Provider Network and Contracting Guidance
Frequently Asked Questions

This document is intended to be a companion piece to the *Provider Network and Contracting Guidance for Prepaid Health Plans, LME/MCOs contracted for Behavioral Health I/DD Services for Medicaid Direct, Partners/Subcontractors and Providers, v1.0* (the Guidance) dated 1/26/2022.

The following are responses to questions received from stakeholders and interested parties relating to the Guidance. These questions and responses are intended to provide clarification and/or additional instruction relating to Health Plan contracts and networks.

The use of the term "Health Plan" in this document is intended to be inclusive of Prepaid Health Plans (as defined in G.S. § 108D-1(30)), entities contracted as PIHPs for Behavioral Health I/DD Services for Medicaid Direct, and Subcontractor Network Vendors (such as for Pharmacy services, vision care services, or NEMT) who are contracted with a PHP and/or a PIHP for Behavioral Health I/DD Services for Medicaid Direct.

Frequently Asked Questions and Responses

Note: Questions 1 and 2 were published in the Guidance under Section 3. No changes have been made.

1. **Question**: What if a provider wishes to participate in a Standard Plan Health Plan's network but only to be part of the Standard Plan's BH I/DD Tailored Plan program network established under a Standard Plan/BH I/DD Tailored Plan partnership?

   Answer: Given that a Standard Plan Health Plan's network is open to "any willing provider", a provider who wishes to participate only in the Standard Plan's BH I/DD Tailored Plan program network through the Standard Plan Health Plan's partnership with a BH I/DD Tailored Plan Health Plan may contract with the Standard Plan Health Plan/Subcontractor/Broker just for this purpose.

2. **Question:** What if a Standard Plan Health Plan is partnered with multiple BH I/DD Tailored Plan Health Plans and a contracted provider wishes to participate only in one BH I/DD Tailored Plan program's network?

   Answer: A Standard Plan Health Plan who utilizes its Standard Plan program network with multiple BH I/DD Tailored Plan programs shall allow a provider to choose the BH I/DD Tailored Plan program networks with which it will participate and with which networks it will not participate.

Note: Questions from this point onward are new questions not previously published.

3. **Question**: May a BH I/DD Tailored Plan and its partnering Standard Plan coordinate on the content of the Standard Plan's amendment to existing provider network participation agreements prior to the submission of the amendment to the Department?

   Answer: Yes. Nothing in this guidance is intended to prohibit a Standard Plan from coordinating and discussing with its partnering BH I/DD Tailored Plan the Standard Plan's amendment prior to submission of the amendment to the Department for acceptance. The Department encourages partners to work together to assure the amendment(s) submitted are compliant with the Tailored Plan contract and that the two parties are in agreement before the amendment(s) are submitted to the Department

4. **Question**: Please confirm that the Standard Plan should submit the amendment template for the Tailored Plan product to the Department for approval.

   Answer: Yes, each Health Plan who is using an amendment with existing network participation agreements is required to obtain approval of its amendment. Per the Standard Plan Contract and BH I/DD Tailored Plan Contract, all provider contract templates must be submitted to the Department for review and acceptance, including new amendments, appendices, addenda, or attachments that make up the provider contract template.

5. **Question**: Once the Department approves the Standard Plan templates, can they be used prior to approval for the SAME templates through the Tailored Plan submission?

   Answer: A Health Plan may use filed provider contract documents before their acceptance as long as the provider is informed the document is subject to change. A Standard Plan need not wait for their partnering BH I/DD Tailored Plan to receive approval of the amendment.

6. **Question**: Is there an expectation that the Standard Plan submits and receives approval to the Good Faith Contracting policy in advance of any templates being used?

   Answer: The guidance indicated that the Good Faith Contracting Policy is not required to be updated with the outreach program until the appropriate health plan contract with DHHS is amended, but a Health Plan may update the policy before that point if it chooses.

7. **Question:** Does this guidance also apply to a Health Plan building a “new” network in a new region?

   Answer: To the degree that a Health Plan has existing network providers who are located in the new region and/or who are in a border area to the region and provide services to beneficiaries who reside in the new region, then yes, the Health Plan could leverage those existing network participation agreements as outlined in the guidance document.

8. **Question:** Does a Health Plan need to apply the “outreach plan” to the new providers joining the network or only to the existing one?

   Answer: The outreach plan is intended for existing network providers. Health Plans should ensure that a contract with a newly contracted provider clearly outlines the programs’ networks that the provider has agreed to join. That could be accomplished through a product attachment/addendum/amendment or other contractual provision included as part of the base provider contract template.

Note: Questions 9 and 10 and responses were recently posted in the general TP FAQ tracker.

9. **Question:** Do LME/MCO's leveraging the current BH/IDD Network and sending amendments to current par providers have to develop an outreach program and update the Good Faith Contracting Policy or is this specific to the Standard Plan leveraging the SP network to build the TP Physical health network?

   Answer: The idea of the outreach program is to ensure that existing network providers are informed of the addition of the new program and have some context for the amendment if the health plan is leveraging existing contracts to build the network for the new program. The provisions were intended to apply to any Health Plan as referenced in the guidance. The update to the Good Faith Contracting (GFC) policy is optional at this point, but the Department intends to update the Standard Plan and Tailored Plan contracts to require the GFC policy to be updated as indicated.

10. **Question:** Do both the LME/MCO and SP partner have to develop separate outreach programs – such as one for providers under a LME/MCO network and the other for providers under the SP network

    Answer: Any entity who is leveraging an existing network and existing provider contracts to build a new program's network is expected to have its own outreach program for its existing network providers. In the case of Tailored Plan (LME/MCO) and Standard Plan partners, the two entities could develop the outreach together, but each entity is responsible under the guidance to provide outreach to its existing network providers.

11. **Question:** Please confirm that the BH I/DD Tailored Plan should approve the Standard Plan's amendment before the Standard Plan sends to the Department

    Answer: Refer to Question 3.

12. **Question:** In regard to Section 1.A.1. of the Guidance and the use of the word "and" when referring to amendments and stand-alone contracts. This implies that both are required for any provider. Please provide clarification whether Health Plans can use an amendment **or** a stand-alone contract.

    Answer: Consistent with previous position taken by the Department, a provider always has the ability to request a stand-alone Medicaid related network participation agreement from a Health Plan, and the Health Plan is required to have such an agreement available.

13. In regard to Section 1.A.4. of the Guidance and the requirement to amend the existing network participation agreements to bring the agreement into compliance with any applicable provider contract standards across any applicable NC Medicaid program, please clarify whether a Health Plan should add existing language to the Medicaid attachment or a separate attachment.

    Answer: A Health Plan is free to choose the vehicle it uses to amend an existing network participation agreement to comply with any new or different standards from the new NC Medicaid program.

14. **Question:** In regard to Section 1.A.5. of the Guidance and the requirement to have stand-alone provider network participation agreements where the agreement is inclusive of a single NC Medicaid program only, please provide clarification if multiple agreements will be required to satisfy this scenario if a participating provider decides to participate in a new program.

    Answer: Refer to Question 13.

Version

DATE	SECTION UPDATED	CHANGE
03-10-22	**Version 1.0**	**Original**