STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

January 23, 2025

SENT VIA ELECTRONIC MAIL

The Honorable Carla Cunningham, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 402, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

The Honorable Larry Potts, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B1, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2023-134, Section 9E.16.(b1) requires the Department of Health and Human Services and the LME/MCOs to develop a proposal for potentially opening the LME/MCO closed provider networks described in G.S. 108D-23 for services and supports that are excluded from prepaid health plan coverage except under BH IDD tailored plan contracts. The proposal shall be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions regarding this report, please contact Karen Wade, Director of Policy, at Karen.Wade@dhhs.nc.gov.

Sincerely,

DocuSigned by:
Jay Ludlam
06565C1C2A8F4C8...
on behalf of Devdutta Sangvai

Devdutta Sangvai
Secretary

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

January 23, 2025

SENT VIA ELECTRONIC MAIL

The Honorable Jim Burgin, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 620, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

The Honorable Larry Potts, Chair
Joint Legislative Oversight
Committee on Medicaid
North Carolina General Assembly
Room 307B1, Legislative Office Building
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Proposal for Opening LME/MCO Closed Provider Networks for Services and Supports Excluded From Prepaid Health Plan Coverage Except Under BH IDD Tailored Plan Contracts

Session Law 2023-134, Section 9E.16.(b1)

Report to

Joint Legislative Oversight Committee on Health and Human Services
and

Joint Legislative Oversight Committee on Medicaid

By

North Carolina Department of Health and Human Services

January 23, 2025

Contents

Executive Summary

This report by the North Carolina Department of Health and Human Services (DHHS) addresses the proposal to open Local Management Entity/Managed Care Organization (LME/MCO) closed provider networks some or all services, as mandated by Section 9E.16.(b1) of Session Law 2023-134. Historically, these networks have been closed for behavioral health, intellectual and developmental disabilities (I/DD), substance use disorder (SUD), and traumatic brain injury (TBI) services. The proposal aims to enhance access to critical services while ensuring provider quality and network sustainability. Key considerations include the implementation of objective quality standards, the exclusion of previously terminated providers, and ensuring financial viability for existing network providers.

A significant pressure highlighted in the report is compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which prohibits Medicaid managed care plans from applying more restrictive limitations on behavioral health benefits compared to medical/surgical benefits. Recent federal feedback suggests that North Carolina's closed networks for behavioral health services do not align with MHPAEA, necessitating network adjustments to meet parity requirements. DHHS will need to work closely with the Centers for Medicare & Medicaid (CMS), North Carolina General Assembly, LME/MCOs and behavioral health providers in navigating the critical step toward opening access to high-quality behavioral health services for Medicaid enrollees while addressing federal compliance and State workforce shortages.

Introduction

Pursuant to Section 9E.16.(b1) of Session Law (S.L.) 2023-134 (see Appendix A), the North Carolina Department of Health and Human Services (DHHS) is submitting this proposal for potentially opening the local management entity/managed care organization (LME/MCO) closed provider networks described in G.S. 108D-23 for services and supports that are excluded from prepaid health plan (PHP) coverage except under BH IDD tailored plan contracts.[1] While DHHS is submitting the recommendations in this report, LME/MCOs were consulted in recommendations development and their feedback is included throughout.

Historically, LME/MCOs have maintained closed networks for mental health, intellectual and developmental disabilities (I/DD), substance use disorder (SUD) and traumatic brain injury (TBI) services. This was codified in G.S. 108D-21. In 2018, the North Carolina General Assembly passed S.L. 2018-48, creating Behavioral Health and Intellectual/Developmental Disability Tailored Plans (BH I/DD Tailored Plans)—specialized Medicaid managed care plans for individuals with significant mental health needs, severe Substance Use Disorder (SUD), Intellectual and Developmental Disabilities (I/DD), and Traumatic Brain Injury (TBI) to be administered by the LME/MCOs. Among other features, S.L. 2018-48 required that BH I/DD Tailored Plans have closed networks for all mental health, SUD, I/DD, and TBI services. This was later codified in G.S. 108D-23, along with requiring open networks for services that are covered benefits under the standard benefit plans and BH I/DD Tailored Plans.

With passage of Section 9E.16.(b1) of S.L. 2023-134, the General Assembly stated its intent that, "when BH I/DD Tailored Plans, as defined under G.S. 108D-1, begin, local management entities/managed care organizations (LME/MCOs) accept, as network providers, all providers that meet objective quality standards and accept network rates. DHHS and the LME/MCOs shall develop a proposal for potentially opening the LME/MCO closed provider networks described in G.S. 108D-23 for services and supports that are excluded

[1] Current Operations Appropriations Act of 2023, S.L. 2023-134, House Bill 259, 2023. https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2023-2024-/SL2023-134.html

from prepaid health plan coverage except under BH I/DD tailored plan contracts." LME/MCOs will also carry over the recommendations of this report to services in the NC Medicaid Direct contract so that expectations are consistent across all LME/MCO contracts.

DHHS and LME/MCOs are required to submit to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid a proposal and any required legislative changes to implement it, including statutory revisions to G.S. 108D-21, G.S. 108D-23, G.S. 108D-26 of Article 3 of Chapter 108D.

According to Section 9E.16.(b1) of S.L. 2023-134, this report must consider all of the following:

1. The need to ensure access to care for enrollees while also ensuring the delivery of high-quality services and supports to those enrollees.
2. The continued exclusion of providers previously terminated by an LME/MCO for cause, including new entities created by the same owners or managing employees of those providers.
3. The development by DHHS and the LME/MCOs of objective quality standards for the providers that deliver services and supports that are excluded from PHP coverage except under BH I/DD Tailored Plan contracts.
4. The need to ensure financial viability and operating stability for existing LME/MCO network providers.
5. The Medicaid risk category assigned to provider types under G.S. 108C-3(g).

Because of these considerations, DHHS' proposal includes the following sections:

- Need for Improved Access to Mental Health, SUD, I/DD, and TBI Services
- Proposal for Opening Networks for BH I/DD Tailored Plan Services
- Proposed Statutory Revisions

The MHPAEA and accompanying regulations prohibit Medicaid managed care plans from applying any financial requirement or treatment limitation to behavioral health benefits that is more restrictive than the predominant financial requirement or treatment limitation that applies to medical/surgical benefits.[2,3] In recent correspondence, CMS provided feedback that the State's closed networks for behavioral health services offered by BH I/DD Tailored Plans and the statewide Children and Families Specialty Plan (CFSP) may not be aligned with the intent of federal law. DHHS is in active discussions with CMS on this topic, and the outcome of these discussions will inform the implementation of the recommendations in this report which could include a requirement by CMS to open networks for some or all behavioral health services to ensure compliance with MHPAEA.

Need for Improved Access to Mental Health, SUD, I/DD, and TBI Services

The North Carolina General Assembly, DHHS, and LME/MCOs all recognize that there is a need to increase access to mental health, SUD, I/DD, and TBI services across the State. North Carolinians are experiencing increased mental health and SUD needs since 2019, with significant increases in rates of drug overdose, youth suicide, anxiety and depression. Nationally, North Carolina ranks last in children's access to mental health care.

[2] Mental Health Parity and Addiction Equity Act and Final Medicaid Mental Health Parity Rules for Medicaid Managed Care Organizations; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 FR 18390 (May 31, 2016).

[3] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 FR 68240 (Jan. 13, 2014).

More than half of North Carolina's adults and children with mental illness receive no treatment, and many others receive mental health care through emergency departments that are overused and often require excessive wait times. Compounding these challenges, there are acute shortages in North Carolina's mental health and SUD workforce, contributing to the State's mental health, SUD, and child welfare systems being overstretched and under-resourced.[4] Nearly 40 percent of North Carolinians live in a mental health professional shortage area.[5]

At the same time, the COVID-19 pandemic exacerbated existing shortages in the State's home and community-based services (HCBS) workforce, creating challenges for North Carolinians with I/DD and TBI, among other conditions, to obtain the supports necessary to live safely in the community.[6] Between 2016 and 2021, North Carolina lost over 9 percent of its direct care workforce.[7] In addition, the State ranks 46th in the affordability and access of its long-term care services and supports (LTSS) system targeted toward individuals with a range of disabilities, including home and community-based services for individuals with mental illness, IDD, and TBI.[8] Together, these dynamics underscore the imperative to identify strategies to address access challenges for the population that will enroll in BH IDD Tailored Plans and those who will continue to be served in NC Medicaid Direct by the LME/MCOs.

North Carolina's General Assembly took significant action to combat the State's mental health and SUD crisis and mental health, SUD and HCBS workforce challenges. The State's expansion of Medicaid under the Affordable Care Act, which was authorized by the General Assembly in March 2023 and launched in December 2023, has provided over 600,000 North Carolinians with comprehensive health insurance coverage. Also, North Carolina's State Fiscal Year (FY) 2023–2025 budget appropriated transformative funding to improve access to care for mental health, SUD, I/DD, and TBI, including, but not limited to:[9]

- $130 million to increase Medicaid rates for mental health, SUD, and I/DD services;
- $20 million to expand the NC Loan Repayment Program for licensed behavioral health professionals practicing in rural areas;
- $125 million for behavioral health crisis improvements, including mobile crisis and behavioral health urgent care initiatives, which will further reduce reliance on emergency departments in moments of crisis;
- $20 million to add 350 new slots to the Innovations waiver, which provides critical supports to individuals with I/DD;
- $120 million to increase the wages of direct care workers providing Innovations waiver services;
- $110 million to keep rate increases implemented during the COVID-19 Public Health Emergency for personal care services;

[4] NCDHHS, "Investing in Behavioral Health and Resilience, March 2023. https://www.ncdhhs.gov/investing-behavioral-health-and-resilience/download?attachment
[5] "Responding to North Carolina's Behavioral Health Workforce Crisis". Responding to North Carolina's Behavioral Health Workforce Crisis (unc.edu)
[6] Watts, Burns, Ammula. "Ongoing Impacts of the Pandemic on Medicaid Home & Community-Based Services (HCBS) Programs: Findings from a 50-State Survey". KFF, 2022. https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/
[7] NCDHHS, "North Carolina Launches Caregiving Workforce Strategic Leadership Council", March 2023. https://www.ncdhhs.gov/news/press-releases/2023/03/07/north-carolina-launches-caregiving-workforce-strategic-leadership-council
[8] AARP, 2023 LTSS Scorecard. https://ltsschoices.aarp.org/scorecard-report/2023/states/north-carolina#toc-indicator-highlights
[9] Current Operations Appropriations Act of 2023, House Bill 259, 2023. https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2023-2024/SL2023-134.html

- $99 million to support justice-involved mental health and SUD supports, including community-based pre-arrest diversion and reentry programs and community-based and detention center-based restoration programs; and
- $83 million to expand and improve child behavioral health supports, including expanding intensive supports in the community and developing a foster care trauma assessment.

The budget also authorized the statewide expansion of the TBI Waiver, which provides critical supports to help individuals with TBI live successfully in the community. The budget investments are still being implemented but are expected to have a significant impact in improving access to care for North Carolinians.

As part of the renewal of its Section 1115 demonstration renewal, DHHS is requesting the ability to use $100 million in Medicaid funding to strengthen the mental health, SUD, I/DD, TBI, and LTSS workforce. If approved, this funding will be used to expand the State's student loan repayment for behavioral health professionals and fund recruitment and retention payments for direct support professionals and other professionals providing mental health, SUD, I/DD, and LTSS services.

While these efforts are expected to be transformative, given the scale of the mental health and SUD crisis and workforce challenges, DHHS is exploring more strategies to expand access to mental health, SUD, I/DD, and TBI services. **With the launch of BH IDD Tailored Plans on July 1, 2024, the General Assembly directed DHHS and LME/MCOs to explore opening the LME/MCO networks as another strategy to increase access to critical mental health, SUD, I/DD, and TBI services for Medicaid enrollees.**

Approach to Developing Recommendations

DHHS developed recommendations using a multi-step process—conducting a literature review, facilitating a workgroup of DHHS subject matter experts, fielding stakeholder surveys, facilitating a working session with LME/MCOs (2/20/2024), and incorporating written feedback collectively submitted from LME/MCOs. The literature review evaluated other states' approaches to using "any willing provider" for mental health, SUD, I/DD, and TBI services as a strategy to strengthen access to these services and did not identify relevant precedent for consideration by DHHS.

DHHS convened an internal workgroup comprised of members from the Division of Health Benefits (DHB) and Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS), both of which hold contracts with the LME/MCOs. These workgroup members included subject matter experts (SMEs) in mental health, SUD, I/DD, and TBI services. The workgroup discussed principles to use in determining whether to open the LME/MCO network for specific services; recommendations on whether to open networks for each service; and potential quality standards for services that are open network.

To collect input from key stakeholders on their perspective on transitioning some or all BH IDD Tailored Plan and NC Medicaid Direct services to open networks and inform recommendations, in December 2023, DHHS also developed and transmitted surveys to all LME/MCOs and 39 provider associations, providers, advocacy groups, and consumer groups (see Appendix B). Provider associations and advocacy and consumer groups also sent the survey to individual members for their completion. DHHS presented the survey and solicited feedback at several stakeholder meetings—the Monthly DMHDDSUS Provider Meeting (12/9/2023), the LME/MCO CEO Meeting (12/12/2023), the DMHDDSUS/LME/MCO Clinical Leadership Meeting (12/19/2023), the State Consumer and Family Advisory Committee Meeting (12/13/2023). The survey distributed to LME/MCOs and

provider associations covered respondents' positions on opening LME/MCO networks for each service covered by BH IDD Tailored Plans and NC Medicaid Direct but not Standard Plans; reasons for provider exclusions from networks; access to services for historically marginalized populations; historically underutilized providers' ability to participate in networks; and provider quality standards that would be supported by respondents. The survey distributed to consumers, family members, caregivers, and consumer advocates focused on consumers' experiences with LME/MCO services, including their ability to access services and the quality of the care they receive.

DHHS received survey responses from five LME/MCOs,[10] 6 advocacy groups, 30 provider associations/ individual providers, and 82 consumers, family members, caregivers, and consumer advocates. For the latter group, survey data does not reflect whether the respondents were enrolled with LME/MCOs, a different health plan, or were uninsured. DHHS synthesized the input received from the surveys, and the workgroup considered the results in developing their final recommendations. In general, provider associations and individual providers favored or were neutral about opening networks and LME/MCOs opposed opening networks, with some exceptions. For example, LME/MCOs were more supportive of opening networks for residential services and TBI waiver services than for other services. There was variability in responses amongst the LME/MCOs; for most service types, there were two LME/MCOs that were neutral or supportive of open networks and three LME/MCOs that opposed open networks.

Access continues to be a top concern for consumers. Nearly half of consumer respondents reported that they often could not see a provider because the provider is out of network. Respondents noted challenges with accessing services such as respite, TBI, and I/DD services. Multiple respondents shared needing to travel 1–2+ hours and/or out-of-state to access needed services.

DHHS, LME/MCOs, providers, and consumers all agree that in the future state, preserving quality of services is of the utmost importance, and this principle is at the center of all recommendations in this proposal.

To solicit additional feedback from LME/MCOs on developing recommendations about potentially opening LME/MCO provider networks, DHHS collected written feedback from LME/MCOs and conducted a working session with LME/MCOs on February 20, 2024. Based on the totality of feedback, DHHS's recommendations are included in this report to the General Assembly.

Proposal for Opening Networks for BH IDD Tailored Plan Services

Section 9E.16.(b1) of S.L. 2023-134 requires DHHS and LME/MCOs develop a proposal for opening the LME/MCO closed provider networks described in G.S. 108D-23 for services and supports that are excluded from PHP coverage except under BH IDD Tailored Plan contracts.[11]

The following proposal is submitted to the General Assembly:

- **LME/MCOs should have open provider networks for:**

[10] As of February 1, 2024, Eastpointe and Trillium Health Resources have consolidated into one entity, and Sandhills Center has dissolved. https://medicaid.ncdhhs.gov/blog/2024/02/01/ncdhhs-consolidates-local-management-entitymanaged-care-organizations-ahead-tailored-plan-launch

[11] Current Operations Appropriations Act of 2023, House Bill 259 "§ 108D-22 (2023). https://www.ncleg.gov/EnactedLegislation/SessionLaws/HTML/2023-2024/SL2023-134.html

    - Services that are currently included in **both the Standard Plan and BH IDD Tailored Plan contracts** as required in G.S. 108D-22;[12]
    - Select services that require State **licensure** where opening networks does not significantly risk provider viability; and
    - Services that are subject to **federal HCBS health and welfare monitoring requirements** except for the services noted below.
- **LME/MCOs should keep closed provider networks for:**
    - Team-based services that **do not require State licensure.** Specifically, LME/MCO networks should be closed for Assertive Community Treatment (ACT); Multi-Systemic Therapy Services (MST); Community Support Team (CST); and Intensive In-Home Services.
    - Child and Adolescent Day Treatment, which is provided in schools that may not have the capacity to add additional providers.
    - Services where opening networks might risk provider financial viability or destabilization of provider operations such as SUD Residential Treatment Services.
    - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), where there is a Certificate of Need process to establish new facilities.
    - Four services that are **subject to HCBS health and welfare monitoring requirements** that either have particular acute health and welfare risks—Residential Supports (Innovations and TBI waivers) and Respite (Innovations and TBI waivers, 1915(i))—or where the **service is currently undergoing a significant transition**—Remote Supports (TBI waiver) and Financial Support Services (Innovations and TBI waivers).
    - All **1915(b)(3) waiver services**, given that they are not subject to health and welfare monitoring requirements, and they are in the process of transitioning to 1915(i) authority.
- **Given the diversity of In Lieu of Services (ILOS), it is proposed that DHHS has discretion on whether a given ILOS is offered through an open or closed network. DHHS would ask LME/MCOs to make a MHPAEA compliant recommendation for each ILOS.**

More details on these recommendations, according to each of the priority considerations established by the NC General Assembly in S.L. 2023-134, are described below.

1. The Need to Ensure Access to Care for Enrollees While Also Ensuring the Delivery of High-Quality Services and Supports to Those Enrollees

The proposal to open LME/MCOs' mental health, SUD, I/DD, and TBI service networks aims to improve access to care. At the same time, DHHS must balance the need to improve access with provider sustainability and ensuring that the highest quality services are provided to enrollees. LME/MCOs have expressed concerns that opening networks could impact provider viability in rural areas and could jeopardize the quality of the providers in their networks and their oversight role to maintain the quality of their networks. LME/MCOs have also noted that there is no study known to DHHS or the LME/MCOs indicating a causal relationship between access to care and open behavioral health, I/DD, or TBI provider networks, and that neither DHHS nor LME/MCOs have undertaken a study to identify the root cause of access concerns in the State.

[12] DHHS and the LME/MCOs share concerns about a fully open network for BH crisis services, given that they must serve all North Carolinians despite a lack of uniform payer coverage. Ensuring sustainability and broad accessibility requires strategic, focused funding of these services through select providers. With LME/MCO input, DHHS is exploring ways to create long term stabilization of the crisis system and may consider recommending a closed network for all Medicaid managed care plans in the future.

Also, the recommendations account for DHHS' use of a centralized process to credential and enroll providers and provider agencies, which aligns with federal and State requirements. As required by federal and State guidelines, and in an effort to align with NCQA, data collected and verified by the credentialing body includes licensure, accreditations, certifications, education and training, board certification, malpractice insurance and history, State licensing board sanctions, Medicare/Medicaid sanctions, work history, and additional attestations (e.g., illegal drug use, felony convictions, disciplinary actions, etc.).[13] Once DHHS collects information and credentials providers, the credentialing vendor verifies the information collected. Also, DHHS performs monthly monitoring, ensuring credential maintenance, and completes revalidation, to include primary source verification of all enrollment criteria, every five years. DHHS provides credentialing decisions to LME/MCOs, which must accept the credentialing determination. However, LME/MCOs can request additional information as part of their contracting process with providers upon approval from DHHS, if this information is not credentialing-related data.

This process is intended to ensure that high-quality providers deliver care for Medicaid enrollees, eliminate redundant data entry for providers, and create uniform credentialing standards across the State. With the full deployment of centralized enrollment, DHHS will provide plans with licensure and other information, which had been requested by LME/MCOs.

LME/MCOs indicated concerns with DHHS's centralized enrollment approach, noting that LME/MCOs are monitoring for quality and performance in real time. Accordingly, LME/MCOs advocated for the ability to make decisions outside of the DHHS's centralized enrollment process, but DHHS does not currently intend to permit this. DHHS recognizes stakeholder feedback received but believes that it is important to have a consistent process across the State. DHHS is in the process of implementing a Provider Data Management / Credentialing Verification (PDM/CVO) solution that will more closely align with the NCQA standards. Once implemented, the new PDM/CVO will perform credentialing on behalf of DHHS and manage data intake and maintenance throughout the provider lifecycle.[14]

DHHS does not intend to change the LME/MCOs' ability to terminate provider contracts with or without cause. Just like Standard Plans, LME/MCOs will retain the ability to continue to remove providers from their network that are deemed poor quality or are not meeting contract expectations. LME/MCOs can continue to use grievance and complaints, plans of correction, and performance on standardized quality metrics when considering contract termination of a provider. To ensure that terminations do not disproportionately impact certain providers, DHHS intends to monitor termination rates across provider characteristics such as whether an organization is a historically underutilized provider.

a) Recommendations for LME/MCO Services in Open Networks

For services that require state licensure or are subject to federal HCBS health and welfare monitoring requirements that do not provide substantial risk to enrollees or existing providers, DHHS recommends that services provided by BH IDD Tailored Plans and NC Medicaid Direct have an open network. These include child residential services, psychiatric residential treatment facilities (PRTF), most Innovations and TBI waiver services, 1915(i) services, and psychosocial rehabilitation. A majority of LME/MCOs responded to the December survey that they were in favor of or neutral about opening networks for these services except for psychosocial rehabilitation and PRTF. The rationale for these recommendations is described below, and

[13] National Committee on Quality Assurance, "Standards and Guidelines for the Certification of Credentialing Verification Organizations," 2023.
[14] More information on DHHS' new PDM/CVO can be found at https://medicaid.ncdhhs.gov/providers/provider-data-management-credentialing-verification-organization.

service-by-service recommendations are provided in Table 1. In addition, DHHS proposes that given the variability in ILOS offered across and within LME/MCOs, LME/MCOs propose to DHHS whether the network be open or closed for each ILOS using MHPAEA compliance as a consideration, with DHHS ultimately having discretion on whether to accept the recommendation. LME/MCOs support closing networks for all ILOS.

Licensure

Facilities and professionals that require State licenses are subject to an additional layer of patient safety and quality oversight. Examples of licensure bodies include DHHS' Division of Health Service Regulation (DHSR), and Division of Social Services, and the North Carolina Medical Board.

Licensing bodies generally set quality and patient care standards for their licensees and oversee compliance with those standards through initial licensing and renewal process and monitoring and auditing. Losing their licensure has detrimental, and far-reaching consequences for providers, strongly incentivizing providers to provide high-quality patient care. By requiring that providers of open network services are licensed, LME/MCOs can report and escalate concerns to licensure and oversight bodies to investigate and take action against the provider's license. DHHS believes that this additional protection reduces the risk of diminishing network quality with opening LME/MCO networks; however, LME/MCOs have raised concerns about the timeliness of DHSR approval processes driven by staffing constraints. DHHS is working on addressing these concerns.

In their December survey responses, the majority of LME/MCOs supported or were neutral about opening networks for child mental health residential services, which require licensure. LME/MCOs also reported that it has been difficult to recruit providers for residential services. The majority of LME/MCOs were against opening networks for Psychosocial Rehabilitation Services and PRTF.

Monitoring for Health and Welfare

States are required to "provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees" obtaining HCBS.[15] BH IDD Tailored Plans will cover HCBS authorized through the 1915(c) Innovations waiver, the 1915(c) TBI waiver, and the 1915(i) State Plan Amendment (SPA); after BH IDD Tailored Plan launch, NC Medicaid Direct will cover HCBS authorized through the 1915(c) Innovations waiver, the 1915(i) SPA, and the 1915(b)(3) waiver. North Carolina's 1915(c) waivers, 1915(i) SPA, and BH IDD Tailored Plan and NC Medicaid Direct contracts provide details on how North Carolina meets these federal requirements. For example, for Innovations and TBI waiver enrollees, waiver care coordination must include:

- Conducting a review of the member's Individual Support Plan for waiver compliance, medical necessity, and the member's health and safety needs;
- Ensuring that issues of health, safety and wellbeing (rights restrictions, abuse/neglect/exploitation, backup staffing) and non-waiver service needs (medical care) are addressed and documented as appropriate

DHHS believes that although some Innovations waiver, TBI waiver, and 1915(i) service providers and locations are not licensed, these health and welfare monitoring requirements provide a robust additional check of quality, permitting LME/MCO services to be provided through open networks for most

[15] Federal requirement cited applies to 1915(i) services and can be found at 42 CFR 441.730(a). Similar requirements exist for 1915(c) waiver services at 42 CFR 441.303(a).

Innovations waiver, TBI waiver, and 1915(i) services without compromising the quality of services provided. Exceptions are described in detail in Section (b) below.[16] In their December 2023 survey responses, the majority of LME/MCOs supported or were neutral about opening networks for most Innovations, TBI, and 1915(i) waiver services that require monitoring for health and welfare. In written feedback collectively submitted from the LME/MCOs in March 2024, LME/MCOs changed their position, voicing concerns that opening the networks could compromise the quality of services provided.

Beyond Innovations waiver, TBI waiver, and 1915(i) services, DHHS recommends that for **child mental health residential services and PRTF,** all of which are licensed, LME/MCOs be required to perform similar health and welfare monitoring as an additional mechanism to ensure quality as these services are transitioned to open networks. LME/MCOs noted that they would need additional resources to implement new health and welfare monitoring requirements.

Recognizing that this will be a new monitoring responsibility that may require additional reimbursement, DHHS recommends that open networks for these residential services (child mental health and PRTF) are phased in by July 2025. Over the coming year, DHHS, in collaboration with the LME/MCOs, will develop detailed health and welfare monitoring requirements for these residential services to incorporate into the BH IDD Tailored Plan and NC Medicaid Direct contracts.

Consistency Across Medicaid Managed Care Plans

DHHS believes that open and closed network requirements should be consistent across BH IDD Tailored Plans, Medicaid Direct and the statewide CFSP. As such, DHHS recommends that the Medicaid Direct and CFSP requirements for open and closed networks be updated to align with this report.

[16] The exceptions are Residential Supports (Innovations and TBI waivers), Respite (Innovations and TBI waivers, 1915(i) SPA), Remote Supports (TBI waiver), Financial Support Services (Innovations and TBI waivers), and all 1915(b)(3) waiver services.

b) Recommendations for LME/MCO Services to Retain in Closed Networks

DHHS recommends that LME/MCOs should keep closed networks for the following services, pending CMS concurrence related to MHPAEA compliance:

- Assertive Community Treatment (ACT);
- Multi-Systemic Therapy (MST);
- Community Support Team (CST);
- Intensive In-Home Services;
- Child and Adolescent Day Treatment;
- SUD Residential Treatment Services (ASAM 3.1, 3.3, 3.5, 3.7);
- Intermediate Care Facilities-IDD (ICF-IID);
- Select Home and Community Based Services (HCBS):
    - Residential Supports (Innovations and TBI Waivers);
    - Respite (Innovations and TBI Waivers, 1915(i));
    - Remote Supports (TBI Waiver);
    - Financial Support Services (Innovations and TBI Waivers); and
    - All 1915(b)(3) Waiver Services (Individual Support, Intensive Recovery Support, In-Home Skill Building, One-Time Transitional Costs, Respite, Supported Employment, and Transitional Living Skills).

ACT, MST, CST, and intensive in-home services all use multi-disciplinary team-based care models, which require a substantial investment to start up and maintain but lack DHSR licensure or additional oversight which increases risk to patient safety. Child and Adolescent Day Treatment requires an integrative approach with schools, and there is limited capacity at schools to absorb additional providers. For SUD Residential Treatment Services, some of which are newly covered by Medicaid, opening the networks could negatively impact the financial viability and operating stability of existing providers. Furthermore, opening the networks could jeopardize access to care for Medicaid enrollees and individuals using State-funded services. New ICF-IIDs require a Certificate of Need (CON), meaning that DHHS identifies when new providers are needed for this service.

For Residential Supports (Innovations and TBI waivers), Respite (Innovations and TBI waivers, 1915(i)), Remote Supports (TBI waiver), Financial Support Services (Innovations and TBI waivers), and all 1915(b)(3) waiver services, DHHS recommends maintaining closed networks at the launch of BH IDD Tailored Plans.

- Of all HCBS offered by BH IDD Tailored Plans, **Residential Supports** and **Respite** pose the most significant health and safety risks due to the vulnerability of the populations being served and some locations of service provision are not required to be licensed;[17] as a result, keeping provider networks for these services closed initially will serve as an additional measure to assure quality.
- **Remote Supports** is a pilot TBI waiver service, and DHHS will decide whether to continue the service after the pilot concludes. During the pilot period, DHHS recommends that the provider network be closed.
- DHHS is currently updating its service definition for **Financial Supports Services** (Innovations and TBI waivers) and recommends having a closed provider network until this update is completed.

[17] 10A NCAC 27G .5100 identifies the respite settings that are subject to licensure.

- Finally, because **1915(b)(3) waiver services** are not subject to the same health and welfare monitoring requirements as HCBS authorized under other authorities, and the current 1915(b)(3) waiver services are transitioning to 1915(i) authority, DHHS recommends retaining a closed network for 1915(b)(3) waiver services.

DHHS intends to create more robust network adequacy standards for all services to ensure access. Also, DHHS will revisit the decision to open provider networks for these services in July 2025.

Currently, when an LME/MCO identifies that it has an access gap for a particular service, it utilizes an open enrollment period to open its provider network for a time-limited period; it then closes enrollment once it has filled the network adequacy gap. All LME/MCOs currently maintain open networks for outpatient therapy and prescriber services. For services that have closed provider networks, LME/MCOs may continue to use an open enrollment approach when network gaps are identified. To ensure robust provider networks for closed network services, DHHS recommends that, as part of their network access report, LME/MCOs be required to submit an annual plan for DHHS approval for how they will enact open enrollment in the given plan year.

This requirement will take effect for Tailored Plan Contract Year 2, meaning that LME/MCOs will be required to first submit the open enrollment plan ninety days prior to the start of that Contract Year. Within the open enrollment plan, LME/MCOs will be required to describe the parameters (e.g., network adequacy gaps) that will trigger open enrollment. DHHS will also require that LME/MCOs include in the plan data showing that there is robust access to closed network services, which may include, but are not limited to member and provider grievances, Consumer Assessment of Healthcare Providers and Systems survey data, appointment wait time data, and equity measures. Additionally, LME/MCOs will be required to show that they have a significant portion of historically underutilized providers in their networks. Once approved, each LME/MCO's open enrollment plan will be published as part of its network access plan.

Table 1. Service-by-Service Recommendations

By service, recommended actions for whether the provider network should be open or remain closed are:

Category	Service Name	Service Requires Licensure	Service Currently Requires Health & Welfare Monitoring	Recommended Action		
				Open Network		Closed Network
				Open Network Effective 90 Days After Enacted Statute	Implement Health & Welfare Monitoring and Phase in Open Network by July 2025	
Mental Health Services	Child and Adolescent Day Treatment	✓				✓
	Assertive Community Treatment (ACT)					✓
	Community Support Team (CST)					✓
	Intensive In-Home Services					✓
	Multi-Systemic Therapy (MST) Services					✓
	Psychosocial Rehabilitation	✓		✓		
SUD Residential Treatment Services	ASAM 3.1 – Clinically Managed Low-Intensity Residential	✓				✓
	ASAM 3.3 – Clinically Managed Population-Specific High Intensity Residential	✓				✓
	ASAM 3.5 – Clinically Managed High Intensity Residential (Adult/Pregnant & Parenting) and Medium Intensity Residential (Adolescent)	✓				✓
	ASAM 3.7 – Medically Monitored Intensive Inpatient Services	✓				✓
Residential Mental Health Services	Child Residential Level I	✓		✓	✓	
	Child Residential Level II – Family Type	✓		✓	✓	
	Child Residential Level II – Program Type	✓		✓	✓	
	Child Residential Level III	✓		✓	✓	

Category	Service Name	Service Requires Licensure	Service Currently Requires Health & Welfare Monitoring	Recommended Action		
				Open Network		Closed Network
				Open Network Effective 90 Days After Enacted Statute	Implement Health & Welfare Monitoring and Phase in Open Network by July 2025	
	Child Residential Level IV	✓		✓	✓	
	Psychiatric Residential Treatment Facilities (PRTFs)	✓		✓	✓	
Residential I/DD Service	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	✓				✓
Services Offered Through Both the Innovations and TBI Waivers	Assistive Technology		✓	✓		
	Community Networking		✓	✓		
	Community Transition		✓	✓		
	Crisis Services	✓	✓	✓		
	Day Supports	✓	✓	✓		
	Home Modifications		✓	✓		
	Natural Supports Education		✓	✓		
	Residential Supports*	✓	✓			✓
	Respite*	✓	✓			✓
	Supported Employment		✓	✓		
	Supported Living		✓	✓		
	Vehicle Modification Services		✓	✓		
Services Only Offered by the Innovations Waiver	Community Living and Support		✓	✓		
	Financial Support Services		✓			✓
Services Only Offered by the TBI Waiver	Cognitive Rehabilitation	✓	✓	✓		
	Intensive In-Home Support		✓	✓		
	Life Skills Training		✓	✓		
	Occupational Therapy	✓	✓	✓		
	Personal Care Services	✓	✓	✓		
	Physical Therapy	✓	✓	✓		
	Remote Supports		✓			✓
	Speech and Language Therapy	✓	✓	✓		

Category	Service Name	Service Requires Licensure	Service Currently Requires Health & Welfare Monitoring	Recommended Action		
				Open Network		Closed Network
				Open Network Effective 90 Days After Enacted Statute	Implement Health & Welfare Monitoring and Phase in Open Network by July 2025	
1915(b)(3) Services	Individual Support					✓
	Intensive Recovery Support					✓
	In-Home Skill Building					✓
	One-Time Transitional Costs					✓
	Respite*	✓				✓
	Supported Employment					✓
	Transitional Living Skills					✓
1915(i) SPA Services	Community Living and Supports		✓	✓		
	Community Transition		✓	✓		
	Individual and Transitional Support		✓	✓		
	Respite*	✓	✓			✓
	Supported Employment/Individual Placement Supports		✓	✓		
In Lieu of Services (ILOS)	Vary by LME/MCO			^	^	^

***** Some, but not all, Residential Supports and Respite service sites of care are subject to licensure requirements.
^ DHHS recommends that it have discretion in determining which ILOS have open v. closed provider networks. When LME/MCOs propose new ILOS, they will be asked to make a recommendation for whether the provider network should be open or closed with rationale for the proposal. Similarly, LME/MCOs will be asked to provide a recommendation and rationale on whether existing ILOS should have open or closed networks. LME/MCOs favored having closed networks for all ILOS.

2. The Continued Exclusion of Providers Previously Terminated by an LME/MCO for Cause, Including New Entities Created by the Same Owners or Managing Employees of Those Providers

In their survey responses, LME/MCOs indicated that receiving additional credentialing data would support them in maintaining the quality of their networks. DHHS has onboarded a new centralized credentialing vendor and is implementing the State's new centralized credentialing process. After the centralized credentialing vendor is fully onboarded, health plans will begin to receive provider licensure and accreditation information; they will continue to receive National Provider Identifier and tax ID as they do today.

DHHS and its centralized credentialing vendor collect provider ownership information during the credentialing process. During the credentialing process and at a regular monthly cadence, providers are cross-referenced against national exclusion lists. While LME/MCOs cannot ask for credentialing data from providers, they can request additional information for the purposes of provider contracting. Also, as noted above, LME/MCOs will continue to have the ability to terminate provider contracts with or without cause.

3. The Development by DHHS and the LME/MCOs of Objective Quality Standards for the Providers That Deliver Services and Supports That are Excluded from Prepaid Health Plan Coverage Except Under BH IDD Tailored Plan Contracts

DHHS recommends that objective quality standards for providers that deliver services and supports that are excluded from prepaid health plan coverage except under BH IDD Tailored Plan contracts include:

- The standards being implemented as part of the centralized credentialing effort; and
- The implementation of health and welfare monitoring requirements for residential services as described above.

DHHS also recommends that it have the flexibility to establish additional objective quality standards based on its monitoring of provider terminations. In their December survey responses, LME/MCOs stressed the importance of maintaining a high-quality provider network; however, the LME/MCOs did not propose specific quality standards.

4. The Need to Ensure Financial Viability and Operating Stability for Existing LME/MCO Network Providers

As described above, DHHS explicitly considered financial viability and operating stability of existing providers in making service-specific recommendations. Based on these concerns, DHHS has recommended continuing to keep closed networks for ACT, CST, MST, and intensive in-home services, recognizing that these team-based services do not require licensure but are expensive to stand up and continuously operate. Where applicable, providers will continue to be required to be subject to fidelity review. Additionally, DHHS has recommended keeping closed networks for SUD Residential Treatment, as opening the networks could negatively impact the financial viability and operating stability of existing providers.

Outside of network standards, in partnership with the General Assembly, DHHS is already pursuing several strategies to ensure financial viability and operating stability including provider rate increases and workforce initiatives. As noted above, the NC General Assembly appropriated over $500 million to bolster the State's mental health, SUD, I/DD, and TBI providers via wage increases, rate increases, loan repayment programs, and staffing retention program.

DHHS has also requested authority from CMS to make a $100 million investment in its behavioral health and I/DD workforce via the renewal of its pending Section 1115 demonstration. Specific requests include a clinical loan repayment initiative and recruitment and retention payments for direct care workers and paraprofessionals.[18]

[18] North Carolina 1115 Demonstration Waiver Request. https://medicaid.ncdhhs.gov/nc-medicaid-reform-section-1115-demonstration-renewal-application/download?attachment

5. The Medicaid Risk Category Assigned to Provider Types Under G.S. 108C-3(g)

CMS establishes three screening levels for providers based on risk of fraud, waste, or abuse posed by each provider type—limited, moderate, and high. For providers in the high categorical risk level, states must:

- Obtain disclosures regarding ownership and criminal convictions and check databases to confirm identity and licensure.
- Conduct an on-site visit to confirm the accuracy of information submitted on provider's application.
- Conduct a fingerprint-based criminal background check of individual providers/individuals with ownership interest in institutional providers.

North Carolina's clinical policy team reviews every Medicaid service against the national Medicaid Provider Enrollment Compendium (MPEC), which offers credentialing guidance to State Medicaid Agencies on assigning risk levels, based on 42 CFR 424.518. The State's high categorical risk providers generally mirror MPEC and are outlined in G.S.108C-3(g). [19]The evaluation of a provider's categorical high-risk determination is completed during the centralized credentialing process, and this evaluation will continue to remain in place for all services, regardless of open or closed network status.

[19] Federal regulations were amended in November 2023. State statute will be updated to ensure alignment.

Proposed Statutory Revisions

Section 9E.16.(b1) of Session Law (S.L.) 2023-134 requires that the DHHS note any statutory revisions including G.S. 108D-21, G.S. 108D-23, and G.S. 108D-26. The following statutory revisions are recommended.

G.S. 108D-21 is repealed in its entirety.

§ 108D-23. BH IDD tailored plan provider networks.

(a) Each LME/MCO shall operate provider networks with respect to its BH IDD tailored plan contract in accordance with federal law and this section. If any provision of this section conflicts with applicable federal law, federal law shall control to the extent of the conflict.

(b) With regard to services and supports that are covered benefits under both standard benefit plans and BH IDD tailored plans, each LME/MCO shall be subject to the same provider network requirements applicable to PHPs under G.S. 108D-22.

(c) With regard to services and supports that are excluded from PHP coverage except under BH IDD tailored plans, each LME/MCO shall operate a ~~closed network, which is the network of providers that have contracted with the LME/MCO to provide those services to enrollees,~~ network in accordance with all of the following:

(1) A closed network must include all essential providers designated in accordance with G.S. 108D-22(b) that (i) are located or provide services within the region for which the LME/MCO holds a BH IDD tailored plan contract and (ii) provide any covered behavioral health, intellectual and developmental disability, or traumatic brain injury service in that region; and (iii) shall not exclude federally recognized tribal providers or Indian Health service providers from its closed network. The LME/MCO's network may be closed only for the following services as determined by the Department in its ~~BH IDD Tailored Plan~~ contracts with LME/MCOs:

a. Selected services that do not require state licensure.

b. The following services notwithstanding any requirement they hold state licensure.

i. Child and Adolescent Day Treatment.

ii. SUD Residential Treatment Services.

1. ASAM 3.1 – Clinically Managed Low-Intensity Residential.
2. ASAM 3.3 – Clinically Managed Population-Specific High Intensity Residential.
3. ASAM 3.5 – Clinically Managed High Intensity Residential (Adult/Pregnant & Parenting) and Medium Intensity Residential (Adolescent).
4. ASAM 3.7 – Medically Monitored Intensive Inpatient Services.

iii. Intermediate Care Facilities for Individuals with Intellectual Disabilities.

c. Selected Home and Community Based Services, notwithstanding any requirement they hold state licensure.

i. Residential Supports.

ii. Respite.

iii. Remote Supports.

iv. Financial Support Services.

v. 1915(b)(3) Waiver Services.

d. Selected In Lieu of Services.

(2) All other services shall be provided in an open network on a schedule to be determined by the Department.

(3) ~~If~~ a provision of this section conflicts with applicable federal law; or if ~~With regard to services identified by~~ the Department identifies services ~~as~~ necessary to improve access for behavioral health, intellectual and developmental disability, and traumatic brain injury services an LME/MCO shall accept all providers of those services that (i) meet objective quality standards and (ii) accept network rates, notwithstanding the requirement to operate a closed network.

§ 108D-24. Children and families specialty plan networks.

(a) The entity operating the children and families specialty plan shall develop and maintain a ~~closed only~~ network as provided in ~~this~~ section G.S. 108D-23 with respect to the covered services described in G.S. 108D-62(c).

~~(b) The requirement to operate a closed network is applicable only to the provision of the following services:~~

~~(1) Intensive in-home services.~~

~~(2) Multisystemic therapy.~~

~~(3) Residential treatment services.~~

~~(4) Services provided in psychiatric residential treatment facilities.~~

~~(c) A closed network is the network of providers that have contracted with the entity operating the CAF specialty plan to provide to enrollees the services described in subsection (b) of this section.~~

~~(d) The entity operating the CAF specialty plan shall not exclude federally recognized tribal providers or Indian Health Service providers from its closed network.~~

SECTION 9E.16.(b4) Article 3 of Chapter 108D of the General Statutes is amended by adding a new section to read:

§ 108D-26. ~~Other~~ PIHP provider networks.

(a) Beginning on the date that BH IDD tailored plans begin operating, each LME/MCO under contract with the Department (i) to provide coverage of services as a PIHP or (ii) to provide coverage of any services approved under the 1915(i) option may operate a closed network in accordance with federal law and this section. If any provision of this section conflicts with applicable federal law, federal law shall control to the extent of the conflict

(b) A closed network is the network of providers that have contracted with the LME/MCO to provide to enrollees the services and supports covered by the LME/MCO either as a PIHP or under the 1915(i) option. The LME/MCO's network may be closed only for the following services as determined by the Department in its PIHP contracts:

a. Selected services that do not require state licensure.

b. The following services notwithstanding any requirement they hold state licensure.

a. SUD Residential Treatment Services.

1. ASAM 3.1 – Clinically Managed Low-Intensity Residential.
2. ASAM 3.3 – Clinically Managed Population-Specific High Intensity Residential.

3. ASAM 3.5 – Clinically Managed High Intensity Residential (Adult/Pregnant & Parenting) and Medium Intensity Residential (Adolescent).
4. ASAM 3.7 – Medically Monitored Intensive Inpatient Services.
    b. Intermediate Care Facilities for Individuals with Intellectual Disabilities.

c. Selected Home and Community Based Services, notwithstanding any requirement they hold state licensure.
    ii. Residential Supports.
    iii. Respite.
    iv. Remote Supports.
    v. Financial Support Services.
    vi. 1915(b)(3) Waiver Services.

d. Selected In Lieu of Services.

(c) All other services shall be provided in an open network on a schedule to be determined by the Department.

(d) If a provision of this section conflicts with applicable federal law; or if ~~With regard to services identified by~~ the Department identifies services as necessary to improve access for behavioral health, intellectual and developmental disability, and traumatic brain injury services, an LME/MCO shall accept all providers of those services that (i) meet objective quality standards and (ii) accept network rates, notwithstanding the requirement in this section to operate a closed network.

Appendix A: Section 9E.16 of Session Law (S.L.) 2023-134

SESSION LAW 2023-134

HOUSE BILL 259

BH IDD TAILORED PLAN UPDATES

SECTION 9E.16.(a1) Section 9D.7(a) of S.L. 2022-74 is repealed.

SECTION 9E.16.(a2) The Division of Health Benefits, Department of Health and Human Services (DHHS), shall implement BH IDD tailored plans, as defined under G.S. 108D-1, no later than July 1, 2024. The initial term of the BH IDD tailored plan contracts shall last not less than four years.

SECTION 9E.16.(b1) It is the intent of the General Assembly that, when BH IDD tailored plans, as defined under G.S. 108D-1, begin, local management entities/managed care organizations (LME/MCOs) accept, as network providers, all providers that meet objective quality standards and accept network rates. DHHS and the LME/MCOs shall develop a proposal for potentially opening the LME/MCO closed provider networks described in G.S. 108D-23 for services and supports that are excluded from prepaid health plan coverage except under BH IDD tailored plan contracts. The proposal shall be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Medicaid no later than February 1, 2024. The proposal shall include any necessary legislative changes, including revisions to the statutory changes in subsections (b2) through (b4) of this section, and shall consider all of the following:

(1) The need to ensure access to care for enrollees while also ensuring the delivery of high-quality services and supports to those enrollees.
(2) The continued exclusion of providers previously terminated by an LME/MCO for cause, including new entities created by the same owners or managing employees of those providers.
(3) The development by DHHS and the LME/MCOs of objective quality standards for the providers that deliver services and supports that are excluded from prepaid health plan coverage except under BH IDD tailored plan contracts.
(4) The need to ensure financial viability and operating stability for existing LME/MCO network providers.
(5) The Medicaid risk category assigned to provider types under G.S. 108C-3(g).

SECTION 9E.16.(b2) G.S. 108D-21 reads as rewritten:

"§ 108D-21. LME/MCO provider networks.

~~Each~~ Until the date that BH IDD tailored plans begin operating, each LME/MCO operating the combined 1915(b) and (c) waivers or providing coverage of any services approved under the 1915(i) option shall develop and maintain a closed network of providers to ~~furnish~~ provide mental health, intellectual or developmental disabilities, ~~and~~ substance ~~abuse~~ use disorder, and traumatic brain injury services to its enrollees. A closed network is the network of providers that have contracted with the local management entity/managed care organization operating the combined 1915(b) and (c) waivers."

SECTION 9E.16.(b3) G.S. 108D-23 reads as rewritten:

"§ 108D-23. BH IDD tailored plan provider networks.

~~Each entity operating a BH IDD tailored plan 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. A closed network is the network of providers that have contracted with the entity operating a BH IDD tailored plan to furnish these services to enrollees. A closed network must include all essential providers, as designated in accordance with G.S. 108D-22(b), that (i) are located within the region for which the entity holds a~~

~~BH IDD tailored plan contract and (ii) provide any covered behavioral health, intellectual and developmental disability, or traumatic brain injury service in that region.~~

(a) Each LME/MCO shall operate provider networks with respect to its BH IDD tailored plan contract in accordance with this section.

(b) With regard to services and supports that are covered benefits under both standard benefit plans and BH IDD tailored plans, each LME/MCO shall be subject to the same provider network requirements applicable to PHPs under G.S. 108D-22.

(c) With regard to services and supports that are excluded from PHP coverage except under BH IDD tailored plans, each LME/MCO shall operate a closed network, which is the network of providers that have contracted with the LME/MCO to provide those services to enrollees, in accordance with all of the following:

(1) A closed network must include all essential providers designated in accordance with G.S. 108D-22(b) that (i) are located or provide services within the region for which the LME/MCO holds a BH IDD tailored plan contract and (ii) provide any covered behavioral health, intellectual and developmental disability, or traumatic brain injury service in that region.

(2) With regard to services identified by the Department as necessary to improve access for behavioral health, intellectual and developmental disability, and traumatic brain injury services, an LME/MCO shall accept all providers of those services that (i) meet objective quality standards and (ii) accept network rates, notwithstanding the requirement to operate a closed network."

SECTION 9E.16.(b4) Article 3 of Chapter 108D of the General Statutes is amended by adding a new section to read:

"**§ 108D-26. Other provider networks.**

(a) Beginning on the date that BH IDD tailored plans begin operating, each LME/MCO under contract with the Department (i) to provide coverage of services as a PIHP or (ii) to provide coverage of any services approved under the 1915(i) option shall operate a closed network in accordance with this section.

(b) A closed network is the network of providers that have contracted with the LME/MCO to provide to enrollees the services and supports covered by the LME/MCO either as a PIHP or under the 1915(i) option.

(c) With regard to services identified by the Department as necessary to improve access for behavioral health, intellectual and developmental disability, and traumatic brain injury services, an LME/MCO shall accept all providers of those services that (i) meet objective quality standards and (ii) accept network rates, notwithstanding the requirement in this section to operate a closed network."

SECTION 9E.16.(b5) G.S. 108D-1 is amended by adding a new subdivision to read:

"(30a) Prepaid inpatient health plan or PIHP. – A prepaid inpatient health plan, as defined in 42 C.F.R. § 438.2."

SECTION 9E.16.(b6) Subsections (b2) through (b5) of this section become effective July 1, 2024.

SECTION 9E.16.(c) No later than June 1, 2024, DHHS shall develop and submit a proposal to the Joint Legislative Oversight Committee on Medicaid to transition the administration of the Community Alternatives Program for Disabled Adults (CAP/DA) to the BH IDD tailored plans by January 1, 2025, notwithstanding G.S. 108D-40(a)(11).

SECTION 9E.16.(d) It is the intent of the General Assembly that the Medicaid Traumatic Brain Injury waiver be expanded throughout the State. Within 60 days after the effective date of this act, DHHS shall submit an amended waiver application to expand the Traumatic Brain Injury waiver statewide by January 1, 2025, or any later date approved by the Centers for Medicare and Medicaid Services. DHHS shall not implement the waiver expansion if that implementation exceeds the authority of the Division of Health Benefits under G.S. 108A-54(e)(1) or creates a recurring cost to the State that would reasonably be anticipated to exceed a future authorized budget for the Medicaid program.

SECTION 9E.16.(e) No later than January 1, 2024, DHHS shall develop and submit a proposal to the Joint Legislative Oversight Committee on Medicaid for a Medicaid Reentry Section 1115 Demonstration Opportunity waiver to provide services to the adult incarcerated population, to be managed under BH IDD tailored plan contracts, notwithstanding G.S. 108D-40(a)(9), and to begin no later than January 1, 2025. The proposal shall provide that, upon release from incarceration, Medicaid-eligible individuals shall be transitioned to a managed care plan for which the individual is eligible under G.S. 108D-40 or, if the individual is excluded from managed care, to the Medicaid Direct fee-for-service program. DHHS shall not implement the waiver if that implementation exceeds the authority of the Division of Health Benefits under G.S. 108A-54(e)(1) or creates a recurring cost to the State that would reasonably be anticipated to exceed a future authorized budget for the Medicaid program.

SECTION 9E.16.(f) Except as otherwise provided, this section is effective when it becomes law.

Appendix B: Stakeholder Surveys

LME/MCO Survey Questions

1. LME/MCO Name: _____
2. Please specify which accreditation standards your LME/MCO follows:
   - NCQA
   - URAC
3. Please indicate your position below on opening Tailored Plan networks for select services covered by Tailored Plans but not Standard Plans.

1 ***I strongly oppose opening the Tailored Plan network***	**2** ***I somewhat oppose opening the Tailored Plan network***	**3** ***I am neutral about opening the Tailored Plan network***	**4** ***I somewhat support opening the Tailored Plan Network***	**5** ***I strongly support opening the Tailored Plan Network***	***Please feel free to add any comments on your position.***

4. Please indicate your position below on potentially opening Tailored Plan networks for each of the services covered by Tailored Plans but not Standard Plans on a scale of 1 to 5. Please provide a brief rationale for the services that you rate as 1 or 2.

Service	**1** ***Strongly oppose opening the Tailored Plan network***	**2** ***Somewhat oppose opening the Tailored Plan network***	**3** ***Neutral about opening the Tailored Plan network***	**4** ***Somewhat support opening the Tailored Plan Network***	**5** ***Strongly support opening the Tailored Plan Network***	***If rated as 1 or 2, please provide a brief rationale***
Psychosocial Rehabilitation						
Substance Abuse Non-Medical Community Residential Treatment						
Substance Abuse Medically Monitored Community Residential Treatment						
Clinically managed population-specific high intensity residential program						
Child and adolescent day treatment services						
Assertive community treatment (ACT)						
Community support team (CST)						

Service	1 *Strongly oppose opening the Tailored Plan network*	2 *Somewhat oppose opening the Tailored Plan network*	3 *Neutral about opening the Tailored Plan network*	4 *Somewhat support opening the Tailored Plan Network*	5 *Strongly support opening the Tailored Plan Network*	*If rated as 1 or 2, please provide a brief rationale*
Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)						
Innovations Waiver services						
Community navigator						
Financial support services						
Community living and support						
Natural supports education						
Specialized consultation						
TBI Waiver services						
Resource facilitation						
Occupational therapy						
Physical therapy						
Speech and language therapy						
Cognitive rehabilitation						
In-home intensive support						
Life skills training						
Natural supports education						
Remote supports						
TBI and Innovations Waiver services						
Day supports						
Residential supports						
Respite						
Supported employment						
Community transition						
Crisis services						
Assistive technology						
Supportive living						
Community networking						
Home modifications						
Specialized consultation						
Vehicle modification services						
1915(i) SPA services						
Community Transition Community Living and Supports						

Service	1 *Strongly oppose opening the Tailored Plan network*	2 *Somewhat oppose opening the Tailored Plan network*	3 *Neutral about opening the Tailored Plan network*	4 *Somewhat support opening the Tailored Plan Network*	5 *Strongly support opening the Tailored Plan Network*	*If rated as 1 or 2, please provide a brief rationale*
Respite						
Supported Employment/Individual Placement Supports						
Community Living and Supports						
Individual and Transitional Support						

5. Today, what specific factors would lead your LME/MCO to exclude a provider from your network (beyond negotiation of provider rates)? Please be specific.
6. In the past year, has an NC Medicaid-enrolled provider sought to participate in your network but was excluded? *Yes/No*
7. *[If Yes]* Please explain the specific criteria and/or data points that you used to support your decision-making, if possible.
8. How does your LME/MCO ensure access to services when in-network capacity is not available (e.g., use a single case agreement to allow for a member to access service out-of-network, arrange for a member to access services via telehealth if medically appropriate)? Please be specific.
9. North Carolina's centralized credentialing system aligns with NCQA accreditation standards and requires providers looking to enroll in NC Medicaid and contract with an NC Medicaid Managed Care health plan to meet objective quality standards (including necessary training and education, experience, competency, licensure, accreditations, federal exclusions, liability record, etc., by provider type). Do you support establishing any additional quality standards for providers of open network Tailored Plan services? *[Yes/No]*
10. *[If Yes]* Please list the additional quality standards that you would support requiring for providers of open network Tailored Plan services.
11. Are there other mechanisms NCDHHS or Tailored Plans can use to ensure the quality of services that would be open network in Tailored Plans? *[Yes/No]*
12. *[If Yes]* Please list other mechanisms NCDHHS or Tailored Plans can use to ensure the quality of services that would be open network in Tailored Plans. Please be specific.

Provider Association Survey Questions

1. Organization Name: _____
2. Please indicate your position below on opening Tailored Plan networks for select services covered by Tailored Plans but not Standard Plans.

1 *I strongly oppose opening the Tailored Plan network*	2 *I somewhat oppose opening the Tailored Plan network*	3 *I am neutral about opening the Tailored Plan network*	4 *I somewhat support opening the Tailored Plan Network*	5 *I strongly support opening the Tailored Plan Network*	***Please feel free to add any comments on your position.***

3. Please indicate your position below on potentially opening Tailored Plan networks for each of the services covered by Tailored Plans but not Standard Plans on a scale of 1 to 5. Please provide a brief rationale for the services that you rate as 1 or 2.

Service	**1** ***Strongly oppose opening the Tailored Plan network***	**2** ***Somewhat oppose opening the Tailored Plan network***	**3** ***Neutral about opening the Tailored Plan network***	**4** ***Somewhat support opening the Tailored Plan Network***	**5** ***Strongly support opening the Tailored Plan Network***	***If rated as 1 or 2, please provide a brief rationale***
Psychosocial Rehabilitation						
Substance Abuse Non-Medical Community Residential Treatment						
Substance Abuse Medically Monitored Community Residential Treatment						
Clinically managed population-specific high intensity residential program						
Child and adolescent day treatment services						
Assertive community treatment (ACT)						
Community support team (CST)						
Intermediate care facilities for individuals with intellectual disabilities (ICF-IID)						
Innovations Waiver services						
Community navigator						
Financial support services						
Community living and support						
Natural supports education						
Specialized consultation						
TBI Waiver services						

Service	1 *Strongly oppose opening the Tailored Plan network*	2 *Somewhat oppose opening the Tailored Plan network*	3 *Neutral about opening the Tailored Plan network*	4 *Somewhat support opening the Tailored Plan Network*	5 *Strongly support opening the Tailored Plan Network*	*If rated as 1 or 2, please provide a brief rationale*
Resource facilitation						
Occupational therapy						
Physical therapy						
Speech and language therapy						
Cognitive rehabilitation						
In-home intensive support						
Life skills training						
Natural supports education						
Remote supports						
TBI and Innovations Waiver services						
Day supports						
Residential supports						
Respite						
Supported employment						
Community transition						
Crisis services						
Assistive technology						
Supportive living						
Community networking						
Home modifications						
Specialized consultation						
Vehicle modification services						
1915(i) SPA services						
Community Transition Community Living and Supports						
Respite						
Supported Employment/Individual Placement Supports						
Community Living and Supports						
Individual and Transitional Support						

4. To what extent are there North Carolina providers looking to join LME/MCO networks that are excluded because of closed network provisions?

5. What are the primary reasons that providers are not permitted to join LME/MCO closed networks? To what extent do you feel these are justified?
6. North Carolina's centralized credentialing system aligns with NCQA accreditation standards and requires providers looking to enroll in NC Medicaid and contract with an NC Medicaid Managed care health plan to meet objective quality standards (including necessary training and education, experience, competency, licensure, accreditations, federal exclusions, liability record, etc., by provider type). Do you support establishing any additional quality standards for providers of open network Tailored Plan services? *[Yes/No]*
7. *[If Yes]* Please list the additional quality standards that you would support requiring for providers of open network Tailored Plan services.
8. Are there other mechanisms NCDHHS or Tailored Plans can use to ensure the quality of services that would be open network in Tailored Plans? *[Yes/No]*
9. *[If Yes]* Please list other mechanisms NCDHHS or Tailored Plans can use to ensure the quality of services that would be open network in Tailored Plans. Please be specific.

SCFAC and CFAC Survey Questions

1. I am a:
    - Consumer
    - Family Member
    - Caregiver
    - Advocate
    - Other: _____
2. Is it easy for you to get an appointment with a doctor for any mental health, substance use, intellectual/developmental disabilities (I/DD), or traumatic brain injury (TBI) services that you need? [Yes/No]
3. If yes, what types of services?
4. Do you have trouble getting an appointment for any mental health, substance use, intellectual/developmental disabilities (I/DD), or traumatic brain injury (TBI) services that you need? [Yes/No]
5. If yes, what types of services?
6. Is there anything else that you want to tell us about getting care through LME/MCOs?