EVALUATE MEDICAID AND NC HEALTH CHOICE BEHAVIORAL HEALTH PROVIDER CLASSIFICATION

Session Law 2016-94, Section 12H.15

Report to the

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

By

North Carolina Department of Health and Human Services

December 1, 2016

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I. Introduction

Session Law 2016-94, Section 12H.15. (see ***Appendix A***), requires the Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA), in collaboration with statewide behavioral health stakeholders, to evaluate the classification of providers delivering behavioral health services, other than Critical Access Behavioral Health Agencies (CABHAs), as high categorical risk provider types and propose an evaluation tool to be used to classify the categorical risk of different behavioral health providers.

Under Federal Law 42 CFR § 455.450 (see ***Appendix B***), state Medicaid agencies must screen all initial and revalidation provider applications for enrollment in Medicaid. The rigor of these screenings depends on whether the particular provider falls into a "limited," "moderate," or "high" categorical risk level for fraud, waste, and abuse.

For those categories of providers deemed to pose limited risk, DMA is only required to verify that the provider meets all federal and state requirements applicable to the provider type, verify licensure, and conduct federal database checks. For moderate risk providers, DMA must perform the limited screening plus conduct an on-site visit. For high risk providers, DMA must perform the limited and moderate screenings plus require provider fingerprinting and conduct a criminal background check.

With some exceptions, states have discretion to determine the risk level applied to provider types, including behavioral health providers. North Carolina has designated the categorical risk of each provider type at NCGS § 108C-3 (see ***Appendix C***). Currently §108C-3(g)(2) designates all "[a]gencies providing behavioral health services, excluding Critical Access Behavioral Health Agencies" as high risk.

This high risk designation currently impacts approximately 7,200 behavioral health providers who are enrolled in NC Medicaid either directly or through a Local Management Entities-Managed Care Organization (LME-MCO). These providers are required to go through the high risk screening process upon initial enrollment with Medicaid and during revalidation, which is required by federal law every 5 years.

The purpose of this report is to evaluate the current designation of behavioral health providers as high risk for fraud, waste, and abuse and propose an evaluation tool that will allow a more nuanced approach to determining the categorical risk of different types of behavioral health providers.

II. Evaluation and Stakeholder Collaboration

DMA first met internally to discuss behavioral health service provider types that are currently deemed high risk and methods of evaluating the risk level posed by these providers. DMA had reviewed federal and State law and drafted a categorical risk tool prior to Session Law 2016-94. DMA used the initial tool as the foundation for the final tool included with this report.

Following the initial assessment, DMA identified and reached out to behavioral health stakeholders across the state who are impacted by risk categorization and developed a plan for

stakeholder collaboration. Stakeholders who participated in the collaborative process included LME-MCOs, provider and professional associations, a consumer organization, and individual providers.

To foster collaboration, DMA created a stakeholder listserv to disseminate information and receive questions, comments, and recommendations. DMA also scheduled several stakeholder meetings to facilitate discussion on risk categorization and the development of a categorization evaluation tool. All stakeholder meetings were held on Dorothea Dix campus with a call-in option. Stakeholders were given the opportunity at meetings and via the listserv to review and provide feedback on the draft evaluation tool. Please see ***Appendix D*** for a list of stakeholders who participated. Please see ***Appendix G*** for a list of questions received from stakeholders and answers as provided by DMA through the listserv.

Stakeholder Recommendations Included:

1. Using the tool for all Medicaid and Health Choice provider types.
2. Classifying providers who have been suspended from the Medicare program as high categorical risk.
3. Separating Licensed Independent Practitioners (LIPs) into three distinct categories for evaluation:
    a. LIP Professionals: This category would include licensed behavioral health providers who were directly enrolled with Medicaid before the LME-MCO system was established. These practitioners want to see Medicaid clients with their other mix of clients from the community.
    b. Group LIP Practices: This category would include group behavioral health practices, which are likely interdisciplinary, but usually only provide outpatient services such as assessment, therapy, and medication management. They are enrolled with LME-MCOs as "agencies," but they need to be differentiated from the large enhanced agencies which provide a larger array of services.
    c. Agencies: This category would include large agencies that employ LIPs and provide a range of enhanced services.
4. Lowering the categorical risk for providers with national accreditation.
5. Increasing the categorical risk for providers who lose national accreditation to high.
6. Adding a definition for "agency" in NCGS §108C-2 or otherwise revising the language of NCGS §108C-3(g)(2) to clarify who is covered by that provision. Currently §108C-3(g)(2) uses the language "[a]gencies providing behavioral health services." However, agency is not defined in the statute; only "provider" is defined in the statute. This creates confusion. For purposes of this report, "agency" is defined as a provider delivering behavioral health services, excluding directly enrolled outpatient behavioral health service providers (which are covered under §108C-3(g)(3)) and CABHAs.
7. Continuing collaboration between DMA and stakeholders during the evaluation process.
8. Evaluating directly enrolled outpatient behavioral health service providers under §108C-3(g)(3) as well as providers under §108C-3(g)(2), excluding CABHAs.

DMA took all stakeholder feedback and recommendations into account in writing this report and finalizing the categorization evaluation tool in ***Appendix E***.

III. Classification Evaluation Tool

The Classification Evaluation Tool is comprised of two parts: (1) the Evaluation Tool for Behavioral Health Provider Categorical Risks (see ***Appendix E***), and (2) the DMA Guidelines for Behavioral Health Provider Categorical Risk (see ***Appendix F***).

The Evaluation Tool is designed to score the categorical risk level of each provider type. The tool contains 14 risk evaluation questions, which the reviewer scores as "met" or "not met." The more questions that are marked as "met," the higher the score. The tool also contains four risk reduction questions, which the reviewer scores as "yes" or "no." For every question answered "yes," the score is reduced by one. The higher the final score, the higher the categorical risk. The tool has a dedicated section to document the final disposition and list the person(s) conducting the review. Categorical risk levels are determined by a composite score as follows:

- High Categorical Risk: 11-14 (79% - 100%) of the Questions Answered "Met"
- Moderate Categorical Risk: 6-10 (42% - 78%) of the Questions Answered "Met"
- Limited Categorical Risk: 0-5 (0% - 41%) of the Questions Answered "Met"

The Guidelines offer guidance on how to score each question in the Evaluation Tool to ensure consistency in scoring. Relevant state and federal regulations are listed for each question for reviewers to use as a reference. All data from the date of enactment of §108C-3 through December 2016 will be included in the evaluation.

Used together, the Evaluation Tool and Guidelines are intended to ensure objective risk categorization across behavioral health providers types. DMA has identified behavioral health providers in the following care settings to be individually evaluated:

- Assertive Community Team
- Mobile Crisis Management
- Multi-systemic Therapy
- Partial Hospitalization
- Professional Treatment Services in Facility-Based Crisis
- Psychosocial Rehabilitation
- Substance Abuse Comprehensive Outpatient Program
- Substance Abuse Intensive Outpatient Service
- Substance Abuse Medically Monitored Community Residential Treatment
- Substance Abuse Non-Medical Community Residential Treatment
- Psychiatric Residential Treatment
- Ambulatory Detoxification
- Non-Hospital Medical Detoxification
- Medically Supervised or ADATC Detoxification Crisis Stabilization
- Outpatient Opioid Treatment
- Residential Treatment Services-Level II -IV

IV. Next Steps

DMA will begin collaborating with stakeholders on the evaluation process. As DMA proceeds, the Evaluation Tool and Guidelines may require further development and refinement. Following this evaluation, DMA will develop recommended legislative changes and expects to submit statutory amendments to §108C for the 2017 long session of the General Assembly as needed.

V. Appendices

Please see the appendices that follow for documentation referenced in the report.

Appendix A: Session Law 2016-94, Section 12H.15.

EVALUATE MEDICAID AND NC HEALTH CHOICE BEHAVIORAL HEALTH PROVIDER CLASSIFICATION
SECTION 12H.15.

The Department of Health and Human Services, Division of Medical Assistance (Department), in collaboration with statewide behavioral health stakeholders, shall evaluate the classification of agencies providing behavioral health services, other than Critical Access Behavioral Health Agencies (CABHAs), as high categorical risk provider types in accordance with G.S. 108C-3(g)(2) and propose an evaluation tool to be used to classify the categorical risk of different categories of behavioral health agencies. The Department shall consider current federal and State law and include any recommended legislative changes. By December 1, 2016, the Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

Appendix B: 42 CFR § 455.450 Screening Levels for Medicaid Providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(a) *Screening for providers designated as limited categorical risk.* When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following:
  (1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.
  (2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with §455.412.
  (3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with §455.436.

(b) *Screening for providers designated as moderate categorical risk.* When the State Medicaid agency designates a provider as a "moderate" categorical risk, a State Medicaid agency must do both of the following:
  (1) Perform the "limited" screening requirements described in paragraph (a) of this section.
  (2) Conduct on-site visits in accordance with §455.432.

(c) *Screening for providers designated as high categorical risk.* When the State Medicaid agency designates a provider as a "high" categorical risk, a State Medicaid agency must do both of the following:
  (1) Perform the "limited" and "moderate" screening requirements described in paragraphs (a) and (b) of this section.
  (2) (i) Conduct a criminal background check; and (ii) Require the submission of a set of fingerprints in accordance with §455.434.

(d) *Denial or termination of enrollment.* A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its—
  (1) Application denied under §455.434; or
  (2) Enrollment terminated under §455.416.

(e) *Adjustment of risk level.* The State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:
  (1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.
  (2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

Appendix C: NCGS § 108C-3. Medicaid and Health Choice provider screening.

(a) Provider Screening. - The Department shall conduct provider screening of Medicaid and Health Choice providers in accordance with applicable State or federal law or regulation.

(b) Enrollment Screening. - The Department must screen all initial provider applications for enrollment in Medicaid and Health Choice, including applications for a new practice location, and all revalidation requests based on Department assessment of risk and assignment of the provider to a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(c) Limited Categorical Risk Provider Types. - The following provider types are hereby designated as "limited" categorical risk:

(1) Ambulatory surgical centers.
(2) End-stage renal disease facilities.
(3) Federally qualified health centers.
(4) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.
(5) Histocompatibility laboratories.
(6) Hospitals, including critical access hospitals, Department of Veterans Affairs Hospitals, and other State or federally owned hospital facilities.
(7) Local Education Agencies.
(8) Mammography screening centers.
(9) Mass immunization roster billers.
(10) Nursing facilities, including Intermediate Care Facilities for the Mentally Retarded.
(11) Organ procurement organizations.
(12) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and audiologists), optometrists, dentists and orthodontists, and medical groups or clinics.
(13) Radiation therapy centers.
(14) Rural health clinics.
(15) Hearing aid dealers.
(16) Portable X-ray suppliers.
(17) Religious nonmedical health care institutions.
(18) Registered dieticians.
(19) Clearinghouses, billing agents, and alternate payees.
(20) Local health departments.

(d) When the Department designates a provider as a "limited" categorical level of risk, the Department shall conduct such screening functions as required by federal law.

(e) Moderate Categorical Risk Provider Types. - The following provider types are hereby designated as "moderate" categorical risk:

(1) Ambulance services.
(2) Comprehensive outpatient rehabilitation facilities.
(3) Critical Access Behavioral Health Agencies.
(4) Repealed by Session Laws 2013-378, s. 6, effective October 1, 2013.
(5) Hospice organizations.
(6) Independent clinical laboratories.
(7) Independent diagnostic testing facilities.
(8) Pharmacy Services.
(9) Physical therapists enrolling as individuals or as group practices.

(10) Revalidating adult care homes delivering Medicaid-reimbursed services.

(11) Revalidating agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.

(12) Revalidating agencies providing home or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).

(13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home infusion.

(14) Nonemergency medical transportation.

(f) When the Department designates a provider as a "moderate'" categorical level of risk, the Department shall conduct such screening functions as required by federal law and regulation.

(g) High Categorical Risk Provider Types. - The following provider types are hereby designated as "high" categorical risk:

(1) Prospective (newly enrolling) adult care homes delivering Medicaid-reimbursed services.

(2) Agencies providing behavioral health services, excluding Critical Access Behavioral Health Agencies.

(3) Directly enrolled outpatient behavioral health services providers.

(4) Prospective (newly enrolling) agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.

(5) Agencies providing HIV case management.

(6) Prospective (newly enrolling) agencies providing home or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).

(7) Prospective (newly enrolling) agencies providing personal care services or in-home care services.

(8) Prospective (newly enrolling) agencies providing private duty nursing, home health, or home infusion.

(9) Providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the cessation of the payment suspension.

(10) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector General or another state's Medicaid program within the previous 10 years.

(11) Providers who have incurred a Medicaid or Health Choice final overpayment, assessment, or fine to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid and Health Choice in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine.

(12) Providers whose owners, operators, or managing employees were convicted of a disqualifying offense pursuant to G.S. 108C-4 but were granted an exemption by the Department within the previous 10 years.

(h) When the Department designates a provider as a "high" categorical level of risk, the Department shall conduct such screening functions as required by federal law and regulation.

(i) For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.

(j) For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Health Insurance Program for Children agencies of other states. (2011-399, s. 1; 2013-378, s. 6.)

Appendix D: Stakeholder List

External Organizations	Invited	Attended
National Alliance on Mental Illness	Yes	Yes
Cardinal Innovations	Yes	Yes
Mental Health Coalition	Yes	No
Eastpointe	Yes	Yes
NC Provider Council	Yes	Yes
Smoky Mountain Center	Yes	Yes
Trillium	Yes	Yes
Partners	Yes	Yes
BenchMarks	Yes	Yes
National Association of Social Workers	Yes	Yes
Alliance	Yes	Yes
Autism Society	Yes	Yes
Coastal Horizons	Yes	No
NC Council	Yes	Yes
NC Psychiatric Association	Yes	Yes
NC Psychological Association and Professional Association Council	Yes	Yes
North Carolina Community Health Center Association	Yes	Yes
Sandhills	Yes	Yes
Medicaid Investigation Unit, NC Department Of Justice	Yes	Yes

Appendix E: Evaluation Tool for Behavioral Health Provider Categorical Risks

	PROVIDER TYPE:			
	REVIEW DATE(S):			
	SCORING:			
	REVIEW ITEM:	**Met**	**Not Met**	**Comments**
1.	Does the provider type have greater than __**%** involvement with payment suspensions?			
2.	__% of overall provider types on Payment Suspension?			
3.	Does the provider type have greater than __% involvement with credible allegations of fraud?			
4.	__% of overall provider types identified with credible allegations of fraud			
5.	Does the provider type have greater than ___% involvement with prepayment review?			
6.	__% of overall provider types on Prepayment Review?			
7.	Does the provider type have greater than _% involvement on the OIG Exclusion List for NC?			
8.	__% of overall provider types on the OIG Exclusion List for NC?			
9.	Does the provider type have greater than__% involvement on the State Exclusion List?			
10.	__% of overall provider types on the State Exclusion List?			
11.	Does the provider type have greater than__% involvement with identified Overpayments?			
12.	__% of overall provider types involvement with identified Overpayments?			
13.	Is there a Quality of Care concern identified for the provider type based on formal State or National study?			
14.	Is there a Moratorium placed on the provider type?			
	RISK REDUCTION ITEMS	**Yes**	**No**	**Comments**
15.	Is there a Policy in place for the provider type?			
16	Is there accreditation in place for the provider type?			
17.	Is there a licensure requirement in place for the provider type?			
18.	Is there an Evidence-Based Treatment (EBT) Model in place for the provider type?			

Total MET:	**0**
% MET:	**0%**
TOTAL NOT MET :	**0**
% NOT MET:	**0%**
Overall %	**0%**
Risk Reduction (Items 15 - 18)	

COMMENTS:

Key: Categorical Risk Determination
High Categorical Risk: 11-14 Answered "MET" or 79% - 100%
Moderate Categorical Risk 6-10 Answered "MET" or 42% - 78%
Limited Categorical Risk: 0-5 Answered "MET" or 0% - 41%
Final Disposition:
Reviewer (s):

Appendix F: DMA Guidelines for Evaluating Behavioral Health Provider Categorical Risk

	Questions	Guidelines	State and Federal Regulations
1.	Does the provider type have greater than __**%** involvement with payment suspensions?	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers involved with payment suspensions during the specified time period. If the % of provider type is at ____% or above, the reviewer will respond with" met." If the provider type is below _____% the reviewer will respond with "not met".	**42 CFR 455.23 NCGS 108C-5**
2.	__% of overall ***(insert name of service)*** providers on Payment Suspension?	Reviewer will rate the provider type based on the % of overall ***(insert name of service) p***roviders on payment suspensions. If the % of ***(insert name of service) p***roviders on payment suspension is above _____% then the reviewer will respond with "met." If the % of ***(insert name of service)*** providers on payment suspension is below _____%, the reviewer will respond with "not met."	**42 CFR 455.23 NCGS 108C-5**
3.	Does the provider type have greater than __% involvement with credible allegations of fraud?	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers involved with credible allegations of fraud during the specified time period. If the % of provider type is at ____% or above, the reviewer will respond with "met." If the provider type is below _____% the reviewer will respond with "not met."	**42 CFR 455.23 42 CFR 455.2 NCGS 108C-5**
4	__% of overall ***(insert name of service)*** providers identified with credible allegations of fraud	Reviewer will rate the provider type based on the % of overall ***(insert name of service)*** providers with credible allegations of fraud . If the % of ***(insert name of service)*** providers with credible allegations of fraud is above _____% then the reviewer will respond with "met." If the % of (***insert name of service)*** providers with credible allegations of fraud is below _____%, the reviewer will respond with "not met."	**42 CFR 455.23 42 CFR 455.2 NCGS 108C-5**
5.	Does the provider type have greater than ___% involvement with prepayment review?	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers involved with prepayment reviews during the specified time period . If the % of provider type is at ____% or above the reviewer will respond with "met". If the provider type is below ____% the reviewer will respond with "not met."	**42 CFR 455.16 NCGS 108C-7**
6	__% of overall ***(insert name of service)*** providers on Prepayment Review?	Reviewer will rate the provider type based on the % of overall ***(insert name of service)*** providers on prepayment review. If the % of ***(insert name of service)*** providers on prepayment review is above _____ % ,the reviewer will respond with "met." If the % of ***(insert name of service)*** providers on prepayment review is below _____%, the reviewer will respond with "not met."	**42 CFR 455.16 NCGS 108C-7**
7	Does the provider type have greater than _% involvement on the OIG Exclusion List for NC?	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers included on OIG Exclusion List for NC during the specified time period . If the % of provider type is at _____% or above, the reviewer will respond with" met". If the provider type is below _____% the reviewer will respond with "not met"	**42 CFR 1001.1801 42 CFR 455.436 42 CFR 455.450 42CFR 455.2**
8	__% of overall ***(insert name of service)*** providers on the OIG Exclusion List for NC?	Reviewer will rate the provider type based on the % of overall ***(insert name of service)*** providers included on the OIG Exclusion List for NC. If the % of ***(insert name of service)*** providers included on the OIG Exclusion List for NC is above _____%, the reviewer will respond with "met." If the % of ***(insert name of service)*** providers included on the OIG Exclusion List for NC is below _____%, the reviewer will respond with "not met."	**42 CFR 1001.1801 42 CFR 455.436 42 CFR 455.450 42CFR 455.2**
9	Does the provider type have greater than__% involvement on the State Exclusion List?	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers included on the State Exclusion List during the specified time period. If the % of provider type is at _____% or above the reviewer will respond with "met." If the provider type is below _____% the reviewer will respond with "not met."	**NCGS 108C-9 NCGS 108C-11**

10	__% of overall ***(insert name of service)*** providers on the State Exclusion List?	Reviewer will rate the provider type based on the % of overall ***(insert name of service)*** providers included on the State Exclusion List. If the % of ***(insert name of service)*** providers included on the State Exclusion List is above _____% then the reviewer will respond with "met." If the % of ***(insert name of service)*** providers included on the State Exclusion List is below _____%, the reviewer will respond with "not met."	**NCGS 108C-9 NCGS 108C-11**
11	Does the provider type have greater than__% involvement with identified Overpayments	Reviewer will rate the provider type based on the % of ***(insert name of service)*** providers with identified overpayments during the specified time period. If the % of provider type is at _____% or above the reviewer will respond with "met." If the provider type is below _____% the reviewer will respond with "not met."	**42 CFR 455.16 NCGS 108C-7 10A NCAC 22F**
12	__% of overall ***(insert name of service)*** providers with identified overpayments?	Reviewer will rate the provider type based on the % of overall ***(insert service)*** providers with identified overpayments. If the % of ***(insert name of service)*** providers with an identified overpayment is above _____%, the reviewer will respond with" met." If the % of ***(insert name of service)*** providers with an identified overpayment is below _____%, the reviewer will respond with "not met."	**42 CFR 455.16 NCGS 108C-7 10A NCAC 22F**
13	Is there a Quality of Care concern identified for the provider type based on formal State or National study?	The reviewer will review and determine applicability of studies to include but not limited to CMS, OIG, Keiser, NC Institute of Medicine as an indicator of potential provider risk.	**42 CFR 456**
14	Is there a Moratorium placed on the provider type?	The reviewer will determine if a temporary moratoria has been placed on a specific provider type by the Secretary. If a temporary moratoria has been placed on a specific provider type the reviewer will respond with "met". If there has not been a temporary moratoria placed on a provider type the reviewer will respond with "not met."	**42 CFR 455.470**
15	Is there Policy in place for the provider type?	The reviewer will determine if there is a policy in place for the provider type to deliver or provide Medicaid services. If there is a policy in place the reviewer will respond with "Yes." If there is no policy in place to deliver or provide Medicaid services the reviewer will respond with "No."	**42CFR 431.50 NC Medicaid State Plan NC Clinical Coverage Policies**
16	Is there accreditation in place for the provider type?	The reviewer will determine if there is an accreditation requirement in place for the provider type to deliver or provide Medicaid services. If there is accreditation requirement in place the reviewer will respond with "Yes." If there is no accreditation requirement in place to deliver or provide Medicaid services the reviewer will respond with "No."	**NCGS 122C-81**
17	Is there a licensure requirement in place for the provider type?	The reviewer will determine if there is a licensure requirement in place for the provider type to deliver or provide Medicaid services. If there is licensure requirement in place the reviewer will respond with "Yes." If there is no licensure requirement in place to deliver or provide Medicaid services the reviewer will respond with "No."	**NCGS 122C**
18	Is there Evidence-Based Treatment (EBT) Model in place for the provider type?	The reviewer will determine if there is an EBT Model requirement in place for the provider type to deliver or provide Medicaid services. If there is EBT Model requirement in place the reviewer will respond with "Yes." If there is no EBT Model requirement in place to deliver or provide Medicaid services the reviewer will respond with "No."	

Appendix G: Stakeholder Listserv Questions and DMA Responses

QUESTION	ANSWER
What are the provider types/categories?	The provider types or categories for Behavioral Health as they pertain to the evaluation requirement include the following: • Assertive Community Team • Mobile Crisis Management • Multi-systemic Therapy • Partial Hospitalization • Professional Treatment Services in Facility-Based Crisis • Psychosocial Rehabilitation • Substance Abuse Comprehensive Outpatient Program • Substance Abuse Intensive Outpatient Service • Substance Abuse Medically Monitored Community Residential Treatment • Substance Abuse Non-Medical Community Residential Treatment • Psychiatric Residential Treatment • Ambulatory Detoxification • Non-Hospital Medical Detoxification • Medically Supervised or ADATC Detoxification Crisis Stabilization • Outpatient Opioid Treatment • Residential Treatment Services-Level II -IV
Who will complete the tool?	The Department will identify the reviewers from the Division of Medical Assistance and relevant stakeholder groups.
Are Intellectual/Developmental Disabilities (I/DD) providers considered "behavioral health agencies"?	For the purpose of Session Law 2016-94, Section 12H.15 I/DD providers are not considered behavioral health providers. I/DD providers are providers identified under the Innovations Waiver program and are considered *moderate risk* in accordance with 108C-3(e)(12) if undergoing revalidation and *high risk,* if newly enrolling in accordance with 108C-3(g)(6).
What is the difference between the State Exclusion list and the Office of Inspector General (OIG) list?	State Exclusion List identifies those North Carolina providers prohibited from enrollment due to State adverse actions and are not subject to OIG exclusion list or providers waiting to be placed on the OIG exclusion list. OIG Excluded Providers list contain providers who have defrauded or abused the Medicaid program and are prohibited from participation in any federal healthcare program.
House Bill 1030 Session Law 2016-94 Section 12H.15 refers to "agencies providing behavioral health services" and "categories of behavioral health agencies". 108C differentiates between directly enrolled behavioral health providers, agencies providing behavioral health services, hospitals, PRTFs, etc., so it seems that the Session Law is intended to focus on agencies providing behavioral health services. How is the stakeholder group defining "agency"? Is this based on the type of contract that the provider has with the MCO?	Agencies for the purpose of Session Law 2016-94, Section 12H.15 are defined as providers delivering behavioral health services, excluding Critical Access Behavioral Health Providers and Directly Enrolled Outpatient Behavioral Health Services Providers referenced in NCGS 108C-3(g)(3).
What would prevent adding a taxonomy code for "FQHC employee" since all BH providers in an FQHC are billed incident to a medical provider and bill nothing directly?	All Directly Enrolled Outpatient Behavioral Health Services Providers are determined *High Risk* in accordance with NCGS 108C-3(g)(3). FQHCs are determined *Limited Risk*. Should FQHCs bill behavioral health services beyond the brief intervention prescribed for the population served the FQHCs will be considered *High Risk* and subject to the same screening requirements for Directly Enrolled Outpatient Behavioral Health Services Providers.
Clarify provider types: Licensed Independent Providers (LIPs) are those directly enrolled in Medicaid and contract with LME/MCOs; Group LIP Practice: these are LIPs that work in group practices but provide outpatient services (they might just share an office space with other behavioral health providers); and Agencies- these are larger practices.	Categorization of Licensed Independent Providers will be considered should the recommendation to Evaluate Directly Enrolled Behavioral Health Services Providers under §108C-3(g)(3) be approved by the North Carolina State Legislature.
We would like to recommend that behavioral health providers be removed from the high risk category all together in 108C. It has put up barriers to practice and puts unfair standards on LIPs.	A recommendation will be submitted to Re-evaluate Directly Enrolled Behavioral Health Services Providers during the course of Re-evaluating Agencies providing behavioral health services, excluding Critical Access Behavioral Health Agencies.