

**CONTRACT BETWEEN
THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND
SUBSTANCE ABUSE SERVICES

AND ALLIANCE BEHAVIORAL HEALTH**

Contract # 1018-01

Preamble.

Whereas N.C.G.S. Chapter 122C establishes that both the North Carolina Department of Health and Human Services and the counties, through their area authorities, also known as Local Management Entities, are responsible, within available resources, for the state's public mental health, developmental disabilities, and substance abuse services system; this Contract is intended to specify and delineate duties, responsibilities, and expectations of the parties to better coordinate the delivery and management of public services. It is not legally possible, and therefore not intended, to supplant those legal duties established by statutes and administrative rules. The parties recognize that the General Assembly, as the sovereign power of the State, may from time to time make changes to the state's public health system that will impose duties on one party or both that differ from the scope of work of this Contract. Accordingly, the parties have made provision and agree to conform to changes made to the law, notwithstanding a contractual term previously agreed upon.

General Terms and Conditions

1.0 Parties to the Contract

This Contract is entered into by and between the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (hereinafter referred to as "DMH/DD/SAS"), a Division of the North Carolina Department of Health and Human Services, (hereinafter referred to as the "Department" or "DHHS") and Alliance Behavioral Health, a political subdivision of the State of North Carolina (hereinafter referred to as the "LME/MCO"). DMH/DD/SAS and LME/MCO may be referred to herein individually as a Party and collectively as the Parties.

2.0 Terms of Contract

The term of this Contract shall be for a period commencing October 13, 2018 and ending June 30, 2019. Thereafter, this Contract shall renew automatically for a one-year period unless either Party provides notice of non-renewal at least one hundred twenty (120) days prior to the termination date, or unless the Contract is terminated for cause pursuant to paragraph 21.0. The Parties may jointly renew and amend the Contract as deemed necessary, pursuant to Section 16.0.

3.0 Contract Documents

This Contract shall consist of these General Terms and Conditions, and the following attachments, all of which are incorporated herein by reference:

- (1) Attachment I – Scope of Work
- (2) Attachment II – Performance Expectations
- (3) Attachment III – Financing
- (4) State Certifications

In the event of a conflict in terms between the Contract Documents, the documents shall be accorded precedence in the following order: the Contract, Attachment I - Scope of Work, Attachment II – Performance Expectations, Attachment III – Financing.

Nothing in this Contract or the referenced Attachments shall be construed to create an entitlement to services purchased with State or State-allocated federal funds.

4.0 Assignment

No assignment of the LME/MCO obligations or of the funding provided to the LME/MCO pursuant to this Contract shall be permitted unless such assignments are made pursuant to changes in governance or counties participating in the LME/MCO. Other assignments shall be made in writing signed by the Parties thereto, and shall require the prior written approval of DHHS, which approval shall not be unreasonably withheld.

5.0 Subcontracting

The LME/MCO may subcontract the functions contemplated under this Contract, subject to all applicable State and federal laws, rules, and regulations. The LME/MCO shall be responsible for the performance of any subcontractor and will maintain full accountability for meeting all requirements outlined in this Contract. The LME/MCO shall inform the subcontractor of the sources of funding for the Contract and of any special compliance or reporting requirements associated with each fund source (e.g., block grants). The LME/MCO shall require subcontractors to accurately report and appropriately use State and federal grant funds, and shall establish procedures for the oversight, monitoring and evaluation of subcontractors.

6.0 Beneficiary

Except as herein specifically provided otherwise, this Contract shall inure to the benefit of and be binding only upon the Parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this Contract and all rights of action relating to such enforcement, shall be strictly reserved to the parties. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the LME/MCO that any person or entity, other than DMH/DD/SAS or the LME/MCO, receiving services or benefits by virtue of this Contract shall be deemed an incidental beneficiary only.

7.0 Entire Agreement

This Contract and any documents incorporated specifically by reference represent the entire agreement between the Parties and supersede all prior oral or written statements or agreements between the Parties.

8.0 Availability of Appropriated Funds

The Parties to this Contract agree and understand that the payment of the sums specified in this Contract is dependent and contingent upon the appropriation, allocation, and availability of funds for this purpose to the DMH/DD/SAS. To the extent that funds are not appropriated, allocated and/or made available to the LME/MCO for the purposes set forth in this Contract, the LME/MCO may elect to terminate the Contract and shall not be responsible for further performance under this Contract. Notwithstanding the foregoing, the termination of this Contract shall not relieve any party of its obligations imposed by applicable laws existing at the time of termination.

9.0 Responsibilities of DMH/DD/SAS

The responsibilities of DMH/DD/SAS under this Contract are as follows:

- (1) Verify that the catchment area of the LME/MCO meets the minimum population requirement of 500,000 as specified in N.C.G.S. §122C-115;
- (2) Allocate state appropriated and block grant funding to maximally support non-Medicaid behavioral health services, functions and activities described in Attachments I, II and III - Scope of Work, Performance Expectations and Financing, provided that nothing contained herein shall limit the Secretary's authority to suspend funding pursuant to N.C.G.S. §122C-124.1 and 147;
- (3) Monitor the LME/MCO for compliance with the terms of this Contract and compliance with applicable State and federal laws, rules, and regulations;
- (4) Publish individual and comparative reports regarding the LME/MCO's performance measures under this Contract.
- (5) Participate in the Intra-Departmental Monitoring Team (IMT).

- (6) Collaborate with the LME/MCO on quality improvement activities, detection and prevention of fraud and abuse of non-Medicaid funds, and other activities that impact the services provided to consumers;
- (7) Notify LME/MCOs of policy or procedure changes, including but not limited to changes in covered services or conditions of administrative funding, at least ninety (90) days prior to effective date of change, except when changes in applicable State and federal laws, rules, and regulations, dictate adherence to a less than 90-day implementation timeline; and
- (8) All other responsibilities contained in this Contract.

10.0 Responsibilities of the LME/MCO

The responsibilities of the LME/MCO are as follows:

- (1) Serve as a Local Management Entity as defined by N.C.G.S. § 122C-3(20b) for public mental health, developmental disabilities, and substance abuse services.
- (2) Participate in the Intra-Departmental Monitoring Teams (IMT);
- (3) Perform the functions outlined in Attachments I, II and III – Scope of Work; Performance Expectations, and Financing.
- (4) Manage service capacity and quality by enforcing provider compliance with applicable State and federal laws, rules, and regulations, including termination of LME/MCO provider contracts and defense of all actions taken by the LME/MCO against providers in all applicable departmental or administrative hearings and in state and federal courts as applicable;
- (5) Be wholly responsible for the work to be performed and for the supervision of its employees. The LME/MCO represents that it has hired or contracted with all personnel required in performing the services under this Contract. Such employees shall not be employees of the Department;
- (6) Utilize State and non-Medicaid federal funds allocated for services under this Contract for DMH/DD/SAS approved mental health, developmental disabilities, and substance abuse services for individuals in the catchment area or Cross Area Service Programs (CASPs) in accordance with DHHS Target Population benefit plan categories and State and federal priorities;
- (7) Participate in local, regional and state disaster preparedness and recovery initiatives to develop and implement natural and other disaster response plans, assist, to the degree possible, with response to such events, and support DMH/DD/SAS in execution of grant funded services that may be required post disaster. This includes working with the LME/MCOs, local provider network to identify and sustain relevant participation in disaster response activities.
- (8) Submit to the DMH/DD/SAS all plans, reports, cost reports or other documents required by applicable State and federal laws, rules, regulations, policies, guidelines, and standards funding agreements, and this Contract;
- (9) Develop a local business plan (LBP) that describes the activities to transition to the functions of a Tailored Plan for Behavioral Health and IDD including necessary changes to infrastructure, staffing, reinvestment in community services and efforts to partner with physical healthcare managed care organizations. The first Transition Local Business Plan shall be due July 1, 2019. In consideration of the changing role of the LME/MCOs, pursuant to N.C.G.S. §122C-112.1. (a)(3)the Secretary will establish a process and criteria for submission, review and approval of LME/MCO Transition Local Business Plans, including determining the specific requirements for the Transition LBP.
- (10)Oversee the LME/MCO network providers who receive state appropriations and/or federal block grant funds for compliance with state and federal regulations.
- (11)Monitor sub-grantees for compliance with the terms of subcontracts including but not limited to all reporting requirements of the LME/MCO;
- (12)Allow the DMH/DD/SAS appropriate access to all public meetings and public records as those terms are defined by State law and which pertain to the functions or activities funded in any amount by this Contract;
- (13)Crosswalk consumers to the Common Name Data Service (CNDS) when the consumers are enrolled into the Consumer Data Warehouse (CDW);
- (14)Accurate and timely submission of CDW, Incident Response Improvement System (IRIS), North Carolina-Treatment Outcomes and Program Performance System (NC-TOPPS), NC Tracks benefit plans and other DMH/DD/SAS required data for each consumer as needed to comply with any required Departmental data system;
- (15)Set rates and determine financial incentives for providers,

- (16) Provide Care Coordination for consumers of non-Medicaid services in accordance with the requirements of N.C.G.S. §122C-115.4(b)(5);
- (17) Implement the approved LME/MCO crisis plan based on availability of crisis funding;
- (18) When requested by DHHS, LME/MCO will promptly disclose salaries and benefits of any requested employees, including the origin of the funding stream supporting the salary; and
- (19) All other responsibilities contained in this Contract.

11.0 Accreditation

LME/MCO shall be accredited by URAC NCQA. Any LME/MCO currently accredited by URAC that intends to submit an application to operate a Tailored Plan must apply to NCQA for Managed Behavioral Health Organization (MBHO) accreditation no later than November 1, 2020..

12.0 Notice of Certain Reporting and Audit Requirements

In accordance with the Federal Funding Accountability and Transparency Act (FFATA), LME/MCOs that receive a sub award of more than \$25,000 in federal financial assistance (through block grants or other federal grants, exclusive of Medicaid) are required to obtain a DUNS number at <http://fedgov.dnb.com/webform> and to register in the System for Award Management (SAM) at www.sam.gov. The LME/MCO shall send proof of the DUNS number prior to the initiation of the contract and the receipt of any sub award payments to the DMH/DD/SAS Business Officer.

The LME/MCO shall use or expend the funds available under this Contract only for the purposes for which they were appropriated by the General Assembly or received by the State. State funds include federal grant funds that flow through the State. In addition, specific state funds allocated to the LME/MCO by the DHHS or the DMH/DD/SAS must be used in accordance with the requirements set out in the allocation letters which accompany those funds, to the extent that such requirements are not inconsistent with the terms and conditions of this Contract. The LME/MCO is subject to the requirements of 2 CFR Part 200, known as the OMB Super Circular, and the N.C. Single Audit Implementation Act of 1987, as amended in 1996.

The LME/MCO shall furnish to the State Auditor, upon his/her request, all books, records, and other information that the State Auditor needs to fully account for the use and expenditure of state funds in accordance with N.C.G.S. §147-64.7.

13.0 Record Retention

LME/MCO shall retain records at their own expense in accordance with the Records Retention and Disposition Schedule for Local Management Entities (APSM 10-6) and applicable State and Federal laws, rules or regulations. At a minimum, LME/MCO shall maintain all grant records for a period of five years after the grant closes and a final expenditure report has been approved, provided there are no unresolved audit findings, pending litigation, claims, investigations or other official actions involving the records. If the final expenditure report is amended, or if any of the above actions take place during the ensuing timeframe, the five-year retention period starts over.

In order to protect documents and public records that may be the subject of DHHS litigation, the DMH/DD/SAS shall notify the LME/MCO of the need to place a litigation hold on those documents. DMH/DD/SAS will also notify the LME/MCO of the release of the litigation hold. If there is no litigation hold in place, the documents may be destroyed, disposed of, or otherwise purged through the biannual Records Retention and Disposition Memorandum from the DHHS Controller's Office.

The LME/MCO shall facilitate and monitor the compliance of its contracted providers with all applicable requirements of record retention and disposition, which includes the implementation of the proper protections and safeguards for records (security, privacy, and storage) for the duration of the record retention period, including monitoring to determine if a provider going out of business, has arranged for their records to be stored in an environment that ensures the continued preservation and safeguarding of records to protect their privacy, security, and confidentiality for the duration of the record retention period, and that the provider has submitted to the LME/MCO a copy of their record storage log and documentation that outlines where the records are stored, the designated custodian, and contact information. Any

documents generated or received by the LME/MCO related to all aspects of TCLI shall be stored per State Record Retention requirements.

LME/MCO shall include in contracts with providers the responsibility for compliance with service record documentation and retention. If the LME/MCO is notified that a contracted provider has abandoned records, the LME/MCO must submit a formal report to the NC Department of Health and Human Services. If the LME/MCO is notified that a contracted provider has potentially violated State or federal laws, rules or regulations governing health information privacy and security including but not limited to the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, 110 Stat. 1938 ("HIPAA"), as amended by title XIII of Division A and title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), 45 CFR Parts 160, 162 and 164 (HIPAA Privacy and Security Rule), and N.C.G.S. 122C-52 through 122C-56, the LME/MCO must notify the provider in writing of the potential violation and monitor and follow up with the provider regarding any required compliance steps such as risk assessments, mitigation efforts, notification of affected individuals, and submission of reports to DHHS or the US Department of Health and Human Services, Office of Civil Rights. When an LME/MCO dissolves or is terminated, the successor LME/MCO is obligated to assume responsibility for the records of the dissolved LME/MCO for the duration of the retention schedule for those records per APSM 10-6. This includes client records, administrative records and other records covered by the retention schedule. If allowed by law, the successor LME/MCO has the option of scanning the records and disposing of the paper copies or renting storage space and retaining the records in storage. These records can be disposed of when the retention period in the appropriate schedules has been met. Records which have met the retention schedule requirements shall be destroyed if these records are not subject to audit, investigation, or litigation.

If a provider's contract is terminated or if the provider closes network operations, but continues to have operations elsewhere in the state, the provider may either provide copies of medical records of individuals to the LME/MCO or submit a plan for maintenance and storage of all records for approval by the LME/MCO. The LME/MCO has the sole discretion to approve or disapprove such a plan.

The following steps are required of any LME/MCO as soon as the LME/MCO is made aware of the abandonment of any medical records of individuals served pursuant to this Contract in their catchment area:

- (1) The LME/MCO is to notify the applicable DHHS Division(s) based on funding source and licensure, i.e. DMA, DMH/DD/SAS and/or DHSR.
- (2) The LME/MCO is to contact the provider via trackable mail informing them of their report to DHHS regarding the abandonment.
- (3) The LME/MCO is to secure the records and complete an inventory log of the records.

14.0 Liabilities and Legal Obligations

Each party hereto agrees to be responsible for its own liabilities and that of its officers, employees, agents or representatives arising out of this Contract.

15.0 Compliance with Laws

LME/MCO staff and its subcontractors shall fully comply with all requirements and restrictions of all state and federal grant programs, and their accompanying state fund Maintenance of Effort (MOE) requirements in all LME/MCO expenditures and reimbursements using state and federal funds, and in all LME/MCO subcontracting with entities that are eligible to receive these funds, the DMH/DD/SAS shall apprise LME/MCO in writing of the requirements and restrictions of these funding sources. The LME/MCO shall notify all staff and contractors in writing of the requirements and restrictions of these funding sources and shall monitor compliance with these requirements and restrictions.

16.0 Disengagements

Upon approval by DHHS of any county(ies) disengagement in accordance with N.C.G.S. § 122C-115(a3), the respective transferring and receiving LME/MCOs shall timely respond to information and data requests from DHHS.

With the applicable county(ies), the transferring LME/MCO shall develop, coordinate and implement a transition plan, all as reviewed and granted prior approval by DHHS, to ensure that consumer services are not disrupted to more than a minimal extent by the county(ies) disengagement. This transition plan must be submitted to DHHS for review and approval at least (60) days prior to the effective date of any approved county disengagement. The transition plan must address the continuity of services for consumers, distribution of real property (if applicable), and provision to Division's LME/MCO Liaison of evidence of written notice of the county disengagement to consumers in the affected county(ies).

The receiving LME/MCO shall develop, coordinate and implement a transition plan to ensure the continuity of services for consumers. This transition plan must be submitted to DHHS for review and approval at least sixty (60) days prior to the effective date of any approved county disengagement. The plan implementation will include provision to Division's LME/MCO Liaison of evidence of written notice of the county disengagement to consumers in the affected county(ies).

17.0 Amendment

All amendments to this contract must be in written form and executed by duly authorized representatives of DMH/DD/SAS and the LME/MCO against DHHS. This Contract may not be amended orally, by performance or by written form not jointly executed by DMH/DD/SAS and the LME/MCO. The parties agree that this Contract shall be amended, as necessary, to maintain compliance with State or federal law, rules, or regulations.

18.0 Choice of Law

The laws of the State of North Carolina shall govern and control this Contract. The parties agree that in litigation initiated by the LME/MCO, related to matters concerning this Contract, venue for legal proceedings shall be Wake County, North Carolina. The parties further agree that in any action initiated by DHHS against the LME/MCO under or arising from or involving the validity, construction, interpretation or enforcement of this Contract, venue shall be appropriate in the County where the LME/MCO's primary administrative office is located.

19.0 Federal Certifications

The LME/MCO agrees to execute the following federal certifications:

- (1) Certification Regarding Lobbying;
- (2) Certification Regarding Debarment;
- (3) Certification Regarding Drug-Free Workplace Requirements; and
- (4) Certification Regarding Environmental Tobacco Smoke.

20.0 Severability

In the event that a court of competent jurisdiction holds that a provision or requirement of this Contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent that it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this Contract shall remain in full force and effect.

21.0 Confidentiality

Any medical records, personnel information or other items exempt from the NC Public Records Act or otherwise protected by law from disclosure given to the LME/MCO under this Contract shall be kept confidential and not divulged or made available to any individual or organization except as otherwise provided by law. Both parties shall comply with all applicable confidentiality laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the administrative simplification rules codified at 45 Parts 160, 162, and 164, substance use disorder patient records laws codified at 42 U.S.C. §290dd-2 and 42 CFR Part 2, and the Health Information Technology for Economics and Clinical Health Act.

22.0 Termination for Cause

This Contract is terminable for cause by DHHS in accordance with the provisions of N.C.G.S. §122C-115.4(d), 122C-124.1, 122C-124.2, and 122C-125. Additionally, pursuant to Chapter 122C of the North Carolina General Statutes, DHHS may remove certain duties and responsibilities from the LME/MCO and may suspend funding to the LME/MCO and no provisions herein shall be construed to diminish, lessen, limit, share, or divide the authority of DHHS or the Secretary of DHHS to so act.

23.0 Secretary's Authority Undiminished

Certain functions delegated to the LME/MCO pursuant to this Contract are the duty and responsibility of DHHS as the grantee of federal grant funds. The parties understand and agree that nothing in this Contract shall be construed to diminish, lessen, limit, share, or divide the authority of the Secretary of DHHS to perform any of the duties assigned to the DHHS 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 DHHS to reimburse the LME/MCO for any of its duties under this Contract.

24.0 Originals

In witness whereof, the LME/MCO and DMH/DD/SAS have executed this Agreement in duplicate originals, one of which is retained by each of the parties.

25.0 Notice

The persons named below shall be the persons to whom notices provided for in this Contract shall be given. Either Party may change the person to whom notice shall be given. Any notice required under this Contract will only be effective if actually delivered to the parties named below. Delivery by hand, by first class mail, or by email are authorized methods to send notices.

For the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services:

| | |
|---|---|
| IF DELIVERED BY US POSTAL SERVICE | IF DELIVERED BY ANY OTHER MEANS |
| Kody Kinsley, Interim Senior Director | Kody Kinsley, Interim Senior Director |
| Division of MH/DD/SAS 3001 Mail Service Center Raleigh, NC 27699-3001 | Division of MH/DD/SAS 306 N. Wilmington Street Raleigh, NC 27699-3001 Phone (919) 733-7011 Email kody.kinsley@dhhs.nc.gov |

For the LME/MCO:

| | |
|---|---|
| IF DELIVERED BY US POSTAL SERVICE | IF DELIVERED BY ANY OTHER MEANS |
| Rob Robinson, CEO Alliance Behavioral Healthcare 4600 Emperor Blvd. Suite 200 Durham, NC 27703 | Rob Robinson, CEO Alliance Behavioral Healthcare 4600 Emperor Blvd. Suite 200 Durham, NC 27703 |

Signature Warranty

Each individual signing below warrants that he or she is duly authorized by the party to sign this Contract and to bind the party to the terms and conditions of this Contract.

BY: Rob Robinson Witness: Carol Wolff
DocuSigned by: 28AAF53BDC1D48A... DocuSigned by: 32469A999D1F461...
 Name

TITLE: CEO

DATE: 10/15/2018 | 4:55 PM EDT

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

BY: Kody H. Kinsley
DocuSigned by: 28AAF53BDC1D48A...
 Division Director or Designee

DATE: 10/20/2018 | 9:07 AM EDT

ATTACHMENT I — SCOPE OF WORK

The LME/MCO shall perform all requirements of this Contract in accordance with its terms and all applicable requirements of the North Carolina General Statutes, within available resources as set forth at N.C.G.S. § 122C-2. In the event that funding is reduced by the N.C. General Assembly for LME/MCO responsibilities under this Contract or its statutory functions, and other funds are not available to the LME/MCO to meet its statutorily required functions, the scope of work and performance measures set forth herein may be modified by agreement of the parties as soon as practicable after such funding reductions.

1.0 Definitions

For purposes of this Contract, the following words and phrases shall mean as defined herein:

- A. "Allowable non-UCR expenditure" shall mean an expenditure paid in support of services that are not supported with an approved shadow claim and are not disallowed per federal guidelines.
- B. "Allowable shadow claim" shall mean a claim submitted to the NC Tracks system and processed successfully.
- C. "Benefit Plan Recipients" shall mean those individuals who meet certain eligibility requirements and diagnostic criteria of a plan of services known as a benefit plan.
- D. "Fee-for-service (FFS) claim" shall mean a claim for services paid by the LME/MCO with State or Federal grant Funds to a provider that is fully adjudicated through NC Tracks and can be credited to a fee-for-service account.
- E. "Grantee" shall mean DHHS or DMH/DD/SAS, the State government entity to which a federal grant, is awarded and which is responsible and accountable for the use of the funds provided and for the performance of the grant-supported project or activity.
- F. "High cost consumer" means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.
- G. "High risk consumer" shall mean a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months, which may include persons, including persons with a traumatic brain injury requiring DMH/DD/SA services, who have been discharged from a DHHS state facility, local community hospital or specialty hospital, hospital emergency department, facility based crisis service, non-hospital medical detoxification service, mobile crisis management (MCM) service, crisis respite service, other crisis service, and jails, detention centers, youth development centers, children or youth with severe emotional disturbance whose behavioral health residential placement has been abruptly disrupted two times; persons with serious mental health needs being discharged from prisons, and consumers who are under an outpatient commitment order, to the extent that the LME/MCO has been notified of the recent or impending discharge or outpatient commitment order.
- H. "Shadow claim" shall mean an encounter record against non-Medicaid funds to be used for verification of expenditures, settlement, Maintenance of Effort (MOE) determinations, performance measure calculations, and data analyses that is fully adjudicated through NC Tracks but cannot be credited to any fee-for-service account.
- I. "Subgrantee" or "subrecipient" shall mean the LME/MCO or other legal entity to which a sub grant is awarded or sub award is made and which is accountable to the grantee for the use of the funds provided. The terms sub grant/subgrantee and sub award/sub recipient are used interchangeably in practice.

2.0 General Administration and Governance

2.1 Governing Board and Consumer and Family Advisory Committee (CFAC)

The LME/MCO shall comply with applicable provisions of N.C.G.S. Chapter 122C regarding the composition, meeting schedule, training and support of the governing Board and the Consumer and Family Advisory Committee (CFAC).

2.2 Capacity and Competency

The LME/MCO shall have an administrative and organizational structure adequate to perform the functions required under this Contract. The LME/MCO shall employ sufficient individuals with training, education, experience, licensing or certification appropriate to their position and responsibilities to carry out the requirements of this Contract.

2.3 Conflict of Interest

The term "conflict of interest" refers to situations in which a financial interest may adversely affect, or have the appearance of adversely affecting, an individual's professional judgment in performing any activity or duty in connection with this Contract. No official or employee of the LME/MCO shall acquire any personal interest, direct or indirect, in any provider contracted with State or Federal Block Grant Funds that would be considered a conflict of interest under this Contract. The LME/MCO Board of Directors, advisory committees, employees, volunteers, agents, and contractors shall not participate in clinical or administrative activities or decisions in which there is or may be a conflict of interest. The LME/MCO shall not serve as legal guardian or representative payee for any individual.

3.0 Business Management and Accounting

3.1 Management of Non-Medicaid Funds

The LME/MCO shall timely reimburse providers for duly authorized services provided and billed, contingent upon receipt of timely payments from DMH/DD/SAS. This includes estimating the percentage of authorized services that shall be delivered so that only those funds that shall be spent are encumbered.

3.2 Financial Records

In addition to meeting all applicable State and Federal statutory and regulatory requirements, the LME/MCO shall comply with Generally Accepted Accounting Principles and N.C.G.S. Chapter 159, as applicable. The LME/MCO shall maintain up-to-date and accurate accounting records for accounts payable and receivable. At each regularly scheduled Board meeting, the LME/MCO shall present to its Board a finance report and other financial information as determined by the Board and set forth in N.C.G.S. Chapter 122C.

3.3 Contracting for Service Delivery

All provider contracts shall be in writing and must specify that the provider comply with all applicable State and federal laws, rules and regulations. The LME/MCO shall require providers to utilize evidence based practices where such exist, and to the extent they are required by applicable service definitions. The LME/MCO shall retain one fully executed original of each provider contract, which may be an electronic document containing an electronic signature in accordance with the Electronic Signatures in Global and National Commerce Act and N.C.G.S. Chapter 66. Contracts may be executed after their effective date if necessary to maintain access to care, and so long as there is a specified effective date of the contract, without any ambiguity as to the start of the performance period allowed. The LME/MCO shall make provider contracts available for the DMH/DD/SAS's inspection within two working days after it receives the DMH/DD/SAS's written request. The LME/MCO shall not contract with any provider that has been debarred, suspended terminated or otherwise lawfully prohibited from participation in any federal or state government procurement activity. Non-Medicaid federal funds can only be contracted to not-for-profit organizations, in accordance with current federal block grant requirements. State and non-Medicaid federal funds may only be used to purchase services that conform to state-approved service definitions.

4.0 Information Management

4.1 Information Technology Infrastructure

The LME/MCO must have the ability to send files in standard Electronic Data Interchange (EDI) format. All electronic Protected Health Information (PHI) must be encrypted when transmitted electronically. The LME/MCOs IT infrastructure shall be fully compliant with the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, (HIPAA), Public Law 104-191; the HIPAA Privacy and Security regulations in 45 CFR Parts 160, 162, and 164; and the regulations governing the Confidentiality of Substance Use Disorder Patient Records in 42

CFR Part 2. The LME/MCO must have an internet connection and browser capabilities as well as file sharing capabilities with Secure File Transfer Protocol (SFTP) Software.

4.2 Federal Health Information Technology Interoperability Standards

In the implementation of electronic health record technology and throughout all of their information technology applications used in the support of an electronic health record, the LME/MCOs shall monitor and adhere to the Federal health information technology interoperability standards that shall be specified as a result of the American Recovery and Reinvestment Act of 2009, specifically, but not exclusively Title XIII - Health Information Technology (short title "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act").

4.3 Consumer Information

The LME/MCO shall require contract providers submit to timely submit NC-TOPPS information and outcomes on individuals requesting and/or receiving non-Medicaid services through federal, State and county funds. The LME/MCO shall maintain accurate and up-to-date consumer information and eligibility records in a manner which protects the privacy rights of consumers. The parties shall request and record individual social security numbers only when it is imperative for the performance of their duties and responsibilities as prescribed by law (N.C.G.S. §132-1.10). The LME/MCO shall submit through the CDW system timely consumer admissions, updates, discharges, and eligibility information to DHHS, as specified in DHHS policy, including additions, deletions, and changes in consumer status. The LME/MCO shall require contracted providers to submit required information within the time frames set by the LME/MCO and according to DHHS policy.

4.4 Analysis of Data

The LME/MCO shall analyze consumer access, service authorization and claims payment data to inform management decision-making in areas including: identification of high cost/high need consumers; provider billing patterns and trends; utilization of various services in the service array; identification of network inadequacy in the service array; consumer assessment, outcomes, and survey data; consumer movement among providers, consumer access, initiation, engagement, retention, continuity of care and personal consumer outcomes, including employment and community living status.

4.5 Service Claims and Eligibility Data

The LME/MCO shall have the ability to send and receive the current version of the HIPAA transactions. Transactions that will be used from the beginning of this Contract include the following:

- (1) 834 – Member Enrollment and Eligibility Maintenance
- (2) 835 – Remittance Advice
- (3) 837I – Institutional claims
- (4) 837P – Professional claims
- (5) 999 – Batch acknowledgment for 5010 version

All claim data submitted by the LME/MCO to DMH/DD/SAS, the MMIS or a contractor acting on DHHS's behalf shall include the National Provider Identification number (NPI) of the Network Provider.

4.5.1 Rates and Reimbursement

LME/MCO will only be reimbursed funds based on rates entered into NC Tracks. LME/MCO can establish rates specific to an LME/MCO, provider, or consumer as the LME/MCO determines necessary and appropriate. LME/MCOs may offer different rates to different providers offering the same services according to the LME/MCO's established plan with criteria, such as paying enhanced rates for evidence-based practices or for positive outcomes.

LME/MCO shall only bill the State for the amount paid to the provider. If services are not reimbursed on a fee-for-service basis (e.g., case rates and other funding methods) claims must still be reported through NCTracks to capture service events. The amount billed to the State must not exceed the amount paid to the provider, and the LME/MCO must bill the most appropriate Benefit Plan and related procedure code for the service delivered.

4.5.2 Website

The LME/MCO shall maintain a web site on the Internet that includes current and accurate information on how consumers and families may access services. The home page shall prominently identify the toll-free telephone number(s) the public may call for access to services and to address other customer service needs.

5.0 Claims Processing

5.1 Provider Reimbursement

All payments for services to providers shall be subject to review and audit for their conformity with applicable State and Federal laws, rules and regulations and those of any applicable contract between the LME/MCO and the provider.

The LME/MCO may use different reimbursement amounts for different specialties or for different practitioners in the same specialty; and will establish measures that are designed to maintain quality of services, control cost consistent with its responsibilities to enrollees.

The LME/MCO shall deny claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any denied claims billed shall be returned to the provider with an explanation for the denial.

5.2 First and Third Party Payments

The LME/MCO shall require its providers to pursue all applicable first and third party payments for services in order to minimize the usage of public resources. In the event that a consumer has third party coverage or is determined to be able to pay any portion of the cost of services in accordance with N.C.G.S. §122C-146, the LME/MCO shall coordinate benefits so that costs for services otherwise payable by non-Medicaid funds are avoided or recovered from a liable first or third party payers. The LME/MCO's claims system shall include appropriate edits for coordination of benefits and first and third party liability. The LME/MCO shall develop and implement monitoring of provider compliance with first and third party requirements.

6.0 Provider Relations and Support

6.1 Adequacy of the Provider Network

The LME/MCO shall develop and manage a qualified provider network in accordance with community needs including enrollment, disenrollment, credentialing and assessment of qualifications and competencies in accordance with applicable State and federal laws, rules, and regulations and the provider qualifications established by the LME/MCO and deemed necessary for the effective provision of quality services. The LME/MCO shall have the authority to select which providers may enroll in the LME/MCO Closed Network consistent with the LME/MCO selection and retention criteria.

The LME/MCO shall conduct an annual Network Adequacy and Accessibility Analysis of its provider network that incorporates data analysis of access to and choice of providers, as well as input from consumers, family members, providers and other stakeholders. LME/MCO will review all services, including crisis services, and identify service needs and will prioritize strategies to address any network needs identified. The assessment shall take into consideration the characteristics of the population in the entire catchment area and shall include input from individuals receiving services and their family members, the provider community, local public agencies, and other local system stakeholders. The LME/MCO shall assess the adequacy, accessibility and availability of its current provider community and create a Network Development Plan to meet identified community needs, following the Department's published Network Adequacy and Accessibility requirements.

For Assertive Community Treatment, Individual Placement and Support-Supported Employment (IPS-SE) model, Peer Support Services, Community Support Team, Tenancy Supports, Psychosocial Rehabilitation and other services available to meet the goals of community integration and treatment/support under TCLI, the LME/MCO will contract with a sufficient number of providers in accordance with the State-funded service array. The provider network shall not be used to segregate consumers eligible under TCLI from other consumers. Providers shall not be set aside as the only providers serving individuals in the TCLI benefit plan when other providers of the same services are also in the LME/MCO's provider network.

6.2 Choice of Providers

The LME/MCO shall offer consumers a choice of at least two qualified providers of outpatient therapy services. LME/MCO shall use best efforts to consumers a choice of providers within such radius requirements for other location-based services covered under this Contract, except for services with limited demand or services for which there is not sufficient funding to support more than one provider in a geographic area. The LME/MCO shall make information on providers available to consumers to support informed choice.

6.3 Provider Manual

The LME/MCO shall develop, maintain, and distribute a Provider Operations Manual that informs providers of LME/MCO processes, procedures, deadlines, and other relevant information. This distribution may occur by making the manual available electronically on its website. The manual shall contain, or refer providers to the following requirements: consumer rights information, documentation and billing requirements, privacy and security requirements, clinical standards of practice, on-call coverage, availability, appointment and access requirements, nondiscrimination and no-reject requirements, credentialing requirements, including notification of changes in address, licensure, and insurance, authorization and UR requirements, care coordination and discharge planning requirements, appeal, complaint investigation and resolution procedures, performance improvement procedures, including consumer satisfaction surveys, incident reporting and outcomes requirements; compensation and claims processing requirements, including required electronic formats, mandated timelines, and coordination of benefits requirements. The Provider Manual shall be reviewed and updated as needed.

6.4 Enrollment of Providers

6.4.1 Credentialing

The LME/MCO shall use the same written policies and procedures for credentialing and re-credentialing of state-funded providers as are required for Medicaid providers. Such providers fall under the LME/MCO scope of authority under the terms of this Contract and for all services provided with funding from DMH/DD/SAS. The LME/MCO shall maintain credentialing records that demonstrate compliance with its policies and procedures. These records shall be made available to DMH/DD/SAS for inspection during business hours. The credentialing and recredentialing criteria must be consistent with State and Federal laws, rules and regulations governing the professional areas for those providers. The LME/MCO shall monitor contracted providers for continued compliance with these criteria.

6.4.2 Contracting with Providers

The LME/MCO may choose not to contract with providers based upon its available funding resources, and on the LME/MCO's determination of provider qualification or need for the type of service offered by the provider. If the LME/MCO declines to contract with individual providers or provider agencies to deliver non-Medicaid funded services, it is not required to offer appeal rights. If the LME/MCO has determined that it has sufficient numbers of providers to meet the needs of its non-Medicaid consumers, it is not obligated to conduct credentialing reviews of providers requesting to contract with the LME/MCO. The LME/MCO is not required to contract with providers beyond the number necessary to meet the needs of non-Medicaid consumers. The LME/MCO shall require providers to provide services consistent with the applicable DMH/DD/SAS Service Definition. LME/MCOs are also encouraged to offer differential rates for providers meeting certifications or attaining fidelity that is expected to result in better outcomes for consumers in order to reward and potentially increase the quality of services. LME/MCOs shall disseminate State goals for quality treatment and integrated community living to providers in order to achieve these goals.

For Assertive Community Treatment (ACT), the LME/MCO will contract only with providers who are in fidelity or providers who are working toward fidelity to the Tool for Measurement of ACT (TMACT) model in accordance with the DOJ Settlement Agreement and current policy. For Supported Employment services for mental health and substance abuse disorders, the LME/MCO will contract only with providers who are in fidelity to the Individual Placement and Support - Supported Employment (IPS-SE) model in accordance with the DOJ Settlement Agreement and current policy. A provider's attainment of a fidelity score does not in itself guarantee the provider an LME/MCO contract. Instead, LME/MCOs must consider the need for services (supported by Network Adequacy and Accessibility Analysis) and other predetermined criteria such as outcomes, other quality indicators, and adherence to the service definition in their contracting decisions.

6.5 Provider Monitoring

The LME/MCO shall monitor non-Medicaid State and federally funded Network Providers in accordance with State and federal laws, rules, and regulations.

The LME/MCO will utilize the following information to monitor provider performance: focused monitoring reports, utilization management data, service effectiveness outcomes, data and reports submitted by the provider pursuant to the provider's contract with the LME/MCO, quality of care outcome measures and thresholds, incident, grievance, complaint and appeal records, and consumer satisfaction surveys. The LME/MCO shall provide training and technical assistance the LME/MCO deems necessary and practical to providers regarding administrative, clinical procedures and practices (including SOC, child and family teaming, family-driven, youth-guided foundational elements as well as requirements specific to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG or SABG) and Community Mental Health Services Block Grant (CMHSBG or MHBG).

LME/MCOs shall require Block-Grant funded providers to participate in the DMH/DD/SAS's Independent Peer Reviews in compliance with Federal Block Grant regulations. LME/MCO shall further require Block Grant funded providers to participate in clinical fidelity review monitoring and technical assistance processes for evidence-based practices.

6.5.1 Post-Payment Clinical and Administrative Reviews

The LME/MCO shall conduct post-payment reviews of non-Medicaid funded services to monitor whether services delivered are clinically appropriate and provided in accordance with the NC Administrative Code; the DMH/DD/SAS Records Management and Documentation Manual; the DMH/DD/SAS State Funded Enhanced Mental Health and Substance Abuse Services Manual and the DMH/DD/SAS Service Definitions; the Person-Centered Planning Instruction Manual; DMH/DD/SAS policies; and the NC General Statutes, as applicable.

The information below is related to accountability for State funds as well as to block grant funds as outlined in 42 USC 300x-5 and 300x-31 and 42 USC 300x-55:

- (1) LME/MCOs will develop and implement a policy and/or procedure mandating that the federal program requirements are conveyed to intermediaries and providers of block grant services.
- (2) The LME/MCO shall cooperate with DMH/DD/SAS monitoring activities of the LME/MCO's appropriate use of block grant and State fund, including:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Consumer level encounter/use/performance analysis data; and
 - f. Audits
- (3) LME/MCOs will implement payment method controls to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.

6.6 Technical Assistance to Providers

In order to foster a stable and high quality provider system, the LME/MCO may offer technical assistance to providers to assist them in navigating the MH/DD/SUD system. In order to promote a network of high quality evidence-based services, the LME/MCO may provide current ACT programs and current IPS-SE programs with training and technical assistance consistent with the current service definition requirements. The LME/MCO shall not be required to provide technical assistance that would be considered a normal operational procedure of a service provider. The LME/MCO shall not be required to provide technical assistance to a provider who has not assimilated previous technical assistance into its provider infrastructure.

6.7 Provider Disputes

The LME/MCO shall establish written procedures for dispute resolution with providers in accordance with the LME/MCO accrediting body requirements.

7.0 Access, Screening, Triage and Referral

7.1 Access/Customer Services Call Center

Pursuant to N.C.G.S. § 122C-115.4, the LME/MCO shall publicize and operate a toll-free telephonic Access/Customer Services call center designed to serve as a uniform portal of entry into care and receive a high volume of calls from consumers, family members, community stakeholders and others, with call response and abandonment rates within the State standard, defined as response rate of less than 30 seconds for more than 90% of calls and abandonment at 5% or less. When calling the access line, the consumer shall not be required to navigate an automated calling menu.

The Access/Customer Services call center shall be able to provide information about providers and community resources, accept complaints, and perform screening, triage, and referral, including telephonic crisis intervention. The LME/MCO shall publicize priority preference for substance abuse admission and treatment for injecting drug users and substance using pregnant women. The function of screening, triage, and referral is required to be completed by a Qualified Professional and /or by a licensed professional. A licensed clinician will be available for consultation. If the call is determined to be clinical in nature such as an individual needing a screening and triage either in routine, urgent or emergent type call, the customer call center staff will do a warm line transfer to an available qualified professional for screening, triage, and referral.

The LME/MCO shall host a direct, toll free TTY access line. The LME/MCO shall utilize a Relay Service (Telephone or Video) when telephonic assistance from a Relay Service is requested by a consumer. Foreign language interpretation shall be available at no cost to the caller in compliance with the Limited English Proficiency requirements of Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d.

The LME/MCO Access/Customer Services staff shall have electronic access to any crisis plans developed by providers of consumers receiving non-Medicaid services reimbursed by the LME/MCO. in order to expedite crisis services. The LME/MCO staff shall have the ability to schedule appointments within 24 hours of initial contact.

7.2 Screening

The LME/MCO shall collect all of the elements specified in the State's uniform screening tool for persons screened by the LME/MCO. Screening shall include an assessment of the urgency of the consumer's needs.

7.3 Triage and Referral

The LME/MCO shall refer consumers to the providers of the consumer's choice from among available providers contracted with the LME/MCO, subject to the following access standards:

- (1) In instances where there is immediate danger to self or others, the LME/MCO shall have procedures for immediate contact with local emergency responders. These procedures should include monitoring the individual's status until emergency responders arrive on the scene.
- (2) An Emergent need is a life-threatening condition in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self. When the individual's need is Emergent, the LME/MCO shall assure that the individual receives face to face services within two hours from the date and time of the LME/MCO's determination of the need for services.
- (3) An Urgent need is a condition in which a person is not imminently at risk of harm to self or others, but by virtue of the person's substance use or condition, could rapidly deteriorate to an Emergent need without immediate intervention and/or diversion. In instances where the individual presents with an Urgent need, the LME/MCO shall refer the individual to a provider capable of delivering face-to-face services within forty-eight hours of the request for services.
- (4) A Routine need is a condition in which the person describes signs and symptoms resulting in (1) impaired behavioral, mental or emotional functioning which has impacted the person's ability to participate in daily living or markedly decreased the person's quality of life, or (2) an impairment which can likely be diagnosed as a substance abuse disorder. In instances where the need is considered Routine, the LME/MCO shall refer the individual to a provider capable of delivering face-to-face services within 14 calendar days of the request for services.

The LME/MCOs shall report quarterly to DMH/DD/SAS a summary of consumers screened, triaged and referred, using the approved DMH/DD/SAS form and definitions.

7.4 Access to State Operated Facilities

A single-entry mechanism shall be in place for admission to and discharge from State operated institutions. The LME/MCO shall serve as the designee of the Director of the DMH/DD/SAS in approving admission to the appropriate 24-hour facility in accordance with N.C.G.S. § 122C-261(f)(4). In so doing, the LME/MCO shall first make every effort to identify an appropriate alternative treatment location prior to approving the admission to a State psychiatric hospital.

8.0 Service Management

8.1 Medical Director

The LME/MCO shall have a Medical Director who is employed or contracted in this position and responsible for the coordination of clinical policy and clinical monitoring between the LME/MCO and contracted providers. The LME/MCO Medical Director, or appropriately licensed designee, oversees the dissemination of clinical policy, monitoring of fidelity to evidenced-based models of care, coordination of ongoing education of providers in relation to best practices, quality management, and ongoing monitoring of consumer outcomes, and collaboration with other stakeholders, including DHHS medical leadership, within the LME/MCO catchment area.

8.2 Service/Benefit Design and Priority Populations

The LME/MCO shall adopt and publish annually, during the term of this Contract the benefit plan for non-Medicaid services that defines the available services and eligibility criteria for individuals in each DMH/DD/SAS benefit plan. The benefit plan shall be flexible to maximize the services that consumers may receive an adequate service array, within available resources. Nothing in this Contract shall be construed or interpreted as creating an entitlement to non-Medicaid services.

LME/MCOs shall authorize non-Medicaid funds for medically necessary services for DMH/DD/SAS-specified priority populations with mental health, intellectual or developmental disabilities or substance abuse disorders. The priority populations are as follows: (Numeric listing is not indicative of more or lesser priority.)

- 1) Individuals who are at risk of harming self or others;
- 2) High Risk consumer as that term is defined at N.C.G.S. Chapter 122C*
- 3) Young children who exhibit atypical patterns of social-emotional and behavioral development;
- 4) Children and adolescents with or at risk for serious emotional disturbance (SED);
- 5) Children with Co-occurring MI/SU or MI/DD
- 6) Individuals with a Serious Mental Illness (SMI) or Substance Use Disorder who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community;
- 7) Youth and young adults (ages 16 to 30) who experience a first episode psychosis (FEP);
- 8) Individuals with Severe and Persistent Mental Illness (SMI), who are not stable;
- 9) Individuals with Co-occurring MI/SU or MI/DD;
- 10) Individuals who are Homeless or at Risk of Homelessness;
- 11) Individuals with Traumatic Brain Injury (TBI) requiring services funded under this contract;
- 12) Individuals who are Criminal or Juvenile Justice System involved;
- 13) Individuals who are Deaf or Hard of Hearing;
- 14) Veterans, military service members and their families;
- 15) Individuals with complex medical disorders;
- 16) Individuals who are part of the TCLI target population of individuals with SMI or SMPI who are in or at risk of entry into adult care homes or who are discharged from a state psychiatric hospital with unstable housing;
- 17) Department of Social Services (DSS) involved adults (includes individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps); adult caregivers and children involved with CPS; children in DSS custody who have had more than two disrupted placements (due to behavioral issues) in therapeutic residential settings in a 12 month period; adult caregivers of children in DSS custody who are engaged in reunification efforts;

- 18) Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal Management (Level 3.2-WM to 4.0 WM);
 - 19) Individuals with an opioid use disorder;
 - 20) Individuals who inject illegal drugs or substances;
 - 21) Pregnant women who use alcohol and/or other drugs;
 - 22) Individuals with Communicable Disease Risk/HIV;
 - 23) Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD;
 - 24) Individuals with I/DD who are at risk of abuse, neglect or exploitation;
 - 25) Individuals with I/DD who are transitioning from institutions and residential placements; and
 - 26) Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement; and .
- 26) Individuals with co-occurring I/DD and MH disorders requiring psychiatric treatment and are at risk of losing I/DD habilitation services as a result of MH rehabilitation services

Within available resources LME/ must ensure continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services.

8.3 Service Definitions

The LME/MCO shall only authorize and fund services approved by DMH/DD/SAS, and only by providers qualified to provide such services. LME/MCOs can utilize existing approved statewide alternative service definitions or develop and request approval for new alternative service definitions to fill network adequacy and accessibility service needs not met with current service definitions. Services reported under alternative service definitions may be used to support performance measures, while non-UCR services cannot.

8.4 Crisis Services

As mandated by N.C.G.S. § 122C-117(a) (14), the LME/MCO shall provide a comprehensive crisis services system that includes a 24 hours per day/7 days per week/365 days per year crisis response service and access to a full array of crisis services.

To promote effective linkages between IDD Crisis Service providers, and Mobile Crisis providers, the LME/MCO will include within all Mobile Crisis provider contracts a requirement that a formal, written affiliation agreement be established and maintained with the IDD Crisis Service Providers in their regions. The agreements will be developed collaboratively between the Mobile Crisis Teams and IDD Crisis Services Providers and will outline the roles and responsibilities of both parties.

8.5 Cross Area Service Programs (CASP)

Any LME/MCO that receives State or federal funding for a Cross Area Service Program (CASP) to provide comprehensive regional or statewide services across multiple LME/MCOs, shall collaborate with the DMH/DD/SAS to designate a provider to receive such designated CASP funds to serve the needs of an identified population. The LME/MCOs responsible for CASP funding shall identify, use and track CASP funding and services as approved by the NC General Assembly and designated in DMH/DD/SAS allocation letters. The CASP is designated by the DMH/DD/SAS to receive specialty funding to provide comprehensive regional or statewide services across multiple LME/MCOs. Services are directed through a provider entity designated by the DMH/DD/SAS who meets LME/MCO credentialing criteria and is approved by the LME/MCO to serve the needs of an identified consumer population. A CASP contract cannot be terminated without DMH/DD/SAS approval. Services are targeted to eligible designated consumers and their families in an identified region or regions, but available to all eligible consumers and their families statewide as capacity allows.

Subject to designated CASP providers meeting LME/MCO credentialing requirements, LME/MCOs responsible for coordinating Cross Area Service Program funding will collaborate with the DMH/DD/SAS and recognize DMH/DD/SAS -designated Cross Area Service Program providers.

8.6 Person Centered Planning

The LME/MCO shall review and accept or reject Person Centered Plans (PCP) submitted with authorization requests for consumers receiving State funded services that require PCPs (including all consumers

transitioning out of State hospitals and adult care homes), and shall require contracted provider to comply with the requirements established in the DMH/DD/SAS Records and Documentation Manual. Approval or denial of service or treatment authorization requests associated with a complete PCP satisfies this requirement.

8.7 Service Authorization

The LME/MCO shall review requests for authorization for non-Medicaid funded services in accordance with the LME/MCO's benefit plan. The LME/MCO shall respond to properly completed and submitted routine non-Medicaid service authorization requests within 14 calendar days for at least 95% of requests; and expedited requests within three (3) working days, for at least 95% of requests.

Applicants for services and consumers who receive non-Medicaid funded services meet the eligibility criteria of the Service Definition, the Benefit Plan, or conditions placed on funds through the allocation letters, if such conditions are not inconsistent with the terms of this Contract. The LME/MCO shall maintain documentation to support this determination, and make it available to DMH/DD/SAS or its agents upon request.

8.7.1 Wait List for State Funded I/DD Service Requests

The LME/MCO shall develop and maintain a waiting list of persons with intellectual and/or developmental disabilities that are waiting for any State-funded IDD service as required by G.S. §122C – 112.1 (a) (35) and G.S. §122C-115.4 (b) (8). The wait list data should include number of persons who are waiting for any State funded service. The waitlist data shall be reported at least annually to the DMH/DD/SAS along with the methodology for adding or removing individuals from the waitlist.

8.7.2 Children with Complex Needs Settlement Requirements

In accordance with state statutes and the executed settlement agreement entered in *Disability Rights North Carolina v. Richard Brajer in his official capacity as Secretary of DHHS. Eastern District, Western Division, file number 5:16-cv-854*, and if funds are allocated to the LME/MCO for this purpose, LME/MCO shall designate a staff person to be the point of contact for Children with Complex Needs who will work with the DHHS Statewide Coordinator, and others involved in the provision of services for the child in accordance with the terms of that settlement agreement. In addition, LME/MCO will supply data and reports to DMH/DD/SAS as required under the agreement. Children with Complex Needs shall include the following: Medicaid eligible children between the ages of 5 and up to but under age 21 with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder, who are at risk of not being able to enter or remain in a community setting. The term "at risk" is defined for this purpose as acts or behaviors that present a substantial risk of harm to the child or to others.

8.7.3 Utilization Management

The LME/MCO shall evaluate the medical necessity, clinical appropriateness, efficiency, and effectiveness of requests for authorization of non-Medicaid services against established guidelines and criteria.

The LME/MCO shall have sufficient numbers of experienced and qualified utilization management staff to meet the terms of this Contract. Individuals who authorize services for individuals with mental health/substance abuse needs shall be at minimum Master's level Behavioral Health professionals licensed by the State of North Carolina with a minimum of two years post-Master's experience in a clinical setting with the population served or an equivalent combination of education and experience as determined by LME/MCO. Individuals who authorize services for individuals with intellectual/developmental disability needs shall be Qualified Professionals as defined at 10A NCAC 27G .0104(19).

8.7.3 Consumer Notification and Appeals of LME/MCO Service Authorization Decisions

The LME/MCO shall comply with the requirements of 10A NCAC 27G .7004 regarding the notification to consumers of decisions to deny, reduce, suspend or terminate non-Medicaid funded services and appeals of such decisions.

9.0 Care Coordination

9.1 Care Coordination Functions

The LME/MCO shall provide Care Coordination for high cost/high risk consumers in accordance with the requirements of N.C.G.S. §122C-115.4(b)(5). Clinical functions of care coordination shall be carried out by

licensed care coordination staff for MH/SA Care Coordination or by Qualified Professionals for Care Coordination for consumers with Intellectual/Developmental Disabilities as defined at 10A NCAC 27G .0104(19). Administrative care coordination functions may be carried out by non-licensed staff working in a consultative role with the clinical care coordination staff. Care Coordinators for the child/youth MH/SA population shall be trained in SOC, child and family team training and family-driven, youth-guided foundational elements.

The LME/MCO will collaborate with the discharging facility to schedule follow-up appointments for consumers who have been provided services in inpatient hospital units, facility based crisis services, and non-hospital medical detoxification services within seven (7) calendar days of discharge. The LME/MCO will attempt to contact consumers who do not attend scheduled appointments within five (5) calendar days of the missed appointment.

The LME/MCO shall have a written plan for addressing care coordination needs, including definition of priority populations, levels and types of care coordination tasks, referral pathways to and from medical care managers, other referral sources and resources, and objective outcome measures for care coordination effectiveness.

9.2 Care Coordination for Discharge from State Operated Psychiatric Hospitals, Alcohol and Drug Abuse Treatment Centers, Developmental Centers and Neuro-Medical Treatment Centers

The LME/MCO shall work collaboratively with DSOHF to ensure effective and timely planning for discharge and transition of consumers from DSOHF facilities to appropriate community or home-based providers in keeping with the discharge protocols outlined in the DSOHF contract, of the same year, with the LME/MCO.

9.3 Care Coordination for High Cost/ High Risk Consumers

Until such time as the Commission adopts another definition by rule the terms “high risk consumer” and “high cost consumer” mean as defined at N.C.G.S. 122C-115.4(f). This standard shall be applied separately to MH and SA age/disability groups in order to identify “high costs consumers” and the IDD individuals in need on the LME/MCO Innovations wait list. Within the “high cost/high risk” definitions, care coordination is prioritized for persons in need of MH/DD/SA services who are being discharged from State facilities, community hospitals, and crisis services who have no payer other than public/state non-Medicaid funds or whose inpatient stay is paid by LME/MCOs. Additionally those transitioning from State psychiatric hospitals, adult care homes, jails and prisons should be prioritized. The LME/MCO will monitor to ensure continuity of care during any transition between ACT and Tenancy Support, as well as any other service transitions for the TCLI population.

9.4 Assignment for High Risk/High Cost Children with Serious Emotional Disturbance (SED)

The LME/MCO, in working with high risk/ high cost children with serious emotional disturbance (SED) who receive non-Medicaid funded services, will consider the following factors in doing an initial or subsequent assessment and in cases where one or more of these factors is/are present will assign a Care Coordinator specializing in SED to the identified child :

- (1) First psychiatric hospitalization
- (2) Any psychiatric hospitalization at a State facility
- (3) Any private psychiatric hospital-stay with reauthorization for stay
- (4) Four or more hospitalizations in the child's lifetime
- (5) Readmission to psychiatric hospital within 30 days of discharge
- (6) Juvenile or Child, who is currently, or has been within the past 30 days, in a Youth Development Center or Youth Detention Center or Adult Detention Center operated by NC Department of Public Safety and for whom the LME/MCO has received notification of discharge or concern about an unmet mental health or substance abuse service need.
- (7) Child in DSS custody who has had 2 or more ~~than two~~ disrupted behavioral health residential placements in a 12-month period.
- (8) All PRTF placements
- (9) More than six months in any enhanced outpatient service
- (10) More than six months of residential care below PRTF
- (11) Three Moble Crisis Management calls 12 months prior to the assessment.
- (12) Two prior outpatient providers in 12 months prior to current request for services

- (13) Four or more psychotropic medications
 - (14) Two or more agencies involvement within a System Of Care (SOC) framework whose lack of consensus is adversely impacting treatment efficacy.
- Care Coordination for this population shall be provided in accordance with the SOC practice standards.

9.5 System of Care

9.5.1 System of Care for High Risk/High Cost Child SED Population

Subject to available funding allocated to the LME/MCO for this purpose, the LME/MCO shall monitor SOC implementation, practice and fidelity by their network providers utilizing the following criteria, to the extent that such criteria are required by the applicable Clinical Coverage Policy/ Service Definition:

- (1) Use Child and Family Teams (CFT) as the mechanism for developing Person Centered Plans (PCP), facilitate the planning process and convene the CFT at least once every 30 days.
- (2) Build each CFT around the youth and family to meet their unique needs; and include relevant public and private providers, schools and natural and community supports that actively participate in the implementation, monitoring and evaluation of the PCP.
- (3) Complete a strengths assessment process, in addition to the CALOCUS, that promotes the identification of the functional strengths of each youth, family and community and use them to build strategies included in the PCP which is based on the critical needs and unique strengths of the youth and family as identified by and in cooperation with the CFT, including sensitivity to racial, ethnic, linguistic and cultural differences of each family.
- (4) Promote service delivery within the context of families and develop strategies built on social networks and natural or informal supports.
- (5) Design strategies with consideration given to maximizing the skills and competencies of family members to create greater self-sufficiency for parents and youth
- (6) Make verifiable efforts for services and supports to be delivered in the community within which the youth and family live, using the least restrictive settings possible to preserve community and family connections and manage costs.
- (7) Regularly update the PCP to take into account changes with the youth and family, as well as the results of the supports and services provided, and document the shift of activity from formal supports to informal supports for greater self-sufficiency.
- (8) Develop and implement proactive and reactive crisis plans in conjunction with the PCP that anticipate crises and utilize family, team and community strengths to identify and describe who does what and when; every member of the CFT is provided a copy of the plan.

9.5.2 System of Care Coordinator

Subject to available funding allocated to the LME/MCO for this purpose, the LME/MCO shall employ or contract with an adequate and appropriate level of dedicated System of Care (SOC) Coordinators and staff for Child Mental Health and Child Substance Abuse Disorder comprehensive SOC planning, implementation, coordination, and training of SOC required core functions within all counties and providers of the LME/MCO's service area. These dedicated LME/MCO SOC Coordinators and staff shall develop, facilitate, integrate and evaluate the following required SOC core functions and responsibilities throughout the LME/MCO catchment area:

- (1) Provide Leadership and Involvement in the Community Collaborative(s): The SOC Coordinators and staff shall serve as staff to each city or county local community collaborative in the LME/MCO's service area, and shall recruit and maintain membership that includes family members, youth, child-serving agencies and a variety of community partners.
- (2) Promote Youth and Family Leadership and Involvement: The SOC Coordinators and staff shall foster participation and involvement of youth and families at all levels of the System of Care, include youth and family representation at each local collaborative, ensure that youth and families are leading their person-centered planning processes, and I provide and support leadership opportunities for youth and families.
- (3) Ensure SOC Fidelity: The SOC Coordinators and staff shall work with all provider agencies to ensure the fidelity of these agencies and their staff in the implementation of SOC principles and processes, and shall provide or facilitate regular consultation, technical assistance and training to provider agencies in SOC implementation fidelity.
- (4) Participate in Interagency Collaboration Efforts: The SOC Coordinators and staff shall work with the LME/MCO and other community agencies in identifying and responding to community needs, network adequacy and accessibility to service needs, shall participate in other interagency efforts

- in support of the behavioral health system, and shall provide information, education, and training to partner agencies to explain changes in the mental health system, as well as promote best practices in mental health and substance abuse disorder treatment and recovery services.
- (5) Provide SOC Consultation, Technical Assistance, and Training: The SOC Coordinators and staff shall regularly identify and respond to consultation, technical assistance and training needs of the collaboratives, provider agencies, families and LME/MCO staff, and shall either directly provide such SOC consultation, technical assistance, and training or facilitate the provision of such activities.
 - (6) Facilitate and Support SOC Quality Management Processes: The SOC Coordinators and staff shall take an active role in promoting LME/MCO and community-wide quality management processes in promoting services access, timeliness, appropriateness, quality, and effectiveness of care with youth and families, and advocating for the concerns of families, providers, and community partners in the regular evaluation and improvement of the effectiveness of the implementation of System of Care in local communities.
 - (7) Participation in DMH/DD/SAS Reporting, Coordination, and Monitoring Activities: The SOC Coordinators and staff shall complete and submit LME/MCO SOC Coordination Reports to the DMH/DD/SAS System of Care Coordinator. These Reports shall be submitted to DMH/DD/SAS in accordance with the DMH/DD/SAS requirements. LME/MCO SOC Coordinators and staff shall regularly participate in conference calls, webinars, meetings, trainings, conferences, and site visits in order to support a high level of statewide coordination, networking, monitoring, and evaluation for and with SOC Coordinators and staff. DMH/DD/SAS staff will conduct regular desk-top and on-site monitoring of System of Care functions and activities of SOC Coordinators and staff in order to monitor the implementation of these requirements as a central undergirding philosophy and practice in the planning and delivery of services to these child and family populations throughout the LME/MCO catchment area.

9.6 Outpatient Commitment

If the LME/MCO is timely served with a copy of the order and the consumer is eligible for LME/MCO services, the LME/MCO shall provide care coordination services for its consumers who are under an outpatient commitment order. This includes maintaining up-to-date records on each consumer in the catchment area with an outpatient commitment order including the name or names of their treatment provider(s) and documentation that the LME/MCO frequently and routinely contacts the service provider(s) to verify the consumer's compliance with the outpatient commitment order. If the LME/MCO, after reasonable efforts, cannot identify a known service provider or locate the individual under commitment, or determines that the individual has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the LME/MCO shall report such failure as required by N.C.G.S. § 122C-273.

10.0 Transitions to Community Living Initiative (TCLI)

10.1 Integrated Community Living

LME/MCO must perform Diversion, In-Reach, and Transition activities for the population specified in the August 2012 Settlement Agreement between the State of North Carolina and the U.S. Department of Justice (DOJ Settlement Agreement) and according to the requirements of this section.

LME/MCO shall make all services in the Transitions to Community Living Initiative (TCLI) benefit package included in the DMH/DD/SAS approved adult services array, including Peer Support Services, IPS-SE, and ACT, available to TCLI participants.

In addition to the other general provisions of this Contract related to special populations, the following activities are required for individuals in the TCLI Benefit Plan, as specified by DHHS, and shall follow the requirements outlined in the DOJ Settlement Agreement and subsequent DHHS-approved, related plans.

10.2 Transition Planning

Transition Planning refers to the process of developing a person-centered transition plan to assist an individual in transitioning from an Adult Care Home or State hospital to a more integrated community living arrangement. This plan shall be used by the treatment provider to develop the person-centered recovery treatment plan. All transition planning conducted or overseen by the LME/MCO shall be person-centered and follows the guidelines set forth by DHHS in support of the DOJ Settlement Agreement.

Subject to available funding allocated to the LME/MCO for this purpose, LME/MCO shall hire or contract for in-reach and transition staff who meet one of the following qualifications:

- (1) Care Coordinator
- (2) Certified Peer Support Specialist (must be Certified Peer Support Specialists within six (6) months of being hired).
- (3) Meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training.

Transition staff responsibilities:

- (1) Provide timely and effective discharge/transition planning
- (2) Develop an effective, person-centered transition plan for each TCLI participant that includes all required elements for a successful transition.

10.3 Diversion

The LME/MCO will employ staff or contract with an adequate number of staff to perform the requirements of the DOJ Settlement related to diverting individuals from admission to licensed Adult Care Homes. The LME/MCO will produce for the DMH/DD/SAS their criteria and analysis that demonstrates adequate staffing levels. The LME/MCO will:

- (1) Produce for the DMH/DD/SAS their criteria and analysis that demonstrates adequate staffing levels.
- (2) Develop a Community Integration Plan (CIP) that meets DHHS quality standards for all individuals in the TCLI priority population process of diversion. The CIPs must clearly document that the individual's decision was based on informed choice, and the degree to which the individual's decision has been implemented.
- (3) Review the diversion information to assess if Medicaid and/or non-Medicaid services, based on eligibility are offered to individuals whether moving to the community or to an Adult Care Home.
- (4) Connect individuals who have a CIP with services and supports that they are eligible for and determine if person is housing slot eligible.
- (5) Refer all individuals who choose to be admitted to an ACH for In-Reach, per the In-Reach requirements of the DOJ Settlement Agreement.

10.4 In-Reach

The LME/MCO must be able to demonstrate the sufficiency of staffing levels to perform In-Reach activities for the TCLI Population upon request by DMH/DD/SAS. In-Reach activities must include at a minimum the following and will be documented in the DHHS Transition to Community Living Database.

- (1) Explaining fully the benefits and financial aspects of clinically-appropriate community-based integrated settings, including supported housing;
- (2) Facilitating and accompanying individuals on visits to supported housing options/locations;
- (3) Assessing Adult Care Homes residents' interest in supported housing;
- (4) Exploring and addressing the concerns of any of Adult Care Home residents, or their guardians, who decline the opportunity to move to supported housing or who are ambivalent about moving to supported housing despite being qualified for such housing;
- (5) Coordinating tenancy support transitions to housing;
- (6) Explore the individual's interest in finding employment, provide basic benefits counseling/information, and/or continuing their education;
- (7) Reporting concerns about rights of individuals, suspected potential abuse, neglect, or exploitation that arise during the in-reach and transition process to the appropriate Department of Social Services in accordance with State law; and
- (8) Completing the DHHS In-Reach Tool for each individual.

10.5 Tenancy support services

Tenancy support services may be provided through ACT providers or through separate tenancy support providers. For those eligible for the TCLI benefit package, tenancy support services should be available at least twice per month for all individuals approved for a TCLI housing slot and not receiving tenancy support through ACT services.

10.6 TCLI Supportive Housing Efforts

The LME/MCO shall accomplish the milestones required under the Transitions to Community Living Initiative (TCLI) related to supportive housing for individuals in the TCLI Benefit Plan. A designated single point of contact (Housing Coordinator) at the LME/MCO shall be identified to coordinate all housing efforts and work closely with other TCLI team members. The LME/MCO shall fulfill the following general requirements:

- (1) Educate and be a resource of support to TCLI consumers, families and service providers in identifying, accessing and maintaining affordable housing,
- (2) Maintain minimum staffing levels through contracts or FTEs to to coordinate housing activities
- (3) Meet LME/MCO-specific housing goals as established annually by the DHHS on or before July 1 of each fiscal year. The Department and the LME/MCO will determine the number of slots it will fill for each year of the settlement agreement in accordance with NCGS §122C-20.10.

11.0 Community Collaboration

11.1 Community Relationships and Prevention Efforts

To the extent feasible, the LME/MCO shall collaborate with other public agencies, health care providers, and human services agencies within their catchment area for the benefit of non-Medicaid consumers. These include, but are not limited to: Departments of Social Services, Local Education Agencies, Local Health Departments, community hospitals, housing and homeless services agencies, vocational rehabilitation and employment agencies, domestic violence agencies, jails, detention centers, training schools, prisons, public schools, colleges and universities, law enforcement, courts, corrections agencies, Juvenile Court Counselors, and other primary healthcare providers, including rural and community health centers and Federally Qualified Health Clinics, and NC Department of Military and Veteran's Affairs or subsequent agencies.

The LME/MCO shall publicize its website, which includes information on the services available in the community, how consumers may access services, and how they may be assisted in navigating the service delivery system.

Subject to available funding allocated to the LME/MCO for this purpose, the LME/MCO shall engage in public awareness campaigns designed to reduce the stigma attached to disabilities, increase the visibility of the LME/MCO and MH/DD/SAS providers in the community, promote prevention, wellness and recovery activities including community, State and federally supported campaigns that promote healthy behaviors (e.g. mental health awareness month, recovery awareness, prevention day, etc.). Any public awareness campaigns (radio or television ads, billboards, etc.) must provide the appropriate LME/MCO contact information.

Subject to available funding allocated to the LME/MCO for these purposes, the LME/MCO shall participate in community-wide prevention and early intervention strategies, coalitions, and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.

A general list of these major initiatives includes the following:

- (1) The Synar Amendment;
- (2) Enforcing Underage Drinking Laws;
- (3) NC Controlled Substance Reporting System (CSRS)
- (4) other initiatives to educate and prevent underage access and use of tobacco and alcohol products and the misuse and abuse of prescription drugs;
- (5) Services and supports specific to military personnel and their families;
- (6) Prevention and community education efforts regarding suicide, violence and trauma, communicable disease risk, Fetal Alcohol Spectrum Disorders (FASD), and health disparities for Native Americans and other underserved racial, ethnic, cultural, and linguistic minorities; and
- (7) Prevention and early intervention services utilizing Evidence Based Practices.

Prevention services shall include information, consultation, education and instruction for the general population. Each LME/MCO shall develop a written plan for consultation and education services specifying populations that will be targeted and objectives to be obtained per 10A NCAC 27G .6801 and .6903.

11.2 Community Collaborative

The LME/MCO shall encourage and promote community collaboration between: (1) family members of a child receiving non-Medicaid services (2) public and private agencies that serve children and families; and (3) community partners. The LME/MCO shall report promptly upon request of DMH/DD/SAS on the participants and outcomes of its efforts to form such collaborations.

11.3 Division County Departments of Social Services (DSS) Offices

The LME/MCO will work with county DSS Leadership to develop protocols regarding difficult cases involving mutually shared consumer beneficiaries. The LME/MCO will provide to DMHDDSAS, quarterly rosters of the placements and locations of foster care children in therapeutic settings.

11.4 Natural and Community Supports

The LME/MCO shall work with other public, faith-based, and non-profit organizations to increase the service options available to individuals and to increase the availability of natural, community and recovery supports. The LME/MCO shall pursue opportunities to increase consumers' access to free or low cost medications, affordable housing, employment and other supports and services.

11.5 Disaster Emergency Response

The LME/MCO shall participate in the development of community disaster emergency response plans and shall work with its non-Medicaid funded providers to meet the behavioral health needs of the community in the event of a community-wide disaster or emergency situation. The LME/MCO shall designate an employee or subcontractor to participate in statewide disaster and emergency response planning with DMHDDSAS and the state Emergency Management (EM) agency within the Department of Public Safety (DPS). In the event of a disaster or emergency event, the designated person or organization will coordinate with the DMHDDSAS Disaster Response Coordinator for assistance and support to DPS/EM, Red Cross and other emergency support agencies.

12.0 Housing

12.1 Development of Housing Opportunities for Consumers

The LME/MCO shall work in collaboration with other public agencies and DHHS' housing staff to increase the expansion of supported housing opportunities available to persons with mental illness, intellectual/developmental disabilities, and/or substance use disorders.

12.2 Quarterly Meetings

LME/MCO shall send a representative to the four quarterly meetings of Housing Specialists that are offered by the DMH/DD/SAS housing staff.

12.3 Education and Outreach

LME/MCO shall collaborate with appropriate stakeholders to provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, and on negotiating reasonable accommodations including the following:

- (1) Collaborate with the Transition Team, DHHS professionals and their vendors along with other stakeholders to identify and secure housing.
- (2) Make available in multiple venues where service providers and other stakeholders convene, information to identify housing resources, expand knowledge of eligibility requirements for difference housing programs, how to access affordable housing resources, information to increase awareness of the Fair Housing Act, Americans with Disabilities Act, Landlord and Tenant Rights, barriers associated with Not In My Back Yard (NIMBY), and information to reduce stigma associated with mental illness, intellectual and developmental disabilities and substance use disorders.
- (3) Offer to provide technical support to Service Providers and Consumers on accessing housing, and the process of making Reasonable Accommodation request.
- (4) Appropriately link consumers to the Service System when housing is at risk of becoming destabilized.

12.4 Collaborative Relationships

LME/MCO shall use best efforts to develop a positive working relationship with local public housing authorities (PHA) and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources:

- (1) Regularly, strategically seek out means of establishing / nurturing partnerships with PHAs.
- (2) Gain knowledge of, and seek out ways to support PHAs' supportive housing plan.
- (3) Stay abreast of, and plan to attend at least one public meeting annually at a PHA in the catchment area.
- (4) Work toward the ability to include PHAs in 10-Year Plan, and other local housing meetings.

LME/MCO shall also use best efforts to establish partnerships with other local, affordable housing and MH/DD/SU advocates and stakeholders to improve access, increase the supply of resources for MH/DD/SU consumers, and identify and secure housing and support service funding opportunities from private, city/county, state, and federal sources:

- (1) Meet with property managers, and provide training opportunity for Landlords on supportive housing.
- (2) Maintain regular communication with area housing agencies, and supportive housing advocates
- (3) Gain knowledge of and strive to work collaboratively with local non-profits, developers, MH/DD/SAS stakeholders including NC Oxford House to encourage and support development of new supportive housing.
- (4) Arrange a site visit of newly opened Oxford Houses as made known within two months.
- (5) Gain knowledge of and strive to work collaboratively with local MH/DD/SAS advocates and stakeholders to encourage and support development of new supportive housing (participating jurisdiction, affordable housing providers, local Coalition, Center for Independent Living, etc.).
- (6) Work with existing partnerships to establish additional resources (i.e. additional vouchers, housing opportunities, and programs).
- (7) Identify potential housing development partners (i.e. Dept. of Social Services, city officials, faith community, public housing agencies, jail, prison, psychiatric hospitals, mental health, substance abuse, Intellectual Developmental Disability professionals and advocates).
- (8) Strive to enhance working knowledge of funding sources and how to successfully secure and utilize to increase the supply of permanent supportive housing.
- (9) Offer to provide technical assistance and support to identified agencies applying for state and federal funding opportunities (i.e. justification of need, providing data and information as it relates to available support services) as resources allow.

13.0 Development of Employment Opportunities for Consumers

Within available resources, the LME/MCO shall work with DMH/DD/SAS and the Division of Vocational Rehabilitation Services (DVRS) to increase employment outcomes for consumers aligning with Employment First principles and best practices for recovery, self-determination, and full community inclusion. LME/MCOs shall develop an organizational emphasis on community-based, integrated and competitive employment outcomes, including defining provider roles in promoting employment, and communicating that information to the providers. The LME/MCO shall also foster relationships with their local VR offices, Workforce Development boards, Department of Public of Instruction (DPI) post-secondary transition partners, and the NC Business Leadership Network.

Within available resources the LME/MCO shall:

- (1) Contract with providers for Supported Employment/Long Term Vocational Support (SE/LTVS) that serve individuals with MH/SU and IDD and meet fidelity to the approved model/service definition;
- (2) Prioritize access to the new evidence-based SE/LTVS model and service definition to individuals with MH/SU and IDD equally, including the DOJ Special Healthcare Population;
- (3) Collaborate with DMH/DD/SAS to develop Performance Improvement Plans and/or Clinical Practice Guidelines to include/increase employment as an outcome in the service array;
- (4) Identify and refer individuals who may benefit from transition to SE/LTVS;
- (5) Monitor LTVS allocations and ensure these funds are provided to eligible individuals, including those eligible individuals exiting DVRS employment services;
- (6) Track and report on employment performance outcomes and funding utilization quarterly to DMH/DD/SAS using approved reporting mechanism.

- (7) Partner with DMH/DD/SAS to implement fidelity monitoring, technical assistance processes, and training/education opportunities for employment providers and vocational staff as well as LME/MCO Care Coordinators, Community Guides, and other clinical staff.

14.0 Consumer Affairs and Customer Service

14.1 Supports to the Consumer and Family Advisory Council (CFAC) and the Human Rights Committee

The LME/MCO shall maintain and provide competent, qualified staff and support to the CFACs and Human Rights Committees to fulfill the functions of these committees. LME/MCO shall encourage staff to link with SOC Coordinators and Community Collaboratives for purposes of exchanging information between CFACs and collaboratives on issues related to children with behavioral health needs.

14.2 Consumer and Family Outreach, Education, and Handbook

The LME/MCO shall develop a Member Handbook and make it electronically available to persons receiving State-funded services. The Handbook should be designed to assist them in understanding the North Carolina public MH/IDD/SA system, member rights and responsibilities, complaint processes, and information about the non-Medicaid benefit plan. The LME/MCO shall publicize either through its website, targeted brochures, the Member Handbook or other means, that injection drug users and substance-abusing pregnant women have program admission priority.

14.3 Customer Services

The LME/MCO shall maintain, publish and staff a toll-free customer service line during normal business hours. This line may be the same as the toll-free number used for 24/7 screening, triage and referral. A customer service staff person shall respond to inquiries received on this line within one business day.

14.4 Complaints and Appeals Regarding Non-Medicaid Services

The LME/MCO shall respond to complaints and process appeals from consumers about non-Medicaid services in accordance with applicable provisions of State and federal laws, rules and regulations. The LME/MCO will resolve complaints within 30 days of receipt, for at least 90% of complaints. The LME/MCO shall report all required information regarding critical incidents and consumer complaints and appeals to DHHS in the manner and timeframes outlined in this Contract and shall report aggregate information on incidents, complaints and appeals to the LME/MCO governing Board, the human rights committee and CFAC quarterly.

15.0 Quality Management

15.1 Identification and Remediation of Problems and Consumer Adverse Events

The LME/MCO shall have a process for timely identification, response, reporting, and follow-up to consumer incidents. The LME/MCO shall require contracted providers to report Level II and Level III incidents, as those terms are defined at 10A NCAC 27G .0602, in the NC Incident Response Improvement System. The LME/MCO shall monitor and respond to critical incidents in accordance with the requirements of 10A NCAC 27G .0608 and to ensure the health and safety of consumers. The LME/MCO shall report aggregate information on incidents and deaths to the LME/MCO Board, the Human Rights committee and the CFAC quarterly. The LME/MCO shall ensure that provider contracts include a requirement to comply with applicable critical incident and death reporting laws, regulations, and policies and event reporting requirements of national accreditation organizations. The LME/MCO shall review, investigate, and analyze trends in critical incidents, deaths, and take preventive action to minimize their occurrence.

15.2 Management Reports

The LME/MCO shall produce reports referenced in Attachment II and use them for planning, decision making, and improvement. The reports shall analyze and summarize patterns and trends related to consumers, providers, and LME/MCO operations.

15.3 Quality Management and Performance Improvement Projects

The LME/MCO shall establish a quality improvement committee to review LME/MCO and provider responses to individual and network concerns and problems and address opportunities for improvement of LME/MCO operations and the provider network. The committee shall have a process for reviewing and incorporating trends and input from providers, consumers, family members, and other stakeholders into its

decisions. The LME/MCO shall conduct quality improvement studies as needed and provide the results of these studies to the Board, the CFAC, and, on request to DHHS.

The LME/MCO shall conduct and maintain a minimum of three (3) performance improvement projects. Topics for performance improvement projects shall be identified through consumer, family, provider, and stakeholder surveys, performance measures, quality improvement studies, and continuous data collection and analysis. The LME/MCO shall give priority to projects that address initiatives of the NC General Assembly and DHHS

Any projects developed and implemented in accordance with this Contract may also be used to meet the requirements of LME/MCO's accreditation body and DMA. Reports on all performance improvement projects shall be submitted to DMH/DD/SAS no later than August 31 of each year.

15.4 Consumer Surveys

The LME/MCO shall participate with DHHS in the collection of information on the experiences of individuals receiving MH/IDD/SA services, including the annual Consumer Perception of Care Survey and the National Core Indicators Survey. Upon request from DMH/DD/SAS, the LME/MCO shall follow up with a specific respondent about his/her stated concerns within a reasonable time period. The LME/MCO shall use the results to address areas of concern and identify potential areas for improvement.

ATTACHMENT II — PERFORMANCE EXPECTATIONS

1.0 Process for Monitoring and Reporting of Local System Quality and Compliance

1.1. Quarterly Reports on Performance

The DMH/DD/SAS shall evaluate the LME/MCO's overall performance of the Scope of Work of this Contract through compliance with reporting requirements, and statewide measures of service quality, as described in this Attachment. DMH/DD/SAS shall calculate and release quarterly the LME/MCO's performance on indicators identified in this Attachment.

1.2. Correction of Errors

If the LME/MCO believes information in the quarterly performance data to be erroneous, the LME/MCO shall contact the DMH/DD/SAS LME/MCO Liaison within fifteen (15) days of the release of the data referenced above to request a data review. The LME/MCO shall provide evidence to support the request and to assist DMH/DD/SAS to make a determination concerning the request. Acceptable evidence shall include but not be limited to documentation that information that was submitted to DMH/DD/SAS by the end of the month prior to the release date was erroneously included or excluded. DMH/DD/SAS shall provide a final written response to the LME/MCO within fifteen (15) days of receiving the LME/MCO's request, unless DMH/DD/SAS notifies the LME/MCO of need for a fifteen (15) day extension. After final written response, DMH/DD/SAS shall use the corrected version of the data for all future distribution, reporting and analysis and measurements set forth in section 4.0.

2.0 Compliance with DHHS Reporting Requirements

The LME/MCO shall submit to DMH/DD/SAS, in a format that meets DHHS approval, reports on performance measures in this Contract that cannot be determined by DMH/DD/SAS from submitted shadow claims and other required information needed to monitor LME/MCO adherence to the requirements of this Contract. When self-reported by the LME/MCO, the DMH/DD/SAS or its representatives may review the source data to verify that the information submitted is accurate.

The DHHS shall calculate the LME/MCO's compliance with requirements for reporting information, as described in this Contract. The DHHS shall review measures to identify comparative patterns and trends in order to evaluate areas of strength and weakness in the LME/MCO's compliance.

The LME/MCO shall submit complete and accurate data required by DMH/DD/SAS for tracking of information on individuals enrolled with the LME/MCO to receive public MH/DD/SA services and providers contracted to provide those services, including information on consumer eligibility for services, fee-for-service service claims and shadow claims, and demographics, adverse events and service outcomes for consumers served by the LME/MCO. All data shall be submitted on a schedule provided by the DMH/DD/SAS for each data system. All consumers shall be cross-referenced in the DHHS Common Name Data Service. The LME/MCO shall require contract providers to comply with reporting requirements for data that providers submit directly to DHHS data systems and shall monitor such compliance. The DHHS shall maintain a current listing of all reporting requirements on the DMH/DD/SAS website at <http://www.ncdhhs.gov/divisions/mhddsas>

2.1 TCLI Special Healthcare Population

Special reporting is required to measure progress in the Transitions to Community Living Initiative. The LME/MCO must track all services received by individuals that fall under any of these characteristics of the TCLI benefit plan population:

- (1) Individuals with SMI who reside in an adult care home determined by the State to be an IMD;
- (2) Individuals with SPMI who are residing in ACHs licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness;
- (3) Individuals with SPMI who are residing in ACHs licensed for between 20-49 beds in which 40% or more of the resident population has a mental illness;
- (4) Individuals with SPMI who are or will be discharged from a State Psychiatric Hospital and who are homeless or have unstable housing;

- (5) Individuals diverted from entry into ACHs pursuant to the pre-admission screening and diversion process;
- (6) Individuals provided and referred to supported employment (data must be reviewed and validated by LME/MCO);
- (7) Individuals in the In-Reach process; and
- (8) Individuals in the TCLI Benefit Package.

Additional reporting may be required by the August 2012 USDOJ Settlement Agreement and subsequent monitoring of progress, and these additional reporting requirements will be negotiated between the parties as an amendment to this Contract.

Complete data shall be entered into the TCLI reporting system by the 10th of each month for the previous month's information.

3.0 System Performance Indicators

DMH/DD/SAS shall use the measures in this section to monitor the LME/MCO's performance on outcome measures and performance indicators. DMH/DD/SAS may use performance on one or more of the performance measures in Section 3.0 to evaluate the LME/MCO's readiness to participate in specific DMH/DD/SAS initiatives. DMH/DD/SAS may monitor LME/MCO performance at catchment area, sub region, and/or county level.

The three categories of performance measures, standards and remediation for unsatisfactory performance are described below:

- 1) Administrative Function Indicators, which have a standard established in Attachment I Scope of Work of this Contract. These indicators are reported monthly by the LME/MCO.
 - a) The Administrative Function Indicators and standards are as follows:
 - i) Percent of calls abandoned (Standard – 5% or less)
 - ii) Percent of calls answered within 30 seconds (Standard – 95% or higher)
 - iii) Percent of psychiatric inpatient readmits assigned to Care Coordination (Standard – 85% or higher)
 - iv) Percent of routine authorization requests processed in 14 days (Standard – 95% or higher)
 - v) Percent of expedited authorization requests processed in 3 days (Standard – 95% or higher)
 - vi) Percent of claims processed within 30 days (Standard – 90% or higher)
 - vii) Percent of complaints resolved in 30 days (Standard – 90% or higher)
 - b) Unsatisfactory performance is defined as not meeting the indicated standard.
- 2) Performance Measures are listed in this section of Attachment II. Benchmarks are set annually for each measure. Performance Measures are reported quarterly by the LME/MCO for measures that cannot be calculated by DHHS.
 - a) A minimal standard and optimal benchmark is assigned to each performance measure and may be based on national data or standards, best practice, or performance achieved historically by LME/MCOs in North Carolina.
- 3) Watch Measures are a designated subset of the Performance Measures. These indicators are reported quarterly, by the LME/MCO for measures that cannot be calculated by DHHS.
 - a) Unsatisfactory performance is defined as not meeting the Minimum Standards set by DMH/DD/SAS.
 - b) Indicators with a denominator less than ten shall be exempt from consideration of performance, with the exception of TCLI.
- 4) Clinical Indicators: are intended to describe whether consumers' symptoms of behavioral health diagnoses have abated such that the behavioral health issue is mitigated and/or under control. The members of the Quality Management Director's Forum shall work with DHHS to identify five additional Watch Measures to begin to assess the clinical outcomes of consumers receiving treatment, services and supports. One of the measures is to be directed at measuring TCLI consumers uninterrupted housing longevity. These five measures will be submitted to DHHS for the Secretary's review by

December 1, 2018. Three of the measures will be selected for addition to the Watch Measures identified in this contract with data collection beginning January 1, 2019.

Performance Measures

3.1. Prevention and Early Intervention Indicators

3.1.1. Selective and Indicated Substance Use Prevention Services

Measure: The percent of at-risk youth (ages 6-17) who complete an evidence-based selective or indicated substance use prevention program each Report Period, as a percentage of persons estimated to be in need according to the most recent data available from the National Survey on Drug Use and the NC Youth Risk Behavior Survey.

Source: SAPTBG Semi-Annual Report

3.2. Access to Community Care Indicators

3.2.1 Access to Timely Emergent Care

Measure: The percent of calls to the LME/MCO's Call Center during the quarter where the caller was in need of emergent mental health, intellectual or developmental disabilities, or substance use services and received a face-to-face service (assessment and/or treatment) within 2.25 hours of the request for care. Emergent calls referred to 911 for safety/medical reasons will be counted as seen within time requirements.

Source: LME/MCO self-report from call center records.

3.2.2. Access to Timely Urgent Care

Measure: The percent of calls to the LME/MCO's Call Center during the quarter where the caller was in need of urgent mental health, intellectual or developmental disabilities, or substance Use services and received a face-to-face service (assessment and/or treatment) within 2 calendar days of the request for care.

Source: LME/MCO self-report from call center records.

3.2.3. Access to Timely Routine Care

Measure: The percent of calls to the LME/MCO's Call Center during the quarter where the caller was in need of routine mental health, intellectual or developmental disabilities, or substance abuse services and received a face-to-face service (assessment and/or treatment) within 14 calendar days of the request for care.

Source: LME/MCO self-report from call center records.

3.2.4. Penetration Rates

Measure: The percent of eligible population (Medicaid enrollees and uninsured persons) who received at least one MH/IDD/SA service during the report period.

Reported separately by Age/Disability:

- (1) Adult MH
- (2) Child MH
- (3) Adult SUD
- (4) Child SUD
- (5) Adult I/DD
- (6) Child I/DD

Source: Claims/Encounters

3.3. Inpatient and Institutional Care Indicators

3.3.1. Short Term Care in State Psychiatric Hospitals

Measure: The percent of persons with stays in a State psychiatric hospital for seven days or less.
Source: HEARTS

3.3.2. Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment

Measure: Number of admissions, discharges, and average length of stay for persons discharged from psychiatric inpatient facilities for acute mental health care.
Source: Claims/Encounters

3.3.3. Admission Rate and Length of Stay in Community Hospitals for Substance Use Disorder Treatment

Measure: Number of admissions, discharges, and average length of stay for persons discharged from community hospitals for acute care for a substance use disorder.
Source: Claims/Encounters

3.5 Transitions to Community Living Initiative (TCLI) Measures

3.5.1 TCLI Housing Goals

Measure: The percent of the LME/MCO's monthly housing slots filled
Source: TCLI Subsidy Administrator Report
Benchmark: 100% of the monthly total of the annual requirement

3.5.2 IPS-Supported Employment Goals

Measure: The percent of the LME/MCO's monthly number of required individuals served by fidelity IPS-SE providers
Source: LME/MCO Self-Report (DMH/DD/SAS validated)

3.5.3 Community-Based Mental Health Services in Place Prior to Transition

Measure: The percent of persons who transitioned to supportive community housing with tenancy support services in place 30 days prior to transition
Source: TCLI Subsidy Administrator Report and Claims/Encounters

3.5.4 Transition within 90 days

Measure: The percent of persons who transitioned to supportive housing within 90 days of assignment to a transition team
Source: TCLI Subsidy Administrator Report

3.5.5 Timely Quality of Life Survey Completion

Measure: The percent of Quality of Life surveys completed before individuals' transition dates or within 30 calendar days before or after 11- and 24-month anniversaries in supportive housing
Source: TCLI Subsidy Administrator Report and participant Quality of Life Surveys submitted to DHHS.

4.0 Watch Measures

4.1 Access & Engagement

4.1.1 Initiation of Substance Use Disorder Services

Measure: The percent of persons who initiated treatment for a substance use disorder within 14 days of the diagnosis (initiation).

Source: Claims/Encounters

4.1.2 Engagement in Substance Use Disorder Services

Measure: The percent of persons who had at least two additional services for substance use disorder within 30 days of the initiation visit (engagement).

Source: Claims/Encounters

4.1.3 Initiation for Persons receiving Mental Health Services

Measure: The percent of persons who initiated treatment for a mental health disorder within 14 days of the diagnosis (initiation).

Source: Claims/Encounters

4.1.4 Engagement for Persons Receiving Mental Health Services

Measure: The percent of persons who had at least two additional services for that diagnosis within 30 days of the initiation visit (engagement).

Source: Claims/Encounters

4.1.5 Timely Support for Persons with Intellectual or Developmental Disabilities

Measure: This measure provides the percent of persons with intellectual or developmental disabilities (IDD) starting a new episode of care during the measurement period who receive a billable service within 45 days of approval of their initial Individual Service Plan (ISP).

4.2 High End Services

4.2.1 Crisis Care in Emergency Departments

Measure: The percent of all visits to local emergency departments that are for principal mental health, developmental disabilities, or substance use disorder diagnoses.

Source: NCDETECT & NC Medicaid Data

4.2.2 Emergency Department Readmissions

Measure: This measure provides the number and percent of persons admitted to an emergency department during the measurement period that are readmissions to an emergency department for mental health, intellectual or developmental disabilities, or substance abuse services within 30 days of a prior discharge.

Source: Claims/Encounters

4.2.3 State Hospital Readmissions within 30 days and 180 days

Measure: The percent of persons readmitted to a State psychiatric hospital within 30 and 180 days of discharge.

Source: Claims/Encounters

4.2.4 ADATC Readmissions within 30 days and 180 days

Measure: The percent of persons readmitted to a State alcohol and drug treatment facility within 30 and 180 days of discharge.

Source: HEARTS and claims/encounters

4.2.5 Community MH Inpatient Readmissions within 30 Days

Measure: The percent of persons readmitted to a community inpatient hospital, facility based crisis service, or psychiatric residential treatment facility for MH treatment within 1-30 days of discharge.

Source: Claims/Encounters

4.2.6 Community SUD Inpatient Readmission within 30 Days

Measure: The percent of persons readmitted to a community inpatient hospital or detox/facility based crisis service for substance use disorder treatment within 1-30 days of discharge.
Source: Claims/Encounters

4.3 Continuity and Coordination

4.3.1 Follow-Up after Discharge from a State Psychiatric Hospital

Measure: The percent of persons discharged from a State psychiatric hospital who receive a community-based service within seven calendar days.
Source: HEARTS and claims/encounters

4.3.2 Follow-Up after Discharge from State Alcohol and Drug Abuse Treatment Center

Measure: The percent of persons discharged from ADATCs who receive a community-based service within seven calendar days.
Source: HEARTS and claims/encounters

4.3.3 Follow-Up after Discharge from Community Mental Health Inpatient Treatment

Measure: The percent of persons discharged from a community hospital for mental health treatment who receive a community-based outpatient visit, intensive outpatient encounter or partial hospitalization service within seven calendar days and within 30 calendar days.
Source: Claims/Encounters

4.3.4 Follow-Up after Discharge from Community Substance Use Disorder Inpatient Treatment

Measure: The percent of persons discharged from an inpatient facility for substance use disorder treatment who receive a community-based outpatient visit, intensive outpatient encounter or partial hospitalization service within seven calendar days and within 30 calendar days.
Source: Claims/Encounters

4.3.5 Follow-Up after Discharge from a Community Crisis Service

Measure: The percent of persons discharged from a community-based crisis service (emergency department, mobile crisis management, facility based crisis, and detox) who receive a community-based or State facility service within three calendar days.
Source: Claims/Encounters

4.3.6 Medical Care Coordination (All Populations)

Measure: The percentage of continuously enrolled Medicaid enrollees under the 1915 b/c waiver who received a behavioral health (MH/IDD/SA) service during a moving one-year measurement period that also had at least one primary care or preventive health service during that period. For persons ages 7-20, the measure looks for a primary care or preventive health service over a two-year period (the measurement year and the year prior).
Source: Claims/Encounters

4.4 Social Determinants

The LME/MCO shall incorporate a preliminary environmental review of the availability and needs for community supports for social determinants of health for the catchment area within the Network Adequacy and Accessibility Analysis described in the Scope of Work 6.1 Adequacy of the Provider Network.

4.4.1 Employment

4.4.2 Housing

4.4.3 Transportation

4.4.4 Food Insecurity

5.0 Benchmarks and Penalties

Beginning January 1, 2019, the following measures shall have a performance standard and corresponding penalty for each measure not met. Data is reported monthly and the results will be averaged on a quarterly basis and compared against the performance standard. The quarters used will be standard set traditional quarters. Penalties for each quarter will be assessed in the second month following the data reporting. LME/MCO shall be subject to a separate penalty for each standard not met.

The measure of how many consumers are transitioned to housing is the exception to the quarterly reporting and penalty schedule. Calculation for achieving the targeted numbers of persons housed will be assessed one time per year during the reporting cycle in which DHHS submits reporting for the Transition to Community Living to the federal Department of Justice.

| Measure | Performance Standard | Penalty |
|---|-----------------------------|------------------|
| Follow Up After Discharge (MH): State Psychiatric Hospital, Facility Based Crisis & Community Mental Health Inpatient within 1-7 days | 40% Quarterly | \$150,000 |
| Follow Up After Discharge (SUD): State ADATC, Facility Based Crisis & Community SUD Inpatient Treatment within 1-7 days | 40% Quarterly | \$150,000 |
| Number identified in housing at the time of the NC report to federal DOJ | | \$50,000 maximum |

5.1 Performance Expectation Dispute Resolution

In addition to the correction of errors process set out above in section 1.2, if the LME/MCO disputes the assessment of a penalty as set out in section 4.0, the LME/MCO shall submit, within fifteen (15) days of receipt of notification of the penalty assessment, its dispute, including the factual and legal basis, in writing delivered with receipt confirmation via overnight mail, email, or facsimile transmission addressed to the Director of the DMH/DD/SAS or his designee. Upon receipt of the dispute, the Director/designee shall review the disputed penalty and within thirty (30) days of receipt, with additional time as may be mutually agreed in writing, the parties shall use reasonable efforts to attempt to resolve the dispute. The goal of this informal resolution process shall be to resolve potential claims before they escalate to litigation. Within the time-frame stated the Director/designee shall schedule telephone and/or face to face meetings as he/she, in his discretion, believes are necessary in order to achieve resolution without conflict where possible. The parties shall each act in good faith in attempting to resolve the matter during the informal resolution process. Within ten (10) days following the end of the informal resolution process, unless a settlement is agreed to in writing signed by each party, the Director/designee shall issue his decision. If the LME/MCO is not satisfied with that decision, the LME/MCO may invoke any legal or administrative remedy available to it under State law. Nothing contained herein shall abate or stay any penalty from continuing to accrue in accordance with Section 4 above, unless the LME/MCO obtains a stay from a tribunal of competent jurisdiction.

ATTACHMENT III — FINANCING

1.0 Administrative

1.1 Determination and Use

The LME/MCO administrative funding shall be up to 12% of the amount of non-Medicaid single-stream funding allocated in the prior year. The LME/MCO is responsible for covering administrative costs related to management of non-Medicaid state and federally-funded services within this amount, as well as LME/MCO functions described more fully in the Scope of Work.

Funds provided under this contract by DMH/DD/SAS to the LME/MCO for administration are to be utilized for required functions outlined in N.C.G.S. Chapter 122C, as well as the following functions related to the management of State and non-Medicaid federally funded services, and those more fully described in the Scope of Work:

1. General Administration and Governance;
2. Business Management and Accounting;
3. Information Management Analysis and Reporting;
4. Claims Processing;
5. Provider Relations, Monitoring and Support;
6. Access, Screening, Triage, and Referral;
7. Service Management;
8. Utilization Management;
9. Community Collaboration;
10. Care Coordination;
11. Transitions to Community Living Initiative;
12. Housing;
13. Consumer Affairs and Customer Service, including support of the CFAC; and
14. Quality Management.

Division funding for administration shall not be utilized to fund the administration of the Medicaid service delivery system. There is no annual settlement for administrative funding, however LME/MCOs are required to provide evidence of all administrative expenditures for each function listed above on the monthly Financial Reporting tool, and, upon request, provide backup documentation.

2.0 Increase or Reduction in Funding

In the event DMH/DD/SAS receives an increase in State appropriated funding and/or an increase in federal funding for community MH/DD/SA services, or if the State or federal funding is reduced, the State and federal allocations may be adjusted in accordance with the formula used for all other LME/MCOs. The LME/MCO will be allowed to use up to 12% of expansion service funding or additional allocations for administration. If funding is reduced or de-allocated during the term of this Contract, the LME/MCO may use 12% of the original funding allocation for the year for administrative expenses as required by the funding source, and determined by the Division to best meet the needs of the MH/IDD/SUD/TBI priority populations. When time and allocation requirements permit, DMH/DD/SAS will consult with representatives from LME/MCOs to obtain feedback on proposed changes in funding distribution.

In the event DMH/DD/SAS receives an expansion or reduction in SABG or MHBG funding, allocations to LME/MCOs may be adjusted by DMH/DD/SAS, in accordance with the requirements set forth by the SAMHSA award. The LME/MCO is required to follow the DMH/DD/SAS currently approved SABG and MHBG funding plans, and requirements set forth in the allocation letters.

3.0 Services Funding

3.1 Enrollment, Reporting and Submission of Claims

Except as allowed herein, the LME/MCO shall use State and federal non-Medicaid funds only to purchase services included in the state-funded service array or as specified on the allocation letter or approved as an alternative service. The LME/MCO shall report services through the NCTracks claims system, unless the funds were allocated on a Non-UCR basis, or the LME/MCO chooses to reimburse the provider on a Non-UCR basis. For services paid for pursuant to UCR-funded methodology, the LME/MCO shall enroll individuals into the appropriate population group and report service units to NCTracks. Reporting shall contain accurate and complete content to allow either (a) claims payment through the appropriate source of federal funds not included in single stream funding or (b) processing as shadow claims data that is accepted in NCTracks (not denied). LME/MCO shall adhere to requirements set forth in allocation letters, when such requirements are consistent with the terms of this Contract

The LME/MCO shall submit to NCTracks (or current State claims system) an electronic claim for every service reimbursed by the LME/MCO within 15 business days of the close of the month in which the service was paid or processed, or the DMH/DD/SAS timely filing deadline for prior year dates of service, whichever comes first. The LME/MCO shall correct 90% of claim denials in NC Tracks within 30 calendar days and 95% within 45 calendar days. Notwithstanding the foregoing, the LME/MCO shall not be deemed in non-compliance with these standards if the issues cannot be corrected due to issues arising from NC Tracks. The LME/MCO shall conduct data validation of all data it submits to NCTracks.

3.2 Alternative Services

If the LME/MCO desires to contract with providers for services not included in the State-funded service array, or the list of alternative services approved by DMH/DD/SAS, the LME/MCO shall submit the LME/MCO Alternative Service Request for Use of DMH/DD/SAS State Funds request form. DMH/DD/SAS will respond with approval, denial or a request for more information regarding the alternative service request within fifteen (15) days of receipt. DMH/DD/SAS shall notify all LME/MCOs of alternative services approved for each LME/MCO within thirty (30) days of such approval. If an alternative service is already approved for another LME/MCO, the LME/MCO may choose to offer such service and shall notify DMH/DD/SAS in writing prior to implementation. If a new service code and/or rate is required, the LME/MCO shall not begin to use the new code or rate prior to the date that DMH/DD/SAS specifies as the implementation date for the new service or rate.

3.3 Non-UCR Expenditures

LME/MCO may choose to pay for unique services or fund innovative projects that cannot be reported through the UCR/claims methodology.

For State Single Stream funds to be accounted for as Non-UCR the LME/MCO shall submit a report to include the following:

- 1) Purpose of the funding,
- 2) Provider name and location,
- 3) Type of expenditure (capital, start-up, operations, services),
- 4) Start and end date,
- 5) Disability area
- 6) Expected number served and
- 7) Proposed method for the collection of outcome data to evaluate the investment.

DMH/DD/SAS must ensure that expenditures meet block grant requirements, including MOE. If the non-UCR funds are in support of a service that is also eligible to bill through NC TRACKS, the LME/MCO shall assure that the combination of total UCR and non-UCR funding paid is no more than the actual cost of the service.

For Federal funds and Special Categorical State funds, the LME/MCO shall submit the Fund Realignment Request Form to move funds from UCR to Non-UCR, with an explanation for the transfer attached (this form is also used to move funds between accounts or from Non-UCR to UCR). DMH/DD/SAS will respond with approval, denial or a request for more information regarding the Fund Realignment request within fifteen (15) days of receipt. If no timely response is received, the LME/MCO may proceed as if approved.

3.4 Reinvestments

3.4.1 Reinvestment Plans

It is the overarching goal of DHHS to ensure that the LME/MCOs are prepared to become Tailored Plans while also continuing to make necessary investments in their catchment regions to sustain services and systems-of-care for the residents of North Carolina. In accordance with S.L. 2018-5, the Current Operations Appropriations Act of 2018, DHHS must use the LME/MCO reinvestment plans for these purposes in the calculation of Solvency reports to submit to the General Assembly as representation of the overall funds available to the behavioral health system in the state. To accomplish these goals, LME/MCOs shall submit their board-approved reinvestment plans after November 2018 to the Department for consideration and approval.

3.4.2 Reinvestment Plan requirements

As part of that submission, and also for approval, LME/MCOs will describe all intended expenditures to fund preparation activities to ready themselves to bid on and possibly become Tailored Plans. The reinvestment plan submission will provide:

- a) Descriptions of the purpose of the funding, noting capital or labor expenses, the recurring nature of the cost, and what to-date has already been spent towards completing the project.
- b) The nature of the project, and how it broadly aligns to the readiness of the LME/MCO as outlined by the readiness requirements established by the DHHS.
- c) In total – the overall ratio of expenses between internal readiness reinvestments versus the investments in community services.
- d) A narrative of how the ratio of investment for internal readiness preparations and total investment in the community varies from past expenses.

3.4.3 Reinvestment Plan Criteria

DHHS will provide specific guidance, formatting, and timelines for Reinvestment Plan submission and will evaluate the submitted Plans in accordance with the following broad criteria:

- a) The continuity of community investment over time and efforts by the LME/MCO to meet unmet need in community.
- b) The per-member or per-population investments being made in the community.
- c) The strategies driving the reinvestments in preparing for transition to a Tailored Plan,
- d) how efficient the strategies are, and
- e) how the reinvestment elements align to a broader risk-based strategy preparatory to transition.

4.0 Single Stream Payment Plan and Settlement Methodology

DMH/DD/SAS shall distribute to each LME/MCO not less than one twelfth of each LME/MCO's Single Stream Fund (SSF) continuing allocation on a monthly basis, subject to adjustments and availability of funds allocated by the General Assembly for this purpose. DMH/DD/SAS shall reimburse LME/MCOs for Non-UCR State Special Categorical funds and Non-UCR Federal funds after the LME/MCO has expended the funds and reported the expenses on the FSR schedule. Provider contracts shall specify the Federal aid category when Federal funds are utilized to reimburse the provider.

The Parties shall adhere to the following settlement methodology:

1. LME/MCOs must submit allowable shadow claims and non-UCR expenditures (services/expenses that have been funded with single stream funding but cannot be submitted to DMH/DD/SAS via claims) in an amount equal to 90% of the SSF for the period July 1 through June 30 each fiscal year.
2. DMH/DD/SAS will provide guidance on the settlement process, including required documentation in advance of settlement review. An on-site review will be scheduled upon completion of the LME/MCO contracted certified external audit and the close of the timely filing deadline each year.
3. The written report will be completed and sent to the LME/MCO within 120 days after the on-site review is completed.

4. The LME/MCO must supply, in a timely manner, all documentation necessary to complete the settlement process. Failure to provide adequate documentation may result in settlement expenditure disallowances.
5. Preliminary findings are provided to the LME/MCO in draft report format to provide the LME/MCO with an opportunity ask questions and provide clarifying information including but not limited to additional documentation to DMH/DD/SAS.
6. If the final settlement report indicates that the LME/MCO must submit a payback of funds. The resolution and appeals process will be conducted in accordance with G. S. 150B.

5.0 Federal Grant Maintenance of Effort

The LME/MCO shall meet or exceed the DMH/DD/SAS designated Maintenance of Effort (MOE) requirements necessary to meet federal grant requirements.

6.0 State Fund Balance

For these purposes, State fund balance is comprised of any state funds allocated by DMH/DD/SAS that were not expended in prior fiscal years. The LME/MCO may retain 12% of its unrestricted State fund balance. In the event the unrestricted State fund balance for any year is in excess of the twelve percent (12%) which the LME/MCO may retain, the fund balance amount above 12% shall be handled in accordance with 10A NCAC 27A .0111. Any State funds received from DMH/DD/SAS remaining at the end of the fiscal year shall be maintained in a State fund balance, separate from operations and other fund balances. Any funding received as the direct result of funding sources or revenues not received directly pursuant to the terms and conditions of this Contract, including but not limited to funds obtained through savings achieved under the 1915(b)/(c) Waiver and Medicaid risk reserve funds, shall not be considered part of the unrestricted State fund balance.

The following shall be excluded from the DHHS determination of the 15% unrestricted fund balance: (a) any portion of State fund balance that is designated as restricted by the LME/MCO Board and approved by DMH/DD/SAS; and (b) funds otherwise required to be reserved by North Carolina General Statutes or as otherwise determined to be reserved by the independent auditor.

In order to expend State fund balance dollars, the LME/MCO must request Division approval from the DMH/DD/SAS in writing at least 60 days prior to the proposed expenditure. At minimum, requests shall include: (i) amount of funds requested for designation by purpose, (ii) a detailed justification for the proposed utilization of the funds requested for designation by purpose, including a timetable for expending the designated funds, (iii) impact analysis, by purpose, if the request(s) to designate funds is not approved by the DMH/DD/SAS, and (iv) a copy of the LME/MCO Board minutes which reflect the Board's approval to request the designation of such funds.

7.0 Disallowances

Any funds or part thereof transferred by DHHS to the LME/MCO shall be subject to reimbursement by the LME/MCO to DHHS in the event the expenditure of those funds is disallowed pursuant to a State or federal audit. When those funds are disallowed by DHHS, the LME/MCO may recoup those funds back from the provider and the provider shall have no right of appeal.

8.0 Restrictions on the Expenditure of Substance Abuse Prevention and Treatment Block Grant (SAPTBG or SABG) Funds and Community Mental Health Services Block Grant (CMHSBG or MHBG) Funds

CMHSBG and SAPTBG funds are prohibited to be used to provide or purchase inpatient hospital services, except for SAPTBG funds that may be used with exception as described in 45 CFR 96.135 (c)*.

CMHSBG and SAPTBG funds are prohibited to be used to make, or to allow to be made, any cash payments to any recipients or intended recipients of health or MH/DD/SA services.

CMHSBG and SAPTBG funds are prohibited to be used for the purchase or improvement of land, purchase, construction or permanent improvement (other than minor remodeling) of any building or other facility, or purchase of major equipment, including medical equipment.

CMHSBG and SAPTBG funds are prohibited to be used to satisfy any requirement for the expenditure of non-Federal funds as a condition of receipt of Federal funds. (i.e. Federal funds may not be used to satisfy any condition for any State, local or other funding match requirement).

CMHSBG and SAPTBG BG funds are prohibited to be used to provide financial assistance to any entity other than a public or nonprofit private entity.

CMHSBG and SAPTBG funds are prohibited to be used towards the annual salary of any LME/MCO, provider, or contractor employee, consultant, or other individual that is in excess of Level I of the most current US Office of Personnel Management federal Executive Salary Schedule.

SAPTBG funds are prohibited to be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

SAPTBG funds are prohibited to be used to provide individuals with treatment services in penal or correctional institutions of the State (This includes jails, prisons, adult and juvenile detention centers, juvenile training schools, etc.)

PATH formula grant funds shall not be expended:

- a) to support emergency shelters or construction of housing facilities;
- b) for inpatient psychiatric treatment costs or inpatient substance abuse treatment costs;
- or
- c) to make cash payments to intended recipients of mental health or substance abuse services, except as permitted by 45 CFR § 96.135(c).

Note exception for substance abuse inpatient hospital services under the SAPTBG is as follows:

45 CFR Part 96.135(c) Exception regarding inpatient hospital services.

(3) With respect to compliance with the agreement made under paragraph (a) of this section, a State (acting through the Director of the principal agency) may expend a grant for inpatient hospital-based substance abuse programs subject to the limitations of paragraph (c)(2) of this section only when it has been determined by a physician that:

- a. The primary diagnosis of the individual is substance abuse, and the physician certifies this fact;
- b. The individual cannot be safely treated in a community-based, non-hospital residential treatment program;
- c. The Service can reasonably be expected to improve an individual's condition or level of functioning;
- d. The hospital-based substance abuse program follows national standards of substance abuse professional practice; and

(4) In the case of an individual for whom a grant is expended to provide inpatient hospital services described above, the allowable expenditure shall conform to the following:

- a. The daily rate of payment provided to the hospital for providing the services to the individual shall not exceed the comparable daily rate provided for community-based, non-hospital, residential programs of treatment for substance abuse; and
- b. The grant may be expended for such services only to the extent that it is medically necessary, i.e., only for those days that the patient cannot be safely treated in a residential, community-based program.

State Certifications

Contractor 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:
(a) He or she is a duly authorized representative of the Contractor named below;
(b) He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and
(c) 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:

Alliance Behavioral Healthcare

Contractor's Authorized Agent:

Signature

DocuSigned by: Rob Robinson 28AAF53BDC1D48A...

Date 10/15/2018 | 4:55 PM

Printed Name

Rob Robinson

Title

CEO

Witness:

Signature

DocuSigned by: Carol Wolff 32469A999D1F461...

Date 10/16/2018 | 7:19 AM

Printed Name

Carol wolff

Title

General Counsel

The witness should be present when the Contractor's Authorized Agent signs this certification and should sign and date this document immediately thereafter.