

Tailored Plan Good Faith Contracting Efforts Policy							
Partners Health Management							
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POLICY

Partners' policy is to make good faith efforts (a minimum of three timely attempts) to contract with a qualified contracting entity. The good faith efforts are extended to Tribal Member Services/Indian Health Care Providers, Essential Providers, Network Adequacy Providers, and all other Out of Network Providers for continuity of care or any willing and qualified provider. These good faith contracting efforts apply to qualified providers for both Medicaid and/or State-funded services to the full extent required by law and contract with the NC Department of Health and Human Services (NCDHHS).

PROCEDURE

- I. **Scope** - This document describes procedural guidelines for determining good faith efforts during the contracting process by Partners.
- II. **Purpose** - To outline the process for good faith efforts during the contracting process and to provide tracking procedures of the good faith efforts.
- III. **Procedure** - Partners will offer a contract, with appropriate reimbursement methodology for the provider type, to any willing and qualified provider that is enrolled in North Carolina Medicaid to the extent required by law or contract with the North Carolina Department of Health and Human Services (NCDHHS). Partners will manage its network to meet availability, accessibility and quality goals and requirements. In developing its network, Partners will negotiate with any willing and qualified provider in good faith regardless of provider or Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan (Tailored Plan) affiliation. The Tailored Plan shall have a strong monitoring program to ensure providers are meeting member/recipient needs and program requirements.

Partners will offer to contract with the qualified provider in writing as outlined in this policy. Partners and all subcontractors will not use exclusivity or non-compete provisions in contracts with providers, including non-medical service providers, e.g., non-emergency medical transportation drivers; will not require a provider to participate in the governance of a Physician Lead Entity (PLE); or otherwise prohibit a provider from providing services for or contracting with any other Tailored Plan.

Partners and all subcontractors will consider all facts and circumstances surrounding a provider's willingness to contract prior to entering into the good faith efforts based on the following:

1. Tribal Member Services/Indian Health Care Provider
2. Essential Provider
3. Network Adequacy Provider
4. All other Out of Network Providers for continuity of care for the member

5. Provider enrolled with North Carolina Medicaid

Partners will not require individual practitioners, as a condition of contracting, to agree to participate in or accept other products offered by Partners, nor will practitioners be automatically enrolled in any other product offered. This requirement will not apply to facility providers.

Definition of Good Faith Effort:

The Good Faith Effort begins when the provider receives a version of the contract which is consistent with the version approved by NCDHHS and includes the standard provisions for provider contracts found in Attachment G. Required Standard Provisions of the Behavioral Health I/DD Tailored Plan and Provider Contracts, including the prescribed provisions located therein. This definition applies to qualified providers contracting to provide Medicaid and/or State-funded Services to the full extent required by law or contract with NCDHHS.

The initial contract offering will serve as the first effort. If the provider does not execute the first effort, Partners will make a second effort at least 10 calendar days after the first effort, taking into consideration any feedback from the provider. If the provider does not execute the agreement after the second effort, Partners will make a third and final effort, at least 10 calendar days after the second effort, taking into consideration any feedback from the provider from the previous efforts. Partners will have exhausted all good faith contracting efforts after the third and final effort. The good faith contracting effort period must be at least 30 calendar days, but Partners may allow additional time if discussions are ongoing, contract revisions are being made or negotiated, the contract is under legal review by the provider or if in the opinion of Partners, such additional time could lead to an executed contract. If after at least 30 days and the three good faith attempts, the provider does not respond to the efforts verbally or in writing, the request to join the network will be considered rejected.

Example of Good Faith Efforts:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1 Contract received by Provider (first attempt)	2	3	4	5	6	7
8	9	10	11 Partners requests contract (second attempt)	12	13	14
15	16	17	18	19	20	21

22 Partners requests contract (third attempt)	23	24	25	26	27	28
29 Final Determination Letter mailed to the provider.	30	1	2			

Reimbursement Requirements:

With the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, Partners shall be prohibited from reimbursing an out of network provider more than 90% of the Medicaid Fee-for-Service rate if the Tailored Plan has made a good faith effort to contract with a provider but the provider has refused that contract.

Unless an agreement has been negotiated, Partners shall reimburse an out of network provider at one hundred percent (100%) of the Medicaid Fee for Services rate for physical health and pharmacy services when Partners has not made a “good faith” effort to contract with the provider in accordance with this policy and BH, I/DD, TBI services when Partners has not made a “good faith” effort to contract with the qualified provider in accordance to this policy or Partners has exercised its authority to maintain a closed network (aka “qualified network”) for these services as set forth in NC Gen.Stat § 108D-23.

Partners, or any subcontractor to the extent that the subcontractor is delegated responsibility by the BH I/DD Tailored Plan by Partners for coverage of services and payment of claims under the contract, shall not include exclusivity or non-compete provisions in contracts with providers or otherwise prohibit a provider from providing services for or contracting with any other BH I/DD Tailored Plan.

Tracking of Good Faith Contracting Effort:

- Contracts and amendments are sent via DocuSign to obtain electronic signatures.
- The contract/amendment sent date and completion date are entered on the contract tracking log. This spreadsheet is maintained by the Provider Network Contracts department.

- Signing status is also tracked within DocuSign. DocuSign is also set to send a reminder email every three days to the person who needs to sign.
- Contact demographic information is managed on the provider email addresses spreadsheet. This spreadsheet includes name and address of person responsible for signing contract/amendments, the Employer Identification Number (EIN), mailing address and phone number. This spreadsheet is maintained by the Provider Network Contracts department and updated as information is received from the Provider Network Enrollment department.

Each good faith effort will be logged and tracked on the Partners Good Faith Contracting Effort tracker. The grid will capture provider demographic information to include location, specialty, tax identification number (TIN), national provider identification number (NPI), point of contact requesting contract, Partners' contracting representative, final determination of the Good Faith Contracting Effort process, and sent date of Good Faith Contracting Final Determination letter.

Communication of Final Determination of Good Faith Contracting Effort:

If after the third and final effort both parties are not able to come to a mutual agreement, a Good Faith Contracting Effort Final Determination letter will be sent to the address given by the provider within five business days after the final decision. The letter will include the reason for the decision, any right of the provider to appeal the decision, and how to request an appeal.

Regulatory references include but are not limited to:

- Rules/Regulations: N.C. Gen. Stat. § 108D-23 ("Entities operating BH IDD tailored plans shall develop and maintain a closed network of providers only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services.")
- NCQA:
- NC DMH/DD/SAS Contract:
- DHB Contract: RFA Section V,A-B, pages 195 (good faith as to Indian Health Care Providers), 199 ((alternative arrangement in contracting with Essential Providers and Department regional exceptions), 203 (good faith efforts for providers of physical health and pharmacy services), 206 (no exclusivity or non-compete clauses with providers), 222-223 (out of network provider payments and BH I/DD Tailored Plan authority to maintain a closed network under N.C. Gen. Stat. § 108D-23."); RFA Sections V.C-VI pages 46-47 (exceptions to network requirements); RFA Sections V.C-VI Page 51 (no exclusivity or non-compete clauses with providers);and Section VII. RFA Attachments Pages 39 (deadline for this policy), 79 (Attachment G Required Standard Provisions for BH I/DD Tailored Plan and Provider Contracts for Medicaid), 167 (no exclusivity or non-compete clauses in NEMT provider contracts),
- MCO P, P &Ps:

REVISION CHRONOLOGY SECTION

Revision Approval Date	Reason for Revision
Click here to enter a date.	Click here to enter text.
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