Medicaid Managed Care Policy Paper

Behavioral Health I/DD Tailored Plan RFA Pre-Release

North Carolina Department of
Health and Human Services

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Contents

I. Introduction

As North Carolina transitions its Medicaid and NC Health Choice programs' care delivery system from predominately fee-for-service (FFS) to Medicaid managed care, the North Carolina Department of Health and Human Services (the Department) is committed to advancing integrated and high-value care, improving population health, engaging and supporting providers and beneficiaries, and establishing a sustainable program with more predictable costs. While Standard Plans will serve the majority of Medicaid and NC Health Choice beneficiaries enrolling in Medicaid managed care, Behavioral Health and Intellectual/Developmental Disability (Behavioral Health I/DD) Tailored Plans will serve populations with more significant behavioral health conditions—including mental health and substance use disorders (SUD)—I/DD, and traumatic brain injury (TBI).

As with the State's transition to Medicaid managed care, the creation of the Behavioral Health I/DD Tailored Plans and certain Behavioral Health I/DD Tailored Plan features is required by State legislation.[1] Behavioral Health I/DD Tailored Plans will be integrated to provide physical health, behavioral health, long-term care, and pharmacy services under one plan. They also will offer certain high-intensity behavioral health, I/DD, and TBI services to meet the needs of the population served by these plans. Behavioral Health I/DD Tailored Plans will administer two of the State's Medicaid Section 1915(c) Home and Community-Based Services (HCBS) waivers: the North Carolina Innovations waiver for individuals with I/DD and the TBI waiver for individuals with a TBI.[2] Behavioral Health I/DD Tailored Plans also will be responsible for managing the State's non-Medicaid (i.e., State-funded) behavioral health, I/DD, TBI, and SUD services, which are targeted to uninsured and underinsured North Carolinians.

The Department recognizes Local Management Entity/Managed Care Organizations' (LME/MCO) deep experience in serving populations with significant behavioral health needs and I/DDs. After more than two years of intensive design work and stakeholder engagement, and as directed by the North Carolina General Assembly, the Department is preparing to issue the Behavioral Health I/DD Tailored Plan Request for Applications (RFA) to seek LME/MCOs (also referred to as "Offerors" during the procurement process) to serve as Behavioral Health I/DD Tailored Plans and support the goals of Medicaid managed care. The RFA will include requirements for both Medicaid and State-funded Services, as well as the evaluation questions that Offerors must complete and submit to the State to be considered for a Behavioral Health I/DD Tailored Plan contract award.

This paper complements prior policy papers issued by the Department between 2017 and 2019. It is intended to give stakeholders additional insight into Behavioral Health I/DD Tailored Plan design areas not previously addressed in other policy papers. To receive a contract, LME/MCOs will need to meet the requirements previewed in this paper and detailed in the RFA, which is expected to be issued in the near future. Notably, these requirements impact the first contract award period and are not an indication of what may or may not be included as requirements for Behavioral Health I/DD Tailored Plan operations in future contract periods. Specifically, this paper highlights design related to the Behavioral Health I/DD Tailored Plan procurement process, administration and entity requirements, financial management and

[1] Session Law 2015-245 has been amended by Session Law 2016-121; Section 11H.17.(a) of Session Law 2017-57, Part IV of Session Law 2017-186; Section 11H.10.(c) of Session Law 2018-5; Sections 4-6 of Session Law 2018-49; and Session Law 2018-48.

[2] The TBI waiver operates in limited areas of the State.

monitoring, provider participation/contracting, quality, care management, and other programmatic features.

II. Behavioral Health I/DD Tailored Plan Procurement Process

The Department will use a comprehensive and thorough application process to award Behavioral Health I/DD Tailored Plan contracts, with criteria established by the Department.[3] The first Behavioral Health I/DD Tailored Plan contract term will last four years. There will be an opportunity for Offerors to submit questions prior to the application deadline. A more detailed schedule of events with specific dates will be outlined in the RFA.

The Department will set actuarially sound capitation rates for Behavioral Health I/DD Tailored Plans; Offerors will not submit price bids as part of their RFA responses. By accepting a contract, Behavioral Health I/DD Tailored Plans agree to accept any actuarially sound capitation rates as developed by the Department and approved by CMS. Consequently, the evaluation of applicants will be based primarily on the Offerors' qualifications and ability to meet the expectations and requirements of both Medicaid managed care and State-funded Services operations, as outlined in the RFA. The Department will establish an overall scoring threshold as a tool to evaluate an Offeror's response against such criteria.

The Department has defined seven Behavioral Health I/DD Tailored Plan Regions within North Carolina, which are consistent with the current LME/MCO catchment areas, as shown in Table 1 and Figure 1 below.[4] The Department defined these Regions through a facilitated process led by the North Carolina Association of County Commissioners (NCACC), which coordinated with its county representatives and consulted with LME/MCOs. Offerors may only apply for the Region(s) in which they are currently operating as an LME/MCO. Upon conducting a comprehensive, impartial evaluation of the applications received in response to the RFA, the Department will award regional contracts in each of the seven (7) Regions.

Table 1: List of Counties by Behavioral Health I/DD Tailored Plan Region

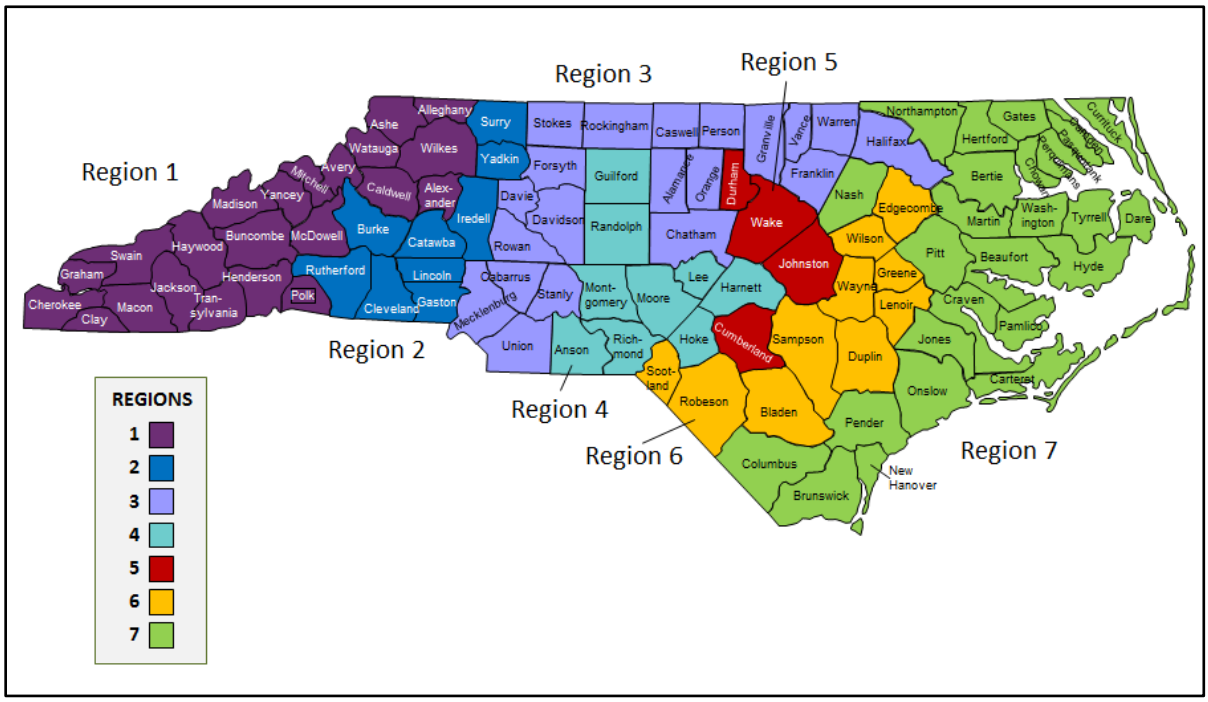
Behavioral Health I/DD Tailored Plan Regions	Counties
Region 1	Alexander, Alleghany, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Swain, Transylvania, Watauga, Wilkes, Yancey
Region 2	Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Rutherford, Surry, Yadkin
Region 3	Alamance, Cabarrus, Caswell, Chatham, Davidson, Davie, Forsyth, Franklin, Granville, Halifax, Mecklenburg, Orange, Rockingham, Person, Rowan, Stanly,

[3] Section 4(10)a. of Session Law 2015-245, as amended by Session Law 2018-48

[4] Counties may not disengage from a Behavioral Health I/DD Tailored Plan Region and realign with another Behavioral Health I/DD Tailored Plan Region.

	Stokes, Union, Vance, Warren
Region 4	Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond
Region 5	Cumberland, Durham, Johnston, Wake
Region 6	Bladen, Duplin, Edgecombe, Greene, Lenoir, Robeson, Sampson, Scotland, Wayne, Wilson
Region 7	Brunswick, Carteret, Columbus, Nash, New Hanover, Onslow, Pender, Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington

Figure 1: Map of Behavioral Health I/DD Tailored Plan Regions



In the event that no Contract is awarded in a Region to the entity currently serving the Region, the Department will, at its discretion, award all or part of the "empty" Region to one or more qualified applicants, using an optional, supplemental questions request.[5] Offerors who would like to be considered for an expanded service area in an empty Region will be asked to respond to additional questions in this supplemental questions request.

The supplemental questions will focus on assessing an Offeror's experience in and approach to developing provider networks and managing community health functions in Regions in which they currently do not operate. Additionally, the supplemental questions request will be used to assess an Offeror's administrative and operational capacity to manage an expanded service area. The Department

[5] There will be only one Behavioral Health I/DD Tailored Plan operating in each county.

also will assess projected enrollment in empty Regions. In the event that award of an empty Region would result in a substantial number of new enrollees being added to any one Offeror, the Department retains the right to divide a Region and award it to two or more qualified Offerors.

III. Behavioral Health I/DD Tailored Plan Administration

A. Entity Status

North Carolina legislation expressly requires that Behavioral Health I/DD Tailored Plans be operated "only by [Local Management Entities/Managed Care Organizations] LME/MCOs that meet certain criteria established by DHHS" for the first contract period of four years, after which point Behavioral Health I/DD Tailored Plan contracts will be open for a competitive bid process to entities operating the initial Behavioral Health I/DD Tailored Plan contracts and any not-for-profit Prepaid Health Plan (PHP) that is licensed to operate in North Carolina.[6] As such, only LME/MCOs may apply to be Behavioral Health I/DD Tailored Plans under this initial RFA and through the duration of the first contract.[7]

To the extent LME/MCOs are considering mergers with one another, the entities can initiate such mergers through currently accepted processes, which require Department approval. Upon completion of a merger, the formerly separate LME/MCOs will be considered a single entity.[8]

B. Entity Governance

Behavioral Health I/DD Tailored Plans operated by an LME/MCO will be subject to the same governance requirements that currently apply, as outlined in N.C. Gen. Stat. § 122C, which includes a single governing board and other advisory boards, as follows:

- **Governing Board:** The entity's governing board must have between 11 and 21 voting members and must include representation of consumers and families, clinical experts, and financial and insurance industry experts. Governing board members must be appointed by the boards of county commissioners within the plan's Region.

- **Consumer and Family Advisory Committee (CFAC):** Recognizing the importance of consumer and family participation in Behavioral Health I/DD Tailored Plan governance and operations, Behavioral Health I/DD Tailored Plans will continue to be required to engage the CFAC, including all local committees within the plan's Region.

- **Other Advisory Boards:** As required by N.C. Gen Stat. § 122C, Behavioral Health I/DD Tailored Plans will also be required to engage a non-binding, advisory-only board of county commissioners.

[6] Section 4(10)a. of Session Law 2015-245, as amended by Session Law 2018-48.
[7] LME/MCOs are local political subdivisions of the State that are overseen by the Department and whose authority, organization, and governance are mandated in statute.
[8] LME/MCOs that are considering or planning for mergers with another LME/MCO after the RFA submission must describe this relationship and related activities in relevant subcontracting sections of the RFA.

The Behavioral Health I/DD Tailored Plan will be required to comply with all applicable provisions of N.C. Gen. Stat. § 122C, Article 4 regarding the composition, meeting schedule, training, compensation, and maintenance of each of these governing and advisory boards.

In response to the RFA's evaluation questions, Offerors must provide transparent and comprehensive information regarding all entities, including parent entities, subsidiaries and business partners who meet the definition of an ownership or controlling interest in the Behavioral Health I/DD Tailored Plan, including the entity's area director and members of the governing board. Each of these persons must disclose the name, address, date of birth, and any other information for the Department to perform required background checks and verify exclusion status.[9]

C. Entity Licensure

In concert with N.C. Gen. Stat. § 122C, LME/MCOs are currently exempt from PHP licensing and solvency requirements set forth by the North Carolina Department of Insurance (DOI), and PHP licensure will not be required as a condition of initial contract award. However, by at least 90 days before the end of the third Contract Year, the Department will require that Behavioral Health I/DD Tailored Plans be licensed as a PHP as set forth by the DOI, provided that legislative authority authorizes this conversion.

D. Subcontracting Relationships

Offerors bidding to become a Behavioral Health I/DD Tailored Plan may form strategic partnerships with subcontracting entities. The Department will require the Offeror to submit information or documentation as part of the RFA response regarding the roles, responsibilities, functions, and experiences of the subcontracting entity. If the Offeror would like for the Department to recognize the experiences of a subcontracting entity when evaluating and scoring its RFA responses, it will need to provide information on the ownership and control of any subcontractors, including name, address, and date of birth of the persons or entities with an ownership or controlling interest in its subcontractors when responding to the RFA evaluation questions. Consistent with Standard Plan requirements, the purpose of this information is to confirm that the subcontracting entity would have:

1. Meaningful long-term financial incentive in the administrative, clinical, and operational success of the Behavioral Health I/DD Tailored Plan's Medicaid managed care contract; and

2. Meaningful long-term involvement in the day-to-day operations of the Behavioral Health I/DD Tailored Plan.

When evaluating an Offeror's response to the RFA evaluation questions, the Department may exercise, at its sole discretion, whether to consider the experience of any subcontractor, or to what extent the experience applies.

In accordance with State legislation, LME/MCOs operating a Behavioral Health I/DD Tailored Plan must subcontract with "an entity that holds a PHP license and that covers the services required to be covered under a Standard Benefit Plan contract."[10] The Department does not require plans that meet these statutory requirements to hold a Standard Plan contract or a license in the same region as the Behavioral Health I/DD Tailored Plan. The Department will evaluate each Offeror's qualifications on each

[9] In accordance with 42 CFR §455.104.

[10] Section 4(10)a.5. of Session Law 2015-245, as amended June 15, 2018 by House Bill 403.

of the functions covered by the RFA and, as part of this evaluation, will consider relevant experience of their subcontractors and partners.

Upon execution, the Offeror must provide the Department with complete copies of any contracts with a PHP for review and approval and, upon request, provide complete copies of contracts with any other subcontractors. The Offeror must ensure oversight and monitoring of such contracts. The Behavioral Health I/DD Tailored Plan RFA outlines additional parameters governing the contractual relationship between Behavioral Health I/DD Tailored Plans and their subcontractors, including PHPs. These parameters focus on ensuring financial and operational integration across physical health, behavioral health, and I/DD services, and a unified member and provider experience. It will be incumbent upon the Offeror, in its RFA response, to describe how its agreement with a subcontractor will support these goals.

IV. Behavioral Health I/DD Tailored Plan Financial Management and Monitoring

The Department developed financial management requirements to monitor and promote program integrity and sustainability. The Department expects the Behavioral Health I/DD Tailored Plan to be a responsible steward of federal, state and local resources.

A. Capitation Rate Setting for Medicaid

Capitation rates for the Medicaid and NC Health Choice populations covered by the Behavioral Health I/DD Tailored Plan will be set by the Department reflecting the contractual requirements and actuarially sound practices in accordance with federal rules. Capitation payments will include monthly per member per month (PMPM) payments, maternity event payments, and payments for additional directed payments to certain providers as required under the Contract. Additionally, the Behavioral Health I/DD Tailored Plan will receive and be responsible for making separate payments to care management agencies and Advanced Medical Home Plus practices that provide Tailored Care Management. These payments are outside of the monthly PMPM capitation payments and maternity event payments paid to the Behavioral Health I/DD Tailored Plans.

The Department will publish a draft Rate Book containing historical data and draft rates by rate cell for each Tailored Plan region. The intent of the Rate Book is to summarize historical data and outline key prospective rate considerations for the Behavioral Health I/DD Tailored Plan population for purposes of providing transparency into the current program costs and utilization along with insight into the rate development process for Behavioral Health I/DD Tailored Plans. The draft capitation rates also provide context on potential premium revenues of the Behavioral Health I/DD Tailored Plan program in each region. The draft capitation rates will be re-evaluated in advance of program implementation to consider more recent program data and all final design considerations.

The capitation rate-setting methodology will align with the process to develop capitation rates for the Standard Plans. The historical service cost and utilization will be informed by a combination of FFS and LME/MCO encounter data. Trends and programmatic changes will be evaluated using historical data and consider all provider reimbursement requirements outlined in the RFA. Managed care assumptions will be incorporated for expected changes in service utilization as a result of Tailored Care Management and integrated service delivery. Care coordination and care management are expected to have an impact on the utilization of acute care services in particular hospital and emergency room utilization. Finally, the

capitation rates will incorporate non-benefit considerations associated with Behavioral Health I/DD Tailored Plan administrative and care management costs as well as risk margin and cost of capital. The non-benefit considerations are being developed utilizing a modeled approach to administrative and care management funding and a consistent approach for the underwriting gain assumption to address risk margin and cost of capital. Further details on the rate development will be provided in the draft Rate Book.

The Department is evaluating potentially including a time-limited risk mitigation provision in the Behavioral Health I/DD Tailored Plan contract. Risk mitigation would occur through a risk corridor, where the Department would participate in the financial risk with each Behavioral Health I/DD Tailored Plan outside of a predetermined corridor. Risk corridors would help mitigate unexpected gains or losses from the implementation of this new program and the broader managed care coverage of services for the Behavioral Health I/DD Tailored Plan population.

Ultimately, capitation rates set by the Department will be submitted to CMS for approval in advance of rate effective dates. Similar to expectations of the LME/MCOs under the current program, Behavioral Health I/DD Tailored Plans will be expected to share financial and encounter data with the Department to facilitate the rate setting and plan oversight process.

B. Medical Loss Ratio

The Medical Loss Ratio (MLR) standards ensure the Behavioral Health I/DD Tailored Plan is directing a sufficient portion of the capitation payments received from the Department to services and activities that improve health in alignment with the Department's program goals and objectives and are in compliance with a minimum MLR of 88% for health care services as defined in statute.[11] Behavioral Health I/DD Tailored Plans will be encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the Region and communities they serve. Behavioral Health I/DD Tailored Plans that voluntarily contribute to health-related resources may count such contributions towards the numerator of the MLR.

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

- Remit to the Department a rebate equal to the denominator of the Department-defined MLR, multiplied by the difference between the minimum MLR threshold and the Department defined MLR;
- Contribute to health-related resources targeted towards high-impact initiatives, as described above and further in the RFA, through Department-approved plans; or
- Allocate a portion of the total obligation to contributions to health-related resources and the remaining portion to a rebate to the Department, with amounts for each at the discretion of the Behavioral Health I/DD Tailored Plan.

Behavioral Health I/DD Tailored Plans shall closely track and report their expenditures to demonstrate value to the Department as well as compliance with MLR standards.

[11] Section 5.(6)c. of Session Law 2015-245.

C. Solvency

The Behavioral Health I/DD Tailored Plan must have and maintain at all times adequate financial resources to guard against the risk of insolvency, pursuant to the terms of the Behavioral Health I/DD Tailored Plan contract and N.C. Gen. Stat. § 122C. Consequently, the Department has established the following financial viability standards for Behavioral Health I/DD Tailored Plans, with the intention of serving as a glide path to DOI licensure requirements:

- Behavioral Health I/DD Tailored Plans must, by Day 1 of Behavioral Health I/DD Tailored Plan launch, fully fund Behavioral Health I/DD Tailored Plan risk reserves at 12.5 percent of total expected annual Behavioral Health I/DD Tailored Plan Medicaid capitation. If a Behavioral Health I/DD Tailored Plan fails to meet such Medicaid risk reserve standards, the Behavioral Health I/DD Tailored Plan must submit a viable plan outlining how the Behavioral Health I/DD Tailored Plan will meet these requirements by the end of Contract Year 2, for approval at the discretion of the Department. Financial reviews will be a part of the Readiness Review requirements.

- Behavioral Health I/DD Tailored Plans must purchase reinsurance to protect against the financial risk of high-cost individuals or propose an alternative mechanism for managing financial risk. The Department reserves the right to revisit reinsurance requirements annually and modify the deductible threshold and coverage levels required.

- Behavioral Health I/DD Tailored Plans must, at least 90 days before the end of Contract Year 3, meet the solvency standards for PHPs set forth by the DOI. This provision of the Behavioral Health I/DD Tailored Plan Contract is contingent upon legislative authority to require the conversion to DOI licensure and oversight.

- Behavioral Health I/DD Tailored Plans 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 Business Days without significant penalty. Significant penalty is a penalty greater than 20 percent. The Department will calculate the Current Ratio for (1) Medicaid operations only and (2) Medicaid and State-funded operations combined.

$$Current\ Ratio = \frac{Current\ Assets}{Current\ Liabilities}$$

- Behavioral Health I/DD Tailored Plans shall maintain a Defensive Interval Ratio above 30 Calendar Days as determined from the monthly, quarterly, and annual financial reporting schedules. The Defensive Interval is defined as cash plus cash equivalents divided by Operating Expenses minus Non-Cash Expenses divided by the period measured in days. The Department will calculate the Current Ratio for (1) Medicaid operations only and (2) Medicaid and State-funded operations combined.

$$Defensive\ Interval\ Ratio = \frac{Cash + Cash\ Equivalents}{(Operating\ Expenses - Non\ Cash\ Expenses)/Period\ (days)}$$

D. Withholds

The Department will use a premium withhold program, under which a portion of the premium will be withheld and paid retrospectively based on the Behavioral Health I/DD Tailored Plan performance on specified metrics, to incentivize Behavioral Health I/DD Tailored Plans in a range of possible areas, including quality improvement, value-based payment, care management, Healthy Opportunities, operational effectiveness, and other Departmental goals. The withhold program will conform to applicable state[12] and federal[13] statute and regulations.

E. Managing Program Costs

Behavioral Health I/DD Tailored Plans shall manage program costs while meeting the quality, access and other Department requirements under the Contract and federal and state laws and regulations. Risk-adjusted cost growth for the Behavioral Health I/DD Tailored Plan's members "must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for non-expansion states."[14] Further, Behavioral Health I/DD Tailored Plans must use the same drug formulary, as established by the Department, and also ensure "the State realizes a net savings for the spending on prescription drugs."[15]

The Department shall monitor annual cost growth of Behavioral Health I/DD Tailored Plan expenditures by Region and population cohort to most closely align with the populations reported in the CMS Office of the Actuary's Actuarial Report on the Financial Outlook for Medicaid. Additionally, Behavioral Health I/DD Tailored Plans shall provide reports to the Department to demonstrate annual cost growth. Each such requested report shall include a narrative that summarizes cost drivers, an evaluation of programs in place to address those cost drivers, and plans for addressing future cost growth.

F. Value-Based Payment

The Department expects Behavioral Health I/DD Tailored Plans to accelerate the adoption of Value-Based Payment (VBP) arrangements in their contracts with providers. In contrast to the status quo FFS model that rewards volume over value, VBP models ensure that provider payments incentivize population health, appropriateness of care, improved quality and outcomes, and other measures of value. VBP is a promising way to align payment incentives with the Department's broader goal of high value, whole person care, achieved by integrating services that address physical health, behavioral health, I/DD, TBI, LTSS, pharmacy, and unmet resource needs.

Behavioral Health I/DD Tailored Plans will serve populations with high needs, and will have networks of a diverse range of behavioral health, physical health, I/DD, and TBI providers. This unique landscape presents challenges to VBP contracting. For example:

- VBP models must be designed to ensure that enrollees have access to necessary services, even when services are higher cost.

[12] Section 5(5)a. of Session Law 2015-245, as amended by Session Law 2018-49
[13] 42 C.F.R. § 438.6
[14] Section 5.(6)a. of Session Law 2015-245.
[15] Section 5.(6)b. of Session Law 2015-245

- Since standard VBP models often attribute patients using the primary care provider (PCP) relationship, many critical behavioral health and I/DD providers could be inadvertently excluded from the VBP arrangements, impacting the Department's goal of integration.
- Many Behavioral Health I/DD Tailored Plan providers will serve a relatively low volume of patients, making measuring outcomes or cost reductions more challenging.
- LME/MCOs and their providers have minimal experience with VBP contracting to date.

Recognizing these challenges, the Department will begin by building in VBP into the payment model for Tailored Care Management, which will allow providers delivering Tailored Care Management to earn additional dollars for improved cost and quality outcomes.[16] Beyond this specific payment model, the Department will develop a menu of state-approved VBP model options to assist Behavioral Health I/DD Tailored Plans and providers in identifying and entering into innovative arrangements that fit this unique landscape and go beyond the Tailored Care Management model. The menu will be determined prior to the launch of Behavioral Health I/DD Tailored Plans. This approach aims to equip all parties to VBP arrangements with the knowledge, tools and experience to adopt, scale, and eventually independently design and operate VBP programs. The Department will define outcomes to which payment should be linked and will specify any guardrails. The Department looks forward to engaging Behavioral Health I/DD Tailored Plans and providers to develop an achievable menu of VBP model options, and also welcomes Behavioral Health I/DD Tailored Plans and providers to propose alternative models for approval.

In addition, in line with Standard Plans, the Department will require Behavioral Health I/DD Tailored Plans to report on their VBP strategies and progress, which will be compared to Department-defined VBP targets starting in Contract Year 2. The targets will be based upon the Health Care Payment Learning and Action Network (HCP-LAN) Framework of Alternative Payment Models (APM), and VBP will be defined as HCP-LAN Categories 2 – 4 in Contract Year 2,[17] though the Department may narrow the definition of VBP over time. The Department will finalize the VBP targets prior to Contract Year 2.

V. Provider Participation/Contracting in Behavioral Health I/DD Tailored Plans

A. Provider Networks

Behavioral Health I/DD Tailored Plans will be required to include any willing provider in their physical health networks, with exceptions for providers who do not meet PHP quality standards or agree to network rates. As directed by the General Assembly, Behavioral Health I/DD Tailored Plans shall maintain closed networks for behavioral health, I/DD, and TBI providers but must include all Essential Providers in their regions unless an alternative arrangement has been approved by the Department.[18,19] The use of closed networks for behavioral health, I/DD, and TBI services is consistent with LME/MCO

[16] More information on the Tailored Care Management model is provided in the Behavioral Health I/DD Tailored Plan Provider Manual for Tailored Care Management.

[17] The HCP-LAN is a federal HHS-convened stakeholder group focused on value-based payment, with representation from public and commercial payers and other health industry representatives.

[18] Session Law 2015-245, Section 4(10)a.6, as amended by Session Law 2018-48

[19] Session Law 2015-245, Section 5, as amended by Session Law 2018-48

practices today. However, the Department also recognizes the potential closed networks may have for limiting access to care. A core focus for the Department in developing network adequacy standards for Behavioral Health I/DD Tailored Plans has been ensuring meaningful availability and accessibility for the spectrum of behavioral health, I/DD, and TBI services, and enhancing expectations for Behavioral Health I/DD Tailored Plans to develop and deepen provider capacity for priority, evidence-based services.

Behavioral Health I/DD Tailored Plans will be required to meet network adequacy standards for physical health services, behavioral health, I/DD, and TBI services. Behavioral Health I/DD Tailored Plan network adequacy standards were informed by Standard Plan network adequacy requirements, current LME/MCO requirements and experience, and the Department's understanding of current provider capacity strengths, gaps, and policy goals. Behavioral Health I/DD Tailored Plans network adequacy requirements include time and distance standards with urban and rural area and adult and pediatric provider type distinctions, appointment wait time parameters, accessibility and cultural competency provisions, and evaluation of providers accepting new patients on a county-level.

Behavioral Health I/DD Tailored Plans will also be required to provide and protect access to out-of-network providers for their members as required under federal law. Protections include adequate and timely coverage for services that members can only access out-of-network, no-cost second opinions from out-of-network providers upon request, and limitations to ensure that costs to members receiving services out-of-network do not exceed costs to members receiving services in-network.

B. Network Oversight

Behavioral Health I/DD Tailored Plans will be required to submit a network access plan – after Contract Award and annually thereafter– that describes their approach to meeting network adequacy standards and demonstrates compliance with network adequacy requirements. The Department is committed to promoting access to high-priority evidence-based interventions and providers that can best meet the needs of Behavioral Health I/DD Tailored Plan members. Some priority areas, given the unique needs of the Behavioral Health I/DD Tailored plan members, include access to:

- Electroconvulsive therapy (ECT) for indicated conditions;
- Clozapine utilization for the treatment of chronic psychotic disorders;
- First episode psychosis (FEP) programs;
- Medication-assisted treatment for opioid use disorders (e.g., office-based opioid treatment (OBOT) and outpatient opioid treatment program);
- Child and adolescent psychiatrists;
- Tobacco cessation treatments and resources; and
- Community integration services and supports

Acknowledging that many of these services and provider types face capacity challenges today, as part of the network access plan, Behavioral Health I/DD Tailored Plans will be required to develop and effectuate strategies for developing access and capacity. Behavioral Health I/DD Tailored Plans will be reviewed on these strategies prior to go-live and must report on their progress at least annually.

C. Provider Payments

To encourage continued provider participation in the Medicaid program and to ensure beneficiary access and support safety net providers, Behavioral Health I/DD Tailored Plans will be subject to requirements for provider payments consistent with Standard Plan practices. These requirements include rate floors – at NC Medicaid Direct levels or levels defined by the Department – for in-network physicians, physician extenders, pharmacies (dispensing fees), hospitals and nursing facilities. For certain in-network providers (e.g., local health departments, public ambulance providers), Behavioral Health I/DD Tailored Plans will also be required to make additional payments based on utilization of specific services. These additional, utilization-based payments will be identified by the Department and approved by CMS.

In addition, Behavioral Health I/DD Tailored Plans will be subject to the following requirements for payments for Tailored Care Management and medical home fees for Advanced Medical Homes (AMHs):[20]

- Required payments to providers (certified AMH+ practices[21] and Care Management Agencies (CMA)[22]) for care management will differ from requirements under Standard Plans.[23] Most importantly, the Department will establish PMPM rates for Tailored Care Management model, which will be risk adjusted (acuity-tiered) according to a standardized methodology. The Department will promote value based payment tied to Tailored Care Management by requiring Behavioral Health I/DD Tailored Plans to offer additional performance incentive payments based on the measures contained in the Department's Technical Specifications Manual.

- All primary care practices certified as AMH Tier 1-3s will also receive Medical Home Fees (the former Carolina Access payments) for the Behavioral Health I/DD Tailored Plan members attributed to them, regardless of whether they are also certified as an AMH+. To incent participation by PCPs with Behavioral Health I/DD Tailored Plans, even those not ready to certify as AMH+ practices, the Department has set the Medical Home fee at $5.00 PMPM for all Behavioral Health I/DD Tailored Plan beneficiaries rather than the $5.00 PMPM for the Aged, Blind, and Disabled (ABD) and $2.50 PMPM for all others that existed under Carolina ACCESS and has been carried over into Standard Plans.

[20] AMHs are State-designated primary care practices that have attested to meeting standards necessary to provide local care management services.
[21] AMH+ practices are primary care practices certified by the Department as AMH Tier 3 practices, whose providers have experience delivering primary care services to the Behavioral Health I/DD Tailored Plan eligible population, or can otherwise demonstrate strong competency to serve that population and have certified by the State as such.
[22] CMAs are provider organizations with experience delivering behavioral health, I/DD, and/or TBI services to the Behavioral Health I/DD Tailored Plan eligible population that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model as certified by the State.
[23] For more on payments to AMH+s/CMAs for care management, please refer to North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans Policy Paper and the forthcoming Behavioral Health I/DD Tailored Plan Tailored Care Management Provider Manual.

D. Out-of-Network Providers

For needed services, Behavioral Health I/DD Tailored Plans will be required to reimburse out-of-network providers at NC Medicaid Direct levels or a mutually agreed upon rate. The Department has designed reimbursement requirements consistent with federal requirements and weighing considerations of in-network availability, any willing provider, closed network, and rate floors provisions across physical and behavioral health services.

If an out-of-network provider for physical health services has refused a contract after the Behavioral Health I/DD Tailored Plan has made a good faith effort to contract, or the provider has been excluded from contracting for failure to meet objective quality standards, the Behavioral Health I/DD Tailored Plan is prohibited from reimbursing the provider more than 90 percent of the NC Medicaid Direct rate for services. In instances where the Behavioral Health I/DD Tailored Plan has not made a good faith effort to contract with an out-of-network provider of physical health service who has refused a contract, or the out-of-network provider for physical health services has not been excluded for failure to meet objective quality standards, the out-of-network provider for physical health services will be reimbursed at 100 percent of the NC Medicaid Direct rate if a contract is not negotiated.

For behavioral health services, out-of-network providers will be reimbursed at 100 percent of the NC Medicaid Direct rate for services.

For emergent or post-stabilization services, out-of-network providers will be reimbursed up to 100 percent of the NC Medicaid Direct rate of services.

For services during transitions of care, out-of-network providers will be reimbursed at 100 percent of the NC Medicaid Direct rate of services.

VI. Quality

As North Carolina transitions to Medicaid managed care, the Department will work with each Behavioral Health I/DD Tailored Plan to build upon its experience in NC Medicaid Direct and the LME/MCO program to further improve outcomes for enrollees. The Department will focus on rigorous and innovative outcomes measurement, promote equity through reduction or elimination of health disparities, and reward Behavioral Health I/DD Tailored Plans and, providers, for advancing quality goals. The Department expects Behavioral Health I/DD Tailored Plans to meet additional standards related to the unique aspects of their population, such as health home requirements and requirements related to North Carolina's 1915(c) waiver, while maintaining all standards relevant to the Standard Plans. The Department expects Behavioral Health I/DD Tailored Plans to promote the highest quality of care for both physical and behavioral health needs, including long term services and supports (LTSS) care and care for I/DD, and to promote integration among physical and behavioral health service providers and providers of LTSS and I/DD care. For Medicaid, the Department will expect Behavioral Health I/DD Tailored Plans to develop Quality Management and Improvement Programs, Quality Assessment and Performance Improvement Plans, and at least three Performance Improvement Projects. Behavioral Health I/DD Tailored Plans will be required to achieve NCQA Health Plan Accreditation with LTSS Distinction for Health Plans by the end of Contract Year 3.

The Department will expect Behavioral Health I/DD Tailored Plans to report a wide range of quality metrics, including outcome metrics; the measures will vary depending on whether the enrollee is

receiving Medicaid or State-funded Services. Beginning in the first year of contracting with Behavioral Health I/DD Tailored Plans, the Department will report plans' performance on these measures, and will in the second contract year implement a withhold program for a small subset of priority measures selected by the Department to reflect Medicaid performance. The full Tailored Plan quality measure set is listed in Appendix A. The measure set may change based on modifications to the underlying measure sets (e.g., HEDIS and CMS Core Adult or Child Measure sets) or changes in state policy priorities.

VII. Other Programmatic Features

A. In-Reach, Transition and Diversion

The Department is committed to preventing institutionalization and providing services and supports in a community setting to the greatest extent possible. In pursuit of this goal, Behavioral Health I/DD Tailored Plans will be required to identify members who are receiving care in an institutional setting and work with them—and their families or guardians, as appropriate—to transition to the community if their needs can be safely met in a community setting. Behavioral Health I/DD Tailored Plans will also be required to identify members who are at risk of requiring care in an institutional setting and provide individualized interventions that ensure the member can remain in a community setting.

The in-reach, transition and diversion requirements developed for Behavioral Health I/DD Tailored Plans build on the accomplishments of the Transitions to Community Living Initiative (TCLI) and the Money Follows the Person (MFP) program, extending the expertise and experience developed in those programs to additional high-need populations. In-reach, transition and diversion requirements for non-Medicaid populations are addressed in a separate policy paper on State-funded Services.

1. In-Reach and Transition Requirements

All members with serious mental illness (SMI) residing in an adult care home (ACH)[24] or state psychiatric hospital and members residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or state developmental center will be eligible to receive in-reach and transition services. Behavioral Health I/DD Tailored Plan in-reach and transition staff[25] will be expected to have prior experience and specific expertise working with members with SMI and/or I/DD (depending on the population that the staff member is working with) and knowledge of community services and supports, including supported housing. For example, in-reach staff working with members with SMI must be certified peer support specialists who can draw upon their own lived experience to engage members in an ACH or state psychiatric hospital on community options available to them. Behavioral Health I/DD Tailored Plans will also be required to provide relevant training to in-reach and transition staff on topics such as engagement methods and assessing community living arrangements for health and safety issues.

Behavioral Health I/DD Tailored Plans will be required to begin in-reach activities upon a member's admission to an ACH, state psychiatric hospital, ICF-IID or state developmental center. The Department recognizes that not all members will be able or willing to begin transition planning at the time they are

[24] Excluding family care homes (2-6 beds).
[25] Transition staff assigned to Behavioral Health I/DD Tailored Plan members will be determined by the member's care setting.

engaged by Behavioral Health I/DD Tailored Plan in-reach staff. For members who choose not to—or are unable to—begin the process of transitioning back to a community setting, Behavioral Health I/DD Tailored Plans will be expected to provide additional opportunities by reengaging the member at intervals until they are ready to be referred for transition services.[26] Required in-reach activities include:

- Ensuring members are accurately and fully informed about available community-based options. This may include facilitating and accompanying members on visits to supported housing settings;
- Identifying and addressing barriers to transition;
- Exploring and addressing the concerns of members and/or their family who decline the opportunity to transition or are ambivalent about transitioning;
- Providing members or their families with opportunities to meet with peers who are living, working, and receiving services in integrated settings; and
- Supporting facility staff to ensure smooth transitions, including by engaging and collaborating with stakeholder groups and local agencies that represent individuals with SMI or I/DD to provide education on the topic of transition.

Most critically, Behavioral Health I/DD Tailored Plan in-reach staff will be required to ensure a warm and timely handoff to transition staff once a member decides to move to a community setting. Transition staff then will lead and coordinate all transition planning activities going forward. They will closely collaborate with the member; facility providers and discharge planners; the Behavioral Health I/DD Tailored Plan housing specialist (if needed); and community providers including the member's primary care physician, clinical specialists, and other services and supports. Specific required transition activities include:

- Assisting members, prior to discharge, in selecting community providers and making arrangements for individualized supports and services—including complex behavioral health, primary care and medical needs—needed to be in place upon discharge;
- Identifying any training needed by the receiving providers or receiving agency to ensure a seamless transition;
- Addressing any barriers to transition, such as network adequacy issues, transportation, housing, assessment, resource identification, and provider or care manager referrals; and
- Exploring and securing appropriate and available funding options and working through any potential funding needs with community providers such as managing spend downs.

Transition staff must also ensure a warm and timely handoff to the care manager assigned to the member after they have transitioned to the community. Prior to and following that handoff, transition staff will be required to remain engaged in members' care, following members for up to 90 days and convening post-discharge meetings to address any areas of concern identified following transition.

[26] The Department will determine a minimum frequency for in-reach in future guidance.

2. In-Reach and Transition Requirements for Children and Youth Members in Behavioral Health Settings[27]

Recognizing that children and youth with mental illness residing in institutional settings have unique needs, the Department will establish separate Behavioral Health I/DD Tailored Plan requirements to ensure that the needs of this population are met. Children and youth members residing in state developmental centers or other ICF-IIDs will receive in-reach and transition services in accordance with the requirements described in the previous section. Behavioral Health I/DD Tailored Plans will be required to conduct in-reach and transition for children and youth members in state psychiatric hospitals, psychiatric residential treatment facilities (PRTFs) and certain residential treatment levels with the goals of reducing the average length of stay, readmissions, and the number of youth in institutional or other out-of-home settings. Required Behavioral Health I/DD Tailored Plan in-reach and transition protocols for children and youth members will include: identification and engagement of children and youth members to receive transition services; collaboration with facilities, community providers, and other youth-specific entities or systems; ensuring individualized, person-centered transition plans; identifying and addressing barriers to transition; and ensuring warm handoffs and linkages to community providers and care managers where appropriate.

3. Diversion Requirements

Behavioral Health I/DD Tailored Plans must provide diversion services to all members who have transitioned from an institutional or correctional setting within the previous six months or are seeking entry into an institutional setting. Members with an I/DD or TBI who do not meet this criteria will also be eligible for diversion services if there is any indication his/her caregiver may be unable to provide required interventions, such as if the caregiver is aging or in fragile health. All child and youth members with I/DD and complex behavioral health needs are also eligible for diversion services.

Behavioral Health I/DD Tailored Plans will be required to ensure that all diversion activities, including identifying eligible members, will be the responsibility of the assigned organization providing Tailored Care Management. If, however, a member is eligible to receive diversion activities but they are not already engaged in Tailored Care Management, then Behavioral Health I/DD Tailored Plans will be required to outreach to the member to engage them in Tailored Care Management and conduct the following diversion activities:

- Screen and assess members for eligibility for community-based services, including supported housing, if needed;
- Educate members on the choice to remain in the community and the services that would be available to support that decision;
- Facilitate referrals and linkages to community-based services; and
- For those who choose to remain in the community, develop a Community Integration Plan and integrate it into members' Care Plan or Individual Support Plan (ISP).

[27] Requirements apply to children and youth in state psychiatric hospitals, psychiatric residential treatment facilities, residential treatment levels II/Program Type, III and IV.

B. Care Management for the Innovations and TBI Waiver Populations

The Department has designed the Tailored Care Management model to meet the unique needs of the Innovations and TBI waiver populations and ensure that members enrolled in the Innovations or TBI waiver have the same access to whole-person care management as all other Behavioral Health I/DD Tailored Plan members. Tailored Care Management will fully encompass the care coordination services that members enrolled in the Innovations or TBI waiver obtain today. On top of the care coordination services, organizations providing Tailored Care Management—AMH+ practices, CMAs, and Behavioral Health I/DD Tailored Plans—will be required to provide all other elements of the Tailored Care Management model to members enrolled in the Innovations or TBI waiver, including coordinating across the full continuum of physical health, behavioral health, LTSS, pharmacy, I/DD, and TBI-related services; providing transitional care management; and addressing members' unmet health-related resource needs.[28]

Behavioral Health I/DD Tailored Plans will be required to auto-enroll the Innovations and TBI waiver population in Tailored Care Management at launch and give these members the option of obtaining Tailored Care Management through an AMH+ practice, CMA, or the Behavioral Health I/DD Tailored Plan.[29] If a member enrolled in the Innovations or TBI waiver has an existing relationship with a care coordinator who meets the Tailored Care Management qualifications and training requirements and is employed by the member's Behavioral Health I/DD Tailored Plan or in the Behavioral Health I/DD Tailored Plan's network, the Behavioral Health I/DD Tailored Plan must give the member the option of choosing that previous care coordinator as the care manager for Tailored Care Management. Members enrolled in the Innovations or TBI waiver will also have the option of opting out of Tailored Care Management and obtaining Innovations and TBI waiver coordination as they do today through the Behavioral Health I/DD Tailored Plan. However, in the event of opt out, these members will not have access to whole-person care management.

Under Tailored Care Management, Innovations and TBI waiver care coordination services will be similar to today. Behavioral Health I/DD Tailored Plans will be required to institute processes to minimize disruption for members with the transition to Tailored Care Management, including maintaining the timing for a member's annual ISP update and requiring results of the Supports Intensity Scale (SIS) to be incorporated into a member's care management comprehensive assessment. Recognizing that the current community navigator service definition largely duplicates Tailored Care Management, the Department intends to eliminate the definition with the launch of Behavioral Health I/DD Tailored Plans. Community navigator functions that are not part of the Tailored Care Management model, such as self-direction, will be incorporated into an amended financial support services definition.

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[28] Additional detail on Tailored Care Management can be found in North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability Tailored Plans and the Tailored Care Management Provider Manual.

[29] Behavioral Health I/DD Tailored Plans will be required to assign members enrolled in the Innovations or TBI waiver to Tailored Care Management that complies with federal requirements for conflict-free case management for 1915(c) waiver enrollees. 42 C.F.R. § 441.301(c)(1)(vi). Behavioral Health I/DD Tailored Plans must ensure that members do not obtain both 1915(c) waiver services and Tailored Care Management from employees of the same provider organization that is certified as a CMA.

C. Stakeholder Engagement

Community engagement is a core component of the delivery and administration of Medicaid and State-funded Services. Building on the groundwork established by the Department and LME/MCOs, Behavioral Health I/DD Tailored Plans will continue to engage with county agencies (e.g., local Departments of Social Services, Local Education Agencies and law enforcement agencies) and community based organizations (CBOs) (e.g., homeless shelters, faith-based organizations and consumer and peer run organizations) to help guide and support the delivery of services to Medicaid members and families in their regions. The Behavioral Health I/DD Tailored Plan will be required to develop and implement a Local Community Collaboration and Engagement Strategy that supports continued engagement with county agencies, CFACs, and CBOs and build partnerships at the local level to improve the health of their members.

Additionally, the Behavioral Health I/DD Tailored Plan will be required to collaborate with other Department partners to ensure that members' unique needs are met. Specifically, the Behavioral Health I/DD Tailored Plan will foster relationships with the Department of Instruction, the Division of Vocational Rehabilitation Services and other stakeholders to increase employment opportunities and improve employment outcomes for members that align with best practices for recovery, self-determination and full community inclusion. The Behavioral Health I/DD Tailored Plan also will be required to collaborate with the North Carolina Housing Financing Agency, the Department and with other public agencies to support the expansion of supported housing opportunities available to members with mental illness, I/DD, TBI and/or SUDs.

VIII. Next Steps

The Department welcomes feedback from stakeholders as it continues to refine the Behavioral Health I/DD Tailored Plan model. Please email comments to Medicaid.Transformation@dhhs.nc.gov by February 14, 2020, including "Behavioral Health I/DD Tailored Plan RFA" in the subject line. The Department is evaluating the implications of budget negotiations with the Legislature which are ongoing as of the publication of this paper, but expects to issue the Behavioral Health I/DD Tailored Plan RFA in the near future. The final timeline will be published in the RFA.

Appendix

Appendix A. Tailored Plan Quality Metrics

The following is the full set of quality measures in the Tailored Plan set. Priority measures are listed in **bold**. The measure set is organized into the following tables:

- Table 1. Pediatric Measures
- Table 2. Adult Measures
- Table 3. Maternal Measures
- Table 4. Acute Care Behavioral Health Utilization Measures
- Table 5. Public Health Measures
- Table 6. Patient and Provider Satisfaction Measures
- Table 7. CMS/SUD Monitoring Protocol Measures
- Table 8. Innovations Waiver Measures
- Table 9. State-University Partnership Learning Network (SUPLN) Measures

Table 1. Pediatric Measures			
NQF #	**Measure Name**	**Steward**	**Reporting Frequency**
	Adolescent Well-Care Visit	NCQA	Annually
1388	**Annual Dental Visits**	NCQA	Annually
2	Appropriate Testing for Children With Pharyngitis	NCQA	Interim and Annually
69	Appropriate Treatment for Children With Upper Respiratory Infection	NCQA	Interim and Annually
	Avoidable Pediatric Utilization PDI 14- Asthma Admission Rate PDI 15- Diabetes Short-Term Complications Admission Rate PDI 16- Gastroenteritis Admission Rate PDI 18- Urinary Tract Infection Admission Rate	AHRQ	Annually
38	**Childhood Immunization Status (Combo 10)**	NCQA	Annually
2508	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	Dental Quality Alliance	Annually
108	Follow-up For Children Prescribed ADHD Medication	NCQA	Annually
1407	**Immunizations for Adolescents**	NCQA	Annually
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Annually
1334	Percentage of Eligibles who Receive Dental Visits	The Child and Adolescent Health Monitoring Initiative	Annually
2803	Tobacco Use and Help with Quitting Among Adolescents	NCQA	Annually
24	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	Annually
1392	**Well-Child Visits in the First 15 Months of Life**	NCQA	Annually

Table 1. Pediatric Measures			
NQF #	**Measure Name**	**Steward**	**Reporting Frequency**
1516	**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life** 0 Visits 1 Visit 2 Visits 3 Visits 4 Visits 5 Visits 6 or More Visits	NCQA	Annually

Table 2. Adult Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Ambulatory Care: ED Visits	NCQA	Annually
	Avoidable ED Utilization	TBD	Annually
58	Avoidance of antibiotics in adults with bronchitis	NCQA	Annually
1879	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia**	NCQA	Interim and Annually
	Admission to an Institution from the Community	CMS	Annually
23	Adult BMI Assessment	NCQA	Annually
105	Antidepressant Medication Management	NCQA	Interim and Annually
1800	**Asthma Medication Ratio**	NCQA	Interim and Annually
	Avoidable Inpatient Utilization PQI 01- Diabetes Short Term Complication Admission Rate PQI 05- COPD or Asthma in Older Adults Admission Rate PQI 08- Heart Failure Admission Rate PQI 15- Asthma in Young Adults Admission Rate	AHRQ	Annually
2372	Breast Cancer Screening	NCQA	Interim and Annually
32	**Cervical Cancer Screening**	NCQA	Annually
33	**Chlamydia Screening in Women**	NCQA	Annually

Table 2. Adult Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Comprehensive Diabetes Care		
N/A	HbA1c control (<7.0%) for a selected population		
55	Eye (Retinal) Exam		
57	**Hemoglobin A1c (HbA1c) Testing (HA1C)**	NCQA	Interim and Annually
59	HbA1c Poor Control (>9.0%)		
61	Blood Pressure Control (<140/90 mm Hg)		
62	Medical Attention to Nephropathy		
63	LDL-C screening		
64	LDL-C control (<100 mg/dL		
575	HbA1c Poor Control (>8.0%)		
3389	**Concurrent use of Prescription Opioids and Benzodiazepines**	PQA	Annually
3175	**Continuation of Pharmacotherapy for Opioid Use Disorder**	USC	Interim and Annually
18	Controlling High Blood Pressure	NCQA	Interim and Annually
2607	Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9%)	NCQA	Annually
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA	Annually
39	Flu Vaccinations for Adults	NCQA	Annually
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	NCQA	Annually
576	**Follow-up After Hospitalization for Mental Illness**	NCQA	Interim and Annually
2082/ 3210e	**HIV Viral Load Suppression (HVL-AD)**	HRSA	Annually
4	**Initiation/Engagement of Alcohol and Other Drug Dependence Treatment**	NCQA	Annually
1598	Inpatient Utilization	CMS	Annually
27	**Medical Assistance with Smoking and Tobacco Use Cessation**	NCQA	Annually
1799	Medication Management for People with Asthma	NCQA	Interim and Annually

Table 2. Adult Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	National Core Indicators (NCI) Survey	National Association of State Directors of Developmental Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI)	Annually
	NC TOPPS Required Service Reporting	NC DHHS	Annually and Interim
2856	Pharmacotherapy Management of COPD Exacerbation	NCQA	Annually
1768	Plan All Cause Readmission	NCQA	Annually
	PQI 92: Chronic Conditions Composite	AHRQ	Annually
	Rate of Screening for Unmet Resource Needs	NC DHHS	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan	NCQA	Annually
543	Statin Therapy for Patients with Cardiovascular Disease	NCQA	Interim and Annually
547	Statin Therapy for Patients with Diabetes	NCQA	Interim and Annually
1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	The Joint Commission	Annually
2597	**Substance Use Screening and Intervention Composite**	ASAM	Annually
2600	**Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence**	NCQA	Annually
1604	Total Cost of Care	TBD	Annually
52	Use of Imaging Studies for Low Back Pain	NCQA	Annually
3400	Use of Pharmacotherapy for Opioid Use Disorder	CMS	Annually
2940	Use of Opioids at High Dosage in Persons Without Cancer	PQA	Annually
2950	**Use of Opioids from Multiple Providers in Persons Without Cancer**	PQA	Annually

Table 3. Maternal Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
2903	**Contraceptive Care: Most & Moderately Effective Methods**	US Office of Population Affairs	Annually
2904	**Contraceptive Care: Postpartum**	US Office of Population Affairs	Annually
NA	**Percentage of Low Birthweight Births (Live Births Weighing Less than 2,500 Grams)**	NC DHHS	Annually

Table 3. Maternal Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
NA	Percentage of Pregnant Smokers Receiving Appropriate Screening/Treatment for Smoking	NC DHHS	Annually
1517	**Prenatal and Postpartum Care**	NCQA	Annually
	Prenatal Depression Screening and Follow-up (PND)	NCQA	Annually
	Postpartum Depression Screening and Follow-up	NCQA	Annually
	Rate of Screening for Pregnancy Risk	NC DHHS	Annually

Table 4. Acute Care Behavioral Health Utilization Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	ADATC Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Annually
	Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment	NC DHHS	Annually
	Community Substance Abuse Inpatient Readmissions	NC DHHS	Annually
	Crisis Care in Emergency Departments	NC DHHS	Annually
	Length of Stay in Community Psychiatric Hospitals	NC DHHS	Annually
	Length of Stay in Community Substance Abuse Facilities	NC DHHS	Annually
	Short Term Care in State Psychiatric Hospitals	NC DHHS	Annually
	Length of Stay in State Psychiatric Hospitals	NC DHHS	Annually
	State Hospital Readmissions within thirty (30) days and one hundred eighty (180) days	NC DHHS	Annually

Table 5. Public Health Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Tobacco Use	NA	Annually
	Nutrition/Physical Activity	NA	Annually
	Opioid Use	NA	Annually

Table 6. Patient and Provider Satisfaction Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
6	**Coordination of Care**	AHRQ	Annually
6	**Customer Service**	AHRQ	Annually
6	**Getting Care Quickly**	AHRQ	Annually
6	**Getting Needed Care**	AHRQ	Annually
	Provider satisfaction with health plan	NC DHHS	Annually
6	Rating of all health care	AHRQ	Annually
6	Rating of Health Plan	AHRQ	Annually
6	**Rating of personal doctor**	AHRQ	Annually
6	Rating of specialist seen most often	AHRQ	Annually

Table 7. SUD/CMS Monitoring Protocol Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Access to additional services using Provider Resource Directory - connecting primary care to SUD service offerings	NC DHHS	Annually

Table 7. SUD/CMS Monitoring Protocol Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	CMS	Annually
	Any SUD Treatment	CMS	Quarterly
	Average Length of Stay in IMDs	CMS	Annually
	Early Intervention	CMS	Quarterly
	Emergency Department Utilization for SUD Per 1,000 Beneficiaries	CMS	Quarterly
	Individuals connected to alternative therapies from other community-based resources for pain management or general therapy/treatment	NC DHHS	Annually
	Inpatient Stays for SUD per 1,000 Medicaid beneficiaries	CMS	Quarterly
	Intensive Outpatient and Partial Hospitalization Services	CMS	Quarterly
	Medicaid beneficiaries treated in an IMD for SUD	CMS	Annually
	Medicaid Beneficiaries with SUD Diagnosis (annually)	CMS	Annually
	Medicaid Beneficiaries with SUD Diagnosis (monthly)	CMS	Monthly
	Medication Assisted Treatment	CMS	Quarterly
	Outpatient Services	CMS	Quarterly
	Overdose Deaths (count)	CMS	Annually
	Overdose Deaths (rate)	CMS	Annually
	PDMP checking by provider types (prescribers, dispensers)	NC DHHS	Quarterly
	Per Capita Spending within IMDs	CMS	Annually
	Per Capita SUD Spending	CMS	Annually
	Residential and Inpatient Services	CMS	Quarterly
	SUD Provider Availability	CMS	Annually
	SUD Provider Availability- MAT	CMS	Annually
	SUD Spending	CMS	Annually
	SUD Spending within IMDs	CMS	Annually
	Withdrawal Management	CMS	Quarterly

Table 8. Innovations Waiver Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Number and percentage of new waiver enrollees who have a Level of Care evaluation prior to receipt of services	NC DHHS	Annually
	Number and percent of actions taken to protect the Innovations waiver beneficiary, where indicated (Deaths will be excluded here) (Include: Consumer Injury, Consumer behavior-abuse, sexual acts, AWOL, illegal acts). Also, were appropriate agencies notified.	NC DHHS	Quarterly
	Number and percentage of deaths reviewed and determined to be of unexplained or suspicious cause	NC DHHS	Ongoing
	Number and percentage of deaths where required Behavioral Health I/DD Tailored Plan follow-up interventions were completed as required.	NC DHHS	Quarterly
	Number and percentage of waiver participants whose ISPs were revised, as applicable, by their care manager to address their changing needs	NC DHHS	Monthly
	Number of Innovations waiver applicants who received a	NC DHHS	Annually

Table 8. Innovations Waiver Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	preliminary screening for potential eligibility		
	Percentage of Behavioral Health I/DD Tailored Plan Provider Satisfaction Survey respondents who reported being given information on how to identify and report instances of abuse, neglect, exploitation, and unexplained death	NC DHHS	Annually
	Percentage of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required	NC DHHS	Quarterly
	Percentage of level 2 and 3 incidents reported within required timeframes	NC DHHS	Quarterly
	Percentage of level 2 or 3 incidents where required Behavioral Health I/DD Tailored Plan follow-up interventions were completed as required	NC DHHS	Quarterly
	Percentage of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields	NC DHHS	Annually
	Percentage of medication errors resulting in medical treatment for Innovations wavier beneficiaries	NC DHHS	Quarterly
	Percentage of members reporting that their ISP has the services that they need	NC DHHS	Annually
	Percentage of members who received appropriate medication	NC DHHS	Quarterly
	Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions[2]	NC DHHS	Quarterly
	Percentage of restrictive interventions (both restraint and seclusion) resulting in medical treatment	NC DHHS	Quarterly
	Proportion of 1915 (c) waiver providers with a required plan of correction	NC DHHS	Annually
	Proportion of beneficiaries reporting they have a choice between providers	NC DHHS	Annually
	Proportion of beneficiaries who are receiving services in the type, scope, amount, and frequency as specified in the ISP	NC DHHS	Quarterly
	Proportion of individuals for whom an annual ISP took place	NC DHHS	Semi Annually
	Proportion of individuals whose annual plan was revised or updated	NC DHHS	Semi Annually
	Proportion of Innovations waiver beneficiaries reporting their Care Coordinator helps them to know what waiver services are available	NC DHHS	Annually
	Proportion of ISPs in which the services and supports reflect member assessed needs and life goals	NC DHHS	Annually
	Proportion of ISPs that address identified health and safety risk factors	NC DHHS	Semi Annually
	Proportion of Level of Care evaluations completed at least annually for enrolled participants	NC DHHS	Semi Annually
	Proportion of Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually
	Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements	NC DHHS	Annually

Table 8. Innovations Waiver Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe.	NC DHHS	Annually
	Proportion of new Innovations waiver beneficiaries who are receiving services according to their ISP within forty-five (45) days of ISP approval	NC DHHS	Annually
	Proportion of New Level of Care evaluations completed using approved processes and instrument	NC DHHS	Annually
	Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services	NC DHHS	Annually
	Proportion of non-licensed, non-certified (c) waiver providers with a required plan of correction	NC DHHS	Annually
	Proportion of PCPs that are completed in accordance with DMA requirements	NC DHHS	Semi Annually
	Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to Behavioral Health I/DD Tailored Plan monitoring schedule	NC DHHS	Annually
	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place	NC DHHS	Annually
	Proportion of records that contain a signed freedom of choice statement	NC DHHS	Annually
	The percentage of continuously enrolled Medicaid enrollees under the Innovations waiver (ages three (3) and older) who received at least one (1) waiver service who also received a primary care or preventative health service	NC DHHS	Monthly
	The percentage of continuously enrolled Medicaid enrollees under the Innovations Waiver ages three (3) to six (6) who received a primary care or preventative health service during the measurement period	NC DHHS	Monthly
	The percentage of continuously enrolled Medicaid enrollees under the Innovations waiver ages seven (7) to nineteen (19) who received a primary care or preventative health service during the measurement period or the year prior to the measurement period	NC DHHS	Monthly
	The percentage of continuously enrolled Medicaid enrollees under the Innovations waiver ages twenty (20) and older who received a primary care or preventative health service during the measurement period	NC DHHS	Monthly
	The proportion of claims paid by the Behavioral Health I/DD Tailored Plan for Innovations waiver services that have been authorized in the service plan	NC DHHS	Annually

Table 9. SUPLN Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Any opioids filled among enrollees with an OUD diagnosis	SUPLN	Annually
	Any benzodiazepine use among enrollees with an OUD diagnosis	SUPLN	Annually

Table 9. SUPLN Measures			
NQF #	**Measure Name**	**Steward**	**Frequency**
	Behavioral Health Counseling with Pharmacotherapy for OUD	SUPLN	Annually
	Days in NICU for children 0-12 months diagnosed with NAS at birth hospitalization	SUPLN	Annually
	Multiple opioid prescribes and pharmacies in enrollees without cancer	SUPLN	Annually
	Number of children 0-12 months diagnosed with NAS at birth & in first year per 1,000 Medicaid covered births	SUPLN	Annually
	PCP visits among enrollees with an OUD diagnosis	SUPLN	Annually
	Percentages of children diagnosed with NAS receiving >= 1 and >=6 well-child visits in first 15 months	SUPLN	Annually
	Screening for HIV, HCV, HBV among enrollees with an OUD diagnosis	SUPLN	Annually