



Solicitation Addendum

Solicitation Number: 30-2020-052-DHB
Solicitation Description: BH I/DD Tailored Plan Request for Applications (RFA)
Solicitation Opening Date and Time: February 2, 2021 at 2:00 PM ET
Addendum Number: 7
Addendum Date: December 18, 2020
Addendum Description/Purpose: Revisions to RFA
Contract Specialist: Kimberley Kilpatrick
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NOTIFICATIONS AND INSTRUCTIONS:

- 1. Return one properly executed copy of this Addendum #7 with response. Failure to sign and return this Addendum #7 may result in the rejection of Offeror's proposal.**
 - 2. Carefully read, review, and adhere to all revisions to the RFA in this Addendum #7**
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1. Section III. Definitions, Abbreviations, Contract Term, General Terms and Conditions, Other Provisions and Protections, D. General Terms and Conditions, 39. Records Retention, sub-paragraphs a. and h. are revised and restated as follows, all other sub-paragraphs of that section remain unchanged:

- a. All records created or modified by the Contractor and not duplicated in Department system via interfaces must be retained for ten (10) years, unless a longer period is required by federal or state law or policy. Federal record retention standards for Medicaid are located in 42 CFR 431.17 and for Medicaid managed care in 42 CFR 438.3(u). The State policy is mandated by the State Archives of North Carolina and is located here: <https://archives.ncdcr.gov/government/retention-schedules>.
- h. BH I/DD Tailored Plan shall comply with all standards for record retention in 42 CFR 438.3(u) and the standards determined by the Department.

2. Section IV. Table 1: Minimum Qualifications is revised and restated in its entirety as follows:

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

3. Section V.A.1.i: Table 1. Key Personnel Requirements is revised and restated in its entirety as follows:

Section V.A.1.i.: <i>First Revised and Restated</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

Section V.A.1.i.: *First Revised and Restated* Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
<p>2. Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for accounting and finance operations, including financial audit activities</p>	<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
<p>3. Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training</p>	<ul style="list-style-type: none"> • Must 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
<p>4. Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • 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

Section V.A.1.i.: *First Revised and Restated* Table 1. Key Personnel Requirements

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<p>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.</p> <ul style="list-style-type: none"> • 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	<p>Individual who oversees and manages all fraud, waste, and abuse and compliance activities</p> <ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program and State-funded Services	<p>Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected</p> <ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years' experience in health care

Section V.A.1.i.: *First Revised and Restated* Table 1. Key Personnel Requirements

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<p>7. Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>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.</p>	<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
<p>8. Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and related member and provider appeals. Individual reports to the CMO.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT)
<p>9. Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>Individual responsible for providers services and provider relations, including all network development and management issues. Individual reports to the COO.</p>	<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
<p>10. Deputy Chief Medical Officer of North Carolina Medicaid Managed Care</p>	<p>Individual who oversees and is responsible for activities as assigned by the CMO including but not limited to the proper provision of covered services to members, developing clinical practice</p>	<ul style="list-style-type: none"> • Must reside in North Carolina

Section V.A.1.i.: *First Revised and Restated* Table 1. Key Personnel Requirements

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<p>Program and State-funded Services</p>	<p>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"> • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If the CMO is a psychiatrist: <ul style="list-style-type: none"> ○ Must be a primary care physician fully licensed to practice in NC and in good standing. ○ Minimum of five (5) years clinical experience and two (2) years' experience in managed care ○ Clinical experience with child/adolescent and adult populations is preferred. If individual does not have child/adolescent and adult populations experience, direct medical staff reports must have experience with these populations. • If the CMO is a primary care physician: <ul style="list-style-type: none"> ○ Must be a psychiatrist fully licensed to practice in NC and in good standing ○ Minimum of five (5) years' experience in a BH and/or I/DD clinical setting and two (2) years' experience in managed care

Section V.A.1.i.: *First Revised and Restated* Table 1. Key Personnel Requirements

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

Section V.A.1.i.: *First Revised and Restated* 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)
13.	<p>Pharmacy Director of North Carolina Medicaid Managed Care Program</p> <p>Individual who oversees and manages the BH I/DD Tailored Plan pharmacy benefits and services.</p> <p><i>Individual reports to the CMO.</i></p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a North Carolina-registered pharmacist with a current NC pharmacist license • Minimum of three (3) working years of Medicaid pharmacy benefits management experience

4. Section V. Scope of Services, A. Unified. 1. Administration and Management, i. Medicaid Program and State-funded Services Administration, (v) is revised and restated in its entirety as follows:

(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 Department to reimburse the BH I/DD Tailored Plan for any of its duties under this Contract. The BH I/DD Tailored Plan will be subject to rigorous monitoring and oversight by the Department across key administrative, operational, clinical, and financial metrics to ensure that the BH I/DD Tailored Plan has an adequate Network, delivers high quality care, and operates a successful Medicaid Managed Care program.

5. Section V. Scope of Services, A. Unified 1. Administration and Management iii. National Committee for Quality Assurance (NCQA) Accreditation (ii) is revised and restated in its entirety as follows:

(ii) *In accordance with 42 C.F.R. § 438.322*, the BH I/DD Tailored Plan shall, starting in Contract Year 1, provide all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO.

6. **Section V. Scope of Services. A. Unified. 1. Administration and Management, ix. Staffing and Facilities for Medicaid and State-funded Services, (xii)(e)(26) is revised and restated in its entirety as follows:**
- (26) [Reserved](#);
7. **Section V. Scope of Services. A. Unified. 1. Administration and Management, vii. Non-discrimination for Medicaid and State-funded Services, (i)(iv)(a)(4) is revised and restated in its entirety as follows:**
- (4) The BH I/DD Tailored Plan's internal complaint process for members, recipients, and employees including [penalties](#);
8. **Section V. Scope of Services, A. Unified 2. Program Operations, i. Service Lines for Medicaid and State-funded Services, (xiii)(b) is revised and restated in its entirety as follows:**
- (b) All costs accrued, due, and owing on these numbers upon termination or expiration of the Contract, including but not limited to, any taxes, [penalties](#) or fines shall be the sole obligation of the BH I/DD Tailored Plan and shall be paid prior to the Department taking title.
9. **Section V. Scope of Services, A. Unified, 3. Compliance, ii. Program Integrity (PI) for Medicaid and State-funded Services, (i), (c) Suspensions and Withholds for Payments to Providers for Program Integrity for Medicaid and State-funded Services, (8) is deleted in its entirety.**
10. **Section V. Scope of Services A. Unified 3. Compliance ii. Program Integrity (PI) for Medicaid and State-funded Services (ii)(e) is revised and restated in its entirety as follows:**
- (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, the Comptroller General, [Members, and Recipients](#) a description of transactions between the BH I/DD Tailored Plan and a party in interest as defined in section 1318(b) of the Public Health Services Act, including the following transactions:
11. **Section V. Scope of Services, A. Unified, 3. Compliance, ii. Program Integrity (PI) for Medicaid and State-funded Services, (ii)(f), (1) and (4) are revised and restated as follows:**
- (1) The BH I/DD Tailored Plan shall have a policy and procedure which complies with the requirements of the DRA of 2005, which requires entities that make or receive annual Medicaid payments of five million (\$5,000,000) or more to provide detailed information in written policies applicable to employees, contractors, and agents about the federal False Claims Act and any state laws that pertain to civil or criminal [penalties](#) for making false claims and statements to the government or its agents. 42 C.F.R. § 438.608(a).
- (4) The BH I/DD Tailored Plan shall require Subcontractors to have compliance programs that meet the requirements of 42 C.F.R. § 438.608 and a policy and procedure that meet the DRA of 2005 requirements.
12. **Section V. Scope of Services, A. Unified, 3. Compliance, iii. Fraud, Waste, and Abuse Prevention for Medicaid and State-funded Services, (i), (g) is revised and restated in its entirety as follows:**
- (g) Refer all allegations of fraud, abuse, or waste to the Department within the timeframes and in the formats specified by the Department.

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

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

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

- (b) Once an allegation of fraud has been referred to the Department, until further written notice by the Department, the BH I/DD Tailored Plan shall not take any further action including the following:
 - (1) Contacting the subject of the investigation about any matters related to the investigation;
 - (2) Continuing the investigation into the matter;
 - (3) Entering into or attempting to negotiate any settlement or agreement regarding the matter; or
 - (4) Accepting any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

15. Section V. Scope of Services, B. Medicaid, 1. Members, iv. Notice of Adverse Benefit Determination (e) Timing of the Notice of Adverse Benefit Determinations, (4) i. and ii. are deleted and (4) is revised and restated in its entirety as follows:

- (4) For denial of payment, the PHP shall give written notice to the Member and, when applicable, an authorized representative at the time of any action affecting the claim. 42 CFR 438.404(c)(2).

16. Section V. Scope of Services, B. Medicaid, 1. Members, iv. Notice of Adverse Benefit Determination (f) Internal Plan Appeals, 8. Request for Plan Appeals iii. Standard resolution of appeals, sub-paragraphs c), d), e), and f) are deleted in their entirety.

17. Section V. Scope of Services B. Medicaid 2. Benefits (v) Utilization Management (b) UM Program Policy (6) is revised and restated in its entirety as follows:

- (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), [42 C.F.R. § 438.905](#), and 438.910(b)-(d).

18. Section V. Scope of Services, B. Medicaid, 3. Care Management, ii. Tailored Care Management, (viii) Development of Care Plan/Individual Support Plan (ISP), (f) is revised and restated in its entirety as follows:

- (f) The BH I/DD Tailored Plan shall ensure that development of the Care Plan or ISP does not delay the provision of needed services to a member in a timely manner, even if that member is waiting for a Care Plan/ISP to be developed, [with the exception of Innovations waiver, TBI waiver, or any forthcoming 1915\(i\) services, for which prior authorization must be documented in the Care Plan/ISP. For members in the Innovations waiver, TBI waiver or any forthcoming 1915\(i\) services, the care manger will complete the minimum elements for the ISP service authorization request, when a member has a service need and the Care Plan is still in development.](#)

- 19. Section V. Scope of Services, B. Medicaid, 4. Providers, i. Provider Network, (vii) a. (1) is modified to add the following:**
- vii. Format of Network Access Plan
 - a) The BH I/DD Tailored Plan's Network Access Plan shall use the current format a provided by the Department.
 - b) The Department will provide the template no later than seven (7) Calendar Days after Contract award.
 - c) Future revisions to the template will be issued no less than thirty (30) Calendar Days' notice.
- 20. Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management (iii) Provider Contracting, (k)(2) is revised and restated in its entirety as follows:**
- (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 [penalty](#) payments to the applicable provider.
- 21. Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (ix)(b)(5) is revised and restated in its entirety as follows:**
- (5) Change to the existing contract terms within [thirty \(30\) Calendar Days](#) of the effective date after the change;
- 22. Section V. Scope of Services, B. Medicaid, 4. Providers, ii. Provider Network Management, (x) Network Provider Credentialing and Re-credentialing Policy, (e) Provider Disenrollment and Termination, (1) Payment Suspension at Re-Credentialing, iii. is revised and restated in its entirety as follows:**
- iii. The BH I/DD Tailored Plan shall not be liable for interests or [penalties](#) for payment suspension when directed by the Department.
- 23. Section V. Scope of Services, B. Medicaid, 4. Providers, iv. Provider Payments (xvi)(a)(1) is revised and restated in its entirety as follows:**
- (1) Tailored Care Management payment for each month in which the AMH+ practice or CMA performed Tailored Care Management for each [Medicaid](#) member. The Tailored Care Management payment shall be a fixed rate prescribed by the Department and acuity tiered. These fixed rates shall apply for Medicaid 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 [Medicaid](#) member is assigned to the AMH+/CMA and engaged in care management. [For NC Health Choice members, payment for Tailored Care Management will be incorporated into the capitation rate.](#)
- 24. Section Scope of Services, B. Medicaid, 4. Providers, iv. Provider Payments is revised and restated to add the following:**
- (xxiv) Physician Incentive Plans
 - (a) The BH I/DD Tailored Plan may develop physician incentive plans provided that any such physician incentive plans are in compliance with the requirements set forth in Section 1903(m)(2)(A)(x) of the SSA and 42 C.F.R §§ 438.3(i), 422.208, and 422.210. In 42 C.F.R. § 422.208, references to 'MA organization', 'CMS', and 'Medicare beneficiaries' must be read as references to 'BH I/DD Tailored Plan', 'the Department', and 'Medicaid beneficiaries', respectively.
 - (b) If the BH I/DD Tailored Plan puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the BH I/DD Tailored Plan must ensure that the physician/physician group has adequate stop-loss protection.

- (c) The BH I/DD Tailored Plan shall submit to the Department all physician incentive plans for review and approval prior to BH I/DD Tailored Plan implementation of such incentives.
- (d) The BH I/DD Tailored Plan shall submit to the Department annual reports containing a detailed overview of any implemented (and previously approved) physician incentive plans, or, if no such arrangement is in place, attest to that fact. Annual physician incentive plan reports must provide assurance satisfactory to the Department that the requirements of 42 C.F.R. § 422.208 are met.
- (e) The BH I/DD Tailored Plan shall provide the following information to any Medicaid Member who requests it:
 - (1) Whether the BH I/DD Tailored Plan uses a physician incentive plan that affects the use of referral services;
 - (2) The type of incentive arrangement; and
 - (3) Whether stop-loss protection is provided.

25. Section V. Scope of Services, B. Medicaid, 4. Providers v. Provider Grievances and Appeals, (viii) Appeals of Suspension or Withhold of Provider Payment, (e) is revised and restated in its entirety as follows:

(e) The BH I/DD Tailored Plan shall pay interest and [penalties, as outlined in Section V.B.6.i.\(iv\)\(d\)](#), for overturned denials, underpayment, or findings it did not have good-cause to suspend or withhold payment from the original [Date of Payment](#), suspension, withhold or denial.

26. Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (iii) is revised and restated in its entirety as follows:

(iii) Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, and [penalties paid or recovered](#), incentive payments paid or recovered, “zero paid” claim lines, cost settlements, sub-capitated services, third-party liability denials, claim line adjustments, and other financial activity associated with payments or recoveries made by the BH I/DD Tailored Plan, its delegees or Subcontractors.

27. Section V. Scope of Services, B. Medicaid, 6. Claims and Encounter Management, ii. Encounters, (vii) Data Validation and Processing, (g) is revised and restated in its entirety as follows:

(g) At the discretion of the Department, the BH I/DD Tailored Plan may be prohibited from submitted a specific encounter type to the Department’s Production Encounter Processing System if the Department identifies a high volume of compliance and/or critical errors (as determined by the Department). If any compliance issues are identified, the Department shall establish a performance improvement plan in order to monitor expected improvements from the BH I/DD Tailored Plan. In addition, if the BH I/DD Tailored Plan’s access to the Production Encounter Processing System is revoked, the BH I/DD Tailored Plan must actively test with the Department until such time that the compliance or critical errors are remediated. Successful testing that would allow production access to be restored is expected to occur within thirty (30) Calendar Days. Any [penalties](#) incurred by the BH I/DD Tailored Plan because of the loss of production access are the responsibility of the BH I/DD Tailored Plan.

28. Section V. Scope of Services, B. Medicaid, 7. Financial Requirements, ii. Medical Loss Ratio, (iii)(b)(2) is revised and restated in its entirety as follows:

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

29. Section V. Scope of Services, C. State-funded Services, 1. Recipients, a. ii. is revised and restated in its entirety as follows:

- ii. Upon BH I/DD Tailored Plan launch, the BH I/DD Tailored Plan may choose to use the following eligibility guidelines for State-funded BH, I/DD, and TBI services established by the Department:
 - a) BH Services:
 - 1. Income: $\leq 300\%$ of the federal poverty level; and
 - 2. Insurance Status/Other Financial Resources:
 - i. Uninsured, or insured with third-party insurance (including Medicaid) that:
 - a) Does not cover the State-funded service and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; or
 - b) Covers the State-funded SUD service, but associated cost-sharing is unaffordable.
 - 3. BH I/DD Tailored Plans shall encourage non-Medicaid covered potential recipients to apply for Medicaid coverage.
 - b) I/DD and TBI Services:
 - 1. Income: no specified limits
 - 2. Insurance Status/Other Financial Resources:
 - i. Uninsured, or insured with third-party coverage (including Medicaid) that:
 - a) Does not cover the State-funded service, and there is no alternative clinically appropriate service available under third-party/Medicaid coverage; and
 - b) Applied for Medicaid coverage.

30. Section V. Scope of Services, C. State-funded Services, 1. Recipients, b. Recipient Engagement, ix. Mailing Materials to Recipients, b) is revised and restated in its entirety as follows:

- b) [Reserved](#).

31. Section V. Scope of Services, C. State-funded Services, 3. Care Management and Prevention, b. iii. Qualifications for the State-Funded BH Care Management Coordinator, a) 1. is revised and restated in its entirety as follows:

- 1. Be a Master's-level fully Licensed Clinical Social Worker (LCSW), Licensed Clinical Mental Health Counselor (LCMC), Licensed Psychological Associate (LPA), [or Registered Nurse \(RN\)](#); [and](#)

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

- v. The BH I/DD Tailored Plan shall develop and maintain a waiting list for potential recipients with I/DD or TBI diagnosis who are waiting to receive care managed consistent with the requirements of [Section V.C, 1.a.xii](#).

33. Section V. Scope of Work, C. State-funded Services, 4. Providers, c. Provider Relations and Engagement, vi. Provider Manual, a) 17. is revised and restated in its entirety as follows:

- 17. Interest and [penalty](#) provisions for late or under-payment by the BH I/DD Tailored Plan;

34. Section V. Scope of Work, C. State-funded Services, 7. Financial Requirements, i. Financial Viability, iv. is revised and restated in its entirety as follows:

- iv. The BH I/DD Tailored Plan shall maintain a Current Ratio above 1.0 as determined from the monthly, quarterly, and annual financial reporting schedules. The Current Ratio is defined as Current Assets divided by Current Liabilities. Current assets include any short-term investments that can be

converted to cash within five (5) Business Days without significant **penalty**. Significant **penalty is a penalty** greater than twenty percent (20%). Financial reporting should be inclusive of both Medicaid and State funds.

35. Section V. Scope of Work, C. State-funded Services, 7. Financial Requirements, i. Financial Viability, ii. is revised and restated in its entirety as follows:

ii. 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.

36. Section IV. Contract Performance for Medicaid and State-funded Services L. Withholds for Medicaid 3. is revised and restated in its entirety as follows:

3. The withhold program will be effective eighteen (18) months following the date of **Standard Plan** launch, or at a later date as determined by the Department.

37. Section VII. RFA Attachments, Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services is revised and restated as Section VII. RFA Attachments, First Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services and attached to this Addendum #7.

38. Section VII. RFA Attachments, Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts is revised and restated as Section VII. RFA Attachments, First Revised and Restated Attachment G. Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts and attached to this Addendum #7.

39. Section VII. RFA Attachments, Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers is revised and restated as Section VII. RFA Attachments, First Revised and Restated Attachment I. Provider Appeals for Medicaid, NC Health Choice, and State-funded Services Providers and attached to this Addendum #7.

40. Section VIII. Attachment Q. Application Response and Completed Attachments is revised and restated as Section VIII. First Revised and Restated Attachment Q. Application Response and Completed Attachments and attached to this Addendum #7.

Execute Addendum #7:

Offeror: _____

Authorized Signature: _____

Name and Title (Typed): _____

Date: _____

First Revised and Restated Attachment A. BH I/DD Tailored Plan Organization Roles and Positions for Medicaid and State-funded Services

The Department requires that the BH I/DD Tailored Plan staff the following roles to fulfill the requirements of the North Carolina Medicaid Managed Care Program and/or State-funded Services.

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
1. Implementation and Readiness Review Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals carry out the implementation and Readiness Review terms of the contract.	<ul style="list-style-type: none"> • N/A
2. Supervising Care Managers for North Carolina Medicaid Managed Care Program and State-funded Services	<p>These individuals are responsible for overseeing assigned care managers.</p> <p>For Medicaid and State-funded Services, these individuals are responsible for reviewing all Care Plans (Medicaid only) and ISPs for quality control and providing guidance to care managers on how to address members' complex health and social needs.</p> <p>For Medicaid, these individuals are responsible for ensuring fidelity to the Tailored Care Management model.</p> <p>For State-funded Services, this position only services recipients with I/DD and TBI.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • If serving members with BH conditions, must: <ul style="list-style-type: none"> ○ Be a master's-level fully Licensed Clinical Social Worker (LCSW), fully Licensed Clinical Mental Health Counselor (LCMHC), fully Licensed Psychological Associate (LPA), fully Licensed Marriage and Family Therapist (LMFT) or licensure as a Registered Nurse (RN) ○ Have three (3) years of experience providing care management, case management, or care coordination to the population being served • If serving members or recipients with an I/DD or TBI, must have one (1) of the following: <ul style="list-style-type: none"> ○ A Bachelor's degree in a field related to health, psychology, sociology, social work, nursing, or another relevant human 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 ○ A Master's degree in a field related to health, psychology, sociology, social

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

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
		<p>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.</p>
<p>3. State-funded BH Care Management Coordinator</p>	<p>This individual is responsible for developing policies, practices and systems that support the provision of case management services for State-funded Services recipients with BH conditions.</p> <p>In accordance with applicable provisions of N.C.G.S. 122C-115.4(g)(1), this individual shall serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated BH System, the Army Reserve Department of Psychological Health, the United States Department of Veterans Affairs, the Juvenile Justice Section of the Division of Adult Correction and Juvenile Justice, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a Master's-level fully LCSW, fully LCMHC, fully LPA, or fully LMFT, or RN • Must have three (3) years of supervisory experience working directly with complex individuals with a BH condition
<p>4. Care Managers for North Carolina Medicaid Managed Care Program and</p>	<p>For Medicaid, these individuals shall be responsible for providing integrated whole-person care management under</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree in a field related to health, psychology, sociology, social work, nursing or another relevant

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

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
State-funded Services	<p>the Tailored Care Management model, including coordinating across physical health, BH, I/DD, TBI, LTSS, pharmacy and Unmet Health-Related Resource Needs.</p> <p>For State-funded Services, these individuals are responsible for providing care management for recipients with I/DD and TBI needs, including coordination across BH, I/DD, TBI and Unmet Health Resource Needs.</p>	<p>human services area or licensure as an RN.</p> <ul style="list-style-type: none"> • If serving members with BH needs, must have two (2) years of experience working directly with individuals with BH conditions. • If serving members or recipients with an I/DD or TBI, must have two (2) years of experience working directly with individuals with I/DD or TBI • If serving members with LTSS needs, the care manager, must have the minimum requirements defined above and shall additionally have at a minimum two (2) years of prior LTSS and/or HCBS coordination, care delivery monitoring and care management experience. This experience may be concurrent with the two years of experience working directly with individuals with behavioral health conditions, an I/DD, or a TBI, as described above
5. Full-Time Care Management Housing Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	<p>This individual or these individuals act as expert(s) on affordable and supportive housing programs for members, recipients, and care managers. This individual or these individuals coordinate with relevant staff at the Department or the BH I/DD Tailored Plan (e.g., Transition Coordinators and DSOHF staff).</p>	<ul style="list-style-type: none"> • Must reside in North Carolina
6. Full-Time Transition Supervisor(s) for North Carolina Medicaid Managed Care Program and State-funded Services	<p>This individual or these individuals are responsible for supervising all in-reach and transition staff and activities and shall be responsible for ensuring the functioning of in-reach and transition activities across settings and populations eligible to receive in-reach and transition services.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs • Must meet the care manager supervisor qualifications described above and outlined in <i>Section V.B.3.ii.(xiv)(c)Care Manager Qualifications</i>.

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
7. Full-Time Transition Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	<p>This individual or these individual(s) are responsible for conducting transition functions and activities to ensure smooth, timely and safe transitions for:</p> <ul style="list-style-type: none"> • individuals who are moving from a state psychiatric hospital to supportive housing; and • individuals moving from a state developmental center or an ACH to a community setting. 	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs <p>Transition Coordinators serving individuals with SMI:</p> <ul style="list-style-type: none"> • Must hold a Master’s degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with SED or SMI; or • Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with SED or SMI. <p>Transition Coordinators serving individuals with I/DD or TBI:</p> <ul style="list-style-type: none"> • Must hold a Master’s degree in a human services field or licensure as a RN plus one (1) year of relevant experience working directly with individuals with I/DD or TBI; or • Must hold a Bachelor’s degree in a human services field or licensure as a RN plus three (3) years of relevant experience working directly with individuals with I/DD or TBI.
8. Full-Time Peer Support Specialist(s) for North Carolina Medicaid Managed Care Program and State-funded Services	<p>This individual or these individual(s) are responsible for conducting in-reach functions and activities for adult members and recipients with BH diagnoses residing in a state psychiatric hospital or an ACH.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must have NC Certified Peer Support Specialist Program Certification
9. Full-Time In-Reach Specialist(s) for North Carolina Medicaid Managed Care Program	<p>This individual or these individuals are responsible for conducting in-reach functions and activities for adult members residing in a State Developmental Center.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor’s degree in a human services field • Two (2) years of experience working directly with complex individuals with I/DD or TBI and their families and/or guardians.

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
10. Diversion Specialist(s) for State-Funded Services	These individuals are responsible for performing diversion functions and activities described in <i>Section V.C.3.d.iv. Diversion Activities</i> for recipients eligible to receive diversion services as described in <i>Section.V.C.3.d.ii. Eligibility for Diversion</i> .	Diversion Specialists: <ul style="list-style-type: none"> • Must reside in North Carolina; and, • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, fully LMFT, or licensed as a RN plus one (1) year of relevant experience working directly with individuals with SMI; or • Must have one (1) year prior relevant and direct experience providing diversion services under TCLI.
11. System of Care Family Partner(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual works directly with and supports families in comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold high school diploma or GED • Must have four (4) years of experience as a primary caregiver for a child or youth receiving Medicaid or State-funded BH services
12. System of Care Coordinator(s) for North Carolina Medicaid Managed Care Program and State-funded Services	This individual or these individuals are responsible for comprehensive planning, implementation, coordination, and training related to the BH I/DD Tailored Plan's core System of Care functions.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold: <ul style="list-style-type: none"> ○ a Master's degree in a human services field plus two (2) years of experience working in or with child public service systems; or ○ a Bachelor's degree in a human services field plus four (4) years of experience working in or with child public service systems
13. DSOHF Admission Through Discharge Manager for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals are responsible for: <ul style="list-style-type: none"> • Coordinating and/or performing transition functions and activities described in <i>Section V.B.3.viii.(iv)</i> and <i>Section V.C.3.e.iv</i> for individuals transitioning out of DSOHF developmental centers or DSOHF psychiatric hospitals. 	DSOHF Admission Through Discharge Managers serving residents of DSOHF Psychiatric Hospitals: <ul style="list-style-type: none"> • Must reside in North Carolina • Must be a Master's level fully LCSW, fully LCMHC, fully LPA, or Bachelor's level RN plus one (1) year of relevant experience working directly with individuals with SMI. DSOHF Admission Through Discharge Manager serving residents of DSOHF Developmental Centers: <ul style="list-style-type: none"> • Must reside in North Carolina

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

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
	<p>Coordinating and/or performing discharge planning functions for BH I/DD Tailored Plan members and state-funded recipients who are not receiving transition functions and activities described in <i>Section V.B.3.viii.(iv)</i> and <i>Section V.C.3.e.iv</i></p> <p>DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall be dedicated to that facility. DSOHF Admission Through Discharge Managers assigned to DSOHF psychiatric hospitals shall also serve as the BH I/DD Tailored Plan liaison to ADATCs in the BH I/DD Tailored Plan's region.</p>	<ul style="list-style-type: none"> • Must hold: <ul style="list-style-type: none"> ○ a Master's degree in a human services field plus three (3) years of relevant experience working directly with individuals with I/DD; or ○ a Bachelor's degree in a human services field plus five (5) years of relevant experience working directly with individuals with I/DD; or ○ hold a Bachelor's-level RN plus three (3) year of relevant experience working directly with individuals with I/DD.
<p>14. Member and Recipient Appeal Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>This individual manages and adjudicates member and recipient appeals in a timely manner.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs
<p>15. Member and Recipient Complaint and Grievance Coordinator for North Carolina Medicaid Managed Care Program and State-funded Services</p>	<p>This individual manages and adjudicates member and recipient complaints and grievances in a timely manner.</p>	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
16. Full-Time Member and Recipient Complaint and Grievance Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient complaints and grievances in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> • Must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing complaints and grievances
17. Full-Time Member and Recipient Appeal Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals work to resolve member and recipient appeals in accordance with state and federal laws and this Contract.	<ul style="list-style-type: none"> • Must have appropriate clinical expertise in treating the member's and recipient's condition or disease for which they will be reviewing appeals
18. Full-Time Member and Recipient Services and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communication with members and recipients.	<ul style="list-style-type: none"> • Must reside in North Carolina
19. Provider Relations and Service Line Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals coordinate communications between the BH I/DD Tailored Plan and providers.	<ul style="list-style-type: none"> • Must reside in North Carolina
20. Provider Network Relations Staff for North Carolina Medicaid Managed Care Program and State-funded Services	These individuals support the Provider Network Director in network development and management.	<ul style="list-style-type: none"> • Must reside in North Carolina

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
21. Provider Complaint, Grievance, and Appeal Coordinator for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual manages and adjudicates provider complaints, grievances and appeals in a timely manner.	<ul style="list-style-type: none"> • Must reside in North Carolina • Fully dedicated to North Carolina DHHS programs
22. Pharmacy Director for the Pharmacy Service Line for the North Carolina Medicaid Managed Care Program	This individual oversees all Pharmacy Service Line staff management and ensures the team meets the requirements of the Contract.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a North Carolina registered pharmacist with a current NC pharmacist license • Minimum of three (3) years of pharmacy benefits call center experience
23. Full-Time Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	<ul style="list-style-type: none"> • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) in good standing
24. Full-Time I/DD and TBI Utilization Management Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct I/DD and TBI UM activities, including but not limited to prior authorization, concurrent review and retrospective review.	<ul style="list-style-type: none"> • Must be a Qualified Professional in the area of Developmental Disabilities as specified in 42 CFR § 483.430 (a) and N.C.G.S. § 122C-3
25. PBM Liaison for the North Carolina Medicaid Managed Care Program	If the BH I/DD Tailored Plan partners with a third-party PBM, this individual serves as the primary contact with the Department to resolve rebate issues and available to pharmacy providers to resolve issues	<ul style="list-style-type: none"> • N/A

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

Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
26. Tribal Provider Contracting Specialist (If applicable) for the North Carolina Medicaid Managed Care Program	This individual or these individuals shall be trained in IHCP requirements and are accountable to developing necessary tribal networks.	<ul style="list-style-type: none"> • Must reside in North Carolina
27. Reserved.		
28. Liaison between the Department and the North Carolina Attorney General’s MID for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the NC Attorney General’s Medicaid Investigation Division.	<ul style="list-style-type: none"> • Must reside in North Carolina
29. Special Investigations Unit (SIU) Lead for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual leads the SIU, which will conduct and manage investigations of prospective and retrospective fraud, waste, and abuse. The lead will coordinate with the Department and OCPI, as well as ensure timely resolution of investigation.	<ul style="list-style-type: none"> • Fully dedicated to North Carolina DHHS programs • Must hold an Associate’s or Bachelor’s degree in compliance, analytics, government/public administration, auditing, security management, or pre-law, or have at least five (5) years of relevant experience • Must complete CLEAR training or provide a timeframe as to when it will be complete
30. Special Investigations Unit (SIU) Staff for the North Carolina Medicaid Managed Care Program and State-funded Services	These individuals conduct and manage investigations of prospective and retrospective fraud, waste, and abuse.	<ul style="list-style-type: none"> • Must hold an Associate’s or Bachelor’s degree in compliance, analytics, government/public administration, auditing, security management, or pre-law, or have at least three (3) years of relevant experience

Section VII. Attachment A. Table 1: BH I/DD Tailored Plan Organization Roles and Positions		
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department
31. Liaison to the Division of Social Services for the North Carolina Medicaid Managed Care Program and State-funded Services	This individual serves as the primary liaison with the Division of Social Services, coordinating outreach, distribution of materials, understand the scope of services/programs coordinate through local DSS offices, and serves as a primary contact to triage and escalate member specific or BH I/DD Tailored Plan questions.	<ul style="list-style-type: none"> • Must reside in North Carolina
32. Waiver Contract Manager for the North Carolina Medicaid Managed Care Program	This individual serves as the primary point of contact and liaison to the Department as it relates to issues surrounding the 1115 Waiver and 1915(c) waivers. This individual shall be trained in the state's waiver contracting requirements.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of seven (7) years of management experience, preferably in human services

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

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

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

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

- a. Entire Agreement: The contract must identify the documents, such as amendments, exhibits, or appendices that constitute the entire contract between the parties.
- b. Definitions: The contract must define those technical managed care terms used in the provider contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in Medicaid member materials issued in conjunction with the Medicaid Managed Care Program.
- c. Contract Term: The contract term shall not exceed the term of the BH I/DD Tailored Plan Contract with the State.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a provider contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division. The contract must also require the provider to notify the BH I/DD Tailored Plan of members with scheduled appointment upon termination.
- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 1. Transition of administrative duties and records; and
 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's Network participation requirements as outlined in the BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy and the timeframe within in which the provider must notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:
 - i. The provider's obligations to be an enrolled Medicaid provider as required by 42 C.F.R. § 455.410, and the grounds for termination if the provider does not maintain enrollment.

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

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

- ii. The provider must ensure the provider's staff is trained to appropriately communicate with patients with various types of hearing loss.
- iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
- x. Providers of Perinatal Care: For all contracts with a provider of perinatal care, a provision that outlines the model for perinatal care consistent with the Department's Pregnancy Management Program. All contracts with Obstetricians shall include a statement that the contracted provider agrees to comply with the Department's Pregnancy Management Program.
- y. Advanced Medical Homes: For all contracts with any provider who is an Advanced Medical Home (AMH), a provision that outlines the AMH model and requirements consistent with the Department's AMH Program. Each contract with an AMH shall include a statement that the contracted provider agrees to comply with the Department's AMH Program.
- z. Local Health Departments: For all contracts with any provider who is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, a provision that outlines the care management requirements consistent with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy. Each contract with an LHD who is carrying out care management for high-risk pregnancy and for at-risk children shall include a statement that the contracted provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.
- aa. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
- bb. Chapter 58 requirements: Pursuant to Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, the contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
- cc. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.
- dd. Providers Subject to Rate Floors and/or Other Payment Directives: For all contracts with providers subject to rate floors or other specific payment provisions as found in *Section V.B.4.iv. Provider Payments* of the BH I/DD Tailored Plan Contract, a provision that indicates the terms and conditions of each applicable payment methodology/requirement, including indicating that the BH

I/DD Tailored Plan shall reimburse providers no less than one-hundred percent (100%) of any applicable rate floor. This requirement will not apply to contracts with an IHCP to the extent the addendum described in *Section VII. Attachment H. Addendum for Indian Health Care Providers* includes the information required by this provision or to contracts when the BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement. When a BH I/DD Tailored Plan and provider have mutually agreed to an alternative reimbursement arrangement, the contractual provision should so indicate.

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

- a. Section VII. Attachment M.2. Advanced Medical Home Program Policy for Medicaid and NC Health Choice Members
- b. Section VII. Attachment M.4. Pregnancy Management Program Policy for Medicaid and NC Health Choice Members
- c. Section VII. Attachment M.5. Care Management for High-Risk Pregnancy Policy for Medicaid and NC Health Choice Members
- d. Section VII. Attachment M.6. Care Management for At-Risk Children Policy for Medicaid and NC Health Choice Members

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

- a. Compliance with state and federal laws
The [Provider] understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Contract and the Company's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The [Provider] understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the [Company's] contract with NC DHHS could result in liability for money damages, including liquidated damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
- b. Hold Member Harmless
The [Provider] agrees to hold the member harmless for charges for any covered service. The [Provider] agrees not to bill a member for medically necessary services covered by the Company so long as the member is eligible for coverage.
- c. Liability
The [Provider] understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the [Company], its employees, agents or subcontractors. Further, the [Provider] understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the [Provider] by the [Company] or any judgment rendered against the [Company].
- d. Non-discrimination
Equitable Treatment of Members

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

e. Department authority related to the Medicaid program

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

f. Access to provider records

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

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

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

Nothing in this [section] shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

g. Provider ownership disclosure

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

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

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

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

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

i. For Medical claims (including BH):

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

ii. For Pharmacy Claims:

1. The [Company] shall within fourteen (14) Calendar Days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.
2. A pharmacy pended claim shall be paid or denied within fourteen (14) Calendar Days of receipt of the requested additional information.

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

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

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

- v. Failure to pay a clean claim within thirty (30) days of receipt will result in the [Company] paying the [Provider] penalties equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.
- vi. The [Company] shall pay the interest and penalties from subsections (e) and (f) as provided in that subsection and shall not require the [Provider] to request the interest or the liquidated damages.

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

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

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

- a. Entire Agreement: The contract must identify the documents, such as incorporated amendments, exhibits, or appendices that constitute the entire contract between the parties.
- b. Definitions: The contract must define technical State-funded Services terms used in the contract, and if those definitions are referenced in other documents distributed to providers and recipients, ensure that definitions are consistent.
- c. Contract Term: The contract term shall not exceed the term of the BH I/DD Tailored Plan Contract with the Department.
- d. Termination and Notice: The contract must address the basis for termination of the contract by either party and notice requirements. BH I/DD Tailored Plan shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately terminate a provider contract upon a confirmed finding of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division, or upon termination of the BH I/DD Tailored Plan contract by the State. BH I/DD Tailored Plan also shall specifically include a provision permitting the BH I/DD Tailored Plan to immediately suspend some or all activities under a network contract upon finding a credible allegation of fraud, waste, abuse, or serious quality of care concerns by the BH I/DD Tailored Plan or the Division.
- e. Survival: The contract must identify those obligations that continue after termination of the provider contract and
 - i. In the case of the BH I/DD Tailored Plan's insolvency the contract must address:
 - 1. Transition of administrative duties and records; and
 - 2. Continuation of care, when inpatient care is on-going in accordance with the requirements of the Contract. If the BH I/DD Tailored Plan provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- f. Credentialing: The contract must address the provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the BH I/DD Tailored Plan's network participation requirements as outlined in the BH I/DD Tailored Plan's Credentialing and Re-credentialing Policy and to notify the BH I/DD Tailored Plan of changes in the status of any information relating to the provider's professional credentials. In addition, the terms must include the following:

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

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

- ii. The provider must ensure the provider’s staff is trained to appropriately communicate with recipients with various types of hearing loss.
 - iii. The provider shall report to the BH I/DD Tailored Plan, in a format and frequency to be determined by the BH I/DD Tailored Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.
 - w. Residential Substance Use Disorder Treatment Providers: For all contracts with any provider who is a residential substance use disorder treatment provider, a provision that outlines their requirement to provide medication assisted treatment (MAT) on-site or refer to an in-network MAT provider.
 - x. Chapter 58 requirements: The contract must include provisions that address the following statutes and subsections:
 - i. G. S. 58-3-200(c).
 - ii. G.S. 58-3-227 (h) (see also Section 2.H for a prescribed provision related to this statute).
 - iii. G.S. 58-50-270(1), (2), and (3a).
 - iv. G.S. 58-50-275 (a) and (b).
 - v. G.S. 58-50-280 (a) through (d).
 - vi. G.S. 58-50-285 (a) and (b).
 - vii. G.S. 58-51-37 (d) and (e).
 - y. Critical Incident Reporting: Contracts must include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations.
 - z. Providers Subject to Other Payment Directives: For all contracts with providers subject to specific payment provisions as found in *Section V.C.4.iv. Provider Payments*, a provision that indicates the terms and conditions of each applicable payment methodology/requirement.
- 2. All contracts between BH I/DD Tailored Plan and providers that are created or amended, must include the following provisions verbatim, except BH I/DD Tailored Plan may insert appropriate term(s), including pronouns, to refer to the BH I/DD Tailored Plan, the provider, the BH I/DD Tailored Plan/provider contract, or other terms and/or references to sections of the contract as needed and based upon context:**
- a. Compliance with state laws

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

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

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

d. Non-discrimination: Equitable Treatment of Recipients:

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

e. Access to provider records

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

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

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

g. Provider ownership disclosure

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

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

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

Section VII. <i>First Revised and Restated</i> Attachment I.1. Table 1: Provider Appeals for Medicaid, NC Health Choice Providers, and State-funded Services Providers	
Reference Number	Appeal Criteria
For Network Providers	
1	<p>A network provider has the right to appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to a network provider for the following reasons:</p> <ul style="list-style-type: none"> a) Program Integrity related findings or activities; b) Finding of waste or abuse by the BH I/DD Tailored Plan; c) Finding of or recovery of an overpayment by the BH I/DD Tailored Plan; d) Withhold or suspension of a payment related to waste or abuse concerns; e) Termination of, or determination not to renew, an existing contract for LHD care/case management services; f) Determination to de-certify an AMH+ or CMA (applicable to Medicaid providers only); and g) Violation of terms between the BH I/DD Tailored Plan and provider.
For Out-of-Network Providers	
2	<p>An out-of-network provider may appeal certain actions taken by the BH I/DD Tailored Plan. Appeals to the BH I/DD Tailored Plan shall be available to an out-of-network provider for the following reasons:</p> <ul style="list-style-type: none"> a) An out-of-network payment arrangement; b) Finding of waste or abuse by the BH I/DD Tailored Plan; and c) Finding of or recovery of an overpayment by the BH I/DD Tailored Plan.

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Section VIII. First Revised and Restated Attachment Q. Application Response and Completed Attachments

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VIII. Attachment Q. Application Response and Completed Attachments

1. Instructions

The Applicant must complete and submit *Section VIII: Applicant's Proposal and Response* with its offer.

The Applicant's Proposal and Response must be submitted in accordance with Department guidelines and the directives herein. The Applicant's Proposal and Response must be typed, page numbered, single-spaced, and in at least a 12-point font on Letter-sized (8 ½" x 11") paper with 1" margins. Page numbers must be in the format "Page X of Y." The Applicant may use a different, but legible, size font for section headings, footers, tables, graphics, and exhibits. Larger graphics, exhibits, charts, and diagrams may be printed as a foldout on a larger size paper if letter-sized paper is not feasible.

As described in *Section II. General Procurement Information and Notice to Applicants* of the RFA, the Applicant must submit fifteen (15) bound copies of its offer. The order of pages in Section VIII. Attachment Q cannot be altered from the MS Word template provided by the Department. All supporting documentation should be included at the end of Attachment Q. Application Response and Completed Attachments in the corresponding order of Attachment Q. Application Response and Completed Attachments with notation at the top of each page notating what the documentation is meant to support {example: *Section VIII.5. BH I/DD Tailored Plan Key Personnel: Resume of Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program Director* or *Section VIII.2. Minimum Qualification Response*}. A response whose page order has been altered risks a lower score or elimination from consideration.

The MS Word template of the Attachment Q. Application Response and Completed Attachments may be requested by contacting Medicaid.Procurement@dhhs.nc.gov.

2. First Revised and Restated Minimum Qualifications Response

The Applicant must demonstrate it meets Minimum Qualifications to have its response evaluated by the Department. The Applicant must agree to the terms below by checking the boxes and providing the information, documentation, including letters, or other details to demonstrate its adherence to each requirement, as applicable and required herein, and signing below.

1. Attestation of Eligibility to Apply and Acknowledgement

- The Applicant certifies it is a local political subdivision of the State and operates as a LME/MCO, as that term is defined in G.S § 122C-3(20c), as of the issuance date of this RFA are due pursuant to this RFA. The Applicant further certifies it is applying only for the Region(s) in which it is operating as an LME/MCO at the time the Applicant submits its Application in response to this RFA; the Applicant acknowledges that there may be an opportunity to respond to Supplemental Evaluation Questions to be considered to fill an Empty Region.

2. Agreement to Terms and Condition

- The Applicant agrees and accepts, without exception, all of the terms and conditions, including confidentiality, privacy and security protections and public records and trade secrets protections, specified in Section III. The Applicant may suggest modifications to the terms and conditions per the instructions in *Section II.C.3.c* and acknowledges such suggestions are not part any subsequent Contract unless explicitly accepted by the Department in accordance with *Section II.C.3.c*.

3. Agreement to Conflict of Interest Requirements

- The Applicant agrees to comply with the Conflict of Interest requirements within this RFA, as outlined in *Section III.D.15. Disclosure of Conflicts of Interests* and *Section V.A.1.ix.(xiii) Conflict of Interest*.

4. Agreement to Performance Bond Requirements

- The Applicant agrees to comply with the Performance Bond requirements within this RFA, as outlined in *Section III.C.37. Performance Bond*.

5. Certification of Location within the United States

- The Applicant certifies the Applicant is not located outside of the United States in accordance with 42 C.F.R. § 438.602(i).

By completing and signing this Minimum Qualifications Response, the Applicant affirms adherence to the required Minimums Qualifications and attests the information provided herein is accurate, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the Applicant.

Applicant Signature

Date

Printed Name and Title

3. First Revised and Restated Applicant’s Response to Evaluation Questions

Applicant must respond to the questions in the Section VIII. Attachment Q. Application Response and Completed Attachments, **excluding those included in Section VIII.17. Supplemental Evaluation Questions for Empty Region(s)** unless otherwise notified by the Department. The Department encourages the Applicant to suggest innovative ways to fulfill the requirements of the Contract rather than rely solely on how business is conducted today.

The Applicant must confirm adherence to and describe its approach to meet the requirements of the Contract. This includes providing a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature and/or detailed information specifically tailored for the North Carolina Medicaid Managed Care program.

The Department requests the Applicant adhere to the page guidelines for each section listed *Section VIII.3. Table 1: Response Page Guidelines* below. The page guidelines assigned in the table below are not related to the evaluation criteria and should not be interpreted as a reference to evaluation weight or importance. Completion of tables within questions will not be counted toward page guidelines where noted within each evaluation question. Supplemental materials, such as samples, draft plans and policies, requested as part of the Section VIII. Attachment Q. Application Response and Completed Attachments will not be counted toward page guidelines where noted within each evaluation question. The Applicant’s detailing of any limitations and/or issues with meeting the Department’s expectations or requirements will not be counted toward page guidelines. The Applicant must describe these limitations/issues in the separate field provided within the evaluation question. Additional supplemental materials provided beyond what is requested in the evaluation questions may not be considered for evaluation.

The Applicant may use an additional ten (10) pages in total if it needs additional space to provide a complete response to questions. The Applicant may use the ten (10) pages on one question or spread the additional pages across several questions, so as long as the total number of additional pages does not exceed ten (10) pages. The Applicant shall indicate in each question if the additional pages are utilized.

For each question, the Applicant shall describe the fully integrated approach the Applicant will provide to fulfill the requirements of the Contract, as well as identify the entity whose experience is included and that the Applicant is proposing to perform the requirements of the Contract. Where requirements between Medicaid and State-funded Services align, questions are aligned to enable the Applicant to provide a single, comprehensive response. For specific evaluation questions, the Department requests that the experience and approach of specific partner(s) be reflected in the response.

Section VIII. 3. Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
		RFA Section reference	N/A	- -
1-5	Qualifications and Experience	-	5 pages, Applies to Question 3 only	
6-81	Scope of Services	-	538	
6-13	Integration	-	69	

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
6	Third Party (Subcontractor) Contractual Relationships; Member Grievances and Appeals; Utilization Management; Provider Network Management; and Provider Directory	V.A.1.iv., V.B.1.vi., V.B.2.i.(v), V.B.4.ii, and V.B.8.v.	15	Both
7	Staffing and Facilities	V.A.1.ix	7	Both
8	Service Lines	V.A.2.i.	7	Both
9	Provision of the Benefits Package	V.B.2.i. and V.C.2.a.	5	Both
10	Reserved	Reserved	N/A	
11	Benefits Package and Utilization Management	V.B.2.i. and V.C.2.a.	7	Both
12	Pharmacy Benefits	V.B.2.iii.	8	Medicaid Only
13	Provider Network	V.B.4.i. and V.C.4.a.	20	Both
14-17	Financial Management		30	
14	Capitation Payments	V.B.7.i	8	Medicaid Only
15	Medical Loss Ratio	V.B.7.ii.	2	Medicaid Only
16	Financial Management and Financial Viability	V.B.7.iii. and V.B.7.iii.(vii)	10	Medicaid Only
17	Financial Requirement for State-funded Services questions	V.C.7.	10	State-funded Services Only
18-28	Care Management		103	
18	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
19	Tailored Care Management	V.B.3.ii.	8	Medicaid Only
20	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
21	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
22	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
23	Tailored Care Management	V.B.3.ii.	5	Medicaid Only
24	Tailored Care Management	V.B.3.ii.	10	Medicaid Only
25	Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver and Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waivers	V.B.3.iv. and V.B.3.ii.(xiii)	10	Medicaid Only
26	Tailored Care Management Data Strategy	V.B.3.11. and V.C.3.	10	Both
27	Transitional Care Management	V.B.3.i., V.B.3.ii.(xi), V.B.3.iii., and V.B.3.v.	10	Medicaid only

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
28	Case/Care Management and Prevention	V.C.3.a.; V.C.3.b.; and V.C.3.c.	20	State-funded Services Only
29-34	Providers		32	
29	Provider Network Management	V.B.4.ii. and V.C.4.b.	10	Both
30	Provider Relations and Engagement	V.B.4.iii. and V.C.4.c.	3	Both
31	Provider Payments	V.B.4.iv. and V.C.4.d.	4	Both
32	Provider Grievances and Appeals	V.B.4.v. and V.C.4.e.	5	Both
33	Engagement with Federally Recognized Tribes	V.A.4.i.	5	Medicaid Only
34	Community Crisis Services Plan	V.A.4.v.	5	Both
35-42	Benefits & Services		68	
35	Provisions of the Benefits Package	V.B.2.i. and V.C.2.a.	10	Both
36	In Lieu of Services & Value-Added Services	V.B.2.i.(vii) and V.B.2.i.(viii)	No Limit	Medicaid Only
37	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	V.B.2.ii.	8	Medicaid Only
38	Non-Emergency Medical Transportation	V.B.2.iv.	5	Medicaid Only
39	Diversion from Institutional Settings	V.B.3.ii.(xii) and V.C.3.d.	10	Both
40	In-Reach and Transition from Institutional Settings	V.B.3.viii. and V.C.3.e.	16	Both
41	In-Reach and Transition from Institutional Settings	V.B.3.viii.	16	Medicaid Only
42	Development of Housing Opportunities for Members and Recipients	V.A.4.iv.	3	Both
43-53	Members & Recipients		59	
43	Advance Directives	V.A.1.viii.	1	Both
44	Eligibility and Enrollment for BH I/DD Tailored Plans	V.B.1.i.	7	Medicaid Only
45	Eligibility for State-funded Behavioral Health, I/DD and TBI Services	V.C.1.a.	7	State-funded Services Only
46	Transitions of Care	V.B.1.11.	7	Medicaid Only
47	Member Grievances and Appeals	V.B.1.vi.	8	Medicaid Only
48	Recipient Complaints and Appeals	V.C.1.e.	8	State-funded Services Only
49	Member Engagement & Recipient Engagement	V.B.1.iii. and V.C.1.b.	8	Both

Section VIII. 3.Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
50	Marketing	V.B.1.iv. and V.C.1.c.	4	Both
51	Member and Recipient Rights and Responsibilities	V.B.1.v. and V.C.1.d.	2	Both
52	AMHs as PCPs and PCP Choice and Assignment	V.B.1.vii. and V.B.1.vii.(ii)	2	Medicaid Only
53	Engagement with Community and County Organizations	V.A.4.ii.	5	Both
54-60	Compliance		22	
54	Compliance Program	V.A.3.i.	3	Both
55	Program Integrity	V.A.3.ii.	3	Both
56	Fraud, Waste, and Abuse	V.A.3.iii.	4	Both
57	Third Party Liability (TPL)	V.A.3.iv. and V.A.3.v.	1	Both
58	Medicaid Service Recipient Explanation of Medical Benefits (REOMB)	V.A.3.vi.	1	Medicaid
59	Confidentiality	III.E.	7	Both
60	Service Level Agreements	VI.B	3	Both
61-66	Quality & Population Health		45	
61	Prevention and Population Health Management Programs	V.B.3.ix. and V.C.3.g.	10	Both
62	Healthy Opportunities	V.B.3.x.	11	Medicaid Only
63	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	5	Both
64	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	2	Both
65	Quality Management and Quality Improvement	V.B.5.i. and V.C.5.a.	2	Both
66	Value-Based Payments	V.B.5.ii.	15	Medicaid Only
67-81	Administration & Management		110	
67	Entity Requirements	V.A.1.ii.	4	Both
68	Reserved.	Reserved	N/A	
69	National Committee for Quality Assurance (NCQA) Accreditation	V.A.1.iii.	2	Medicaid Only
70	Implementation and Readiness Review Requirements	V.A.1.v. and V.A.1.vi.	5	Both
71	Non-Discrimination	V.A.1.vii.	2	Both
72	Staff Training	V.A.2.iii.	4	Both
73	Reporting	V.A.2.iv.	3	Both

Section VIII. 3. Table 1: Response Page Guidelines				
Question #s	RFA Section		Number of Pages	Applicability to Medicaid, State-funded Services or Both
74	BH I/DD Tailored Plan Policies	V.A.2.v.	2	Both
75	Business Continuity	V.A.2.vi.	3	Both
76	Integration with Other Department Partners	V.A.4.iii.	2	Both
77	Claims	V.B.6.i.	7	Medicaid Only
78	Encounters	V.B.6.ii.	16	Medicaid Only
79	Claims for State-funded Services	V.C.6.	10	State-funded Services Only
80	Technical Specifications	V.B.8. and V.C.8	25	Both
81	Technical Specifications	V.B.8. and V.C.8	25	Both
	Use Cases	-	35	-
	Additional Pages Determined by Applicant		10	
	TOTALS		583	

The Evaluation Questions are listed below. By February 2, 2021, the Applicant is required to answer the questions as stated herein, with the exception of the supplemental questions in *Section VIII.17. Supplemental Evaluation Questions for Empty Region(s)* which will be due at a later date, if needed and as communicated by the Department.

Qualifications and Experience

Evaluation Question	
1.	<p>The Applicant shall provide the following:</p> <ul style="list-style-type: none"> a. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written b. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers) c. List of board members and their organizational affiliations
Response	

Evaluation Question	
2.	<p>The Applicant shall provide information requested in <i>Section VIII.3. Table 2: Entities Performing Core Operations</i> for each entity, including, Subcontractors, business partners, and any other individual or organization:</p> <ul style="list-style-type: none"> a. That will perform core Medicaid operations, as defined in <i>Section V.A.1.ii.(iii) BH I/DD Tailored Plan Operating Plan</i>, for the Applicant under the Contract; and b. That will perform core State-funded operations, as defined in <i>Section V.A.1.ii.(iii) BH I/DD Tailored Plan Operating Plan</i>, for the Applicant under the Contract. <p>The Applicant shall include a response describing their contract(s) with an entity that holds a North Carolina PHP license issued by the North Carolina Department of Insurance, pursuant to N.C. Gen. Stat. § 108D-60(5), and how the contract(s) will adhere to the requirements described in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships for Medicaid and State-funded Services</i>.</p> <p>The Applicant shall be fully transparent in describing the experience of its partner entities and shall include all experience, both positive and negative, related to the entity’s role(s) or responsibilities. The Department may exercise, at its sole discretion, in the BH I/DD Tailored Plan RFA evaluation process, whether or not to consider the experience or to what extent the experience applies for entities not performing core operations.</p> <p>Applicant must fill out one (1) table for each entity, including Subcontractors, business partners, and any other entities that meet the criteria listed in 2.a. and/or 2.b. above. Completed tables shall not be counted toward the Applicant’s total page guidelines.</p>
Response	

Section VIII. 3.Table 2: Entities Performing Core Operations

Name of Entity Performing Core Operation(s) _____ Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/>	Response
Identify and define Medicaid and State-funded Services core operation(s) that entity will perform. Identify whether the entity is providing core operation(s) for either Medicaid or State-funded services or both for each core service. Note that for care management and care coordination functions, the Applicant does not need to identify AMH+ practices and CMAs. <ul style="list-style-type: none"> • Managing Medicaid Managed Care member lives; • Managing member and recipient services, including utilization management¹ and the administration of clinical benefits and services); • Managing the provider network; • Performing care management and care coordination functions; • Performing quality management and data reporting; • Processing and paying claims; • Managing single stream funding and other non-Medicaid funds for State-funded Services; and • Assuming risk through capitated contract. 	
Primary Address	
Mailing Address	
Tax ID (if organization)	

¹ Utilization management of State-funded Services may not be delegated by Offeror.

Section VIII. 3. Table 2: Entities Performing Core Operations

<p>Name of Entity Performing Core Operation(s)</p> <p>_____</p> <p>Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/></p>	<p>Response</p>
<p>DOB (if individual)</p>	
<p>Tax ID Number</p>	
<p>Description of the entity’s responsibilities and/or functions in performing activities on behalf of the Applicant as described in Applicant’s Response</p>	
<p>Description of the entity’s experience related to the role(s), responsibilities, and other operations described above</p>	
<p>Description of how the entity will be integrated into the Applicant’s performance of their obligations under the Contract to ensure a streamlined experience for the members, providers and the Department</p>	
<p>Description of how any aspects of the contract that may create barriers to integrated behavioral health, I/DD and /or TBI and physical health care and operations will be addressed</p>	
<p>Description of how the Applicant will manage the subcontracting entity’s contract performance</p>	
<p>Description of the proposed compensation structure between the Applicant and the subcontracting entity</p>	
<p>Disclosure of any potential conflicts of interest that entity providing services may have related to the Applicant, this RFA or any Contract awarded to the Applicant.</p>	
<p>Disclose if the Applicant or any of its board members, officers or managing employees, has a direct or indirect</p>	

Section VIII. 3. Table 2: Entities Performing Core Operations	
Name of Entity Performing Core Operation(s) _____ Medicaid <input type="checkbox"/> State <input type="checkbox"/> Both <input type="checkbox"/>	Response
Ownership interest or controlling interest in the entity as such terms are defined in 42 CFR 455.101. If yes, disclose whether the Applicant or its board members, officers, or managing employees have the conflict, and all of the direct and indirect owners, as well as controlling interest in the entity, including, full name, EIN or SSN (as applicable), addresses and percentage ownership/interest.	
Is the entity HUB certified as provided in G.S. 143-128.4?	

Evaluation Question	
3. The Applicant shall describe its approach and experience in the provision of services to the populations specified in this Contract, including: <ul style="list-style-type: none"> a. Commitment to integrating the Department's goals for Medicaid Managed Care, inclusive of State-funded Services, into its day-to-day operations; b. Lessons learned from experience serving the Medicaid populations included in this Contract and how it informs the Applicant's approach to provision of services going forward; and c. Lessons learned from experience serving the State-funded populations in this Contract and how it informs the Applicant's approach to provision of services going forward. 	
Response	

Evaluation Question	
4.	<p>The Applicant shall disclose, in the <i>Section VIII.3. Table 3: Non-Compliance, Fines, Penalties and Sanctions in the past five (5) years</i>, whether, within the past five (5) calendar years, any federal or state agency has notified the Applicant of any non-compliance or imposed liquidated damages fines and civil penalties, or other sanctions or penalties under the DHB and/or DMH/DD/SAS LME/MCO Contracts, including any findings from the Office of the State Auditor. The Applicant’s response shall include information for the Applicant and any entity providing core operations, listed in <i>Section VIII. 3.Table 2: Entities Performing Core Operations</i>.</p> <ul style="list-style-type: none"> a. If imposed, the Applicant shall describe the non-compliance, State Auditor finding, fine, penalty amount or sanction and include the month and year of the notification or violation; the reason(s) for the finding of non-compliance or fine, penalty or sanction; and the parties involved, as applicable. b. A description of the corrective action taken to address the non-compliance or violation. c. If the non-compliance or violation(s) was the subject of an administrative proceeding or litigation, the Applicant shall indicate the result of the proceeding/litigation. <p>POTENTIAL REQUEST FOR SUPPORTING DOCUMENTATION</p> <p>The Department reserves the right to ask for additional information related to Applicant’s response to this question by issuing a Clarification.</p>
Response	

Section VIII.3. Table 3: Non-Compliance, Fines, Penalties and Sanctions in the past 5 years	
Entity (as identified in Question #4)	
Non-Compliance, State Auditor finding, or Fine, Penalty, or Sanction	
Month & Year of Violation	
Reason for the Non-Compliance, State Auditor finding, Fine, Penalty or Sanction	
Describe any corrective actions taken to prevent future occurrence of the problem. If answered 'No' to the question above, insert 'N/A'	
Was the Violation the subject of an administrative proceeding or litigation?	
If answered 'Yes' to the question above, indicate the result of the proceeding/litigation. If answered 'No' to the question above, insert 'N/A'	

Evaluation Question	
5.	<p>a. The Applicant shall list the counties in its catchment area as of the issuance date of this RFA.</p> <p>b. Is the Applicant aware of any counties that are considering or have started the process to disengage under N.C. Gen. Stat. § 122C-115 or are likely to prior to July 1, 2022? If yes, list the counties, explain the issues and Applicant’s response.</p> <p>c. Have any of the counties expressed concerns with Applicant’s service, management or operations? If yes, list the counties, explain the issues and Applicant’s response.</p>
	Response

Scope of Services

Integration

Evaluation Question	
6.	<p>The Applicant shall confirm its adherence and describe in detail its ability to manage Subcontractors and ensure integrated approaches to plan operations and member or recipient’s care, including:</p> <p><u>For Medicaid and State-funded Services</u></p> <p>a. Overseeing subcontractors in a way that ensures whole-person, person-centered care and adheres to the Department's expectations and requirements outlined in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships</i> for Medicaid and State-funded Services;</p> <p>b. Providing a single phone line for member- and recipient-facing services, as well as provider-facing services and provider-facing plan operations (<i>Section V.B. Medicaid</i> and <i>Section V.C. State-funded Services</i>);</p> <p><u>For Medicaid Only</u></p> <p>c. Ensuring an integrated, holistic utilization management process (<i>Section V.B.2.i.(v) Utilization Management</i>);</p> <p>d. Ensuring a compliant Medicaid appeals process (<i>Section V.B.1.vi. Member Grievances and Appeals</i>);</p> <p>e. Providing a single Medicaid and NC Health Choice Provider Network directory (<i>Section V.B.4.ii. Provider Network Management</i> and <i>Section V.B.8.v. Provider Directory</i>); and</p> <p>f. Ensuring financial integration in any risk sharing arrangements such that there are not separate pools for physical health, behavioral health, or I/DD services.</p>

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
7.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for staffing and facilities as stated in <i>Section V.A.1.i. Staffing and Facilities for Medicaid and State-funded Services</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ol style="list-style-type: none"> a. A description of the Applicant’s internal organizational structure for the BH I/DD Tailored Plan highlighting the Applicant's management structure and definitions of the lines of accountability, responsibility, authority, communication and coordination across the organization. b. Experience with and approach to staffing jointly for Medicaid and State-funded Services operations. c. Approach to recruitment and retention of Key Personnel and how the Applicant proposes minimizing turnover including during the transition from LME/MCO to BH I/DD Tailored Plan operations. d. Location of key personnel and offices providing core Medicaid and State-funded Services operations. e. Estimate of the number of staff anticipated to fulfill all duties and responsibilities of the Contract, including those delineated by the categories found in <i>Section VII. Attachment A: BH I/DD Tailored Plan Organization Roles & Positions</i>. Of the number of staff identified, estimate how many of those staff positions will be filled by current staff versus how many are new staff needed to meet these requirements. f. Experience with addressing workforce shortages and approach to how the Applicant will address potential BH I/DD Tailored Plan workforce shortages (i.e. UM staff, clinical expertise, provider contract management, service line staff).

	<p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Draft organizational charts, identifying which roles support Medicaid, State-funded Services, or both 2. Draft Utilization Management (UM) and Care Management leadership organizational charts
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
8.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.i. Service Lines for Medicaid and State-funded Services</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ol style="list-style-type: none"> a. Approach to establishing service lines, staffing them jointly for Medicaid and State-funded Services operations, and meeting Service Level Agreement standards; b. Approach to customizing and training member and recipient services and provider relations staff on the North Carolina Medicaid Managed Care program, State-funded Services and providing specific responses to potential customer service inquiries; c. Policies for ensuring Warm Transfers are conducted in the timeframes specified in the Contract; d. Process to immediately contact local emergency responders in instances where there is immediate danger to self or others, including monitoring the individual’s status until emergency responders arrive; e. Approach to ensure compliance with HIPAA, 42 CFR Part 2 and all other applicable federal and state confidentiality provisions;

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> f. Approach to ensure all pharmacy prior authorization requests are processed within twenty-four (24) hours for Medicaid; and g. Process to integrate the nurse line and behavioral health crisis line into the Applicant’s care management and health care delivery model for Medicaid;
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
9.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package</i> and <i>V.C.2.a. State-funded BH I/DD and TBI Services</i>.</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. The response also shall describe the Applicant’s approach to facilitating and integrating physical health, behavioral health, I/DD, TBI, LTSS and pharmacy benefits for members. b. Approach to develop expertise in administering physical health, LTSS and pharmacy benefits; c. Experience with innovative Telehealth, Virtual Patient Communication and Remote Patient Monitoring modalities and pilot programs and the proposed approach to encourage use of these modalities, including types of programs, and targeted providers, geographies (including rural), services, and members; and d. Approach to integrating carved-out services (i.e. dental services, LEAs, CDSAs, eyeglasses).

Response
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
10.	Reserved.

Evaluation Question	
11.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's Utilization Management expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package and V.C.2.a. State-funded Behavioral Health, I/DD and TBI Benefit Package</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience with and approach to align the Applicant’s Utilization Management (UM) program with the Department's required clinical coverage policies; b. Approach to reduce provider administrative burden under the BH I/DD Tailored Plan’s UM Program, including overall provider experience for prior authorization requests; c. Experience with and approach for monitoring appropriate utilization of services and monitoring provider quality as part of the UM Program; d. Experience with, methods and approach to balance timely access to care for member and recipients with the administration of the UM Program;

	<p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> e. Proposed evidence-based decision support tool(s) to authorize Medicaid benefits where use of the Department’s clinical coverage policies is not required; f. Approach to build expertise in UM for physical health, pharmacy, and LTSS; g. Approach to ensure that the UM program for Medicaid supports an integrated, holistic review of member’s physical health, behavioral health, I/DD, TBI, LTSS, and pharmacy needs; Approach to ensure UM Program for Medicaid is compliant with mental health parity.
Response	
<p>Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.</p>	

Evaluation Question	
12.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.iii. Pharmacy Benefits for Medicaid</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Methods to ensure adherence to the formulary and PDL under this Contract; b. Approach to engage members in understanding the pharmacy benefit and to providing medication-related clinical services which promote appropriate medication use and adherence; c. Prior authorization process, including overall prescriber experience when requesting prior authorization; d. Approach to implementing a drug utilization review program to address opioid misuse and antipsychotic use in children; e. Integration approach with PBM (if applicable); and

	f. Approach to provide timely, accurate and complete data to support the Department’s rebate claiming process and ensure the Department maintains current rebates levels.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
13	<p>The Applicant shall describe its provider network development strategy, including, but not limited to ensuring the development of a comprehensive network of physical health, behavioral health, I/DD, TBI, LTSS and pharmacy providers for children and adults as required and applicable in <i>Section V.B.4.i. Provider Network</i> and <i>Section V.C.4.a. Provider Network</i>. The response also shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Innovative approaches that will be used to develop and maintain the BH I/DD Tailored Plan’s provider network to ensure network adequacy standards and highest quality care; b. Methods for monitoring and ensuring compliance with access to care standards, including the frequency of reviewing of these standards; c. Experience with and approach to how the Applicant will ensure access to care on an out-of-network basis when timely access to a Network Provider is not possible, including the Applicant’s plan to educate members on accessing out-of-network benefits; d. Methods to educate providers on North Carolina’s Medicaid Managed Care program and State-funded Services and ease the transition from LME/MCO to BH I/DD Tailored Plans; e. Strategies to recruit, support, and sustain providers in traditionally underserved areas, by health need, and overcome expected accessibility challenges; <p><u>For Medicaid Only</u></p>

	<p>f. Approach to how BH I/DD Tailored Plan will meet required time and distance standards and appointment wait time standards for adult service and pediatric service providers;</p> <p>g. Identified gaps between current Medicaid provider network and the network standards for Medicaid services in the BH I/DD Tailored Plan;</p> <p><u>For State-funded Services Only</u></p> <p>h. Identified gaps between current State-funded Services provider network and the network standards for State-funded Services in the BH I/DD Tailored Plan;</p> <p>i. Approach to how BH I/DD Tailored Plan will meet required time and distance standards and appointment wait time standards for providers;</p> <p>j. Strategies to recruit, support, and sustain providers representative of Historically Marginalized Populations; and</p> <p>k. Strategies to ensure access for State-funded Services recipients with BH conditions to case management service providers.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>Provide a draft Network Access Plan that addresses the components listed <i>Section V.B.4.i.(vii) Assurances of Adequate Capacity and Services (42 C.F.R. § 438.207)</i>.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Financial Management

Evaluation Question	
14.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements as outlined in <i>Section V.B.7.i. Capitation Payments</i> and within the rates described in the <i>Section IX. Medicaid Tailored Plan Draft Rate Book</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ol style="list-style-type: none"> a. For all entities proposed to assume risk through the capitated contract as listed in Question #2, provide the net underwriting gain or loss for Medicaid lines of business for the last two completed contract years, by state of operation and year (for all entities proposed to bear risk). Include relevant details on context for any losses; b. Approach to managing utilization and expenditures within the capitation payments and to ensure good stewardship while meeting or exceeding quality standards; c. Methods for reducing administrative costs to and maintaining financial predictability of the North Carolina Medicaid Managed Care program; d. Tools and measures the Applicant uses or will use to track actual and anticipated expenditures relative to the capitation rates to mitigate losses; and e. Measures and the targets for each measure that the Applicant will use to demonstrate value to the Department.
Response	
<p>Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.</p>	

Evaluation Question	
15.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in <i>Section V.B.7.ii. Medical Loss Ratio</i>. Response should include, but is not limited to, the Applicant's approach to ensuring accurate and timely MLR reporting.</p> <p><u>For Medicaid Only.</u></p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
16.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for managing and monitoring financial sustainability, as outlined in <i>Section V.B.7.iii. Financial Management</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach to managing financial risk, including how financial risk will be shared across partnering entities, subject to the parameters laid out in <i>Section V.A.1.iv. Third Party (Subcontractor) Contractual Relationships</i>; b. Approach to strong financial stewardship and protecting against insolvency, including plans for meeting and maintaining minimum capital requirements as outlined in <i>Section V.B.7.iii.(vii) Financial Viability</i>. c. Sources and amounts of capital available to the Applicant, including: <ul style="list-style-type: none"> a. Amount of available capital, by source, as of January 1, 2021; b. Amount of available capital, by source, expected at the time of BH I/DD Tailored Plan launch;

	<p>c. Amount of available capital, by source, expected twelve (12) months following BH I/DD Tailored Plan launch;</p> <p>d. The Applicant's plan for finding additional capital should the Applicant experience financial hardship; and</p> <p>e. For all entities proposed to assume risk through the capitated contract as listed in Question #2, explain any State (including states other than NC) actions and entity responses related to solvency or inadequate financial management or oversight during the past ten (10) years, including all relevant details on the context and proceedings.</p> <p>f. Approach to ensure the separation of non-Medicaid revenue and expense from Medicaid revenue and expense for payment of authorized services.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count) for the Applicant or any entities identified to assume risk in Question #2, as applicable:</p> <ol style="list-style-type: none"> 1. Monthly Financial Reporting Template from the month most recently submitted to the Department. (NOTE: Applicants must provide financial reporting inclusive of the criteria described in <i>Section VII. Attachment J. Reporting Requirements</i> and currently required by the Department in the monthly Financial Reporting Template.) 2. Audited financial reporting, as described in <i>Section VII. Attachment J. Reporting Requirements</i>, from the prior two (2) years immediately preceding the year in which the Application is submitted. 3. Documentation of lines of credit that are available, including maximum credit amount and available credit amount. 4. Documentation of commitment by entities identified as providing capital needed to meet minimum capital requirements. 5. Any other documentation that speaks to the entity's financial health and any alternative arrangements or mechanisms for managing financial risk.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

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Evaluation Question	
17.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements as outlined in <i>Section V.C.7. Financial Requirements</i>. The response also shall include:</p> <p><u>For State-funded Services Only</u></p> <ul style="list-style-type: none">a. Approach to managing utilization and expenditures within allocated funding while meeting or exceeding quality standards;b. Methods for reducing administrative costs to and maintaining financial predictability of the North Carolina state and federally funded Non-Medicaid services;c. Tools and measures the Applicant uses to track actual and anticipated expenditures relative to allocated funding to mitigate losses;d. Measures and the targets for each measure that the Applicant will use to demonstrate value to the Department;e. Approach to ensure the separation of Non-Medicaid revenue and expense from Medicaid revenue and expense for payment of authorized services;f. Tools and measures the Applicant uses to track actual and anticipated expenditures against funding categories of: Single Stream funding (UCR/claims based as well as Non-UCR based expenses), Special Categorical funding, Federal Non-UCR funding as well as State Non-UCR funding by allocated funding account number; andg. Approach to managing federal block grant requirements, including MOE and restriction requirements.
Response	

Care Management

Evaluation Question	
18.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for care management as stated in <i>Section V.B.3.ii. Tailored Care Management</i>. The response also shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none">a. Approach describing how the Applicant will structure itself to ensure successful and appropriate implementation of Tailored Care Management;b. Approach for ensuring all organizations providing Tailored Care Management (AMH+ practices, CMAs, and BH I/DD Tailored Plans) provide care management that is integrated across physical health, BH, I/DD, TBI, LTSS, and pharmacy and addresses Unmet Health-Related Resource Needs to the maximum extent possible;c. Approach for coordinating across the BH I/DD Tailored Plan, NC Medicaid Direct, Medicare, and other authorized Department Business Associates (e.g., CCNC) for members who are enrolled in both full Medicare and Medicaid for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing;d. Approach for ensuring that members do not receive duplicative care management from multiple sources;e. Approach for ensuring utilization management is not involved in care management; andf. Approach to ensure active member engagement in Tailored Care Management, including projected percentage of members that will be actively engaged, by each contract year.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

19. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Provider-based Care Management as stated in *Section V.B.3.ii. Tailored Care Management*. The response also shall include:

Medicaid Only

- a. Approach for building a network of AMH+ practices and CMAs over the life of the contract, including:
 - i. Approach for meeting the Department's annual targets for the percentage of members actively engaged in provider-based care management approaches;
 - ii. Plan for providing ongoing technical assistance to AMH+s and CMAs in the Applicant's network and those seeking certification to enable them to become high-performing providers of Tailored Care Management; and
 - iii. Approach for managing application and certification process for new AMH+ practices and CMAs after BH I/DD Tailored Plan launch.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

20. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management Training as stated in *Section V.B.3.ii. Tailored Care Management*. The response also shall include:

For Medicaid Only

- a. Approach for implementing Tailored Care Management training for care managers and supervising care managers, including:

	<ul style="list-style-type: none"> i. Approach for developing the Tailored Care Management training curriculum, including plans to collaborate with other BH I/DD Tailored Plans on curriculum development; ii. Approach for training care managers across all organizations providing Tailored Care Management; and iii. Approach for assessing competency of care managers.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
21.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and Care Management Assignment as required in <i>Section V.B.3.ii. Tailored Care Management</i>. The response shall include the Applicant’s approach to:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Process for assigning each member to a care management approach and organization providing Tailored Care Management, ensuring that each approach can manage a mix of acuity tiers b. Approach to providing members information about their options for Tailored Care Management, including the types of care management approaches and organizations providing Tailored Care Management, and ensuring that members are not “steered” toward certain care management approaches or organizations
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

22. The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and Care Management Comprehensive Assessment and Care Plan/ISP development as stated in *Section V.B.3.ii. Tailored Care Management*. The response shall include the Applicant’s approach to:
- For Medicaid Only
- a. Care Management Comprehensive Assessments
 - i. Approach for ensuring Care Management Comprehensive Assessments conducted by the BH I/DD Tailored Plan, AMH+ practices, and CMAs meet the requirements set in the RFA;
 - ii. Approach that the Applicant will take in varying content and approach to completing Care Management Comprehensive Assessments based on population;
 - iii. Approach to conducting outreach to BH I/DD Tailored Plan members to initiate and complete the Care Management Comprehensive Assessments; and
 - iv. Proposed strategies to screen and assess BH I/DD Tailored Plan members for Unmet Health-Related Resource Needs as part of Care Management Comprehensive Assessment.
 - b. Care Plans/ISPs
 - i. Approach for ensuring Care Plans and ISPs developed across all organizations providing Tailored Care Management meet the requirements set in the RFA;
 - ii. Approach for involving multi-disciplinary care team in the development of Care Plans and ISPs;

	<ul style="list-style-type: none"> iii. Approach for developing individualized and person-centered Care Plans/ISPs and ensuring the member and the member’s family, advocates, caregivers, and/or legal guardians are actively involved; and iv. Approach for developing ISPs for members enrolled in the Innovations or TBI waiver beyond the requirements established in the waivers.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
23.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for Tailored Care Management and care management for special populations as stated in <i>Section V.B.3.ii. Tailored Care Management</i>. The response shall include the Applicant’s approach to:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Children with complex needs, as that term is defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina; b. Children ages zero (0) up to age three (3) receiving early intervention services; c. Women with high-risk pregnancies; and d. Members on the Innovations or TBI waitlist, and other members with LTSS needs.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

24. a. The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for integrating strategies and coordinating appropriate services to address Unmet Health-Related Resource Needs into Tailored Care Management stated in *Section V.B.3.ii. Tailored Care Management*. The response shall specify planned and past examples of methods to provide non-medical, health-related services and resources to members including:

For Medicaid Only

- a. Providing comprehensive assistance securing health-related services that can improve health and family well-being (i.e., assistance filling out and submitting applications for government assistance programs);
- b. Assisting individuals in securing and maintaining safe and stable housing beyond efforts conducted under TCLI;
- c. Assisting individuals in obtaining food;
- d. Assisting individuals in obtaining transportation;
- e. Providing access to medical-legal support for legal issues adversely affecting health; and
- f. Providing individuals with resources and referrals to address ACEs and trauma.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

25. Describe BH I/DD Tailored Plan’s adherence and approach to meeting Department's expectations and requirements for care management for populations enrolled in the Innovations or TBI waiver in *Section V.B.3.iv. Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver and Section V.B.3.ii.(xiii) Additional Tailored Care Management Requirements for Members Enrolled in the Innovations or TBI Waivers*. The response shall include:
- For Medicaid Only
- a. Approach for transitioning members from LME/MCO care coordination and other authorized Department Business Associates (e.g., CCNC) to Tailored Care Management, including, but not limited to:
 - i. Plans for notifying beneficiaries about differences between LME/MCO care coordination and Tailored Care Management, how to access Tailored Care Management, and the benefits of Tailored Care Management;
 - ii. Process for transitioning members’ ISPs to meet Tailored Care Management requirements; and
 - iii. Plans to train current Innovations waiver care coordinators and supervisors to meet Tailored Care Management requirements.
 - b. Approach for ensuring that Tailored Care Management for members enrolled in the Innovations or TBI waivers complies with federal conflict-free case management regulations as required by 42 C.F.R. § 441.301(c)(1)(vi).

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

26. The Applicant shall describe its approach to meeting the Department's data use and system expectations and requirements outlined in *Section V.B.3.ii. Tailored Care Management* and *Section V.C.3. Care Management and Prevention*. The response shall describe Applicant’s capabilities and experience to implement and maintain reliable:
- For Medicaid and State-funded Services
- a. Technology, systems, and solutions to support Tailored Care Management for Medicaid members and BH I/DD Tailored Plan-based care management for State-funded Services recipients with I/DD or TBI, hereafter collectively referred to as ‘functions’;
 - b. Data governance procedures to ensure the secure, complete, accurate, and timely collection and use of data to support these functions;
 - c. Process to timely respond to data requests from the Department;
 - d. Privacy and security policies to ensure data is accessed, stored, and exchange in a protected manner as required by the Department’s standards and applicable state and federal laws;
- For Medicaid Only
- e. Processes to collect, access, integrate, link, and use identified administrative and state data to support these functions, including data that may be available through the Department from CMS to support care management activities for dual eligible members; and
 - f. Processes and systems to facilitate data sharing between and among all types of Medicaid Managed Care plans (e.g., BH I/DD Tailored Plans, Standard Plans, Tribal Option), the Department (including NC Medicaid Direct), other authorized Department Business Associates, AMH+ and CMA practices, CINs or Other Partners and the member, as appropriate and required to support these functions.

	<p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Anticipated technical capabilities, including the data, processes, systems, including system product/version detail, that the Applicant will use to support Tailored Care Management for Medicaid members and BH I/DD Tailored Plan-based care management for State-funded Services recipients with I/DD or TBI.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
27.	<p>The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for providing transitional care management and care transitions in <i>Section V.B.3.i. Overview, Section V.B.3.ii.(xi) Transitional Care Management, Section V.B.3.iii. Care Coordination and Care Transitions for all Members, and Section V.B.3.v. Other Care Management Programs</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ol style="list-style-type: none"> a. Plans for using ADT feeds and similar techniques to identify high-risk transitions, and the expected results of those efforts; b. Experience with and plans for developing processes and partnerships with SNFs, NICUs, hospitals, rehabilitation facilities, residential settings, State Operated Health Facilities, ICF-IIDs, and other levels of care in order to facilitate transitions; c. Plans to partner with AMH+ practices and CMAs to provide transitional care management including data shared and roles/responsibilities; d. Plans to provide transitional care management for members who are transiting from ACT, ICF-IID, HFW, or CMARC to Tailored Care Management; and

e. Any examples or plans for customization of care management, including the assessment, medication reconciliation, etc., to support transitional care management that differentiates the Applicant from other potential respondents.

PROVIDE SUPPORTING DOCUMENTATION (not part of page count):

1. Three (3), 90-day post-discharge transition plan examples for members transitioning out of three (3) different types of settings. The settings must include:
 - a. A short-term acute care setting;
 - b. A long-term care setting; and
 - c. A third setting of the Applicant’s choosing

The three (3) examples should include at least one (1) example of a member with BH needs and one (1) example of a member with I/DD needs.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

28. The Applicant shall describe its approach to meeting the Department’s expectations and requirements as outlined in *Section V.C.3.a. Model Overview and Objectives; Section V.C.3.b. Case Management for Recipients with Behavioral Health Conditions; and V.C.3.c. Care Management Delivered Through the BH I/DD Tailored Plans for I/DD and TBI Populations*. The response shall include:

For State-funded Only

	<ul style="list-style-type: none"> a. Approach for ensuring recipients with BH conditions who have complex needs are placed in a timely manner in appropriate settings; b. The number of recipients with I/DD and TBI projected to obtain care management through the BH I/DD Tailored Plan per year; c. Approach for prioritizing eligible recipients for care management in light of expected funds available; d. Approach for developing and conducting Care Management Comprehensive Assessments; and e. Approach for developing and completing ISPs.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Providers

Evaluation Question

29.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.4.ii. Provider Network Management</i> and <i>Section V.C.4.b. Provider Network Management</i>. Response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for managing the provider network to comply with any willing provider requirements for physical health and pharmacy services and closed network requirements for behavioral health, I/DD, and TBI services; b. Process for notifying members and ensuring their continued access to covered services in the event of provider termination. Include details as to how Applicant will assign a new PCP as well as maintain continuity of care for members who had scheduled appointments with the terminated provider;
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State-funded Services Only

- c. Approach for managing the provider network to comply with the closed network requirements for behavioral health, I/DD, and TBI services;
- d. Process for notifying recipients and ensuring their continued access to covered services in the event of provider termination. Include details as to how Applicant will maintain continuity of care for recipients who had scheduled appointments with the terminated provider;

For Medicaid and State-funded Services

- e. Description of the BH I/DD Tailored Plan's process and policies for terminating a provider from its network. Provide one (1) State-funded Services and two (2) Medicaid historical examples of the Applicant terminating a provider with cause;
- f. Description of the BH I/DD Tailored Plan's practices and procedures to ensure contracting with Division of State-Operated Healthcare Facilities;
- g. Description of BH I/DD Tailored Plan's policies and procedures used in selection and retention of BH, I/DD, and TBI services network providers. Provide two (2) State-funded Services and three (3) Medicaid examples of the conditions under which the BH I/DD Tailored Plan would issue a provider an adverse determination during the contracting process;
- h. Description of the policies, procedures and processes the BH I/DD Tailored Plan will utilize to ensure 100% of provider network contracting determinations are completed within forty-five (45) days of receipt of complete information for a provider;
- i. Description of BH I/DD Tailored Plan's plan for establishing and maintaining a Provider Network Participation Committee. Include a description of provisions that will be implemented for Committee members to make fair determinations and how decisions will be monitored to ensure fairness;
- j. Description of the operational policies, procedures and processes the BH I/DD Tailored Plan will utilize to load the terms of the provider contracts into the BH I/DD Tailored Plan claim payment platform to accurately pay providers consistent with agreed upon contract terms;
- k. Description of BH I/DD Tailored Plan's process for enrolling providers in its network consistent with the operational timeframes and requirements including communication of the welcome notice, enrollment information, onboarding, and training; and
- l. Description of the BH I/DD Tailored Plan's strategy for developing and monitoring the consumer-facing Provider Directory, including innovative strategies for ensuring data accuracy, timely updates, and accessibility to members, including those with limited English proficiency/literacy or are deaf/hard of hearing.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

30. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.4.iii. Provider Relations and Engagement* and *Section V.C.4.c. Provider Relations and Engagement*. The response shall include:
- For Medicaid and State-funded Services
- a. Description of the Online Provider Portal, including information topics accessed there and key functionality in the Online Provider Portal useful to providers.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question	
31.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department’s expectations and requirements outlined in <i>Section V.B.4.iv. Provider Payments</i> and <i>Section V.C.4.d. Provider Payments</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none">a. Approach to ensure provider payment requirements are met. Include in your response how quickly the BH I/DD Tailored Plan can update its claim system to incorporate changes to provider contracting terms or to rate floors or schedules.b. Approach to negotiating rates with providers.c. Approach to offer providers any alternative payment arrangements in lieu of the rate floor, as applicable.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

32.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.4.v. Provider Grievances and Appeals</i> and <i>Section V.C.4.e. Provider Grievances and Appeals</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <p>a. A description of the BH I/DD Tailored Plan’s provider grievance and appeals processes.</p> <p><u>For State-funded Services Only</u></p> <p>b. A description of the BH I/DD Tailored Plan’s provider complaint and appeals processes.</p> <p><u>For Medicaid and State-funded Services</u></p> <p>c. A description of the BH I/DD Tailored Plan’s approach to educate providers on their rights within the grievance, complaint and appeals process.</p> <p>d. Identification of any provider appeal rights that will be provided in addition to those required in the Contract.</p> <p>e. A description of the Applicant’s process to self-audit the Provider Grievance and Appeals and Provider Complaint and Appeals determinations, including the frequency and how the results are used to drive improvements.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>1. Provide up to three (3) examples each of Medicaid and State-funded services provider complaints, grievances, and/or appeals that have been received and resolved in the past three (3) years.</p> <p>2. Process flows detailing the process for Medicaid and State-funded Services provider grievances, complaints and appeals</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

33. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.A.4.i. Engagement with Federally Recognized Tribes*. The response shall include:

Medicaid Only

- a. Approach to integrate with EBCI Public Health and Human Services (PHHS) offices;
- b. Approach for working with IHCP providers, including:
 - i. Proposed training methods for Tribal Provider Contracting Specialist, if applicable
 - ii. Proposed plan to contract with IHCPs as required under the Contract.
- c. [Approach to integrate with State recognized tribes.](#)

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

34. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in *Section V.A.4.v Community Crisis Services Plan for Medicaid and State-funded Services*. The response shall include:

Medicaid and State-funded Services

- a. Efforts to implement the Community Crisis Services Plan;
- b. Approach to convene the Crisis Planning Committee; and

	<p>c. Plans for coordinating with Standard Plans and local communities around efforts to increase access to and secure the sustainability of non-hospital/ED-based behavioral health crisis options and alternatives to involving law enforcement in behavioral health crisis response.</p> <p>The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements and provide a plan for addressing those limitations/issues.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page limit)</p> <p>1. Community Crisis Services Plan</p>
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Benefits & Services

Evaluation Question

35.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.2.i. Physical Health, Behavioral Health, I/DD, and TBI Benefit Package</i> and <i>V.C.2.a. State-funded BH I/DD and TBI Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience and approach to providing mental health services across community-based and residential settings; b. Experience and approach to providing the continuum of SUD treatment and withdrawal management services across Medicaid and State-funded Services, including opioid and MAT treatment across community-based and residential settings; c. Experience and approach to providing I/DD-related benefits, including Innovations waiver services;
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	<p><u>For State-funded Services Only</u></p> <p>d. Proposed non-core State-funded Services the Applicant intends to offer.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
36.	<p>The Applicant shall describe the In Lieu of Services (ILOS) (<i>Section V.B.2.i.(vii) In Lieu of Services</i>) and Value-Added Services (<i>Section V.B.2.i.(viii) Value-Added Services</i>) that the Applicant plans to propose to the Department for approval. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Description of and rationale for each service; b. Medicaid State Plan service it is in lieu of; c. Proposed population to cover for each service; and, d. Whether the Applicant is providing the service today and its approach for monitoring efficacy and cost-effectiveness, including any adjustments to the service made based upon monitoring. <p>Response to this question will not count toward the Applicant’s page count limit.</p>
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

37. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.2.ii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*. The response shall include:
- For Medicaid Only
- a. Approach to ensuring members and providers are aware of the EPSDT program;
 - b. The category of expanded benefits (e.g., physical health, NEMT and LTSS) where Applicant anticipates EPSDT will be most important and approach for addressing its anticipated importance;
 - c. Description of medical necessity review process, including examples of how the Applicant has applied the process previously on at least two (2) approved and two (2) denied services; and
 - d. Outreach methods to remind members of missed screenings and preventive services.
- PROVIDE SUPPORTING DOCUMENTATION (not part of page count):
- 1. Current EPSDT policies.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

38. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.2.iv. Non-Emergency Medical Transportation*. The response shall include:

For Medicaid Only

- a. Approach to building an adequate NEMT network;
- b. Approach to transitioning NEMT upon BH I/DD Tailored Plan enrollment for members who were using NEMT in NC Medicaid Direct;
- c. Approach to utilizing innovative transportation solutions to most effectively meet needs of members; and
- d. Oversight model of NEMT providers to ensure member rights and maintain high member satisfaction.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question	
39.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for diversion of Medicaid members and potential State-funded Services recipients from placement in an institutional setting or ACH as stated in <i>Section V.B.3.ii.(xii) Diversion from Institutional Settings and V.C.3.d. Diversion from Institutional Settings</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. For adult members/potential recipients with SMI: <ul style="list-style-type: none"> i. Experience with and approach to appropriately identify, engage and divert members/potential recipients from placement in an institutional setting or ACH to a home or community-based setting; and ii. Experience with and approach to identify and connect members/potential recipients at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including waiver services; and <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> b. For members under age eighteen (18) with SED <ul style="list-style-type: none"> i. Experience with and approach to appropriately identify, engage and divert members from placement in an institutional setting to a home or community-based setting; and ii. Experience with and approach to identify and connect members at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including Medicaid, state-funded, and waiver services. c. For members with I/DD <ul style="list-style-type: none"> i. Experience with and approach to appropriately identify, engage and divert members from placement in an institutional setting to a home or community-based setting; and ii. Experience with and approach to identify and connect members at risk for institutionalization to appropriate, high-quality, person-centered community-based services and other supports, including Medicaid, state-funded, and waiver services.
Response	
<p>Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.</p>	



Evaluation Question

40.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for in-reach and transition of the following Medicaid members and non-Medicaid covered State-funded Services recipients from an institutional setting or ACH to a home or community-based setting as stated in <i>Section V.B.3.viii. In-Reach and Transition from Institutional Settings</i> and <i>Section V.C.3.e. In-Reach and Transition from Institutional Settings</i> s:</p> <ul style="list-style-type: none">• Members/recipients age eighteen (18) and above admitted to or residing in a state psychiatric hospitals;• Members/recipients with SMI admitted to or residing in an ACH;• Members admitted to or residing in state developmental centers, including members under age twenty-one (21) (Medicaid only); and• Members admitted to or residing in ICF-IIDs Not Operated by the State, including members under age twenty-one (21) (Medicaid only). <p><u>For Medicaid and State-funded Services</u></p> <p>The response shall include:</p> <ol style="list-style-type: none">a. Experience with and approach for ensuring successful and appropriate in-reach to members and recipients in institutional settings or ACHs who are eligible to receive in-reach and transition services and successful and appropriate transition of members/recipients in institutional settings or ACHs.b. Experience with and approach to identify members/recipients for in-reach and transition services, including policies, procedures and data systems.c. Experience with and approach to ensure individuals responsible for in-reach and transition activities are appropriately trained and supported so that they are able to provide high-quality, person-centered in-reach and transition services for the member populations they will serve, including members with SMI and I/DD<ol style="list-style-type: none">i. Training for individuals responsible for in-reach and transition activities, including initial and ongoing continuous education.ii. Approach for coordination between individuals responsible for in-reach and transition activities and other BH I/DD Tailored Plan-based specialists who can provide additional support for complex discharges, including but not limited to the housing specialist and/or diversion specialists.
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	<p>iii. Approach for supervision, oversight, and accountability of individuals responsible for in-reach and transition activities.</p> <p>d. Description of the Applicant’s in-reach and transition roles and responsibilities, including any overlapping responsibilities between individuals providing in-reach and transition services and rationale for the overlaps.</p> <p>e. Approach to ensure timely, Warm Handoffs:</p> <p>i. Between in-reach staff (i.e., in-reach specialist or peer support specialist) and individuals responsible for transition activities (i.e., transition coordinator or DSOHF admission through discharge manager) when a member/recipient chooses to transition to a community setting.</p> <p>ii. Between transition staff and the member/recipient’s care manager, provider delivering State-funded case management service, or other state-funded service with case management functions (e.g. CST, ACT), if applicable.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>1. Current policies, procedures, and data systems, including those used to identify members/recipients for in-reach and transition services.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
41.	<p>The Applicant shall confirm its adherence to and describe its approach to meeting the Department's expectations and requirements for in-reach and transition for the following Medicaid members from an institutional setting to a home or community-based setting as stated in <i>Section V.B.3.viii. In-Reach and Transition from Institutional Settings</i> a:</p> <ul style="list-style-type: none"> • Member under age eighteen (18) admitted to or residing in a state psychiatric hospital; • Members admitted to or residing in a PRTF; and • Members admitted to or residing in Residential Treatment Levels II/Program Type, III, and IV as defined in the Department’s Clinical Coverage Policy 8-D-2.

	<p>For Medicaid Only</p> <p>The response shall include:</p> <ul style="list-style-type: none"> a. Experience with and approach to: <ul style="list-style-type: none"> i. Reducing the average length of stay in a PRTF, Residential Treatment Service, or state psychiatric facility for members under age eighteen (18); and ii. Reducing the total number and percentage of members under age eighteen (18) residing in a PRTF, Residential Treatment Service, or state psychiatric facility. b. Experience with and approach to ensuring successful and appropriate in-reach to members in institutional settings who are eligible to receive in-reach and transition services and successful and appropriate transition of members in institutional settings. c. Experience with and approach to identifying members for in-reach and transition services, including policies, procedures and data systems. d. Experience with and approach to ensuring individuals responsible for in-reach and transition activities provide high-quality, person-centered in-reach and transition services for the member populations they will serve: <ul style="list-style-type: none"> i. Training for individuals responsible for in-reach and transition activities, including initial and ongoing continuous education. ii. Approach for coordination between individuals responsible for in-reach and transition activities and other BH I/DD Tailored Plan-based specialists who can provide additional support for complex discharges, including but not limited to the housing specialist and/or diversion specialists. iii. Approach for supervision, oversight, and accountability of individuals responsible for in-reach and transition activities. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Current policies, procedures, and data systems, including those used to identify members/recipients for in-reach and transition services.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question	
42.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.iv. Development of Housing Opportunities for Medicaid Members and State-funded Recipients</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience securing and maintaining housing placements for TCLI population b. Priority populations other than TCLI and approach for targeting them for housing efforts
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Members & Recipients

Evaluation Question	
43.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.viii. Advance Directives for Medicaid and State-funded Services</i>. The response shall include:</p>

	<p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Applicant’s current Advance Directives policy (does not count towards page guidelines) and b. Detail describing any proposed changes to the Applicant’s Advance Directives policy anticipated to meet the outlined requirements (Section V.A.1.h.) and the associated timeline for making those changes.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
44.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.1.i. Eligibility and Enrollment for BH I/DD Tailored Plans</i>, and the North Carolina Managed Care Enrollment Policy (<i>Section VII. Attachment M.1.</i>). The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Necessary system interfaces to accept and process member enrollment and disenrollment, in a standard HIPAA compliant manner; b. Integration approach with Enrollment Broker and local DSS offices or EBCI PHHS offices; and c. Approach to enrolling Standard Plan beneficiaries who need a service only offered through a BH I/DD Tailored Plan into a BH I/DD Tailored Plan within twenty-four (24) hours retroactive to the date of the service-related request and ensuring that service authorizations, including expedited ones, for these members are completed in a timely manner consistent with the required timeframes.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

45. The Applicant shall describe its proposed eligibility criteria and its approach for implementing its eligibility criteria as outlined in *Section V.C.1.a. Eligibility for State-funded Behavioral Health, I/DD and TBI Services*. The response shall include:
- For State-funded Services Only
- a. Proposed eligibility criteria for by disability group (e.g., mental health, SUD, I/DD and TBI), including whether the Applicant proposes to use the Department’s guidelines. The response should include:
 - 1. Detailed description of the proposed eligibility criteria, including proposed income level, insurance status (i.e., whether individuals who are uninsured, have Medicaid, have other third-party coverage will be eligible for services), and any other components that will be considered (This sub-part will not be scored.)
 - 2. Rationale for the proposed eligibility criteria
 - 3. Process for consulting its CFAC on the proposed eligibility criteria and description of how the CFAC’s feedback was/will be incorporated
 - 4. Approach for implementing its proposed eligibility criteria, including the role of providers in the implementation
 - b. Approach for monitoring the implementation of the eligibility criteria
 - c. Approach for assisting uninsured State-funded Service recipients in submitting Medicaid applications;
 - d. Approach to managing access to State-funded Services and connecting individuals in need of State-funded Services to providers with capacity to treat them;

	<ul style="list-style-type: none"> e. Approach for developing and maintaining wait lists on the plan level for individuals waiting for State-funded Services, including any recent or planned investments in technology or system infrastructure; and f. Approach to maximizing federal Medicaid funding for Medicaid beneficiaries to expand the reach of State funds and ensure that other available coverage and payment sources are pursued first.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
46.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.1.ii. Transitions of Care</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Approach for conducting “Warm Handoffs” during the crossover and ongoing periods for those members who were previously receiving services through a Standard Plan, another BH I/DD Tailored Plan, CCNC or other transition entities such as the Tribal Option. b. Approach for conducting “Warm Handoffs” on an ongoing basis after BH I/DD Tailored Plan launch, including for those members transitioning to a Standard Plan; and c. Experience and approach for supporting members transitioning between providers when a provider is terminated or otherwise leaves the BH I/DD Tailored Plan’s network. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Draft transition of care process flows detailing the flow of information for members transitioning into and out of the BH I/DD Tailored Plan
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

47. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.vi. Member Grievances and Appeals*, including how the Applicant intends to identify, track and analyze member grievances, appeals, and State Fair Hearing data. The response shall include:
- For Medicaid Only
- a. Approach for educating members about the grievance and appeals process, including assistance and accommodations that the BH I/DD Tailored Plan will provide to verify members understand their grievances and appeals rights and process;
 - b. Confirmation of the ability to process grievance and appeal requests within the timeframes described in the Contract;
 - c. Approach to meeting each of the applicable grievance and appeal timely processing standards processing of requests;
 - d. Process for acknowledging receipt of member grievance and appeals requests;
 - e. Protocols, procedures and staffing levels and requirements for reviewing member grievances and appeals;
 - f. How information and data resulting from the grievance and appeals system is tracked and trended, including how the Applicant uses the data to make program improvements;
 - g. Process for resolving grievances and appeals as expeditiously as a member's health condition requires, including how the Applicant assesses the urgency of a member's health conditions and timelines to account for the urgency of the health condition;

	<p>h. Experience for resolving grievances and appeals at the lowest level of escalation to meet Applicant's current members' needs and methods and strategies used throughout the Applicant's approach to resolve grievance and appeals efficiently and effectively at the lowest level of escalation that meets a member's needs and in a manner that does not discourage members from exercising their rights; and</p> <p>i. Approach to complying with due process principles under the NC Innovations waiver and TBI waiver.</p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <p>1. Draft process flows detailing the process for members grievances and appeals.</p>
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Response

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Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

48.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.C.1.e. Recipient Complaints and Appeals</i>, including how the Applicant intends to identify, track and analyze member complaints, appeals, and State Non-Medicaid Appeals Panel data. The response shall include:</p> <p><u>For State-funded Service Only</u></p> <ul style="list-style-type: none"> a. Approach for educating recipients about the complaints and appeals process, including assistance and accommodations that the BH I/DD Tailored Plan will provide to ensure members understand their grievances and appeals rights and process; b. Confirmation of the ability to process complaints and appeals requests within the timeframes described in the Contract; c. Approach to meeting each of the applicable complaints and appeals timely processing standards processing of requests;
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	<ul style="list-style-type: none"> d. Process for acknowledging receipt of recipients’ complaints and appeals requests; e. Protocols, procedures and staffing levels and requirements for reviewing recipients’ complaints and appeals; f. How information and data resulting from the complaints and appeals system is tracked and trended, including how the Applicant uses the data to make program improvements; g. Experience with, methods and strategies used throughout the Applicant’s approach to resolve complaints and appeals efficiently and effectively at the lowest level of escalation that meets a recipient’s needs and in a manner that does not discourage recipients from exercising their rights; and h. Approach for reviewing State Non-Medicaid Appeals Panel findings and decisions to inform Applicant’s final decisions. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Draft process flows detailing the process for recipients’ complaints and appeals
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

49.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for engaging members and recipients prior to and after BH I/DD Tailored Plan launch, as outlined in <i>Section V.B.1.iii. Member Engagement</i> and <i>Section V.C.1.b. Recipient Engagement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p>
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- a. Overall approach to educating and engaging members on Medicaid Managed Care and recipients on State-funded Services, and on accessing care, including Innovations and TBI waiver services, and improving overall health;
- b. Methods of leveraging appropriate communication to meet the diverse needs and communication preferences of members and recipients, including individuals with Limited English Proficiency and needing adaptive communication;
- c. Approach for making qualified interpreters (including sign language) available to members, recipients, potential members, and potential recipients when requested, and at other times as needed in accordance with the Contract;
- d. Description of how verbal, written and sign language translation or interpreter services are certified;
- e. Method to ensure member and recipient language preferences and communication needs are documented in Applicant’s information system;
- f. Approach to assess member and recipient satisfaction at each point of contact (call, online and in-person), including tools, frequency and process to measure trends in member and recipient satisfaction to support ongoing improvement to the program;
- g. Experience with engaging consumer and family advisory groups and approach for establishing and maintaining engagement with the consumer and family advisory groups including the structure of these groups; and
- h. Strategies to ensure meaningful opportunities for input and incorporation of the consumer and family advisory groups’ input into the design, development and implementation of BH I/DD Tailored Plan policies; and

For Medicaid Only

- i. Description of how Applicant will educate members about the differences between Standard Plans and BH I/DD Tailored Plans.
- j. PROVIDE SUPPORTING DOCUMENTATION (not part of page count):
 1. Draft Welcome Packet and Member ID card aligned with the requirements of the Contract
 2. Sample Member and Recipient Handbook
 3. Sample educational materials with taglines (up to 3 samples)
 4. Sample education materials demonstrating ability to meet Contract’s requirements for translation, accessibility and Cultural and Linguistic Competency (up to 3 samples, including translations in Spanish and Chinese)

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

50. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.iv. Marketing for Medicaid* and *Section V.C.1.c. Marketing*. The response shall include:
- For Medicaid and State-funded Services
- a. Proposed marketing locations, distribution methods, and activities planned for the time period between eight (8) weeks prior to and three (3) months after BH I/DD Tailored Plan launch;
 - b. Demonstrated understanding of the diverse populations that the Applicant may serve throughout its covered Region (e.g., individuals living in different geographic locations, individuals with different racial and ethnic backgrounds, individuals with different literacy levels, individuals with disabilities) and approach for how the Applicant will adapt its marketing materials to reach the various populations and audiences within its covered service area; and
 - c. Process to ensure marketing materials are widely available throughout the Applicant’s covered Region to members, recipients, potential members, and potential recipients, and a plan for how the Applicant intends to prevent the selective distribution of its marketing materials throughout its covered Region.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question

51. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.v. Member Rights and Responsibilities and Section V.C.1.d. Recipient Rights and Responsibilities.*
For Medicaid and State-funded Services

Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question

52. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.1.vii. Advance Medical Homes (AMHs) as Primary Care Providers (PCPs) and Section V.B.1.vii.(ii). PCP Choice and Assignment.*
For Medicaid Only

- a. Approach to providing feedback on quality scoring results to AMH practices; and

	b. Methodology for PCP assignment, including any additional variables that will be used beyond those listed in the contract.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
53.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.ii. Engagement with Community and County Organizations for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Approach to design and implement Local Community Collaboration Strategy; b. Approach to linking members and recipients to natural and community supports to address unmet health related resource needs; c. Prior experiences supporting and working with communities and community-based organizations, including participating in community collaboratives and implementing a similar strategy that the Department is looking to implement through the Contract; d. Approach to reducing burden associated with engagement on agencies/partners.
Response	

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Compliance

Evaluation Question	
54.	The Applicant shall (a) describe its existing compliance program; and (b) describe its plan to meet the Department's expectations and requirements outlined in <i>Section V.A.3.i. Compliance Program for Medicaid and State-funded Services</i> . <u>For Medicaid and State-funded Services</u>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
55.	The Applicant shall describe its plan to meet the Department's expectations and requirements outlined in <i>Section V.A.3.ii. Program Integrity (PI) for Medicaid and State-funded Services</i> . Include in the response current program integrity activities. <u>For Medicaid and State-funded Services</u>
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

56. The Applicant shall describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.3.iii. Fraud, Waste and Abuse Prevention for Medicaid and State-funded Services.*

For Medicaid and State-funded Services

Provide two (2) Medicaid and one (1) State-funded examples of initiatives to proactively prevent fraud/waste/abuse previously enacted and the outcomes achieved; include any work with law enforcement in criminal or civil prosecution fraud cases.

- a. Approach to identify fraud and abuse. Include description of both internal and external policies and procedures.
- b. Describe staffing model for the SIU and how the SIU would work with state or federal investigators.
- c. Description of how the Applicant will work with the Department, MID or the OIG to investigate and prosecute potential fraud/waste/abuse.
- d. Description of how the Applicant will balance the tensions between paying providers timely and accurately with the Applicant’s responsibility:
 - i. To monitor potential fraud/waste/abuse; and
 - ii. To cost avoid and cost recovery.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question	
57.	The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.3.iv. Third Party Liability (TPL) for Medicaid</i> and <i>Section V.A.3.v. TPL for State-funded Services</i> . <u>For Medicaid and State-funded Services</u>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
58.	The Applicant shall describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.3.vi. Recipient Explanation of Medical Benefit (REOMB) for Medicaid</i> . <u>For Medicaid Only</u> a. Procedures to exclude mailing REOMBs containing potentially sensitive clinical information; and b. Actions taken based on data from REOMB mailing responses.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

59. The Applicant shall confirm its adherence and describe its approach to managing sensitive and confidential data as described *Section III.E. Confidentiality, Privacy and Security Protections*. The response shall include:
- For Medicaid and State-funded Services
- a. Overall approach to customer and member data protection including internal programs and policies that minimize the risk of data breaches such as a Customer Data Protection policy.
 - b. Experience in complying with Federal rules and regulations including HITECH, HIPAA, and 42 CFR Part 2;
 - c. Experience with Risk Analysis and Assessments associated with NIST standards;
 - d. Description of software and infrastructure development and release cycles including integrated security and vulnerability testing as well as the patch management process and controls (both platform and software); and
 - e. Description of the vulnerability and breach monitoring processes including internal Network Operations Centers, use of external parties such as US Cert, or other monitoring tools or processes.
- Note: If the response includes a cloud or vendor hosted solutions, these are considered extensions of the Applicant’s infrastructure and should be included in the responses to the questions above.

Response

Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

60.	Evaluation Question	Response
	The Applicant shall describe its internal monitoring activities to ensure that it meets or exceeds each of the Service Level Agreements listed in <i>Section VI.B</i> , as applicable as noted below.	
	Measure	
	Medicaid and State-funded Services	
	1. Service Line Outage	
	2. Call Response Time/Call Answer Timeliness–Member and Recipient Service Line	
	3. Call Wait/Hold Times–Member and Recipient Service Line	
	4. Call Abandonment Rate–Member and Recipient Service Line	
	5. Call Response Time/Call Answer Timeliness–Behavioral Health Crisis Line	
	6. Call Abandonment Rate–Behavioral Health Crisis Line	
	7. Call Response Time/Call Answer Timeliness–Provider Support Line	
	8. Call Wait/Hold Times–Provider Support Line	
	9. Call Abandonment Rate–Provider Support Line	
	Medicaid Only	
	10. Member Enrollment Processing	
	11. Member Appeals Resolution–Standard	
	12. Member Appeals Resolution–Expedited	
	13. Member Grievance Resolution	
	14. Adherence to the Preferred Drug List	
	15. Contracting with AMH+ and CMAs (Medicaid only)	
	16. Number of Individuals Transitioned Into Supportive Housing	
	17. Call Response Time/Call Answer Timeliness–Nurse Line	
	18. Call Wait/Hold Times–Nurse Line	
	19. Call Abandonment Rate–Nurse Line	
	20. Call Response Time/Call Answer Timeliness–Pharmacy Line	
	21. Call Wait/Hold Times–Pharmacy Line	
	22. Call Abandonment Rate–Pharmacy Line	

23. Encounter Data Timeliness/ Completeness–Medical	
24. Encounter Data Timeliness/ Completeness–Pharmacy	
25. Encounter Data Accuracy–Medical	
26. Encounter Data Accuracy–Pharmacy	
27. Encounter Data Reconciliation—Medical	
28. Encounter Data Reconciliation—Pharmacy	
29. Website User Accessibility	
30. Website Response Rate	
31. Timely response to electronic inquiries	
32. Access to Primary/Preventive Care for Individuals under NC Innovations waiver	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Quality & Population Health

Evaluation Question	
61.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.B.3.ix. Prevention and Population Health Programs</i> and <i>Section V.C.3.g. Prevention and Population Health Management Programs</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <p>a. The Applicant’s planned prevention and population health management program designs in priority domains (opioid misuse, tobacco cessation, pregnancy intendedness, birth outcomes, diabetes prevention, hypertension), early childhood interventions, and in other areas of clinical focus. Include description of program, planned interventions at provider, member, system level and expected outcomes.</p> <p><u>For Medicaid and State-funded Services</u></p> <p>b. The Applicant’s planned prevention and population health management program design and description of the Applicant’s:</p>

	<ul style="list-style-type: none"> i. Experience and approach to reduce tobacco use, including proposed specific targets for reducing tobacco use for members with SMI, SED, SUD, I/DD, and TBI; ii. Experience and approach to address opioid misuse. Response must include two (2) examples, including interventions, impact and outcomes; and iii. Experience and approach to educating members about and referring them to programs addressing exercise, nutrition, stress management, substance use reduction/cessation, harm reduction, relapse prevention, and suicide prevention. <p>PROVIDE SUPPORTING DOCUMENTATION: (Does not count towards page guidelines)</p> <ul style="list-style-type: none"> 1. Description of five (5) initiatives the Applicant plans to deploy to collaborate or align with public health programs at the community level (for example, with health departments) or the state level. Must include at least one community and one state-level example, the objective of each, the methodology and the intended outcome.
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Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

62.	<p>The Applicant shall confirm its adherence and describe its approach to meeting Department's expectations and requirements for addressing Unmet Health-Related Resource Needs for all members, as described in <i>Section V.B.3.x. Healthy Opportunities</i>. These strategies must be beyond strategies identified to integrate efforts to address unmet health-related resource needs into Tailored Care Management and should not duplicate information provided in Question 24. The response shall include:</p> <p><u>For Medicaid Only</u></p>
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	<ul style="list-style-type: none"> a. Applicant’s experience and approach to addressing Unmet Health-Related Resource Needs for populations included under this Contract; b. Applicant’s experience and approach to collaborating with health and health-related community stakeholders (i.e., providers, LHDs and DSS, and community-based organizations) to address members’ Unmet Health-Related Resource Needs; c. Strategies the Applicant would employ to partner with Community-Based Organizations (CBOs) and state, regional or private human service agencies to address Unmet Health-Related Resource Needs of members; d. Strategies the Applicant would employ to address key Healthy Opportunities domains (i.e., housing, food, transportation and interpersonal safety), specific to the communities in the Region the Applicant seeks to serve; and e. Applicant’s experience and approach to address Unmet Health-Related Resource Needs at the community or population-level. Detail types of community-based interventions, rationale behind activities, and health outcomes related to the population interventions.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

63.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in <i>Section V.B.5.i. Quality Management and Quality Improvement</i> and <i>V.C.5.a. Quality Management and Quality Improvement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Description of the Applicant’s quality management strategy, quality management program including staffing and tools, IT infrastructure and data analytics capabilities to support quality and value,
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	<p>including how such systems will support stratification and analysis of quality measures at a regional level, and all associated standing (permanent) and innovative QM/QA/QI programs.</p> <p>b. Approach to collect data on and calculate performance on quality measures, including information regarding which of these functions the Applicant intends to perform internally and which it intends to perform jointly with others, as well as approach to ingesting and using quality data from external sources.</p>
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

64.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for performance measurement, assurance, and improvement, stated in <i>Section V.B.5.i. Quality Management and Quality Improvement</i> and <i>V.C.5.a. Quality Management and Quality Improvement</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <p>a. One (1) Medicaid and one (1) State-funded services historical examples (unless unavailable in which case hypothetical examples will be accepted) of multi-year (at least three (3) years) quality improvement plans that demonstrate measure targets and planned interventions—as well as annual updates to the plan. The Applicant must give an example of how its quality improvement efforts reduced health disparities. At least one (1) measure and one (1) QI intervention should focus on BH or I/DD and one (1) measure and one (1) QI intervention should focus on physical health. In addition, at least one (1) measure and one (1) QI intervention should focus on pediatric health. A single historical example can cover more than one of these requirements (for example, a QI intervention addressing pediatric BH). The two (2) examples of quality improvement plans should describe:</p> <p style="margin-left: 40px;">i. IT infrastructure used to support measure analysis and quality improvement efforts;</p>
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	<ul style="list-style-type: none"> ii. Measures results compared to national benchmarks; including measures that did not meet state targets; iii. Evidence of measure indicators; analysis to find drivers; Plan-Do-Study-Act (PDSA) or other methodological approach for evaluation; iv. Two (2) specific QI and two (2) specific performance improvement projects; v. Associated quality improvement training plans—including methodology to target Providers, with specific reference to providers of mental health, substance use disorder and home and community-based services; macro and micro practice interventions, methodology for sharing data and tools and any relationship to advanced payment (AP) or other incentive methods; vi. Associated examples of how quality data was shared with providers. Describe utilization penetration rates among providers and outcomes of using the data and tools/applications. vii. Overall impact of the QM/QA/QI interventions and performance improvement projects. <p>NOTE: The two (2) examples of multi-year quality improvement plans will not be counted toward the Applicant page count. Applicants shall present data to support their analysis of the impact; the analysis should take into consideration issues such as sample size, measurement intervals, and clinical as well as statistical significance of findings. Include measure indicators; analysis to find drivers; PDSA or other methodological approach for evaluation; interventions; planned metrics, realized metrics, and overall impact of the QM/QA/QI programs.</p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

65.	The Applicant shall, in accordance with <i>Section V.B.5.i. Quality Management and Quality Improvement</i> and <i>Section V.C.5.a. Quality Management and Quality Improvement</i> , identify examples of at least ten (10) measures stratified by geography, race/ethnicity, and gender, of which at least five (5) examples should be for Medicaid Services and five (5) for State-funded Services. The Applicant shall describe the IT infrastructure and data analytic capabilities used to support the analysis, analysis of the measures, and associated QM/QA/QI programs implemented to address health disparities. These measures shall include at least one measure calculated using clinical data, as opposed to solely claims or encounter data. This question is for Medicaid and State-funded Services.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

66.	The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements for Value Based Payments stated in <i>Section V.B.5.ii. Value Based Payments</i> , including a description of the Applicant’s approach to ensuring payments to providers increasingly encourage high value, whole person care, including by integrating the provision of services that address physical health, behavioral health, I/DD, TBI, LTSS and unmet resource-needs. The response shall include:
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For Medicaid Only

- a. A description of value-based payment arrangements the Applicant has used in the past, if any. Include the corresponding HCP-LAN framework level, the location, the volume of payments and patients, and the percent of total premium flowing to providers through the VBP arrangement, and any outcome or cost measure improvements realized by the VBP arrangement in the response;
- b. A description of any barriers or challenges the Applicant faced in pursuing the above VBP arrangements and how these challenges were addressed;
- c. Approach to how the Applicant will pursue VBP contracts with its providers, including what types of arrangements it will pursue, how it will involve behavioral health and I/DD providers in its VBP

arrangements, and how it will ensure that physical health, behavioral health, and I/DD services are integrated under its VBP arrangements;

- d. A description of the Applicant’s health information technology (HIT) capabilities and how it proposes to build out both its capabilities and those of its network providers over time to meet the Department’s goal of ensuring provider payments are increasingly focused on measures related to value. The response should include descriptions of the specific HIT systems, data types (e.g., claims data, EMR abstracts), data sharing and data analytic capabilities current in-place and those planned to support shared savings and risk models, including:
 - i. Measuring and tracking total cost of care;
 - ii. Risk adjustment;
 - iii. Receiving administrative, clinical, and claims/encounter data and sharing such data with providers and the Department (including how providers will be expected to integrate and use any BH I/DD Tailored Plan-mandated population health management tools);
 - iv. Calculating and confirming the results of a range of attribution methodologies to ensure that providers, including behavioral health and DD providers, are evaluated on performance for the appropriate enrollees;
 - v. Sharing quality measurement, including of electronic clinical quality measure (eCQMs) across different practices and for specific providers within practices for attributable populations under these contracts;
 - vi. Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts;
 - vii. Reporting capabilities; and
 - viii. Payment functions.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Administration & Management

Evaluation Question	
67.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.ii. Entity Requirements for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none">a. A description of the Applicant’s current governance structure (current at the time of Applicant proposal response submission); andb. Detail describing any proposed changes to the Applicant’s governance structure anticipated to meet the outlined requirements (<i>Section V.A.1.ii.</i>) and the associated timeline for making those changes, including any changes to board representation other than changes in the individual board members through the ordinary course of business.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question

68.	Reserved.
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Evaluation Question	
69.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.iii. National Committee for Quality Assurance (NCQA) Accreditation for Medicaid</i>. The response shall include expected timeline to receive NCQA Health Plan Accreditation with LTSS Distinction and assume that NCQA will provide flexibility on the status of PHP licensure such that not yet obtaining a PHP license will not be a barrier to receiving Health Plan Accreditation with LTSS Distinction.</p> <p><u>For Medicaid Only</u></p>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
70.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.v. Implementation for BH I/DD Tailored Plan Services</i> and <i>Section V.A.1.vi. Readiness Review Requirements</i>.</p> <p><u>For Medicaid and State-funded Services</u></p> <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ol style="list-style-type: none"> 1. Draft Implementation Plan (from Contract Award through 60 days after Implementation), including:

	<ul style="list-style-type: none"> a. Key milestones, activities and Deliverables; b. Proposed staffing and resources to support implementation and readiness; c. System and operational implementation milestones; and d. Required BH I/DD Tailored Plan, Department, and other partner resources to ensure successful implementation.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
71.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.1.vii. Non-discrimination for Medicaid and State-funded Services.</i></p> <p><u>For Medicaid and State-funded Services</u></p>
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

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Evaluation Question	
72.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.iii. Staff Training for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> a. Experience and approach in developing trainings for staff with varying backgrounds, educational and experience levels; b. Strategies for ensuring training incorporates awareness and sensitivity to unique needs of member/recipient populations, including health disparities for HMPs, diverse cultural beliefs and practices, and the needs of individuals with trauma; c. Description of the Applicant's process and methods for providing North Carolina Medicaid Managed Care and State-funded Services training to its personnel, including: <ul style="list-style-type: none"> i. A description of each staff training program (i.e., member and recipient services, provider relations, county and Department staff), including a summary of the topics, the materials used, and the media used in the training; ii. Frequency of the initial and updated training; and iii. Approach to ensuring cross-functional training with other Department Medicaid Managed Care partners (including the Enrollment Broker, the Ombudsman program, and local DSS staff) and State-funded Services partners.
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

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Evaluation Question	
73.	The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.iv. Reporting for Medicaid and State-funded Services</i> and <i>Section VII. Attachment J. Reporting Requirements for Medicaid and State-funded Services</i> . <u>For Medicaid and State-funded Services</u>
Response	
Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
74.	The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.A.2.v. BH I/DD Tailored Plan Policies for Medicaid and State-funded Services</i> . <u>For Medicaid and State-funded Services</u>
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

75. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.A.2.vi. Business Continuity for Medicaid and State-funded Services*. The response shall include:
- For Medicaid and State-funded Services
- a. Approach to meeting the Department’s restoration of service timing expectations including failover site approach (active/active, active/passive and cold, warm, or hot site), technical staffing coverage, data replication and recovery processes, and approach to testing including frequency and testing coverage;
 - b. Approach for maintaining data security during an event that causes the implementation of the business continuity plan;
 - c. Description of the differentiation between the technical approach (system failover, data recovery, etc.) and the business approach (alternate procedures, staffing, training, etc.) including how critical functions will be met during the initial twenty-four (24) hour recovery window;
 - d. Approach to support Department’s overall goals in ensuring continuity of and access to care during disasters or emergencies, including natural or manmade disasters as well as epidemics and pandemics. As part of the response, comment at a high level on how the approach would differ according to the type of disaster or emergency, including for epidemics/pandemics:
 - i. Approach to reducing barriers to care during an emergency for Medicaid members and State-funded Services recipients, including the requirements described in *Section V.A.2.vi. Business Continuity for Medicaid and State-Funded Services*;
 - ii. Description of policies and procedures the Applicant will have in place to facilitate appropriate access to a seventy-two (72) hour emergency supply of a prescription in cases where a pharmacist cannot fill a prescription when presented due to a prior authorization requirement and the prescriber cannot be reached;

	<ul style="list-style-type: none"> e. Description of process and procedures to ensure access to medications during a state of emergency or disaster; and f. Description of how the Applicant’s experience and lessons learned from responding to previous disasters or emergencies (e.g., COVID-19, hurricanes) have informed the Applicant’s proposed approach.
Response	
Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.	

Evaluation Question	
76.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements stated in <i>Section V.A.4.iii. Integration with Other Department Partners for Medicaid and State-funded Services</i>. The response shall include:</p> <p><u>For Medicaid Only</u></p> <ul style="list-style-type: none"> a. Enrollment Broker; b. Ombudsman Program; <p><u>For Medicaid and State-funded Services</u></p> <ul style="list-style-type: none"> c. County DSS offices; d. Division of Public Health; e. Division of Health Services Regulation; and f. Division of Vocational Rehabilitation Services.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

77. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.6.i. Claims*. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The completed table shall include the experience of the Applicant and any entity proposed to process and pay claims in Question #2.

For Medicaid Only

Description of policies and procedures to meet performance standards and prompt pay requirements;

- a. Description for how interest and penalty payments to providers for late payment will be tracked separately from the contracted payment;
- b. Market specific strategies for addressing potential provider payment issues, beginning with the contracting process and technical provider contract setup, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education; and
- c. Proposed average days to payment from claims submission for the Applicant’s proposed claims platform for pharmacy claims and medical claims (days should be separately for medical and pharmacy).

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

78. The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in *Section V.B.6.ii. Encounters*. The response shall include:
- For Medicaid Only
- a. Experience with and approach to performance management strategies to ensure complete, accurate and timely encounter data submissions are made to the Department and meet the standards required under the Contract;
 - b. Demonstrated understanding of the importance of accurate, complete and timely Medical and Pharmacy encounter data to the Department for use in the North Carolina Medicaid and NC Health Choice programs. In addition, Applicant shall specifically include steps to support drug rebates and steps to support capturing all applicable diagnosis information on encounters to support risk adjustment;
 - c. Description of the Applicant’s process for verifying that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements for subsequent submission to the Department, including the frequency of verification.
 - i. Explanation of how the Applicant will identify and handle the partial or complete non-submission of encounter data by a provider or subcontractor.
 - ii. The Applicant will explain how it will achieve the timely, accurate, and complete submission of encounter data to the Department consistent with required standards and formats.
 - iii. The Applicant will explain how data it receives from providers and subcontractors will be integrated and tested prior to submission to the Department to ensure the submission of a cohesive encounter file in accordance with DHHS requirements;

	<ul style="list-style-type: none"> d. Operating model including staffing to support the encounter development and submission process and integration and oversight of subcontractors responsible for encounter submission; e. Description of the Applicant’s past performance in complying with encounter submission SLAs including for other Medicaid customers (e.g. for subcontractors) for other Medicaid customers including the acceptance rates as percentages; f. Leading practices it has adopted to improve data quality in encounter submission, include applicable policies and procedures and the Applicant’s use of the Post Adjudicated Claims Data Reporting (PACDR) version of the X12 837 transaction; g. Procedure to work with providers and internal operations in correcting Encounter errors; and h. Describe the challenges and associated mitigation approaches with encounter data submission (including managing denied claim submission, duplicate submissions, sub capitated claims, value-based arrangements, or non-traditional services such as ILOS, value-added services, health-related resources) and specific steps taken to remediate issues. Include specific data on outcomes achieved.
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Response

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Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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Evaluation Question

79.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department's expectations and requirements outlined in <i>Section V.C.6. Claims Management</i>. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The completed table response shall include the experience of the Applicant and any entity proposed to process and pay claims. The response shall also include:</p> <p><u>For State-funded Services Only</u></p> <ul style="list-style-type: none"> a. Description of policies and procedures to meet performance standards and prompt pay requirements;
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- b. Market specific strategies for addressing potential provider payment issues, beginning with the contracting process and technical provider contract setup, including underpayments, overpayments, pre-and post-claims editing policies and provider billing education; and
- c. Proposed average days to payment from claims submission for the Applicant’s proposed claims platform;
- d. Experience with and approach to performance management strategies to ensure complete, accurate and timely claims data submissions are made to the Department and meet the standards required under the Contract;
- e. Describe experience with Claims Processing and Reprocessing Standards using automated capability to identify, process, and reprocess claims, including provider eligibility validation, state funded recipient benefit plan enrollment and in accordance to N.C. Gen. Stat. § 58-3-225;
- f. Operating model including staffing to support claims processing and reprocessing standards;
- g. Demonstrated understanding of transmittal and process data using ASC X12 standards, support provider payments, comply with data reporting requirements and be of sufficient capacity to expand as needed to accommodate recipient enrollment or program/service changes;
- h. Description of how Applicant will ensure that claims submission contains accurate and complete content to allow either (a) claims payment through the appropriate source of non-Medicaid federal funds- not included in single stream funding or (b) processing as shadow claims data that is accepted in NC Tracks (not denied);
- i. Proposed plan to minimize non-UCR payments, especially for crisis services;
- j. Procedure to work with providers and internal operations in correcting claims errors; and
- k. Describe the challenges and associated mitigation approaches with claims data submission (including managing denied claim submission, duplicate submissions, or non-traditional services) and specific steps taken to remediate issues. Include specific data on outcomes achieved.

Response

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

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Evaluation Question	
80.	<p>The Applicant shall confirm its adherence and describe its approach to meeting the Department’s health information system capacity expectations and requirements outlined in <i>Section V.B.8. Technical Specifications</i> and <i>Section V.C.8. Technical Specifications</i>. The Applicant shall detail any limitations and/or issues with meeting the Department’s expectations or requirements. The response shall include:</p> <p><u>For Medicaid and State-funded Services</u></p> <ol style="list-style-type: none"> a. Description of its current health information system(s), as used to support contracted services including, but not limited to member enrollment, claims payment and processing, encounter data reporting, prior authorization, care coordination, care management, quality management and utilization management, performance reporting, financial operations, and provider data collection and reporting. b. For each contracted service, descriptions of: <ol style="list-style-type: none"> i. How its health information systems will be used to support the service in compliance with Contract Requirements; ii. Whether any modifications or updates to its existing systems will be necessary to meet Contract Requirements and, if so, the Applicant’s plan for their completion; iii. System hardware, program, and architecture supporting the service, and its capacity to interface with external systems; iv. Draft flowcharts and diagrams that demonstrate how the system will interact with external systems, noting which components or processes may be managed by subcontractors. (Excluded from page limit.); v. System capability to store, use, and integrate required volumes of data to support the service, including its ability to scale to meet changing demands; vi. Proposed resources the Applicant will dedicate to implementing and managing the service; and vii. Applicant’s approach and process to comply with privacy and security standards.
Response	

Detail any limitations and / or issues meeting the Department’s expectations or requirements related to this response. No response will be interpreted as no limitations or issues.

Evaluation Question

81. The Applicant shall confirm its adherence and describe its approach to work with State and State Contractors to implement and manage data consumption, integration, exchange, and use as described in *Section V.B.8. Technical Specifications* and *Section V.C.8. Technical Specifications*. The Applicant shall detail any limitations and/or issues with meeting the Department's expectations or requirements. The response shall include:
- For Medicaid and State-funded Services
- a. Experience and approach to developing data exchanges and interfaces, including response batch, EDI, real time, and APIs.
 - b. Innovative approaches and experience with data exchanges focused on transmitting only necessary data for business purposes (including data sharing such as data hubs and real-time data services).
 - c. Approach to comply with the current data exchanges detailed in the Contract.
 - d. Approach to system and service availability including the recoverability of platforms to avoid impacts to the delivery of services to members.
 - e. Approach to functionally testing and integrating new software releases, upgrades, and fixes prior to releasing into production (this is differentiated from the questions above around vulnerability testing).
 - f. Approach to comply with the reconciliation processes for member and Provider, including and any gaps in the reconciliation process.
 - g. Approach and experience in conducting root cause analysis when failures or problems are identified.
 - h. Method to create, maintain and transmit the Provider Directory.

	<ul style="list-style-type: none"> i. Approach and experience with user acceptance testing, system integration testing, and end to end testing to support integration with the Department and Department partners, including commitment to dedicated staff, expected timelines, and testing environments and tools. j. Approach to follow the Department's Enterprise Architecture standards when creating the System Interface Design and throughout the maintenance of this documentation. <p>PROVIDE SUPPORTING DOCUMENTATION (not part of page count):</p> <ul style="list-style-type: none"> 1. Health information system flowcharts and diagrams
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Response

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Detail any limitations and / or issues meeting the Department's expectations or requirements related to this response. No response will be interpreted as no limitations or issues.
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4. Use Case Scenarios

The Applicant must submit its response to the following Use Cases. The Department encourages the Applicant to suggest innovative ways to fulfill the requirements of this Contract.

The use cases represent hypothetical members, recipients, providers, or entities at a specific point in time. Responses must include, at a minimum, the program and services listed within each use case. The Applicant should include any limitations or exceptions to providing the programs and services listed.

The Applicant’s response may not exceed seven (7) pages per Use Case, and may include a detailed narrative, diagrams, exhibits, examples, sketches, descriptive literature or detailed information specifically tailored for the North Carolina Medicaid Managed Care to demonstrate its ability to meet or exceed requirements.

Use Case Scenario A	
A.	<p>Emily, age 46, has had over 10 hospitalizations, emergency department visits and mobile crisis interactions related to her co-morbid illnesses of schizophrenia and alcohol use disorder over the past 180 days. She is a daily cigarette smoker for over 20 years. She has not attended any of her scheduled follow-up appointments. She is homeless in rural North Carolina and estranged from her family, who is out of state, due to her psychotic and substance use disorders. She is her own guardian and has not been willing to participate in applying for Medicaid. She had a job at a local retail store a few years ago, but lost it after relapsing on alcohol and stopping her antipsychotic medication. During her an emergency room visit yesterday for a sprained ankle after an alcohol related fall, she also tested positive for COVID-19 but was asymptomatic and was released to a local shelter with a quarantine bed. Since yesterday the shelter has had difficulty managing several disruptive behaviors (e.g., yelling, not following rules) and are considering not permitting her to remain in the shelter. The Applicant must describe how it would address Emily’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Linkage to care management; b. Behavioral health services; c. Tobacco cessation; d. Community inclusion (including housing and employment); e. Primary care services, including screenings; f. Local public health and social services interface; and g. Quarantine assistance.
Response	

Use Case Scenario B	
B.	<p>Samantha, age 30, has sickle cell disease and is diagnosed with an opioid use disorder over the past 3 years after years of challenging pain crises with limited access to quality primary or specialty medical care. She is currently working part time at a local restaurant but has limited shifts due to reduced hours during the pandemic. Samantha has limited local social supports because her family lives out of state. She is four months pregnant and desires to continue with the pregnancy. She has been started on MAT (buprenorphine) and is currently in a state funded women’s substance use treatment program. She needs to apply for Medicaid for Pregnant Women. The Applicant must describe how it would address Samantha’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Historically Marginalized Populations; b. Behavioral health services, (including State-funded Services), taking into account historically underutilized businesses; c. Long-term housing; d. Transportation; e. Benefits counseling, including assistance with applying for Medicaid; f. Care management; and, g. Physical health services including primary care, specialty health care, and prenatal services (including accessing historically underutilized businesses)
Response	

Use Case Scenario C	
C.	<p>Jimmy, age 23, is about to be released from the State Psychiatric Hospital (SPH), where he has been treated for the last eighteen (18) months for schizophrenia. He also has a history of cannabis abuse and a criminal background due to prior convictions for breaking and entering. Prior to going to the State Psychiatric Hospital, Jimmy had been receiving outpatient therapy and medication management services but rarely attended therapy, and only attended about 50% of his scheduled medication management appointments due to a mix of access issues and paranoia related to his care providers.</p> <p>Jimmy used to live with his parents and younger sister. He is not welcome back to live there due to his cannabis use and criminal history. His parents are supportive and engaged and have attended several treatment team meetings and visited regularly. They have said that they do want him to be within a 30 minute drive so they can continue to support him. Jimmy has no history of living independently. He did have a driver’s license, but it lapsed while he was in the State Psychiatric Hospital. He doesn’t have a car any longer.</p>

	<p>Jimmy has his high school diploma and took some welding courses at the local community college, but he was unable to complete the certificate program. He has a limited work history, having past entry level positions in fast food and hasn't been able to maintain any job for longer than three (3) months. His last job fired him for "insubordination." Jimmy does mention that he would like to try to finish his welding certificate and work either in construction or on 18 wheelers, but he's worried with his mental illness, substance use history, and criminal justice involvement that it is pointless. He is stable and ready to be discharged and will need assistance to reinstate his benefits (including Medicaid) and access supports for stabilization in the community.</p> <p>The Applicant must describe how it would address Jimmy's situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Behavioral health services; including State-funded services; b. In-Reach, Transition supports (including supportive housing) and care management; c. Employment; d. Benefits counseling; e. Transportation; and f. Primary care.
Response	

Use Case Scenario D	
D.	<p>Edward is a 16-year-old male with Prader Willi Syndrome and mild intellectual disability who has also been diagnosed with autism spectrum disorder, obsessive-compulsive disorder, unspecified anxiety, obesity and type-2 diabetes. He lives with his mother and three (3) siblings and rarely sees his father who frequently works construction jobs out of state. Mom has relied on the support of their faith community and the school system. She has also successfully gotten Medicaid for Edward. Mom has tried to keep Edward on a highly regulated diet and plan of blood sugar checks through the years, enlisting the help of the nurse at his school to assist with this plan, but this has gotten more difficult as Edward grew into adolescence.</p> <p>As Edward has gotten older, his obsessive food seeking behaviors have worsened and he has become increasingly aggressive when he does not have open access to food. He has also wanted to do more self-care and, with the assistance of his Mom and the school nurse, has had shown moderate success with skill building. After recently being started on Risperdal by his PCP to help with his behavior, Edward began to gain more weight and his most recent HgbA1C was 10.</p> <p>Due to recent aggression (hitting) toward his mother and his youngest sibling (3 yo) at home, Mom had to call 911 and Edward was taken to his local Emergency Room where he has been for seven (7) days, with poor control of aggression in this unfamiliar and overly-stimulating environment. Mom is seeking residential care or ICF-IID placement as she feels Edward cannot be safe at home currently. After trying over a dozen</p>

	<p>facilities, the local hospital and his Tailored Care Manager have been unable to find a location that can accommodate Edward’s unique needs.</p> <p>The Applicant must address how it would address Edward’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Care Management; b. Unmet health related resource needs; c. Diabetes self-management education; d. Family support and resiliency; e. Primary care and specialty healthcare services, including specialty I/DD and mental health services for children (including EPSDT considerations); f. Innovations Waiver/Wait-List referral; g. Community Inclusion, including diversion; and h. Network management and contracting.
Response	
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Use Case Scenario E	
E.	<p>Kyle, a 35-month-old was referred to local Children’s Developmental Service Agency (CDSA) at 17 months by his pediatrician, Dr. Smith, due to failure to thrive associated with cardiac anomalies, encephalitis, and seizures. He is currently diagnosed with autism spectrum disorder and cerebral palsy, with significant spasticity. The history of seizure activity has resolved, and Kyle no longer takes medication. His heart function has stabilized. In addition to Dr. Smith, Kyle is also followed by neurology. Kyle had been hospitalized on and off for the first 14 months of his life due to seizures, numerous viral infections and significant nutritional issues. Kyle had an NG tube from 6 months of age until he was successfully weaned from it by 20 months. He is a picky eater who is orally hypersensitive but has been able to maintain height and weight in the 25-30th percentile for his age.</p> <p>Kyle’s mom reports that CDSA services has helped Kyle make significant gains while supporting the families’ capacity to care for him. As Kyle approaches 3 years-old, his mom is really interested in preschool placement where Kyle can receive special education services.</p> <p>The most recent report from the early intervention occupational therapist included home observation and discussion with Kyle’s mom states:</p> <p>“Kyle was able to hold and drink from a spouted cup, but arm movements remain unsteady and he often splashes or knocks over the cup when setting it down. He can finger feed a variety of small, soft foods. He is beginning to effectively use a spoon. He continues to have choking responses to rough, hard or chewy textures. His mother reports she continues to feed baby food to maintain nutrition, while having Kyle</p>

	<p>practice using his spoon to feed himself at least half the meal. Mom has a list of foods she is gradually introducing in small bites to increase Kyle’s ability to accept the foods the family typically eats.</p> <p>Kyle has strong preferences and insists on choosing his clothes each day. Kyle can assist with dressing, but due to significant challenges in moving his arms and legs he is unable to undress or dress independently.</p> <p>Kyle has functional receptive language skills and routinely follows 2-3 step directions. Kyle uses 2-3-word phrases and can express his wishes and dislikes with both words and gestures. Kyle tantrums 1-3 times daily when he is unable to communicate his desires.</p> <p>When other children visit, Kyle wants to play, but verbally and motorically has difficulty engaging. He needs a lot of adult facilitation and direction to imitate what the other children are doing. He has a wheelchair but spends much play time out of it. When put in a standing position, he can hold a couch or chair and stand 1-2 minutes on his own. He is just beginning to try a sideways step.”</p> <p>The Applicant must describe how it would address Kyle’s situation. The Applicant shall address the following programs and services in its response:</p> <ul style="list-style-type: none"> a. Behavioral Health/I/DD Services (including Research based- behavioral health treatment (RB-BHT) and consideration of EPSDT); b. Primary care and specialty health care; c. Nutrition services; d. Occupational therapy services; e. Speech and language services; f. Care management; g. Person-center planning; and h. Family support.
Response	

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5. BH I/DD Tailored Plan Key Personnel

The following must be completed by the Applicant as required by *Section V.A.1.i. Staffing and Facilities*.

Section VIII. 5.Table 4: BH I/DD Tailored Plan Key Personnel				
Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
1.	Chief Executive Officer (CEO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who has clear authority over the general administration and day-to-day business activities of this Contract	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Master's degree from an accredited college or university 	
2.	Chief Financial Officer (CFO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for accounting and finance operations, including financial audit activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree or higher in Accounting, Finance or other discipline related to the area of assignment with eighteen (18) semester hours of accounting coursework from an appropriately accredited institution • Minimum of seven (7) years' of progressive accounting experience, of which three (3) years are supervisory 	
3.	Chief Operating Officer (COO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all operations and administrative activities including but not limited to provider and vendor contracting, enrollment and claims management, staffing, and training	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university • Minimum of seven (7) years' experience in a managed care organization 	
4.	Chief Medical Officer (CMO) of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and is responsible for all clinical activities, including but not limited to the proper provision of covered services to	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a primary care physician or psychiatrist, fully licensed to practice in NC and in good standing. 	

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel			
Role	Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
	members and recipients, developing clinical practice standards, clinical policies and procedures, utilization management, pharmacy, population health and care management, and quality management. Individual responsible for ensuring an integrated approach to the physical and behavioral health of members and recipients, including those with I/DD and TBI needs.	<ul style="list-style-type: none"> • Minimum of five (5) years' experience in a health clinical setting and five (5) years' experience in managed care • If a primary care physician, clinical experience with child/adolescent and adult populations is preferred. If individual does not have experience with all populations, direct medical staff reports must have experience. • If a psychiatrist, clinical experience with child mental health or addiction/SUD is preferred. (If individual does not have child mental health or addiction/SUD experience, direct medical staff reports must have experience) 	
5.	Chief Compliance Officer of North Carolina Medicaid Managed Care Program and State-funded Services	Individual who oversees and manages all fraud, waste, and abuse and compliance activities	<ul style="list-style-type: none"> • Must reside in North Carolina • Must hold a Bachelor's degree from an accredited college or university
6.	Chief Information Security Officer (CISO) or Chief Risk Officer (CRO) of the North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for establishing and maintaining the security processes to ensure information assets and technologies are protected	<ul style="list-style-type: none"> • Must hold a Bachelor's degree in information security or computer science from an accredited college or university • Must hold one of the following certifications: CISSP, CISM, or GSEC • Minimum of five (5) years' experience in health care

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
7.	Quality Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all quality management/quality improvement activities, including but not limited to ensuring individual and systemic quality of care, integrating quality throughout the organization, implementing process improvement, and resolving, tracking and trending quality of care grievances. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated quality management/quality improvement experience in a healthcare organization serving Medicaid beneficiaries • Must be a North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO) • Certified Professional in Healthcare Quality (CPHQ) is preferred 	
8.	Utilization Management Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for all utilization management activities, including but not limited to prospective reviews, concurrent reviews, retrospective reviews, and related member and provider appeals. Individual reports to the CMO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of demonstrated utilization review and management experience in physical health, behavioral health, and I/DD benefits • Must be a North Carolina fully licensed clinician (e.g. LCSW, LCMHC, RN, MD, DO, LMFT) 	
9.	Provider Network Director of North Carolina Medicaid Managed Care Program and State-funded Services	Individual responsible for providers services and provider relations, including all network development and management issues. Individual reports to the COO.	<ul style="list-style-type: none"> • Must reside in North Carolina • Minimum of five (5) years of combined network operations, provider relations, and management experience 	

Section VIII. 5.Table 4: BH I/DD Tailored Plan Key Personnel

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

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

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

Section VIII. 5. Table 4: BH I/DD Tailored Plan Key Personnel

Role		Duties and Responsibilities of the Role	Minimum Certifications and/or Credentials Requested by the Department	Applicant's Proposed Staff Name. Applicant must attach resume for each Proposed Staff Name.
	Managed Care Program and State-funded Services	and care coordination programs, including oversight of care management provided by AMH+, State-funded case management providers, and care management agencies and care management delivered by Local Health Departments	health experience in a healthcare organization serving Medicaid beneficiaries, including experience with BH and I/DD populations <ul style="list-style-type: none"> • North Carolina fully licensed clinician (e.g., LCSW, LCMHC, RN, MD, DO, LMFT) 	
13.	Pharmacy Director of North Carolina Medicaid Managed Care Program	Individual who oversees and manages the BH I/DD Tailored Plan pharmacy benefits and services.	<ul style="list-style-type: none"> • Must reside in North Carolina • Must be a North Carolina-registered pharmacist with a current NC pharmacist license • Minimum of three (3) working years of Medicaid pharmacy benefits management experience 	

6. Contractor's Contract Administrators

Contract Administrator for all contractual issues listed herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

Contract Administrator regarding day to day activities herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

HIPAA or Compliance Officer for all privacy matters herein:

Name & Title	
Address 1 Physical Address	
Address 2 Mailing Address	
Telephone Number	
Fax Number	
Email Address	

7. Certification of Financial Condition

The Applicant must complete and sign this Form, and include the required documents as indicated herein.

The undersigned hereby certifies that:

- The Applicant has included the following documents with this completed Certification of Financial Condition.
1. Audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant (CPA for the two most recent fiscal years, including at a minimum balance sheet, income statement, and cash flow statement for each year. Must provide the contact information for the CPA/audit firm.
 2. The current Month End Balance Sheet and Year-to-Date Income Statement at the time of proposal submission.
 3. The most recent corporate tax filing OR independent audit report. If submitting the independent audit report, must include contact information for the audit firm.
- The Applicant is in sound financial condition and, if applicable, has received an unqualified audit opinion for the latest audit of its financial statements.
- The Applicant has included a brief statement outlining and describing its financial stability.
- The Applicant has no outstanding liabilities, including tax and judgment liens, to the Internal Revenue Service or any other government entity.
- The Applicant is current in all amounts due for payments of federal and state taxes and required employment-related contributions and withholdings.
- The Applicant acknowledges that this is a continuing certification, and the Applicant shall notify the Department

If any one or more of the foregoing boxes is NOT checked, the Applicant shall explain the reason in the space below:

The Applicant is encouraged to explain any negative financial information in its financial statement below and are encouraged to provide documentation supporting those explanations:

By completing this Certification of Financial Condition and Legal Action Summary, the Applicant affirms the ability to financially support implementation and on-going costs associated with this Contract, and the individual signing certifies he or she is authorized to make the foregoing statements on behalf of the Applicant.

Signature

Date

Printed Name

Title

The remainder of this page is intentionally left blank.

8. Disclosure of Litigation and Criminal Conviction

The Applicant must provide information regarding litigation and criminal conviction in response to the RFA by completing this Form.

1. The Applicant shall disclose, if it, or any of its subcontractors, or their officers, directors, or key personnel who may provide Services under any contract awarded pursuant to this solicitation, have ever been convicted of a felony, or any crime involving moral turpitude, including, but not limited to fraud, misappropriation, or deception.
2. The Applicant shall disclose if it, or its any of its subcontractors, are the subject of any current litigation or investigations of noncompliance under federal or state law.
3. The Applicant shall disclose any civil litigation, regulatory finding or penalty, arbitration, proceeding, or judgments against it or its subcontractors during the three (3) years preceding its offer that involve (1) Services or related goods similar to those provided pursuant to any contract and that involve a claim that may affect the viability or financial stability of the Contractor, or (2) a claim or written allegation of fraud by the Contractor or any subcontractor hereunder, arising out of their business activities, or (3) a claim or written allegation that the Contractor or any subcontractor violated any federal, state or local statute, regulation or ordinance. Multiple lawsuits and or judgments against the Applicant or subcontractor shall be disclosed to the State to the extent they affect the financial solvency and integrity of the Applicant or subcontractor.
4. In the event the Applicant, an officer of the Applicant, or an owner of a twenty-five percent (25%) or greater share of the Applicant, is convicted of a criminal offense incident to the application for or performance of a State, public or private Contract or subcontract; or convicted of a criminal offense including but not limited to any of the following: embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, attempting to influence a public employee to breach the ethical conduct standards for State of North Carolina employees; convicted under State or federal antitrust statutes; or convicted of any other criminal offense which, in the sole discretion of the State, reflects upon the Applicant's business integrity, such Applicant shall be prohibited from entering into a contract for goods or Services with any department, institution, or agency of the State.
5. The Applicant shall disclose any legal action that could adversely affect the Applicant's financial conditions or ability to meet the requirements any Contract resulting from the RFA.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements set forth in RFA *Section III.D.15. Disclosure of Litigation and Criminal Conviction or Adverse Financial Condition*, and the resulting obligations should a Contract be awarded to the Applicant.

9. Disclosure of Conflicts of Interest

Applicant must provide conflict of interest information by completing this form in its response to the RFA.

Applicant shall:

- Disclose any relationship to any business or associate with whom the Applicant is currently doing business that creates or may give the appearance of conflict of interest related to this RFA and any Contract that may be awarded to Applicant because of the RFA.

- Disclose any Board member, Director or staff member, known by the Applicant to have a conflict of interest or potential conflict of interest related to this RFA and any Contract that may be awarded to Applicant because of the RFA.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements regarding conflicts of interest set forth in *RFA Section III.D.15. Disclosure of Conflicts of Interest*, and the resulting obligations should a Contract be awarded to the Applicant.

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10. Disclosure of Ownership Interest

Applicant must provide information regarding ownership and control as described in 42 C.F.R. § 455.104 by completing this Attachment.

Applicant shall provide, for the Applicant, the following information:

1. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Applicant, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Applicant's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Applicant if that interest equals at least 5% of the value of the Applicant's assets, is an officer or director of a Applicant organized as a corporation, or is a partner in a Applicant organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42. § C.F.R 455.100-104);
2. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Applicant, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Applicant's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Applicant if that interest equals at least 5% of the value of the Applicant's assets, is an officer or director of a Applicant organized as a corporation, or is a partner in a Applicant organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 C.F.R. § 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
3. Whether the person (individual or corporation) with an ownership or control interest in the Applicant is related to another person with ownership or control interest in the Applicant as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Applicant has a 5% or more interest is related to another person with ownership or control interest in the Applicant as a spouse, parent, child, or sibling
4. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity, as defined in 42 C.F.R. § 455.101 in which an owner of the Applicant has an ownership or control interest; and
5. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section D, Paragraph 15, Staffing Requirements) of the Applicant as defined in 42 C.F.R. § 455.101.

By signing the RFA, Applicant certifies that the information provided in this response to the RFA is true to the best of its information and belief. Applicant agrees to notify Department of any changes to the information provided that arise prior to award of any Contract resulting from the RFA. By signing the RFA, Applicant further acknowledges the requirements set forth in RFA Section

11. Subcontractor Identification

The Applicant must identify and provide the information below for all subcontractors that will be used in meeting Contract requirements should a contract be awarded to Applicant.

Legal Name of Contractor and name used for business (if different) and FEIN	Term of Contract between Applicant and Subcontractor	Description of Services Provided by Subcontractor as it relates to RFA Requirements	Estimated Value of the Contract	Is the Subcontractor HUB certified as provided in G.S. 143-128.4?

By signing the RFA, Applicant:

1. Certifies that the information provided in this Response to *Section VIII.11. Subcontractor Identification* is true to the best of its information and belief;
2. Acknowledges the requirements set forth in *RFA Section III.C.46. Subcontractors*, requiring Department approval of any subcontractors used in the performance of any Contract awarded as a result of the RFA; and
3. Attests that it understands, pursuant to NCGS §58-56-26, that, in the event of Contract award, Applicant is solely responsible to provide competent administration of its claims duties.

12. Business Associate Agreement

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUSINESS ASSOCIATE AGREEMENT

This Agreement is made between the North Carolina Department of Health and Human Services (“Covered Entity”) and _____ (“Business Associate”) (collectively the “Parties”).

(1) BACKGROUND

- a. Covered Entity and Business Associate are parties to a Contract entitled BH I/DD Tailored Plan, whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.
- b. Covered Entity is an organizational unit of the North Carolina Department of Health and Human Services (the “Department”) that has been designated in whole or in part by the Department as a health care component for purposes of the HIPAA Privacy Rule.
- c. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a “business associate” within the meaning of the HIPAA Privacy Rule.
- d. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

(2) DEFINITIONS

Unless some other meaning is clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

- a. “Electronic Protected Health Information” shall have the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103.
- b. “HIPAA” means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as modified and amended by the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
- c. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).
- d. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. § Part 160 and Part 164.
- e. “Protected Health Information” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- f. “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
- g. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or the person to whom the authority involved has been delegated.
- h. Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the Privacy Rule.

(3) OBLIGATIONS OF BUSINESS ASSOCIATE

- a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required by Law.
- b. Business Associate agrees to use appropriate safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

- c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware, including breaches of unsecured protected health information as required by 45 C.F.R. § 164.410.
- e. Business Associate agrees, in accordance with 45 C.F.R. § 164.502(e)(1) and 164.308(b)(2), to ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such information.
- f. Business Associate agrees to make available protected health information as necessary to satisfy Covered Entity's obligations in accordance with 45 C.F.R. § 164.524.
- g. Business Associate agrees to make available Protected Health Information for amendment and incorporate any amendment(s) to Protected Health Information in accordance with 45 C.F.R. § 164.526.
- h. Unless otherwise prohibited by law, Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- i. Business Associate agrees to make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(4) PERMITTED USES AND DISCLOSURES

- a. Except as otherwise limited in this Agreement or by other applicable law or agreement, if the Contract permits, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure:
 - i. would not violate the Privacy Rule if done by Covered Entity; or
 - ii. would not violate the minimum necessary policies and procedures of the Covered Entity.
- b. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that:
 - i. The disclosures are Required by Law; or
 - ii. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. Except as otherwise limited in this Agreement or by other applicable law or agreements, if the Contract permits, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
- d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose Protected Health Information if the use or disclosure would violate any term of the Contract or other applicable law or agreements.

(5) TERM AND TERMINATION

- a. Term. This Agreement shall be effective as of the effective date of the Contract and shall terminate when the Contract terminates.
- b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:
 - i. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement and services provided by Business Associate, to the extent permissible by law, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

- ii. Immediately terminate this Agreement and services provided by Business Associate, to the extent permissible by law; or
 - iii. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.
- c. Effect of Termination.
- i. Except as provided in paragraph ii. of this section or in the Contract or by other applicable law or agreements, upon termination of this Agreement and services provided by Business Associate, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - ii. If Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

(6) GENERAL TERMS AND CONDITIONS

- a. This Agreement amends and is part of the Contract.
- b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.
- c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. If a conflict then remains, the Contract terms shall prevail so long as they are in accordance with the Privacy Rule.
- d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

Signature of Authorized Representative

Name of Entity

Name and Title

DATE

13. Location of Workers Utilized by the Contractor

Upon Contract Award, the successful Applicant becomes a Contractor providing goods and or services to the State. In addition to any other evaluation criteria identified in this RFP, the Department may, for purposes of evaluating proposed or actual contract performance outside of the United States, also consider how that performance may affect the following factors to ensure that any award will be in the best interest of the Department:

1. Total cost to the Department;
2. Level of quality provided by the Contractor;
3. Process and performance capability across multiple jurisdictions;
4. Protection of the State's information and intellectual property;
5. Availability of pertinent skills;
6. Ability to understand the Department's business requirements and internal operational culture;
7. Identified risk factors such as the security of the State's information technology;
8. Relations with citizens and employees; and
9. Contract enforcement jurisdictional issues.

In accordance with NC General Statute 143-59.4, the Contractor shall detail the location(s) at which performance will occur, as well as the manner in which it intends to utilize resources or workers outside of the United States in the performance of this Contract. The Department will evaluate the additional risks, costs, and other factors associated with such utilization prior to making an award. Complete items a, b, and c below.

- a) **Will any work under this Contract be performed outside the United States?** YES NO

If yes, list the location(s) outside the United States where work under this Contract will be performed by the Contractor.

[Click or tap here to enter text.](#)

- b) **The Contractor agrees to provide notice, in writing to the Department, of the relocation of the Contractor will performing the services under the Contract outside of the United States.** YES NO

- c) **Identify all U.S. locations at which performance will occur:**

[Click or tap here to enter text.](#)

THE REST OF THIS PAGE INTENTIONALLY LEFT BLANK.

14. State Certifications – Required by North Carolina Law

Instructions: The person who signs this document should read the text of the statutes and Executive Order listed below and consult with counsel and other knowledgeable persons before signing. The text of each North Carolina General Statutes and of the Executive Order can be found online at:

- Article 2 of Chapter 64: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf
- G.S. 133-32: <http://www.ncga.state.nc.us/gascripts/statutes/statutelookup.pl?statute=133-32>
- Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009): <http://www.ethicscommission.nc.gov/library/pdfs/Laws/EO24.pdf>
- G.S. 105-164.8(b): http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf
- G.S. 143-48.5: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-48.5.html
- G.S. 143-59.1: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf
- G.S. 143-59.2: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf
- G.S. 143-133.3: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_143/GS_143-133.3.html
- G.S. 143B-139.6C: http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143B/GS_143B-139.6C.pdf

Certifications

- (1) Pursuant to G.S. 133-32 and Executive Order No. 24 (Perdue, Gov., Oct. 1, 2009), the undersigned hereby certifies that the Contractor named below is in compliance with, and has not violated, the provisions of either said statute or Executive Order.
- (2) Pursuant to G.S. 143-48.5 and G.S. 143-133.3, the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov
- (3) Pursuant to G.S. 143-59.1(b), the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:
- (a) Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); **and**
- (b) [check **one** of the following boxes]
- Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; **or**
- The Contractor or one of its affiliates **has** incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 **but** the United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.
- (4) Pursuant to G.S. 143-59.2(b), the undersigned hereby certifies that none of the Contractor's officers, directors, or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately prior to the date of the bid solicitation.
- (5) Pursuant to G.S. 143B-139.6C, the undersigned hereby certifies that the Contractor will not use a former employee, as defined by G.S. 143B-139.6C(d)(2), of the North Carolina Department of Health and Human Services in the administration of a contract with the Department in violation of G.S. 143B-139.6C and that a violation of that statute shall void the Agreement.
- (6) The undersigned hereby certifies further that:
1. He or she is a duly authorized representative of the Contractor named below;
 2. He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
 3. He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1 and -59.2 shall be guilty of a Class I felony.

Contractor's
Name: _____

Contractor's

Authorized Agent: Signature _____ Date _____

Printed
Name _____

Title _____

15. Federal Certifications

The undersigned states that:

- 1. He or she is the duly authorized representative of the Contractor named below;
- 2. He or she is authorized to make, and does hereby make, the following certifications on behalf of the Contractor, as set out herein:
 - a. The Certification Regarding Nondiscrimination;
 - b. The Certification Regarding Drug-Free Workplace Requirements;
 - c. The Certification Regarding Environmental Tobacco Smoke;
 - d. The Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions; and
 - e. The Certification Regarding Lobbying;
- 3. He or she has completed the Certification Regarding Drug-Free Workplace Requirements by providing the addresses at which the contract work will be performed;

4. [Check the applicable statement]

[] He or she **has completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has made, or has an agreement to make**, a payment to a lobbying entity for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action;

OR

[] He or she **has not completed** the attached **Disclosure Of Lobbying Activities** because the Contractor **has not made, and has no agreement to make**, any payment to any lobbying entity for influencing or attempting to influence any officer or employee of any agency, any Member of Congress, any officer or employee of Congress, or any employee of a Member of Congress in connection with a covered Federal action.

5. The Contractor shall require its subcontractors, if any, to make the same certifications and disclosure.

Signature **Title**

Contractor Name **Date**

[This Certification Must be Signed by the Same Individual Who Signed the Proposal Execution Page]

I. Certification Regarding Nondiscrimination

The Contractor certifies that it will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (h) the Food Stamp Act and USDA policy, which prohibit discrimination on the basis of religion and political beliefs; and (i) the requirements of any other nondiscrimination statutes which may apply to this Agreement.

II. Certification Regarding Drug-Free Workplace Requirements

1. The Contractor certifies that it will provide a drug-free workplace by:
 - a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - b. Establishing a drug-free awareness program to inform employees about:
 - i. The dangers of drug abuse in the workplace;
 - ii. The Contractor’s policy of maintaining a drug-free workplace;
 - iii. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - iv. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - c. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - d. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - i. Abide by the terms of the statement; and
 - ii. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - e. Notifying the Department within ten days after receiving notice under subparagraph (d)(ii) from an employee or otherwise receiving actual notice of such conviction;
 - f. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(ii), with respect to any employee who is so convicted:
 - i. Taking appropriate personnel action against such an employee, up to and including termination; or
 - ii. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
 - g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).
2. The sites for the performance of work done in connection with the specific agreement are listed below (list all sites; add additional pages if necessary):

Address

Street _____
City, State, Zip Code _____
Street _____
City, State, Zip Code _____

Contractor will inform the Department of any additional sites for performance of work under this agreement.

3. False certification or violation of the certification may be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment. 45 C.F.R. 82.510.

III. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000.00 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any subawards that contain provisions for children's services and that all subgrantees shall certify accordingly.

IV. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions

[The phrase "prospective lower tier participant" means the Contractor.]

1. By signing and submitting this document, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originate may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to whom this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this document that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered

Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification

1. **The prospective lower tier participant certifies**, by submission of this document, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

V. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federally funded contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form SF-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award document for subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) who receive federal funds of \$100,000.00 or more and that all subrecipients shall certify and disclose accordingly.
4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction

imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

VI. Disclosure Of Lobbying Activities

Instructions

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or sub-award recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal Identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number, Invitation for Bid (IFB) number, grant announcement number, the contract grant, or loan award number, the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate boxes. Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate boxes. Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with Federal officials. Identify the Federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, D. C. 20503

Disclosure Of Lobbying Activities
(Approved by OMB 0344-0046)

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

<p>1. Type of Federal Action:</p> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<p>2. Status of Federal Action:</p> <input type="checkbox"/> a. Bid/offer/application <input type="checkbox"/> b. Initial Award <input type="checkbox"/> c. Post-Award	<p>3. Report Type:</p> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change <p>For Material Change Only: Year _____ Quarter _____ Date Of Last Report: _____</p>
<p>4. Name and Address of Reporting Entity:</p> <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier (if known) _____ Congressional District (if known) _____		<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</p> Congressional District (if known) _____
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description:</p> CFDA Number (if applicable) _____	
<p>8. Federal Action Number (if known)</p>	<p>9. Award Amount (if known) \$</p>	
<p>10. a. Name and Address of Lobbying Entity (if individual, last name, first name, MI):</p> <p align="center"><i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i></p>	<p>b. Individuals Performing Services (including address if different from No. 10a.) (last name, first name, MI):</p> <p align="center"><i>(attach Continuation Sheet(s) SF-LLL-A, if necessary)</i></p>	
<p>11. Amount of Payment (check all that apply):</p> \$ _____ <input checked="" type="checkbox"/> actual <input checked="" type="checkbox"/> planned	<p>13. Type of Payment (check all that apply):</p> <input type="checkbox"/> a. retainer <input type="checkbox"/> b. one-time fee <input type="checkbox"/> c. commission <input type="checkbox"/> d. contingent fee <input type="checkbox"/> e. deferred <input type="checkbox"/> f. other; specify: _____	
<p>12. Form of Payment (check all that apply):</p> <input type="checkbox"/> a. cash <input type="checkbox"/> b. In-kind; specify: Nature _____ Value _____		
<p>14. Brief Description of Services Performed or to be Performed and Date(s) of Services, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11 (attach Continuation Sheet(s) SF-LLL-A, if necessary):</p>		
<p>15. Continuation Sheet(s) SF-LLL-A attached: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>16. Information requested through this form is authorized by title 31 U. S. C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U. S. C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>		Signature: _____ Print Name: _____ Title: _____ Telephone No: _____ Date: _____
<p>Federal Use Only</p>		<p>Authorized for Local Reproduction Standard Form - LLL</p>

16. Request for Proposed Modifications to the Terms and Conditions

As provided in Section II.C.3, Applicant may submit proposed modifications to the terms and conditions of the RFA for consideration by the Department. The proposed modifications do not alter the terms and conditions of the RFA and have no force or effect on the RFA or any contract unless accepted by the Department and incorporated through a BAFO, negotiation document, addenda to the RFA or amendment to the Contract.

The Department at its sole discretion may consider any proposed modifications submitted in this Attachment.

The Applicant must check the appropriate box to indicate whether it is proposing modifications to the terms and conditions of the RFP:

The Applicant DOES NOT propose modifications.

OR

The Applicant DOES propose modifications as provided in the following table.

	RFA Citation	Redline of Proposed Modification
	(i.e., section & page number)	(i.e., include text as published in RFA and strikethrough words, phrases or sentences proposed to be deleted and underline words, phases, or sentences proposed to be added)
1.		
2.		

17. Supplemental Evaluation Questions for Empty Region(s)

In the event of an Empty Region, the Department will notify eligible Applicants about the opportunity to respond to the Supplemental Evaluation Questions. When making such notification, the Department will identify the Empty Region(s) for which the Department will accept responses to the Supplemental Evaluation Questions. These Supplemental Evaluation Questions are to be completed only upon request by the Department. Applicants who wish to be considered for the award of an Empty Region must submit responses within the time specified by the Department at the time of notification.

In responding to the Supplemental Evaluation Questions below, Applicants should be specific in describing any existing capabilities or community relationships they may have in the Empty Region(s).

Supplemental Evaluation Question	
1.	<p>The Applicant shall describe its approach to meeting and maintaining the capital and other financial requirements, described in the <i>Section V. B. 7. Financial Requirements</i> and <i>Section V. C. 7. Financial Requirements</i>, should it be awarded any Empty Region(s). The response shall include:</p> <ul style="list-style-type: none"> • Amounts of available capital by source expected at the time of BH I/DD Tailored Plan launch; and • Amounts of available capital by source expected 12 months following BH I/DD Tailored Plan launch; and • Amounts of available capital by source expected 24 months following BH I/DD Tailored Plan launch.
List all Entities that <i>may</i> perform core functions or proposed experiences related to this response.	
Response – Region 1	
Response – Region 2	

Response – Region 3
Response – Region 4
Response – Region 5
Response – Region 6

Response – Region 7

Supplemental Evaluation Question

2.	<p>The Applicant shall describe its strategy for developing a provider network in each Empty Region for which it would like to be considered, consistent with the requirements outlined in <i>Section V.E.1. Provider Network</i> and in a way that minimizes disruption for members. The response shall detail any differences from the approach described in response to <i>Question 13 in Section VIII. Attachment Q. Application Response and Completed Attachments</i> on provider network development strategies, and shall include:</p> <ul style="list-style-type: none"> a. Description of any business or community relationships the Applicant may be able to leverage to develop a provider network in the Empty Region prior to BH I/DD Tailored Plan launch; b. Description of other strategic approaches that will be used to develop and maintain a provider network to ensure network adequacy standards and highest quality care in the Empty Region, inclusive of strategies for physical health, behavioral health, pharmacy, I/DD and TBI service providers, as well as networks for both Medicaid and State-Funded systems; c. Description of any unique characteristics of the population in the Empty Region (noting any differences within the region), including any unique health or health resource needs, challenges, and gaps, and a description of how the Applicant will address these needs and mitigate any challenges; and d. Description of strategies to recruit and support providers, including hospitals, in traditionally underserved areas of the Empty Region.
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List all Entities that <i>may</i> perform core functions or proposed experiences related to this response.

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Response – Region 1

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Response – Region 2

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Response – Region 3
Response – Region 4
Response – Region 5
Response – Region 6
Response – Region 7

Supplemental Evaluation Question	
3.	<p>The Applicant shall:</p> <ul style="list-style-type: none"> a. Describe its ability to manage community-based efforts which are focused on health promotion, prevention, and collaboration, including those described in <i>Section V.A.4. Stakeholder Engagement and Community Partnerships</i> and <i>Section V.C.3.g Diversion from Institutional Settings</i>, in the Empty Region; b. Describe any pre-existing relationships the Applicant may be able to leverage in managing community-based efforts, which are focused on health promotion, prevention and collaboration; c. Describe its approach to building capacity to manage community-based efforts, which are focused on health promotion, prevention, and collaboration in the Empty Region. d. Describe any proposed physical facilities or local presence of the Applicant in the Empty Region and the types of roles/functions that would be staffed there. <p>The response shall include approaches to:</p> <ul style="list-style-type: none"> a. Crisis/involuntary commitment (IVC) (including managing local area crisis plans, maintaining continual crisis response systems and facilitating local/regional crisis collaboratives), as described in <i>Section V.A.4.e. Community Crisis Services Plan for Medicaid and State-funded Services</i>;

- b. Disaster Response (including participating in community disaster planning and supporting the provision of medical, behavioral health, I/DD, LTSS, TBI, and pharmacy services to impacted communities);
- c. Community collaboratives, as described in *Section V.A.4.b. Engagement with Community and County Organizations for Medicaid and State-Funded Services*, (including leading or participating in county- or stakeholder- led collaboratives focused on children’s system of care).

List all Entities that *may* perform core functions or proposed experiences related to this response.

Response – Region 1

Response – Region 2

Response – Region 3

Response – Region 4

Response – Region 5

Response – Region 6

Response – Region 7

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Supplemental Evaluation Question

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| 4. | <p>The Applicant shall describe 1) its existing administrative and operational capacity to accept an expanded service area; 2) any past experience with building administrative and operational capacity in a new service area; and 3) a proposed approach to building administrative and operational capacity to accommodate an expanded service area, if awarded. The response shall include approaches to:</p> <ul style="list-style-type: none">a. Provider Network Expansion;b. Staffing;c. Facilities;d. Information Technology;e. Member Services;f. Provider Services; andg. Claims and Utilization Management. |
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List all Entities that *may* perform core functions or proposed experiences related to this response.

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Response

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