



March 23, 2022

**Provider Network and Contracting Guidance for Prepaid Health Plans¹
LME/MCOs contracted for Behavioral Health I/DD Services for Medicaid Direct
Partners/Subcontractors and Providers**

With the addition of the Behavioral Health I/DD Tailored Plan Program to NC Medicaid Managed Care, providers, Prepaid Health Plans (PHPs), LME/MCOs contracted for Behavioral Health I/DD Services for Medicaid Direct, Subcontractor Network Vendors² (Subcontractors), and Brokers need guidance on how to navigate the new managed care landscape as it relates to provider networks and provider contracting. This guidance is intended to help explain various partnership arrangements between Health Plans (includes PHPs and LME/MCOs), Subcontractors, and Brokers and how those arrangements impact providers, provider networks and provider contracting.

Health Plans may participate in multiple NC Medicaid programs³ through direct contracts with the Department or through agreements/partnerships between Health Plans. Subcontractors/Brokers may participate in multiple programs through direct contracts with a Health Plan or through agreements/partnerships between Health Plans. Each program a Health Plan/Subcontractor/Broker participates under will have a provider network associated with it. This memo outlines how a Health Plan/Subcontractor/Broker may leverage one program's network and existing provider network participation agreements for use in another of the Health Plan/Subcontractor/Broker's programs.

To best support the development of provider networks for new NC Medicaid programs, and to ease administrative burden and streamline processes for providers and Health Plans/Subcontractors/Brokers, this guidance outlines the options for providers with existing provider network participation agreements for one or more of a Health Plan/Subcontractor/Broker's programs relating to participation (or not) in a Health Plan/Subcontractor/Broker's new program's network.

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¹ Prepaid Health Plans is defined as in N.C.G.S. § 108D-1(30), and includes PHPs contracted as Standard Plans and as BH I/DD Tailored Plans.

² Subcontractor Network Vendor/Broker means a subcontractor of a Medicaid Managed Care health plan who performs network management relating to some part of the Health Plan's network.

³ NC Medicaid Programs are limited to PHPs' Standard Plans and Tailored Plans and LME/MCOs Behavioral Health I/DD Services under a Medicaid Direct Contract, the Prepaid Inpatient Health Plan (PIHP) contract for Behavioral Health and I/DD Services for Medicaid Services under the Medicaid Direct and other future NC Medicaid Managed Care related programs as applicable.

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1. For Health Plans

A. Leveraging Existing Provider Network Participation Agreements

- 1) A Health Plan⁴ may leverage a provider network associated with one NC Medicaid program for use with another of the Health Plan's NC Medicaid programs through the use of amendments to existing provider network participation agreements⁵ and the use of a stand-alone provider network participation agreement that only includes participation in the new program when requested by the provider.
- 2) Unless the provider requests negotiations for participation in a new program's network or rejects participation in a new program's network pursuant to the Health Plan's directions/process, the Health Plan may consider the provider to have accepted the option to participate in the new NC Medicaid program's network once an amendment to the provider network participation agreement, which includes one or more new program(s) by name(s)/description(s), is issued to the provider and ninety (90) calendar days have passed.
 - a. Health plan shall retain a record of a provider's rejection of participation in any NC Medicaid program and shall make the record(s) available to the Department upon request.
 - b. Health plan shall collect rejection of a provider's participation for each new NC Medicaid program, and a provider's rejection of participation in one program shall have no impact upon the provider's new participation or continued participation in any other NC Medicaid program of the Health Plan.
- 3) Health plan shall outline in writing all the options for a provider including the following:
 - a. Provider may accept the amendment as proposed;
 - b. Provider may ask for a stand-alone provider network participation agreement which includes only the new program network and enter into a Good Faith Contracting episode, as applicable, to negotiate the stand-alone agreement;
 - c. Provider may request negotiations be opened on the amendment, which, if applicable, activates a Good Faith Contracting episode; or
 - d. Provider may reject participation in the new program's network as outlined by the Health Plan.
 - i. The process to reject participation shall be clear and include how a provider who is a health care system or a group may opt out for multiple participating providers under one or multiple contracts with the Health Plan.
- 4) A provider may reject participation in a NC Medicaid program's network according to the rejection process outlined in the notice related to the amendment or according to the provider's in force network participation agreement, as applicable.
- 5) A Health Plan must amend the existing provider network participation agreement to bring the agreement into compliance with any applicable provider contract standards across any applicable NC Medicaid program, including the addition of new services such as hospital or integrated Primary Care Provider services, related to the new program. For example, if a BH I/DD Tailored Plan program network is being added, the existing provider participation agreement must be updated to include any requirements applicable to the agreement that apply through the BH I/DD Tailored Plan Contract.

⁴ Health Plan includes Standard Plans, BH I/DD Tailored Plans, and LME/MCOs contracted for BH I/DD Services for Medicaid Direct.

⁵ "Provider network participation agreement" is the same thing as a Provider Contract as referenced in the PHP Contract and the BH I/DD Tailored Plan Contract.

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- 6) A Health Plan must have stand-alone provider network participation agreements, where the agreement is inclusive of a single NC Medicaid program only, to use with any provider who requests such an agreement to participate in any of the Health Plan's NC Medicaid programs' networks.

B. Submission of Provider Network Participation Agreement Templates

- 1) A Health Plan must submit all provider network participation agreement templates for all programs, including any amendments, addendums, or appendices for the Department's review and acceptance.
- 2) A Health Plan must submit its Subcontractor's/Broker's provider network participation agreements, and related amendments, addendums, or appendices for the Department's review and acceptance. Examples of subcontractors could be a vendor who manages the Pharmacy, Vision, Durable Medical Equipment and/or NEMT network for the Health Plan.
- 3) For the scenario described in Section 1.C.1).c., once the documents in 1.B.1) and 1.B.2) are accepted by the Department for the Standard Plan Health Plan, the BH I/DD Tailored Plan Health Plan must then submit the SAME documents through the PCDU for the Department to accept for the Tailored Plan Health Plan.

C. Examples of Applicable Scenarios

- 1) The process outlined in this Section 1 applies to Health Plans for NC Medicaid programs. This includes, but is not limited to, the following scenarios:
 - a. An LME/MCO leveraging its existing BH, I/DD, TBI Medicaid Direct program network for use with the Behavioral Health I/DD Tailored Plan program network.
 - b. An LME/MCO leveraging its existing BH, I/DD, TBI Medicaid Direct program network for use with the new Prepaid Inpatient Health Plan (PIHP) contract for Behavioral Health and I/DD Services for Medicaid Services under the Medicaid Direct program network.
 - c. A Standard Plan leveraging its existing Standard Plan program network for use with one or more Behavioral Health I/DD Tailored Plan program's network as part of a Tailored Plan/Standard Plan partnership agreement.

D. Next Steps for Health Plans

- 1) Health Plans shall develop an outreach approach to provide an explanation of the Health Plan's decision to leverage an existing program's network in another NC Medicaid program and to outline the provider's options as outlined in Section 1.A.3). The target audience of the outreach shall be existing contracted providers under a program's network that is being leveraged.
 - a. The outreach program shall include at least one (1) verbal attempt prior to the issuance of the amendment and at least one (1) written attempt concurrent with the issuance of the amendment and at least one (1) verbal follow-up attempt within the ninety (90) calendar day period since the amendment was issued.
 - b. A description of the outreach program shall be added to the Health Plan's Good Faith Contracting Policy once the applicable DHHS Contract is amended to include the requirement.
 - i. A Health Plan may choose to include a description of the outreach program in its Good Faith Contracting policy in advance of an amendment to the applicable DHHS Contract requiring such.

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- c. The outreach methods shall include both written (electronically or hard copy) and verbal communications (including telephonically), and should at a minimum include:
 - i. A statement of how a provider can reject the option to participate in a new program,
 - ii. A statement that choosing to reject participation in any program shall not have any impact upon the provider's ability to continue participation under other programs, and
 - iii. A contact at the Health Plan where a provider may pose questions about the new program and the amendment to the provider network participation agreement.
- 2) Health Plans whose Subcontractor/Broker is leveraging an existing program's network in another program (as outlined in Section 2) shall ensure that the Subcontractor/Broker has an outreach program which complies with Section 1.D.1). The target audience of that outreach shall be existing contracted providers under the Subcontractor/Broker's program network that is being leveraged.

2. For Subcontractors and/or Brokers

A. Leveraging Existing Provider Network Participation Agreements

- 1) A Subcontractor/Broker may leverage a provider network associated with one program for use with another of the Subcontractor/Broker's programs through the use of amendments to existing provider network participation agreements and the use of a stand-alone provider network participation agreement that only includes participation in the new program when requested by the provider.
- 2) Unless the provider rejects participation in a new program's network pursuant to the Subcontractor/Broker's directions/process, the Subcontractor/Broker may consider the provider to have accepted the option to participate in the new program's network once an amendment to the provider network participation agreement, which includes one or more new program(s) by name/description, is issued to the provider and ninety (90) calendar days have passed.
 - a. Subcontractor/Broker shall retain a record of a provider's rejection of participation in any NC Medicaid program and shall make the record(s) available to Department upon request. The Subcontractor/Broker shall make the information available via the Health Plan.
 - b. Subcontractor/Broker shall collect rejection of a provider's participation for each new NC Medicaid program, and a provider's rejection of participation in one program shall have no impact upon the provider's new participation or continued participation in any other NC Medicaid program of the Subcontractor/Broker.
- 3) Subcontractor/Broker shall outline in writing all the options for a provider including the following:
 - a. Provider may accept the amendment as proposed;
 - b. Provider may ask for a stand-alone provider network participation agreement which includes only the new program network and enter into a Good Faith Contracting episode, as applicable, to negotiate the stand-alone agreement;
 - c. Provider may request negotiations be opened on the amendment, which, if applicable, activates a Good Faith Contracting episode; or
 - d. Provider may reject participation in the new program's network as outlined by the Health Plan.
 - i. The process to reject participation shall be clear and include how a provider who is a health care system or a group may opt out for multiple participating providers under one or multiple contracts with the Health Plan.

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- 4) A provider may reject participation in a program's network according to the rejection process outlined in the notice related to the amendment or according to the provider's in force network participation agreement, as applicable, and such action shall have no impact upon the provider's continued participation in any other program's network of the Subcontractor/Broker. The provider shall follow the Subcontractor/Broker's policy/process in rejecting participation.
- 5) A Subcontractor/Broker must amend the existing provider network participation agreement to bring the agreement into compliance with any applicable provider contract standards, including the addition of new services such as hospital or integrated Primary Care Provider services, related to the new program. For example, if a BH I/DD Tailored Plan program network is being added, the existing provider participation agreement must be updated to include any requirements applicable to the agreement that apply through the BH I/DD Tailored Plan Contract.
- 6) A Subcontractor/Broker must have stand-alone provider network participation agreements to use with any provider who requests such an agreement to participate in any of the Subcontractor/Broker's program networks.

B. Submission of Provider Network Participation Agreement Templates

- 1) A Subcontractor/Broker's provider network participation agreement templates, including any amendments, addenda, or appendices, must be submitted for the Department's review and acceptance.
- 2) A Health Plan must submit its Subcontractor/Broker's provider network participation agreement templates, and related amendments, addendums, or appendices for the Department's review and acceptance. Examples of subcontractors could be a vendor who manages the Pharmacy, Vision, Durable Medical Equipment and/or NEMT network for the Health Plan.
- 3) For the scenario described in Section 1.C.1).c., once the documents in 2.B.1) and 2.B.2) are accepted by the Department for the Standard Plan Health Plan, the BH I/DD Tailored Plan Health Plan must then submit the SAME documents through the PCDU for the Department to accept for that Health Plan.

C. Examples of Applicable Scenarios

- 1) The process outlined in this Section 2 applies to Subcontractor/Brokers of Health Plans for NC Medicaid Managed Care programs. This includes, but is not limited to, the following scenarios:
 - a. A Subcontractor/Broker directly contracted with a BH I/DD Tailored Plan leveraging its existing Standard Plan program network for use with the Behavioral Health I/DD Tailored Plan program network.
 - b. A Standard Plan leveraging its existing Subcontractor/Broker Standard Plan program network for use with the Behavioral Health I/DD Tailored Plan program network as part of a Tailored Plan/Standard Plan partnership agreement.

3. General Information

- 1) This guidance is not intended to supersede or interfere with the termination process outlined in a in force provider network participation agreement. Therefore, a provider's termination from a NC Medicaid program network shall be governed by the terms of the provider network participation agreement in force between the provider and the Health Plan/Subcontractor/Broker.
- 2) Health Plans/Subcontractor/Brokers are encouraged to ensure the notice(s) and amendment(s) about participation in a new program's network are delivered to the appropriate contact(s) for an in force provider network participation agreement.

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- 3) Health Plans/Subcontractor/Brokers shall send the notice(s) and amendment(s) about participation in a new program's network at the same level as the in force provider network participation agreement being proposed for amendment.
- 4) Providers do not have to wait to receive notice and an amendment from a Health Plan/Subcontractor/Broker to engage the entity about participation in a new program's network. Providers should reach out to their contract representative at the Health Plan/Subcontractor/Broker or the general contact for provider contracting at the entity to discuss participation.

Frequently Asked Questions and Responses

Please refer to the NCMT Provider Contracting Guidance Q&A document issued on 3/10/2022 for questions and responses relating to this guidance.

Version

DATE	VERSION	SECTION UPDATED	CHANGE
01-26-2022	Version 1.0	Original Draft	Original
03-23-2022	Version 2.0	Introduction, Sections 1.A, 1.D, 2.A., added new Section 3; Frequently Asked Question and Responses section	<ul style="list-style-type: none">• Changed the period following issuance of an amendment from 30 days to 90 days• Clarified that the guidance is not intended to interfere with the termination process outlined in a provider contract• Updated introduction• Outlined that providers have several options and added provision where the outline of those options must be included in the notice to providers