



North Carolina Department of Health and Human Services (DHHS) Medicaid Assessment

Stakeholder Engagement Webinar

October 2026

Agenda

- **Overview of the North Carolina Medicaid Assessment**
- **Review of Policy and Program Actions**
- **How to Provide Feedback**
- **Q&A**

Overview of the North Carolina Medicaid Assessment

NC Medicaid Assessment

Project Goal

- The purpose of the assessment is to identify strategic, data-informed strengths and opportunities for North Carolina to **enhance the outcomes, value, efficiency, and long-term sustainability of Medicaid.**
- NCDHHS is proactively undertaking this assessment as a part of its **commitment to the health of North Carolinians.**



NCDHHS is focusing on identifying opportunities to enhance:



Opportunities to Contribute to the Assessment



Medicaid is Critically Important to North Carolinians

Medicaid provides health care to over three million North Carolinians, including:



1 in 4 North
Carolinians



2 of every 5
children



50% of all births



5 in 8 people in
nursing facilities



3 in 10 people with
disabilities



\$30 billion in Medicaid funding fuels NC's economy and workforce



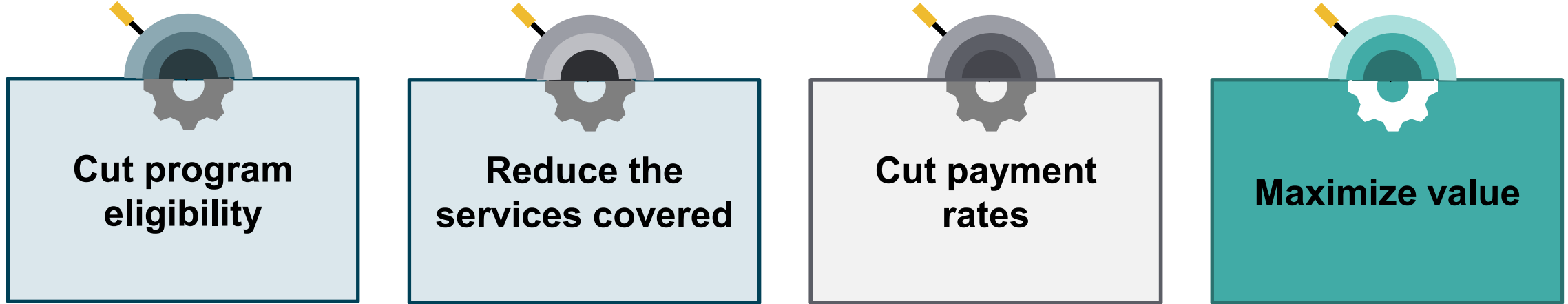
Medicaid is vital for rural North Carolinians, who rely on Medicaid more than urban residents



Medicaid expansion has reduced uninsurance and covered 730,000 North Carolinians

Policy and Program Levers Available to States to Manage Medicaid Costs

States have four major levers to manage Medicaid costs and produce savings:



Focus of this Project: Maximize Value, Outcomes, and Efficiency

While there is no magic bullet to contain Medicaid costs, states can take more nuanced, but also more complex, actions to maximize program value while producing savings.

September 2026 Webinar

Project Overview & Landscape Analysis Webinar

On September 3, 2026, NCDHHS hosted a webinar on the NC Medicaid Assessment. The session reviewed findings from the analysis of national and state data on North Carolina Medicaid cost centers, cost drivers, and outcomes.



Please refer to the webinar [here](#) for a detailed review of findings from the Landscape Analysis.

Key Takeaways from Landscape Analysis Findings

- North Carolina Medicaid is not immune to increasing health care costs.
- While North Carolina's *total Medicaid spending* – as a program and per enrollee – has grown substantially in recent years:
 - North Carolina's Medicaid spending *as a share of the general revenue* has remained flat.
 - North Carolina's per enrollee spending remains below most Peer States and the national average.
- Reductions to the federal matching percentage have recently shifted costs to the state.
- **North Carolina Medicaid – like all Medicaid programs – has opportunities to strengthen program value.** Variations in costs, rates of cost growth, and outcomes, across service lines and populations indicate opportunities to enhance the program effectiveness and efficiency.

Focus for policy action development

Review of Policy and Program Actions

Guiding Principles

DHHS used these Guiding Principles to evaluate and prioritize potential policy and program proposals.



Ensure access to care: Ensure people eligible for Medicaid can access coverage and timely care that meets their needs and provides a positive member experience



Drive whole-person health: Promote positive health outcomes, safety, and well-being through a well-coordinated and high-quality system of care



Ensure good stewardship: Optimize program administration, slow cost growth, address cost drivers, and enable a high performing program



Support program sustainability: Avoid short-term fixes that could lead to negative down-stream impacts



Emphasize achievability: Ensure feasibility by considering state burden, resources, and authority for adoption, and building on and learning from existing state initiatives

Prioritizing Policy & Program Actions



Brainstorming Actions

Through discussion with national and state experts, a large set of actions were considered and initial priorities identified.



Evaluating Actions

DHHS evaluated actions against guiding principles, considering best practices, literature, and other state examples.



Policy and Program Actions Prioritized for Stakeholder Input

Stakeholder input will further inform the state's assessment of potential actions

DHHS considered the actions identified under House Bill 696. Many of these actions were incorporated into the actions for discussion today.

Policy and Program Opportunity Areas



**Hospital
Services**



**Prescription
Drugs**



**Long Term
Services and
Supports (LTSS)**



**Population
Health**



**Care and Case
Management**



**Behavioral
Health**



Managed Care



**Research-Based
Behavioral
Health
Treatment
(RB-BHT)**



Program Integrity

Hospital Services

Action #1: Make Payments Site-Neutral for Some Outpatient Services



Description

- **Equalize rates for certain outpatient services across settings to slow cost growth and incentivize care in the community**
 - Implement site-neutral rates across outpatient hospital, ambulatory surgery centers (ASCs), and clinic settings
- Consider targeting to maintain access:
 - Apply to selected services to preserve specialty access (e.g., evaluation and management (E&M), primary care, and select diagnostic / imaging services); consider leveraging savings to rebalance primary care rates across hospital and community settings
 - Exempt critical access, rural, and safety net hospitals



Considerations

- **Hospital services are currently the largest driver of NC Medicaid costs and cost growth.**
- Site neutral payments could **slow the rate of payment growth for outpatient hospital services** and potentially steer outpatient utilization into community settings, depending on how the policy is designed.
- **Site neutral payment policies have been adopted in several states and have been introduced in NC:**
 - [HB 727](#) would generally limit Medicaid facility fees to hospital campuses, facilities with an ED, and ASCs
 - [SB 316](#) would extend restrictions to outpatient E&M and DHHS-designated diagnostic/imaging services.
- This change would need to be considered in the context of payment reductions under H.R. 1.

Action #2: Strengthen Outpatient Hospital Payment Methodology



Description

- **Improve consistency and transparency of outpatient rates across hospitals, increasing the state's ability to drive program outcomes**
 - Transition the outpatient hospital fee schedule away from percent of charges and instead base rates on a stable, modern methodology such as Enhanced Ambulatory Patient Groups (EAPGs)
 - Encourage or require managed care plans to adopt the state fee schedule



Considerations

- **Hospital charges often bear little relationship to hospitals' actual costs** and can differ widely across hospitals, with variable ties to patient acuity and resource intensity.
- Setting payment based on charges **reduces DHB's ability to incentivize** specific outpatient services that are aligned with **policy priorities**, such as primary care and behavioral health.
- Transitioning to an outpatient prospective payment system would standardize service prices across hospitals and allow DHB to **better incentivize high-value care** based on the needs of the Medicaid population.
- While this would serve as a more rational approach to rate setting, it would be unlikely to drive major cost savings.

Prescription Drugs

Action #3: Carve Pharmacy Benefit out of Managed Care



Description

- **Carve the retail pharmacy benefit out of Managed Care and into FFS to better manage overall pharmacy costs and utilization**
 - The state would administer a single pharmacy benefit for both Managed Care and FFS enrollees.
 - This policy would not apply to the medical pharmacy benefit.



Considerations

- Carving the pharmacy benefit out of Managed Care **would give the state complete control of the pharmacy benefit**, allowing the state to:
 - Increase leverage in **negotiations for supplemental rebates** with manufacturers.
 - **Maximize efficiency** by 1) paying for 340B-acquired drugs at the ceiling price and 2) securing Medicaid rebates on Medicaid-dispensed drugs.
 - **Create savings by eliminating administration and margin paid by the state** on plan rates. Savings may be partially offset by new costs incurred by the state, including an expanded contract with the state's PBA.
- This action would require legislative change to implement.

Action #4: Use PBA to Manage Medical Pharmacy Benefit



Description

- **Introduce tools to better manage the medical pharmacy benefit to ensure appropriate use of specialty drugs across Medicaid**
 - Transition management of physician-administered and outpatient hospital drugs in Medicaid FFS to the PBA
 - The state would also apply the same management protocols used for FFS to managed care.



Considerations

- **Specialty drugs are the most significant driver of prescription drug spending between 2019 and 2025.** Aggregate spending on specialty drugs increased 139% while spending on non-specialty drugs only increased 66%.
- Managing physician-administered and outpatient hospital drugs would help to **ensure appropriate use of specialty drugs** across Medicaid and **increase the state's supplemental rebate revenue.**
 - Applying the same management protocols to managed care would maximize supplemental rebates.
 - NCDHHS could establish policies that prevent disruption to ongoing courses of treatment.
- **There are upfront costs associated with transitioning to the PBA, but longer-term cost savings are expected.**

Action #5: Limit Provider Use of 340B Drug Purchasing Program



Description

- **Reduce administrative burden and maximize Medicaid rebates by limiting provider use of the 340B drug purchasing program**
 - Prevent most providers from using 340B discounted drugs on Medicaid enrollees altogether
 - Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and non-acute care hospitals would be exempt and allowed to use 340B discounted drugs for Medicaid



Considerations

- Carving out 340B from Medicaid would:
 - Allow the state to **maximize revenue by claiming supplemental rebates** on Medicaid prescription drugs, potentially lowering the net cost of Medicaid pharmacy.
 - **Decrease administrative burden** by reducing the number of disputes with pharmaceutical manufacturers and reducing plan overpayment of 340B acquired products.
- The **340B program** allows covered entities to purchase 340B drugs at discounted price; this is **essential for FQHCs/ RHCs that operate on a thin pharmacy-related budget**.
 - In the absence of 340B, providers would purchase drugs at substantially higher upfront costs, **creating cashflow issues for smaller entities** with tight budget.

Action #6: Connect Enrollees Prescribed GLP-1s to Supports



Description

- **Maximize benefits of GLP-1s by providing nutrition-related supports to enrollees**
 - Require PHPs to ensure enrollees who are prescribed GLP-1s are connected to evidence-based nutrition, weight loss, and lifestyle management programs and other supports for obesity treatment
 - Require Care Management entity for FFS enrollees to make the same connections for those enrollees



Considerations

- **GLP-1 medications are a significant cost driver for pharmacy spending**, accounting for 15% of pharmacy spending growth between 2019 and 2025.
- Nutrition-based supports and evidence-based nutrition, weight loss, and lifestyle management programs could **help to sustain the therapeutic benefits of GLP-1s**, resulting in better outcomes and cost savings to the state in the long run.
- PHPs could **leverage existing or future programs** (e.g., ILOS as proposed under the population health section) to enable available supports are reimbursable under Medicaid.
 - Alternatively, PHPs could connect enrollees to existing community services or offer these as value-added services or as part of their reinvestment activities.

LTSS

Action #7: Implement a Skilled Nursing Facility (SNF) Value Strategy



Description

- **Maximize the value of SNF investments by establishing a quality improvement and accountability program**
- Program would include:
 - Public reporting on facility-level quality and performance measures (e.g., resident experience and outcomes, staffing metrics)
 - Targeted technical assistance for under-performing facilities
 - Quality-based financial incentives (e.g., an add-on bonus) that reward facilities achieving strong performance on quality, staffing, and resident outcomes



Considerations

- **SNF spending grew** from 2021-2025, largely driven by increased **average per diem rates** for long-term SNF stays.
- During this timeframe utilization remained largely flat while **quality performance lagged**:
 - 42% of North Carolina SNFs receive just 1 or 2 stars out of CMS' 5-star quality rating system based on health inspections, staffing, and quality measures
 - The average number of fines for health & safety inspection deficiencies and average fine amount per NC facility is above the national average
- This action would complement the SNF Cost Containment Pilot established through the SFY2026-2027 Budget by **driving quality improvements**.
- A quality-based financial incentive program may require legislative action to implement.

Population Health

Action #8: Implement Next-Generation Primary Care Model Pilot



Description

- **Pilot an innovative primary care payment model that gives providers more flexibility to offer whole person care, reduce costs and improve outcomes**
 - Offer capitated primary care payment to advanced medical home (AMH) practices
- Under the pilot, DHHS may also:
 - Provide performance-based incentives linked to outcomes
 - Develop enhanced care delivery expectations (e.g., BH integration) for model participants
 - Incorporate enhanced non-visit-based population payments tied to increased care delivery expectations
 - Require pre-paid health plans (PHPs) to offer the model specified by DHHS



Considerations

- Since 2022, North Carolina's **primary care spending has declined as a share of overall spending**.
- Investments in primary care can reduce costs and avoidable utilization, as well as improve health outcomes. A key access measure remains below the national average despite recent gains in NC.
- Capitated primary care payment is more predictable and can give primary care practices more **flexibility to invest in population health infrastructure and supports** relative to visit-based reimbursement.
- PHPs already must offer value-based payments (VBP) to AMH Tier 3 practices. By designing this new model NCDHHS would **standardize and increase uptake of VBP**.
- This action will leverage Rural Health Transformation Program (RHTP) investments.

Action #9: Develop Maternal Health Vision and Action Plan for NC



Description

- **Increase statewide collaboration on maternal health to ensure a consistent and high impact approach that best uses available resources**
 - Convene partners across the state actively working to address maternal and infant outcomes
 - Develop a shared vision and goals for addressing NC's maternal health crisis and improving maternal and infant health outcomes
 - Identify, assess, and coordinate actions to advance NC's maternal health vision, including technology innovations to mitigate maternity care deserts



Considerations

- **NC has concerning maternal and infant health outcomes.**
 - NC [ranks](#) 35th for maternal mortality and 41st for infant mortality.
 - Birth [outcomes](#) for NC Medicaid births are worse compared to non-Medicaid births, with little improvement in the past five years.
 - **NC also has stark disparities:** the infant mortality rate is [1.7X higher](#) for infants with Black mothers.
- Multiple groups are actively working to improve maternal outcomes in North Carolina (e.g., NC Nurture, the Perinatal Quality Collaborative of North Carolina) and **aligning efforts across all partners could help accelerate impact.**
- As a key [payer](#) of maternal care, DHHS could bolster work underway by mobilizing a coordinated and comprehensive statewide effort to improve maternal and infant health.

Action #10: Continue to Invest in Healthy Opportunities Pilots (HOP)



Description

- **Continue investing in the Healthy Opportunities Pilots (HOP)**
 - Re-launch a limited set of HOP services with available funding in SFY 26/27
 - Secure additional state share funding to sustain HOP beyond existing time-limited funding
 - Prioritize HOP services with the strongest track record of positive impact on health outcomes and health care costs (e.g., healthy food) for a specific population (e.g., individuals with diabetes)
 - Explore opportunities to expand HOP program reach in future state fiscal years



Considerations

- NC has already demonstrated that **addressing upstream drivers of health improves Medicaid enrollees' health and reduce costs.**
 - HOP reduced Medicaid health care costs \$164 per enrollee on average and reduced ED visits and inpatient hospital admissions.
- HOP has been paused for over a year, but will re-launch during SFY 26/27, with limited funding available.
 - Accordingly, eligibility criteria and available services must be narrowed at re-launch.
- State funding is only secured through June 30th, 2027.
 - Continued investment in HOP beyond this date supports critical access to health-related services and preserves the opportunity to reach additional populations that may benefit, and could potentially bend the cost curve over time.

Care and Case Management

Action #11: Strengthen Care Management Accountability & Rigor



Description

- **Strengthen the consistency and impact of care management to better ensure appropriate and cost-effective care**
 - Develop clearer metrics to track PHP and provider performance against existing Standard Plan / AMH care management and Tailored Care Management (TCM) standards
 - Allow Standard Plans to hold delegated care management entities to relevant accreditation standards
 - Tie PHP and provider performance to updated financial and contractual remedies, potentially including corrective action plans, PHP and provider contracting via the AMH downgrade process, and/or financial penalties (e.g., on care management fees or via sanctions/damages) for PHPs and providers that do not meet standards



Considerations

- Some data [points](#) to **uneven care management engagement** for Standard Plans/AMHs, despite increases in NC's investment over time.
- Developing measurable standards **increases accountability and clarifies expectations**, which helps ensure care management is implemented as intended **both by PHPs and care management entities**.
- Providing PHPs more tools and creating clearer standards for accountability for both PHPs and providers could **strengthen oversight capacity and program integrity and ultimately quality outcomes (e.g., reduce avoidable inpatient) and associated costs**.

Action #12: Strengthen CAP/C and CAP/DA Case Management



Description

- **Strengthen case management provided to CAP/C and CAP/DA waiver participants to ensure consistency in service delivery, improve outcomes, and reduce unnecessary use of high-cost services like hospital and emergency department services.**
 - Implement improved operational practices, targeted training and technical assistance, and stronger oversight
 - Potentially rationalize the # waiver case management entities (CMEs)
 - Strengthen connections to physical and behavioral health care management
 - Develop more targeted interventions (e.g., care transitions support) or an integrated care management model



Considerations

- **Participants in the CAP/C and CAP/DA waivers are among the highest-need, highest-cost in NC's Medicaid program.**
 - From 2021 to 2025, total spending for the CAP/DA waiver population increased by 47.9% even though enrollment only increased by 3.6%.
 - Per capita inpatient hospital was also substantially higher than other waiver participants.
- **Care management is fragmented across multiple entities,** without a single point of responsibility.
- Care management **delivery is also inconsistent** across the many care management entities.
- Improving waiver case management services can improve outcomes and member satisfaction and reduce preventable costs.

Behavioral Health

Action #13: Expand Providers Offering Integrated Primary Care and Behavioral Health



Description

- **Improve the physical health of individuals with behavioral health needs by expanding integrated care models**
 - Use incentives to increase adoption of integrated evidence-based care models for individuals with serious mental illness (SMI), serious emotional disturbance (SED) and substance use disorder (SUD) and physical health comorbidities, starting with AMH+ practices
 - Require Tailored Care Management (TCM) Care Management Agencies (CMAs) to provide primary care screening and monitoring that aligns with [U.S. Preventive Service Task Force Recommendations](#)



Considerations

- NC Medicaid enrollees with a SMI, SED, or severe SUD diagnosis represent a **disproportionate amount of spend** in the Medicaid program.
 - These enrollees represent ~27% of NC's Medicaid population but ~54% of total Medicaid health spending.
- **North Carolina is [in line](#) with studies showing disproportionate spend for this population.**
- Among the 10% of costliest Medicaid enrollees, those with SMI, SED, and/or severe SUD have **high hospital costs, primarily for physical health.**
 - In SFY 25, inpatient stays totaled \$1.7B while emergency department (ED) visits totaled \$310M.
- Improved access to integrated physical and behavioral health care would help to achieve better outcomes and cost savings for this population, building on North Carolina's long-standing investments in the behavioral health continuum of care.

Action #14: Expand HCBS Supports for Individuals with Complex Co-Occurring Physical and Behavioral Health Needs



Description

- **Expand availability of Medicaid HCBS for people with significant physical and behavioral needs and maximize Medicaid match for these services**
 - Create specialized step-down supports for individuals with SMI, severe SUD, and/or neurocognitive conditions and co-occurring physical health conditions by establishing a 1915(c)(11) home and community-based service (HCBS) waiver



Considerations

- Beginning on July 1, 2028, states will have a [new HCBS waiver option](#), referred to as 1915(c)(11), to **cover HCBS for individuals whose needs are less than an institutional level of care**. States can cap enrollment for this new waiver option as a way to manage costs.
- Establishing a 1915(c)(11) waiver would allow North Carolina to offer Medicaid supports to adults with complex co-occurring behavioral health and physical health needs so they can **live successfully in the community**.
 - [Services](#) could [include](#), [for example](#), home health aides, personal care services, in-home occupational or physical therapy, adult day health services, home-delivered meals; home modifications, non-medical transportation, respite care, transition set-up, and supported employment.
- In addition to expanding access to these services, this waiver would allow North Carolina to access federal matching funds for some intensive services currently financed with state dollars, allowing existing resources to stretch further.

Action #15: Increase Specialized BH Nursing Facilities



Description

- **Increase Nursing Facility (NF) expertise in addressing complex behavioral health needs to avoid unnecessary hospitalizations**
 - Increase number of NFs (or units within NFs) that can serve as alternatives to hospitalization for individuals with psychiatric/SUD/neurocognitive conditions by enhancing reimbursement rates
 - Require mandatory training for NFs on serving individuals who have co-occurring behavioral health (BH) and physical health needs



Considerations

- As noted earlier, North Carolina has ~\$1.7B in inpatient hospital costs for the costliest Medicaid members with significant behavioral health needs.
- Care in a skilled nursing facility is much less **expensive than a hospital** by bed-day.
- It is typically difficult to place Medicaid enrollees with complex behavioral needs in traditional settings, making expanding access important. **Traditional NFs for rehabilitation are not always equipped to address the needs of Medicaid enrollees with complex behavioral health needs.**
 - For example, over 90% of skilled NF residents with opioid use disorder go untreated.
- This action would also lower the age of eligibility to age 21 to ensure access for younger individuals with complex behavioral health needs and a skilled nursing need. It would target up to 100 beds statewide from currently unused SNF capacity, as currently there are no specialized psychiatric SNF beds operating statewide.

Managed Care

Action #16: Simplify and Streamline Managed Care Administration



Description

- **Reduce administrative complexity in managed care and improve provider and member experience**
 - Reduce the number of managed care plans
 - Improve **standardization** and **simplification** across plans, including more uniformity in administrative processes and streamlined prior authorization workflows



Considerations

- Although **managed care administrative spending is substantial**, with plans reporting over \$1.2 billion in spending in SFY 2025, **providers and members generally report a worse experience navigating managed care** compared with FFS or commercial.
 - In the [most recent survey of NC primary care providers](#), managed care plans consistently performed worse than FFS and commercial payers on administrative domains.
 - Providers report that navigating different systems and workflows across multiple managed care plans contributes to a worse provider experience.
 - In the 2024 CAHPS [report](#), adults in Standard Plans rated their health plan and overall health care lower than adults in NC Medicaid overall.

Action #17: Increase Standardization in Claims Processing



Description

- **Increase use of national standards in claims processing to improve standardization across insurance products and reduce the risk of payment errors**
 - Expand use of National Correct Coding Initiative (NCCI) standards to more outpatient claims in both fee-for-service and managed care



Considerations

- Currently, NC only applies NCCI editing to lab, radiology, and pharmacy services. Expanding NCCI editing to a broader set of outpatient procedures could provide more **consistency in claims practices across the delivery system**, including Medicare and commercial plans.
- This expansion in NCCI editing would extend the process to claims where a procedure code is required, checking that providers are submitting valid and active procedure codes.
- This policy would not change coverage policies.

Action #18: Increase Quality Accountability for Tailored Plans



Description

- **Strengthen Tailored Plan quality oversight to increase the value of care provided by Tailored Plans**
 - Apply the Standard Plan quality and operational oversight mechanisms to Tailored Plans (on a similar implementation timeline as Standard Plans), including:
 - Convening a quality forum of the Tailored Plans to review performance on quality measures, comparable to the Standard Plan forum in its [sixth year](#)
 - Establishing a quality withhold program, comparable to the Standard Plan program launched in 2024



Considerations

- North Carolina quality and cost data for people with SMI/SUD highlight the complexity of the physical health needs in the Tailored Plan population and the ensuing high costs (see slides on Behavioral Health actions for more detail).
- Improved focus on quality for these members could substantially impact outcomes and costs.

Program Integrity

Action #19: Enhance Qualifications and Quality Standards for Non-Clinical Providers



Description

- **Strengthen verification of qualifications and quality monitoring for non-clinical providers** (including but not limited to RB-BHT, peer supports, mobile crisis, and HCBS direct support professionals)
 - Establish/update certification and de-certification requirements, building on existing certification requirements for select non-clinical provider types
 - Establish new requirements and workflows to verify and monitor ongoing qualifications, quality, and oversight for non-clinical providers that are not currently required to enroll in Medicaid (which could include a centralized enrollment pathway for these providers)



Considerations

- North Carolina's **centralized enrollment is limited to provider organizations and clinical providers**. While organizations that provide non-clinical services are enrolled, non-clinical providers employed by those organizations are not. As a result, non-clinical providers do not go through the same screening processes (e.g. background checks) as clinical providers.
- Licensure requirements used to verify clinical provider qualifications are not applicable to non-clinical providers. To help bridge that gap, North Carolina has created **certification requirements for select non-clinical providers** (including RB-BHT and peer supports).
- Data show an **elevated program integrity [risk](#) associated with non-clinical providers**.
- **Uptake and spend on non-clinical services** is substantial and increasing. For example, per-enrollee spend on peer supports increased by 130% from SFY 2021 to SFY 2025.
- DHHS, in partnership with the General Assembly, has already made significant progress on this action, including [recent legislation](#) to **close networks** and tighter clinical coverage policies for RB-BHT.

Action #20: Enhance Data-Driven Oversight of Utilization & Claims



Description

- **Leverage technology and new resources to enhance existing program integrity functions, further reducing fraud, waste and abuse (FWA), specifically in:**
 - Identifying classes of providers and/or services that present an elevated risk of FWA, as well as specific higher-risk providers within those classes
 - Enhancing provider screening, coverage and prior authorization policies, claims editing, and pre-payment review in higher-risk classes
 - Leveraging analytics and post-payment reviews to identify concerning trends and verify compliance of individual providers



Considerations

- National data indicates an **opportunity to prevent both FWA and improper payments in Medicaid.**
- **Effective program integrity policy protects beneficiary wellbeing and promotes responsible stewardship of public dollars**, while avoiding undue constraints on benefit access and administrative burdens on good-faith providers.
- In recent years, advances in technology/analytics has **both created new tools for committing fraud** and provided **new tools for states and managed care plans to more effectively combat it.**
- This action **would leverage new resources in North Carolina's SFY 26-27 State Budget**, which provides funding for the Office of Compliance & Program Integrity (OCPI) and FWA detection technology through the Government Data Analytics Center.

Research-Based Behavioral Health Treatment (RB-BHT)

[ACTION TAKEN] #21: Ensure Appropriate Utilization of RB-BHT Services



Description

- **Ensure appropriate utilization of RB-BHT services through targeted changes to how services are authorized and updating information about covered activities**
- For treatment plans with more than 16 hours of service/week:
 - Require reauthorization of services at least every 90 days (versus 180 days for all other treatment plans).*
 - When requesting service authorization, providers must submit a typical weekly service schedule of all Medicaid-covered and non-Medicaid covered services the beneficiary receives.
- Clarify in the clinical coverage policy activities that are not covered under RB-BHT (e.g., nap time, break time, respite, custodial care).



Considerations

- The RB-BHT **provider market expanded rapidly** in NC over the last several years, coupled with an **exponential growth in spending and utilization**. SFY 2022-SFY2025:
 - The number of beneficiaries receiving RB-BHT increased 249%
 - Claims for RB-BHT increased by 305%
 - Medicaid spending for RB-BHT spending grew by 347%
- This action **aligns with focus from state lawmakers and the federal government** on program integrity, oversight, and enforcement of ABA services. CMS's [ABA Toolkit](#) cites concern with “a number of investigations leading to prosecution pointing to fraud, waste, and abuse in the ABA industry.”

[ACTION TAKEN] #22: Strengthen RB-BHT Treatment Planning and Standards for ASD Diagnosis



Description

- **Align RB-BHT service delivery with national clinical standards and current best practices**
 - Require all beneficiaries have an individualized treatment plan, including how many hours of service they receive per week.
 - Require all treatment plans be based on an assessment conducted using DHB-approved, scientifically validated tools.
 - Incorporate caregivers into treatment by requiring caregiver goals in treatment plans and caregiver involvement in assessments and treatment planning.*
 - Strengthen diagnosis requirements for RB-BHT eligibility, including use of DHB-approved, scientifically validated diagnostic tools.



Considerations

- The increase in RB-BHT service intensity (i.e., how many hours per week a beneficiary receives) over the last several years suggests that some treatment plans were **not informed by an assessment or individualized** to the needs identified in the assessment.
 - From SFY 2022-2025, the increase in claims outpaced the increase in number of beneficiaries receiving services (305% versus 249%)
- Prior to a [8/2026 update](#), the RB-BHT clinical coverage policy did **not align with widely-accepted clinical standards**, including caregiver involvement to support service titration and discharge. At least one health plan reported that caregiver engagement in treatment was limited.

[ACTION TAKEN] #23: Strengthen RB-BHT Provider Requirements



Description

- **Strengthen RB-BHT provider requirements and implement guardrails on use of telehealth***
 - Prohibit out-of-state RBH-BHT providers from enrolling in NC Medicaid (will apply to currently enrolled providers beginning summer 2027)
 - Prohibit paraprofessionals/behavioral technicians from delivering services via telehealth
 - Require technicians providing Applied Behavior Analysis (ABA) be certified by the Behavior Analyst Certification Board or the Qualified Applied Behavior Analysis Credentialing Board
 - Establish new technician supervision minimum standards, including the maximum amount of technician supervision that may be delivered via telehealth



Considerations

- RB-BHT providers **rely on direct observation** of behavior to make decisions regarding treatment planning and treatment delivery. Out-of-state providers who are fully remote have more limited observation opportunities.
- Requiring certification for behavior technicians promotes **standards of professional conduct**, and consistent and **high-quality service delivery**.

How to Provide Feedback

Opportunity to Provide Input & Additional Opportunities for Engagement

Feedback Submission

Submit your feedback by October 7th:



Link: <https://forms.cloud.microsoft/g/LBy9i0i7qT?origin=lprLink>

Next Engagement Opportunity

- NCDHHS will release the NC Medicaid Assessment Report in late October.
- **We plan to open public comment on the report – stay tuned for more information!**

For additional information about the NC Medicaid Assessment, visit:

<https://medicaid.ncdhhs.gov/assessment>

Q&A

Thank you!