Department shall determine if corrections are needed to the enrollment data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
 - (6) The Department shall, if any enrollment corrections are identified, include such correction in the next daily 834 eligibility files sent to the BH I/DD Tailored Plan.
 - (7) The BH I/DD Tailored Plan shall add, modify, or terminate members based on the identified correction and corrected files sent by the Department to address discrepancies identified during reconciliation.
 - (8) The BH I/DD Tailored Plan shall reconcile the monthly 820 payment file with the weekly 834 eligibility file.
 - (9) The Department's capitation payment reconciliation will be based on enrollment reconciliation and may result in changes to the next monthly capitation payment.
 - (10) In addition to the reconciliation process defined above, the BH I/DD Tailored Plan shall be able to identify duplicate members and report those findings to the Department in a format defined by the Department.
 - (ii) AMH+/CMA and PCP Assignment and Reconciliation
 - (a) All AMH+/CMA and PCP assignments will be transmitted to the BH I/DD Tailored Plan by the Department via an 834 transaction daily.
 - (b) The BH I/DD Tailored Plan shall reconcile AMH+/CMAs and PCP data with the Department at least monthly using the monthly 834 file described above.
 - (c) The BH I/DD Tailored Plan is responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.

- (d) The Department shall determine if corrections are needed to the AMH+/CMAs and PCP data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
- (iii) Provider Enrollment and Credentialing
 - (a) The Department or a designated vendor will provide to the BH I/DD Tailored Plan a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment and credentialing information.
 - (1) During the Provider Credentialing Transition Period, the information will be provided daily, in a format and transmission protocol to be defined by the Department.
 - (2) After the Provider Credentialing Transition Period, the information will be provided on a frequency and a format to be defined by the Department. The Department will provide the BH I/DD Tailored Plan a notice of change to the frequency and format not less than one hundred twenty (120) days prior to implementation.
 - (b) The BH I/DD Tailored Plan shall reconcile provider data with the Department, or designated vendor, at least monthly.
 - (c) The BH I/DD Tailored Plan is responsible for notifying the Department, or designated vendor, of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.
 - (d) The Department, or designated vendor, shall determine if corrections are needed to the provider data to address BH I/DD Tailored Plan discrepancies identified during reconciliation.
- iv. Provider Identification Numbers (NPIs, APIS)
 - (i) In accordance with requirements set forth in Sections 1932(d)(4) and 1173(b)(2) of the Social Security Act, the BH I/DD Tailored Plan must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the BH I/DD Tailored Plan.
 - (ii) The Department produces a daily provider file that includes all active and terminated Medicaid Providers. BH I/DD Tailored Plan is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.
- v. Provider Directory
 - (i) The BH I/DD Tailored Plan shall develop a Provider Directory in accordance with *Section V.B.4.ii. Provider Network Management* NCTracks is responsible for integrating the provider directory information to supply the Enrollment Broker with a Consolidated Provider Directory to support BH I/DD Tailored Plan choice counseling and selection.
 - (a) The BH I/DD Tailored Plan should use the National Provider Identifier (NPI) issued by NPPES plus the NCTracks assigned Service Location Code as the unique provider identifier. For those providers who do not qualify for NPIs, the Atypical Provider ID issued by the Department's NCTracks system should be used.
 - (b) The BH I/DD Tailored Plan shall ensure the Provider Directory aligns with the parameters laid out in *Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships*, if the BH I/DD Tailored Plan delegates this activity to a Subcontractor.
 - (ii) Consolidated Provider Directory Data Transmissions
 - (a) The Department has appointed NCTracks with the creation of a Consolidated Provider Directory which will include all Medicaid Managed Care and NC Medicaid Direct providers.
 - (b) The BH I/DD Tailored Plan will, at a frequency defined by the Department, create a full provider directory file including data (as defined in the Contract) on all contracted providers in its network. The BH I/DD Tailored Plan will deliver the file to NCTracks based on defined technical process.
 - (c) The final file format will be determined by NCTracks or the State's PDM; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).

- (d) The transport method will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).
- (e) The Department, at its discretion, may add additional information to the file layout based on the needs of the Department and the final technical configuration determined by the Enrollment Broker or NCTracks.
- (f) The BH I/DD Tailored Plan shall be provided with policies and process flows developed by the Enrollment Broker that defines the overall process.
- (g) The Department has recommended that the Enrollment Broker leverage the open source tools developed by healthcare.gov in developing the Consolidated Provider Directory. The BH I/DD Tailored Plan should review this information as well as it will be the basis of the interface between the BH I/DD Tailored Plan and the Enrollment Broker. The documentation is available at <https://www.healthcare.gov/developers/>.

vi. Technology Documents

- (i) The BH I/DD Tailored Plan shall provide the following documents to the Department for review and approval thirty (30) Calendar Days after Contract Award. The Department may request additional information be made available or developed if the documentation is not satisfactory.
- (ii) Security Compliance Plan: The BH I/DD Tailored Plan shall provide a plan that details how the BH I/DD Tailored Plan will comply with all of the Departments' Confidentiality, Privacy and Security Protections requirements as outlined in the Contract. After approval by the Department, the Security Compliance Plan shall be updated annually and resubmitted to the Department for review. The plan must include at a minimum:
 - (a) Approach to customer and member data protection including internal programs and policies;
 - (b) Approach to compliance with Federal, State, and Department standards including audit and oversight processes;
 - (c) Approach to complying with HITECH and HIPAA;
 - (d) Process and procedures necessary to comply with 42 C.F.R. Part 2, as applicable, and the Department's related requirements. This includes but is not limited to procedures to:
 - (1) Evaluate prior to disclosure whether the information sought to be disclosed is protected by 42 C.F.R. Part 2; and
 - (2) Where appropriate, secure Member consent prior disclosing member protected health information covered under 42 C.F.R. Part 2 requirements and;
 - (3) Establish-functionality or procedures to remove or redact information protected by 42 C.F.R. Part 2 prior to disclosure of the information.
 - (e) Approach to risk analysis and assessment associate with NIST;
 - (f) Processes for monitoring for security vulnerabilities including the use of external organization such as US CERT;
 - (g) Processes and plans for vulnerability and breach management including response processes; and
 - (h) Software and infrastructure development and maintenance processes including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software).
- (iii) Encounter Implementation Approach. The BH I/DD Tailored Plan shall provide a plan that shows how the BH I/DD Tailored Plan will implement its encounter submission capabilities and comply with all requirements as outlined in the Contract. This includes, at a minimum:
 - (a) Approach to meeting performance, accuracy, and timeliness requirements;
 - (b) Operating model including staffing and technology to process and submit encounters;
 - (c) Reference data management process including how the State's reference data (if applicable) will be integrated into the encounter management process;

- (d) Change management plan including how changes to the encounter submission infrastructure are tested and implemented;
 - (e) Quality assurance and process improvement processes including how errors detected by the State's Encounter Processing System are addressed by the BH I/DD Tailored Plan, as well as how continuous improvement is integrated into the overall process. This Section should also include how best practices and technology advances such as the PACDR versions of the 837 are integrated into the Applicant's processes; and
 - (f) The plan should include distinctions for medical (i.e., integrated physical and BH services) and pharmacy encounter management.
- (iv) System Interface Design. The BH I/DD Tailored Plan shall work with the Department or its designated vendor to fully document the system integration, exchanges, and interfaces required to comply with the Contract. This System Interface Design must be maintained throughout the term of the Contract and will follow Department Enterprise Architecture standards. This includes, at a minimum:
- (a) Detailed design by interface showing the BH I/DD Tailored Plan approach to meeting the requirements defined by the State;
 - (b) Approach to managing EDI transactions including technology;
 - (c) Technical integration architecture including the Applicant's technical approach to integrating multiple internal systems with external partners;
 - (d) Operating model around interface and batch management including staffing and technical architecture. This Section should include the processes for managing failures in transmissions; and
 - (e) Software and platform testing processes for new interfaces including the data management approach.
- (v) System Test Plan. The BH I/DD Tailored Plan shall develop and maintain a System Test Plan inclusive of the BH I/DD Tailored Plan's Software Delivery Life Cycle testing (SDLC), including testing phases (Unit/Assembly, System Integration/Regression Testing, Performance/Security Testing, and UAT Testing as applicable) that will occur as part of the implementation. The Test Plan shall be submitted to the Department annually at the end of each Contract Year by July 31 and otherwise upon request by the Department and shall include:
- (a) High level description of the scope of each testing phase;
 - (b) Applications or Systems that are part of the testing;
 - (c) Integrations that are part of the testing;
 - (d) Testing techniques or tools that will be used for testing;
 - (e) Test Environment; and
 - (f) Test Metrics and Reporting of Defects.
- vii. BH I/DD Tailored Plan Data Management and Health Information Systems
- (i) The following Section contains high-level information on Health Information System and member data that will be established, maintained, analyzed, and reported by the BH I/DD Tailored Plan. Specific details on the data, analysis, and reporting will be provided upon Contract Award.
 - (a) The BH I/DD Tailored Plan shall maintain a health information system that collects, analyzes, integrates, and provides operational reporting data for both the BH I/DD Tailored Plan's operations as well as satisfying the reporting requirements detailed in this RFA which may include but are not limited to utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.
 - (b) The BH I/DD Tailored Plan shall comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

- (c) The BH I/DD Tailored Plan shall collect and maintain data on member and provider characteristics and interactions as specified by the Department and on all services furnished to members through a claims processing system or other methods as specified by the state.
 - (d) All data, reports, and information submitted by the BH I/DD Tailored Plan on behalf of the providers (including providers within or outside of its networks) shall be validated by the BH I/DD Tailored Plan as accurate and complete prior to submission.
 - (e) The BH I/DD Tailored Plan shall collect data from providers in standardized formats to the extent feasible and appropriate and where prescribed by the State.
 - (f) The BH I/DD Tailored Plan shall make all collected data available to the Department and upon request to CMS.
- (ii) The BH I/DD Tailored Plan shall submit encounters and claims to North Carolina's Health Information Exchange, known as NC HealthConnex, as defined in N.C. Gen. Stat. § 90-414.4.