Ensuring Person-Centered Care for Children with Autism Spectrum Disorder in the NC Medicaid Program

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Executive Summary

The North Carolina Department of Health and Human Services (NCDHHS) is committed to ensuring access to high-quality and appropriate services for children and youth diagnosed with Autism Spectrum Disorder (ASD). Children with ASD who are enrolled in North Carolina Medicaid (NC Medicaid) have access to a continuum of services and supports, including Research-Based Behavioral Health Treatment (RB-BHT), which covers research-based treatment modalities for ASD that are "supported by credible scientific or clinical evidence."[i]

NC Medicaid is currently experiencing an exponential increase in utilization and spending on RB-BHT. **Between State Fiscal Year (SFY) 2022 and SFY 2026, total Medicaid spending on RB-BHT is projected to increase by approximately 425%, from $121.7 million in SFY 2022 to $639 million in SFY 2026** (see Figure 1), making it one of the most costly services in the NC Medicaid array.[ii] Some portion of this increase may be attributable to the increased number of providers in the market and a 2024 15% rate increase implemented in partnership with the General Assembly.[iii] However, the increases in utilization and associated spending are not spread evenly across all providers, and the increases far outpace the increase in ASD diagnosis in the state. Though NCDHHS recognizes that additional analysis of utilization patterns is needed, the available data raise concerns about the service mix, intensity and consistency of the services being provided by some providers and whether children and youth are consistently receiving services that are individualized to their clinical needs.

In light of these trends, NCDHHS has undertaken a review of its RB-BHT program to identify key drivers of increased utilization and associated spending. **Based on the findings of this review,**

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[i] For more information see Clinical Coverage Policy 8F for RB-BHT available at https://medicaid.ncdhhs.gov/8f-research-based-behavioral-health-treatment-rb-bht-autism-spectrum-disorder-asd/download?attachment

[ii] Total Medicaid spending reflects spending across Behavioral Health and Intellectual/Developmental Disability Tailored Plans (Tailored Plans), Standard Plans, and NC Medicaid Direct. SFY 2023 and SFY 2024 spending data used in this paper reflect data with payment runout through August 2024. The associated dollars reflect all base data adjustments applied as part of NCDHHS's actuary's base data development, including adjustments for completion. Due to limitations of available older data, the SFY 2022 dollars do not reflect any base data adjustments. However, it has runout through August 2023 and should be considered reasonably complete. Counts of users, claim lines, and providers used in this paper do not reflect any base data adjustments for any time period. SFY 2025 and SFY 2026 estimates are based on available capitation rate development information illustrated in the SFY 2026 Rate Books for each respective program. SFY 2026 projections are also inclusive of the RB-BHT fee schedule reduction effective Oct. 1, 2025.

[iii] The 15% rate increase for RB-BHT in 2024 applied to all seven RB-BHT CPT billing codes (97151, 97152, 97153, 97154, 97155, 97156, 97157) and was part of a broader set of Medicaid rate increases.

NCDHHS is releasing for community feedback the following proposed policy actions that would bring the RB-BHT program in closer alignment with national clinical practice guidelines, stabilize spending and utilization at a sustainable level, and ensure that children and youth with ASD in North Carolina have access to medically necessary, high quality, whole-person care:

Utilization and Spending Drivers	Proposed Policy Actions
A. Treatment may not be delivered in line with national clinical practice guidelines, and members' treatment plans may not be individualized.	1. Clarify the RB-BHT Clinical Coverage Policy to ensure all RB-BHT treatment plans are individualized. 2. Require caregiver goals to be incorporated into treatment plans. 3. Develop and publish a statewide RB-BHT services provider manual. 4. Standardize utilization management processes across delivery systems (e.g., NC Medicaid Direct, Tailored Plans, Standard Plans, CFSP). 5. Collaborate with health plans and the North Carolina Department of Justice to strengthen program integrity and documentation standards proportionate to risk. 6. Require certification and credentialing for Applied Behavior Analysis (ABA) technicians as a condition of NC Medicaid participation prior to the provision of services.
B. RB-BHT risks being utilized as the primary treatment after an ASD diagnosis, even when less intensive research-based therapies and supports are available and clinically appropriate.	7. Require whole-person care planning for children and youth with ASD and provide linkages to the full continuum of ASD treatment and support services for the member and their family/caregivers. 8. Clarify provider types that may make an ASD diagnosis and refer to ASD services, including RB-BHT.
C. The RB-BHT Clinical Coverage Policy can clarify billing requirements to reduce provider confusion.	9. Clarify RB-BHT Clinical Coverage Policy requirements on billing.
D. A significant number of new providers have entered the North Carolina market.	10. Work with the General Assembly to amend state statute to allow health plans to operate a closed provider network for RB-BHT. 11. Identify strategies to align rate structure with quality.

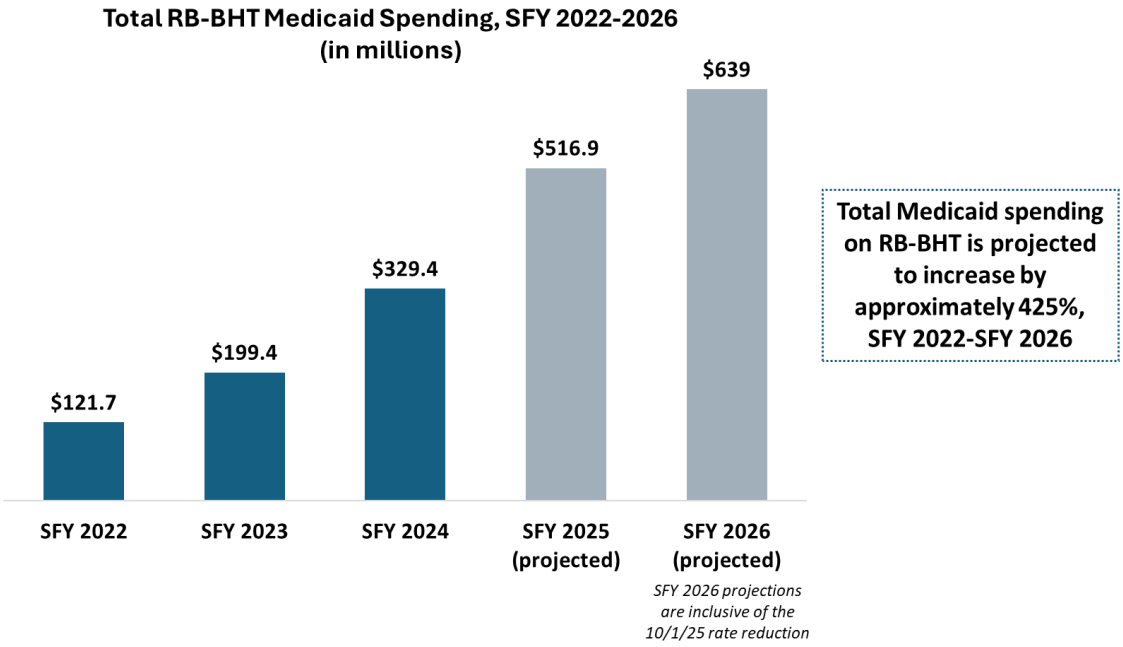
Introduction

Children with Autism Spectrum Disorder (ASD) who are enrolled in North Carolina Medicaid (NC Medicaid) have access to a continuum of services and supports, including Research-Based Behavioral Health Treatment (RB-BHT), which covers research-based treatment modalities for ASD that are "supported by credible scientific or clinical evidence."[iv] Over the last several years, utilization and spending for RB-BHT has increased sharply over a short period of time, and that trend is expected to continue. From State Fiscal Year (SFY) 2022 to SFY 2024, spending grew 171% from $121.7 million to $329.4 million. **By SFY 2026, total Medicaid spending on RB-BHT is projected to hit $639 million**, making it one of the most costly services in the NC Medicaid array (see Figure 1).[v] This increase far outpaces the rise in ASD diagnosis in the state, though some portion of the utilization and spending increases is attributable to greater access to care (due to an expanding provider network, new provider types introduced through licensure changes, and targeted provider outreach to families) and a 2024 15% rate increase implemented across a broad set of Medicaid services in partnership with the General Assembly. However, the sharp increase in RB-BHT utilization and spending in such a short timeframe raises concerns in some instances about the service mix, intensity of services, the consistency of documentation and the use of individualized plans.

[iv] For more information see Clinical Coverage Policy 8F for RB-BHT available at https://medicaid.ncdhhs.gov/8f-research-based-behavioral-health-treatment-rb-bht-autism-spectrum-disorder-asd/download?attachment.

[v] Total Medicaid spending reflects spending across Behavioral Health and Intellectual/Developmental Disability Tailored Plans (Tailored Plans), Standard Plans, and NC Medicaid Direct. SFY 2023 and SFY 2024 spending data used in this paper reflect data with payment runout through August 2024. The associated dollars reflect all base data adjustments applied as part of NCDHHS's actuary's base data development, including adjustments for completion. Due to limitations of available older data, the SFY 2022 dollars do not reflect any base data adjustments. However, it has runout through August 2023 and should be considered reasonably complete. Counts of users, claim lines, and providers used in this paper do not reflect any base data adjustments for any time period. SFY 2025 and SFY 2026 estimates are based on available capitation rate development information illustrated in the SFY 2026 Rate Books for each respective program. SFY 2026 projections are also inclusive of the RB-BHT fee schedule reduction effective Oct. 1, 2025.

Figure 1.



In light of these trends, NCDHHS has undertaken a review of its RB-BHT program design to identify key drivers of increased utilization and associated spending. Based on the findings of this review, NCDHHS is releasing for community feedback a series of proposed policy actions. Any changes that are implemented will be done in close collaboration with clinical experts, families and advocates to ensure those changes build on the strengths of the RB-BHT program to bring it in line with national clinical practice guidelines, stabilize spending and utilization at a sustainable level, and ensure that children and youth with ASD in North Carolina have access to medically necessary, high quality, whole-person care.

RB-BHT in NC Medicaid

Autism Spectrum Disorder (ASD) is a neurological and developmental disorder that can impact how a person interacts and communicates with other people and how they function in school, work, and other areas of life.[1] The specifics of the impact of ASD and the levels and types of support needs for individuals with ASD vary significantly from person-to-person.[vi]

[vi] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies ASD into three levels of severity based on support needed with communication and repetitive behaviors: level 1 ("requiring support"), level 2 ("requiring substantial support"), and level 3 ("requiring very substantial support"). See https://pmc.ncbi.nlm.nih.gov/articles/PMC4430056/#b3-0610421

As the rate of ASD diagnoses has risen, so have the multitude and availability of services and supports that help address ASD-related symptoms and associated challenges, for people with ASD and their families and caregivers. In 2014, the Centers for Medicare & Medicaid Services (CMS) issued guidance reinforcing that the role of states is to "make sure all covered services are available as well as to assure families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs". The guidance also reminded states that ASD diagnosis and treatment is covered for children under age 21 in all states under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) if the services are deemed medically necessary.[vii, 2] CMS acknowledged that, while there are various recognized treatment services for children with ASD, most treatments focus on use of ABA.[viii,ix]

The details of how state Medicaid programs cover ABA (e.g., eligibility, provider qualifications) vary by state. NCDHHS has covered ABA for children under age 21 with an ASD diagnosis through its RB--BHT benefit (Clinical Coverage Policy 8F) since 2019; previously, it was only covered under the EPSDT benefit.[3] RB-BHT also covers any behavioral intervention that is supported by "credible scientific or clinical evidence" for the treatment of ASD and meets the following criteria:

- Is research-based;
- Prevents or minimizes the disabilities and behavioral challenges associated with ASD;
- Promotes, to the extent practicable, the adaptive functioning of a beneficiary;
- Demonstrates clinical efficacy in treating ASD, preventing or minimizing the adverse effects of ASD, and promoting the functioning of a beneficiary to the maximum extent possible.[4]

Under the NC Medicaid RB-BHT Clinical Coverage Policy, a member must have an ASD diagnosis based on a scientifically validated diagnostic tool; a provisional ASD diagnosis is acceptable for children ages 0–3 and is valid for six months.[x] RB-BHT is currently available through Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans (Tailored Plans), Standard Plans and NC Medicaid Direct and will also be covered by the Children and Families Specialty

[vii] EPSDT applies to services that are coverable under Section 1905(a) of the Social Security Act.
[viii] ABA focuses on "analyzing, designing, implementing, and evaluating social and other environmental modifications" to change certain behaviors associated with ASD or to help an individual with ASD develop and maintain new skills (e.g., speech, self-care). (https://link.springer.com/article/10.1007/s40489-025-00506-0; Council of Autism Service Providers, ABA Practice Guidelines (Version 3.0)).
[ix] State legislatures began mandating commercial insurance companies cover services associated with ASD in 2001; as of 2020, all states have a commercial insurance mandate. (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0217064).
[x] For more information see Clinical Coverage Policy 8F for RB-BHT available at https://medicaid.ncdhhs.gov/8f-research-based-behavioral-health-treatment-rb-bht-autism-spectrum-disorder-asd/download?attachment.

Plan (CFSP) upon its launch. North Carolina state statute requires that all plans have open networks for RB-BHT, which means the plans may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates.[5] RB-BHT may be delivered via telehealth or telephonically (audio only) in certain circumstances (less than 10% of RB-BHT claims were for telehealth according to most recent claims data). In addition to RB-BHT, NC Medicaid also offers a range of ASD treatment services and supports, including speech and language, occupational, and physical therapy and Medicaid home- and community-based services (HCBS) (e.g., 1915(i) services, Innovations waiver services) (see Action #7 below for more information).

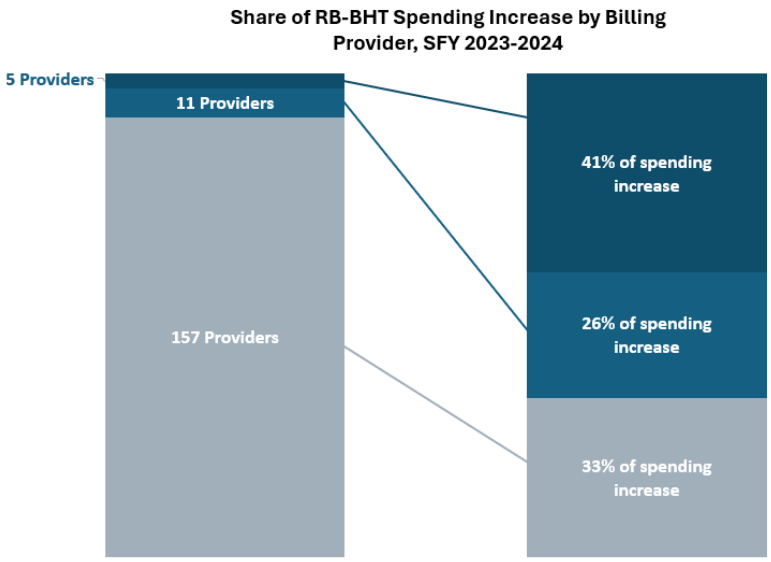
RB-BHT Utilization and Spending Trends

Between SFY 2022 and SFY 2024, NC Medicaid utilization and spending on RB-BHT grew exponentially:

- The number of NC Medicaid members receiving RB-BHT has increased **126%**, from 3,844 members to 8,706 members.
- The number of RB-BHT units of service increased by **157%**, from approximately 6.1 million units to 15.7 million units.[xi]
- Medicaid spending on RB-BHT grew by **171%**, from $121.7 million in SFY 2022 to $199.4 million in SFY 2023 to $329.4 million in SFY 2024, with the bulk of that increase in most recent years concentrated among a small number of providers (see Figure 2).

[xi] Each unit represents a 15-minute increment of services delivered.

Figure 2.



Further, NCDHHS's latest projections estimate approximately $639 million will be spent on RB-BHT in SFY 2026—**a 425% increase** since SFY 2022, making it one of the costliest services in the entire NC Medicaid program.

These increases in utilization and projected expenditures through SFY 2026 far outpace the 70% growth in the number of provider agencies delivering RB-BHT in NC during the same time period, and a 15% rate increase in 2024 that was part of a broader set of Medicaid rate increases authorized in partnership with the General Assembly.[6] There is also no evidence of an increase in ASD prevalence in the state that would account for the corresponding increase in RB-BHT utilization and associated spending. From 2020–2022—the most recent years when Centers for Disease Control and Prevention data are available—ASD prevalence in North Carolina increased by 17%.[xii]

North Carolina is not unique in the spike it is experiencing in utilization of RB-BHT and associated expenditures. Similar trends have been reported nationally, specifically for ABA services, which account for virtually all of North Carolina's RB-BHT claims ***despite the flexibility of treatment modalities available under the RB-BHT service definition*** (several plans report receiving no authorization requests for RB-BHT *other* than for ABA). For example:

[xii] The prevalence of ASD in North Carolina increased from 13.9 children per 1,000 children in 2020 to 16.3 children per 1,000 in 2022 (the most recent year CDC data is available). Further information can be found at https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html.

- Indiana's fee-for-service Medicaid payments for ABA increased 607% from 2017 to 2020.[7]
- Massachusetts reported a 75% increase in Medicaid payments for ABA from 2019 to 2023.[8]
- Nebraska recently adjusted its Medicaid rates for ABA—which it reports were the highest in the nation—after experiencing a nearly 2,000% increase in ABA spending over five years, from $4.6 million in 2020 to $85 million in 2025.[9]

As a result of concerns around rapidly increasing spending and utilization, federal and state Offices of Inspector General (OIG) have issued reports on ABA in multiple states.

Utilization and Spending Drivers and Recommended Policy Actions

NCDHHS is strongly committed to ensuring that people with ASD have appropriate access to the services that they need to achieve their individualized treatment goals. Given that RB-BHT spend substantially outpaces both the increases in ASD prevalence and the growth of the RB-BHT provider network in North Carolina, NCDHHS is concerned that the service may be used when service intensity and duration may sometimes exceed medical necessity, or in ways that are not clinically appropriate, or when other less intensive clinically appropriate treatments are viable and effective alternatives, or that the quality of service delivery in some cases is lower than what should be expected. The current rate of increases in utilization and related spending for RB-BHT is unsustainable without strategic collaboration and is straining the NC Medicaid budget, which is currently facing substantial funding challenges. RB-BHT, when deemed medically necessary, is covered under EPSDT, meaning it is a mandatory—not optional—benefit for children under age 21. The combination of continued growth in RB-BHT spending and Medicaid funding shortfalls could restrict the state's ability to provide other autism and I/DD services that are not federally mandated, such as HCBS provided through the Innovations waiver or 1915(i) SPA.

To understand drivers of the spike in RB-BHT utilization and spending in the state, NCDHHS and its actuaries analyzed RB-BHT claims data, gathered feedback from health plans, and reviewed the Council of Autism Service Providers (CASP) ABA practice guidelines against the RB-BHT Clinical Coverage Policy.[xiii] Based on this work, NCDHHS identified four key drivers of utilization and spending; **this paper proposes a series of policy actions to address each of these drivers.** These proposed actions, several of which will require new funding, aim to stabilize utilization

[xiii] CASP is a non-profit trade association of provider organizations serving individuals with autism spectrum disorder. CASP's practice guidelines are based on scientific evidence and expert clinical opinion regarding the use of ABA as a behavioral health treatment for people diagnosed with ASD. Practice guidelines provide information about standards of care in ABA that should be used in planning, implementing, and evaluating assessment and treatment services.

rates and spending at a sustainable level while ensuring access to critically important, high-quality services for those who need them.

Utilization and Spending Drivers	Proposed Policy Actions
A. Treatment may not be delivered in line with national clinical practice guidelines, and members' treatment plans may not be individualized.	1. Clarify the RB-BHT Clinical Coverage Policy to ensure all RB-BHT treatment plans are individualized. 2. Require caregiver goals to be incorporated into treatment plans. 3. Develop and publish a statewide RB-BHT services provider manual. 4. Standardize utilization management processes across delivery systems (e.g., NC Medicaid Direct, Tailored Plans, Standard Plans, CFSP). 5. Collaborate with health plans and the North Carolina Department of Justice to strengthen program integrity and documentation standards proportionate to risk. 6. Require certification and credentialing for ABA technicians as a condition of NC Medicaid participation prior to the provision of services.
B. RB-BHT risks being utilized as the primary treatment after an ASD diagnosis, even when less intensive research-based therapies and supports are available and clinically appropriate.	7. Require whole-person care planning for children and youth with ASD and provide linkages to the full continuum of ASD treatment and support services for the member and their family/caregivers. 8. Clarify provider types that may make an ASD diagnosis and refer to ASD services, including RB-BHT.
C. The RB-BHT Clinical Coverage Policy can clarify billing requirements to reduce provider confusion.	9. Clarify RB-BHT Clinical Coverage Policy requirements on billing.
D. A significant number of new providers have entered the North Carolina market.	10. Work with the General Assembly to amend state statute to allow health plans to operate a closed provider network for RB-BHT. 11. Identify strategies to align rate structure with quality.

A. Driver: Treatment may not be delivered in line with national clinical practice guidelines and members' treatment plans may not be individualized.

Action 1: Clarify the RB-BHT Clinical Coverage Policy to ensure all RB-BHT treatment plans are individualized.

According to the Council of Autism Service Providers (CASP), behavioral intervention services, like the type provided through RB-BHT, should be highly individualized treatments.[10] ABA practice guidelines developed by CASP emphasize that the number of hours a child receives, the scope of the intervention and treatment goals should be unique to each child's needs. (As noted above, ABA accounts for virtually all RB-BHT claims with several plans reporting it is the only RB-BHT modality requested from providers.) These details should be articulated in a treatment plan informed by results from administration of a standardized assessment tool to determine a child's baseline skills and identify specific qualitative and quantitative progress measures.[11]

To support individualization, ABA treatment plans can identify a scope of intervention, as defined by CASP:

- Focused scope of treatment: Aims to improve or maintain behaviors in a limited number of domains or skill areas—for example, to promote behaviors such as oral care, toileting or to address self-injurious behaviors. Focused ABA is typically provided at a low to moderate intensity.
- Comprehensive scope of treatment: Aims to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive). Target areas on a comprehensive treatment plan may include emotional development, family relationships, language and communication, pre-academic skills, and social relationships.[12] Comprehensive ABA is typically provided at a higher intensity.

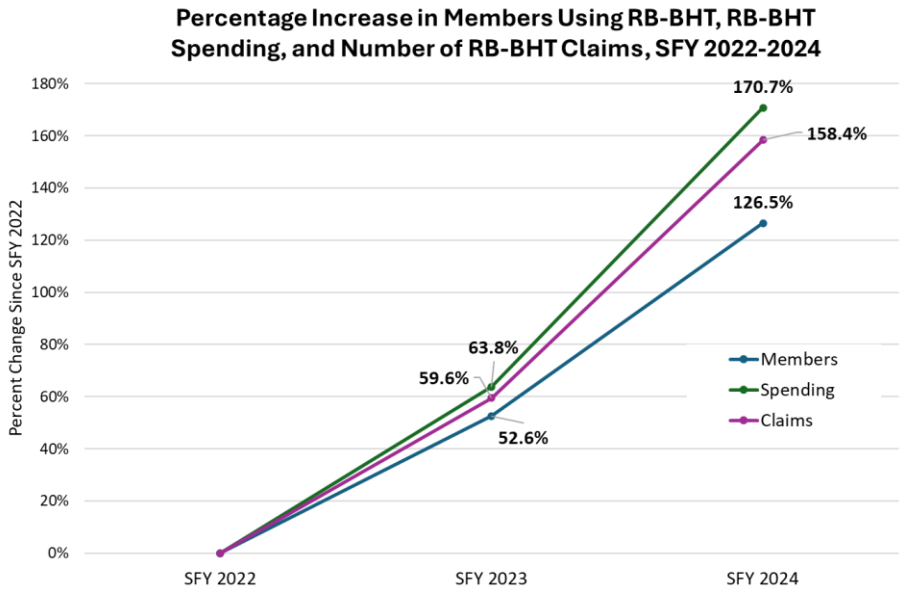
Ultimately, members should receive RB-BHT treatment at the intensity that is medically necessary and most effective to achieve their individualized treatment goals, with ongoing adjustments to the treatment plan based on member progress, including increasing and decreasing intensity as indicated.[13] CASP's guidelines also emphasize that treatment should be provided in a setting most relevant to treatment goals, including natural environments like schools and in the community. As treatment gains are observed, members who begin treatment in a clinical setting should transition to natural settings and, eventually, to other ASD services (see Action #7 below).

North Carolina Current State

The rate of increases in spending and claims for RB-BHT are both outpacing the increase in the number of NC Medicaid members using the service (see Figure 3), a trend that has been underway since at least SFY 2022. Between SFY 2022 and SFY 2024, the volume of RB-BHT claims increased 158.4%. During that same time, the number of distinct NC members using RB-

BHT increased only 126.5%. This suggests that the intensity of RB-BHT being delivered to NC Medicaid members (i.e., the number of hours) is increasing, yet there is no evidence that children with ASD in the state are experiencing an increase in the severity of their ASD-related symptoms. On the contrary, the higher rate of screenings and a greater awareness about ASD means that children with lower support needs are more likely to be diagnosed and access treatment. Data available at the national level shows that most of the increase in ASD prevalence can be attributed to the rise in diagnosis among people with lower support needs. From 2000 to 2016 (years for which the most recent data is available), the national prevalence of non-profound autism among 8-year-olds increased at a faster rate than the prevalence of profound autism among 8-year-olds.[xiv,14,15] There have also been no changes to North Carolina's RB-BHT Clinical Coverage Policy or national clinical practice guidelines recommending an increase in service intensity. The generalized increase in RB-BHT service intensity indicated by claims data suggests that at least some treatment plans are not appropriately informed by an assessment, individualized based upon the specific needs identified in the assessment, or modified or titrated based upon measurable progress and access to other available natural and paid supports. Other factors that may contribute to this trend include an increase in the number of RB-BHT providers in the State.

Figure 3.



[xiv] The CDC defines profound autism as children with autism who are either nonverbal or minimally verbal or have an intelligence quotient (IQ) <50. Non–profound autism is defined as children with autism who do not meet the profound autism criteria.

As part of NCDHHS's review of its RB-BHT Clinical Coverage Policy against CASP guidelines, in addition to surveying its health plans, the State identified several areas of focus:

- While the policy requires that the service be individualized and not in excess of the member's needs, it does not explicitly require that the treatment plan be informed by an assessment.
- Health plans have reported a wide variability in the quality and completeness of treatment plans submitted for authorization of RB-BHT services. Some treatment plans lack clinical justification for requested service hours, such as results of an assessment.
- The RB-BHT Clinical Coverage Policy includes transition/discharge criteria[xv] and titration of services is "expected" under continued stay criteria. However, the policy does not require that treatment planning address titration of services and eventual discharge once behavior objectives and goals are achieved, nor does it address the role of caregivers (or other natural supports) in titration of services, or referrals to non-RB-BHT services (including less intensive and/or long-term supports) (see also Action #7).

Proposed Policy Actions

Update the RB-BHT Clinical Coverage Policy to:

- ✓ Require completed treatment plans:
    - Include all elements and the level of detail as articulated in the RB-BHT Clinical Coverage Policy, including, for example, location of service and the frequency at which progress is evaluated and reported. Note that this requirement is already in place today, but health plans indicate that it is not consistently followed;[xvi]
    - Identify outcomes, at the outset of treatment, that will lead to successful discharge and include a step-down plan (e.g., how service intensity will be titrated) for members who are meeting their goals and who have other available paid and/or natural supports to support continued progress, as clinically appropriate; and
    - For ABA treatment plans, include the scope of treatment (focused or comprehensive, as defined by CASP ABA practice guidelines), clinical justification for the number of service hours requested for a member and which activities

[xv] Discharge criteria include: the member is no longer eligible; treatment goals have been attained; a different treatment modality or level of care would adequately address treatment goals; regression without treatment is not anticipated; the member has not demonstrated significant improvement following reassessment and adjustments to the treatment plan, personnel or modality over at least six months.

[xvi] Current RB-BHT Clinical Coverage Policy requires RB-BHT treatment plans include individualized goals and outcome measurement assessment criteria, "challenges" that are being treated, number of hours of direct service and supervision, service location, parent/caregiver participation needs, frequency of progress evaluation, and provider delivering services.

will be conducted during the requested service hours to achieve treatment goals.

- ✓ Clarify that assessment results must be used to guide treatment planning.
- ✓ Clarify which provider types may develop RB-BHT treatment plans (see also Action #8, which addresses provider qualification for making an ASD diagnosis and service referral).
- ✓ Clarify when and which specific services may be delivered via telehealth and telephonically.

Health plans would also be required to provide technical assistance to providers on these policy changes and to support continued efforts to improve the quality and consistency of treatment plans.

Action 2: Require caregiver goals to be incorporated into treatment plans.

CASP ABA guidelines call for caregiver engagement to support a child achieving their treatment goals and, ultimately, service discharge.[16] While the RB-BHT Clinical Coverage Policy states that the service may include "training of parents, guardians, and caregivers on interventions consistent with the RB-BHT," it is not currently required.[17] Similarly, the RB-BHT Clinical Coverage Policy requires treatment plans document caregiver "participation needs to achieve…goals and objectives," though caregiver goals themselves are not explicitly required, and at least one health plan reports that providers' engagement of families in treatment is limited. Massachusetts has taken a more prescriptive approach to caregiver involvement by requiring ABA treatment plans have at least two specific and measurable caregiver treatment goals, which include instructions for the caregiver on how to implement strategies identified in the behavior management plan and an increase in caregiver training hours as part of transition planning to a lower level of care or the end of the benefit.[18] Nebraska recently began requiring 2–4 hours per month of caregiver involvement in treatment planning.[19]

Proposed Policy Actions

Update the RB-BHT Clinical Coverage Policy to:

- ✓ Require treatment plans include caregiver goals that enable and encourage participation in treatment and support titration of services and discharge when clinically appropriate.
- ✓ Require providers train caregivers, as appropriate, on how to implement strategies identified in the member's treatment plan.[xvii]

[xvii] A caregiver refers to an individual who provides care and support to a child or dependent. This may include a parent, legal guardian or any adult responsible for the child's well-being and daily needs.

- ✓ Require providers share a copy of the child's treatment plan with the child's caregivers.

NCDHHS will also explore establishing minimum standards for caregiver involvement (i.e., a minimum number of hours, specific activities that must include a caregiver).

Action 3: Develop and publish a statewide RB-BHT services provider manual.

Feedback from plans suggests that there is some confusion around the RB-BHT service given its complexity of the service and the number of new providers entering the market. More specifically, health plans report there is a lack of clarity among plans and providers on which treatment modalities can be authorized under RB-BHT and how and when to use specific RB-BHT billing codes (see also Action #9).

Proposed Policy Action

- ✓ Develop a single statewide RB-BHT provider manual. The manual would align with the RB-BHT Clinical Coverage Policy and include—at a minimum—detailed guidance on national clinical practice guidelines (according to nationally accepted best practices like CASP for ABA and best practices for non-ABA ASD services), service eligibility, provider requirements, treatment planning, authorization and reauthorization, billing requirements, utilization management and reporting requirements. NC Medicaid providers offering RB-BHT would be required to comply with the standards outlined in the manual.

Action 4: Standardize utilization management processes across delivery systems (e.g., NC Medicaid Direct, Tailored Plans, Standard Plans, CFSP).

As discussed in more detail below (see Driver "D"), the RB-BHT provider market has expanded rapidly in North Carolina over the last several years. This expansion, coupled with the urgent need to understand and address utilization and spending patterns and the changes proposed in this paper, calls for an increased emphasis on quality and stronger utilization management standards around medical necessity, treatment plan oversight (including individualization of service intensity and duration) and provider fidelity to national clinical practice guidelines.

Currently, the RB-BHT Clinical Coverage Policy requires that the service be provided under an authorized treatment plan that is reviewed—but not updated—at least once every six months by a Licensed Qualified Autism Service Provider and updated, at minimum, annually. As a result, treatment plans—which are the basis for prior authorization—may not be fully up to date on a member's needs (see Action #1 for proposed policy changes for treatment planning). Relatedly, health plans report a lack of clarity on the utilization management criteria they should be applying to RB-BHT and a need for standardized utilization management tools. As evidence of this, several plans noted that the information submitted in treatment plans for authorization of

services often does not sufficiently describe the member's progress towards defined goals, hindering their ability to determine the appropriateness or effectiveness of treatment. This is why Nebraska—after experiencing uncontrolled growth in ABA services—is now requiring treatment plans to be reviewed and updated at least every 90 days.[20]

Proposed Policy Actions

- ✓ Establish standardized core components for health plan utilization management practices and standards. At a minimum, NCDHHS anticipates that the core components will include more defined expectations for: prior authorization and post-utilization review; ensuring utilization management assesses individualization of service intensity and duration of service; and reporting to NCDHHS (frequency and cadence to be determined) on when services are authorized to be delivered via telehealth and the treatment modalities of RB-BHT requested and authorized by providers. Throughout, NCDHHS will provide technical assistance to the health plans to clarify parameters of plans' utilization management flexibilities.
- ✓ Consider whether to require the use of standardized utilization management tools, such as prior authorization forms and processes.
- ✓ Update the RB-BHT Clinical Coverage Policy to require providers submit completed assessment(s) and/or assessment results alongside treatment plans when requesting authorization of services.
- ✓ Update the RB-BHT Clinical Coverage Policy to require reauthorization within three months of initial service authorization and subsequent reauthorizations no less than every six months. Health plans will have the option to require more frequent treatment plan review and reauthorization if they deem it necessary based on provider performance (based on metrics agreed upon by the provider and the plan) and/or a member's historical progress toward meeting treatment goals.

NCDHHS will also work with plans to determine a cadence for reporting on utilization and related expenditures, likely no less frequently than twice per year.

Action 5: Collaborate with health plans and the North Carolina Department of Justice to strengthen program integrity and documentation standards.

Behavioral intervention services provided through RB-BHT, including ABA, are characterized by intensity and variability. Comprehensive oversight by health plans and state agencies is critical to ensuring that the care provided to members with ASD is high quality, person-centered, medically necessary and clinically appropriate. While no audits have been completed in North Carolina, recent audits in other states have identified significant issues with provider billing and documentation that resulted in improper Medicaid payments for ABA. In both Wisconsin and

Indiana, the U.S. Department of Health and Human Services Office of Inspector General found improper or potentially improper payments in virtually **all** sampled "enrollee-months."[21,22] Specific findings included a lack of provider documentation to support the Current Procedural Terminology (CPT) codes billed, the number of units billed, and the dates of service, delivery of ABA to members who did not receive the required diagnostic evaluations or treatment referrals for ABA, and "impossible billing" practices, such as billing for more than 24 hours of ABA in a single service date for a member.[23,24,25]

Proposed Policy Actions

- ✓ Continue working in partnership with the North Carolina Department of Justice and health plans to strengthen program integrity oversight of the RB-BHT benefit, including through the proposed actions outlined in this paper, post-payment review and more effective use of the program integrity tools already available to plans.

Action 6: Require certification and credentialing for ABA technicians as a condition of NC Medicaid participation prior to the provision of services.

According to CASP practice guidelines, certification of ABA practitioners through the national Behavior Analyst Certification Board (BACB) promotes standards of professional conduct in the practice of ABA.[26] In North Carolina, virtually all RB-BHT service hours are provided by paraprofessionals called technicians who work under the supervision of a licensed behavior analyst or licensed assistant behavior analyst.[27] Although the national BACB certifies technicians, North Carolina does not require its technicians to obtain the national certification. North Carolina technicians are required only to complete "competency-based training…equivalent to the minimum hour requirements" that would apply for BACB certification as a "Registered Behavior Technician." At least 29 states currently require certification of their ABA technicians through BACB.[28] There are also no ongoing training or education requirements for technicians in North Carolina.[29,30] North Carolina recently established a state-based Behavior Analyst Licensure Board, the NCBALB, but its licensure is limited to Behavior Analysts or Assistant Behavior Analysts.[31,32]

Proposed Policy Action

- ✓ Require ABA technicians receive BACB Registered Behavior Technician certification prior to the provision of services. Requiring certification is intended to promote and reinforce the quality and consistency of care delivered by technicians. This requirement could be phased in over time to avoid disruptions in care.

B. Driver: RB-BHT risks being utilized as the primary treatment after an ASD diagnosis, even when less intensive research-based therapies and supports are available and clinically appropriate.

Action 7: Require whole-person care planning for children and youth with ASD and provide linkages to the full continuum of ASD treatment and support services for the member and their family/caregivers.

There is no single standard treatment for ASD. While ABA is the highest profile intervention, and often the first referral after an ASD diagnosis, it is not the only treatment option.[33] North Carolina's RB-BHT service definition is meant to be flexible and provide access to the most clinically appropriate services that "prevent or minimize the disabilities and behavioral challenges associated with ASD and promote…the adaptive functioning of a beneficiary." The range of research-based treatments and supports now available to individuals with ASD and their families include behavioral management therapy—such as ABA—intended to reinforce or reduce specific behaviors, speech and language therapy to improve the use of speech and language, occupational therapy to teach skills that help a person live independently, and physical therapy to improve motor skills, as well as educational and school-based therapies for ASD, social skills training, cognitive behavior therapy, joint attention therapy, medication treatment and nutritional therapy.[34] Nonclinical supports available include Medicaid HCBS such as respite, personal care services, and community living and support services that help with life skills and daily activities. Different treatments and supports often complement one another, both for the child receiving services and their families and caregivers.

Yet there may be a lack of awareness among some providers and families of available alternative interventions, therapies and supports other than ABA, including those that meet RB-BHT's standard of "supported by credible scientific or clinical evidence."[35] Additionally, the RB-BHT Clinical Coverage Policy does not require treatment planning to consider other supports and services that may be more appropriate, including HCBS that can facilitate transitions to more natural supports (see also Action #1). To encourage linkages to the full continuum of autism services, New Jersey designed its EPSDT autism benefit as a "multidisciplinary set of services" that includes behavioral therapies, Augmentative and Alternative Communication, clinical interventions, skill acquisition, sensory integration therapy, allied health therapies, and Developmental, Individual Differences, and Relationship-Based approaches.[36] It also published a "Family Guide to Autism Services" that provides detail on the multidisciplinary set of Medicaid-funded services available to families in the state.[37]

Proposed Policy Actions

- ✓ Require health plans to authorize RB-BHT as part of a whole-person autism treatment plan. With input from families, advocates, providers and other stakeholders, NCDHHS

will consider creating a standardized autism treatment plan template, similar to the person-centered plan for behavioral health services or individual support plan for Innovations waiver services. The plan will document (1) linkages to the most appropriate assessments and services and not necessarily the most intensive ones and (2) all ASD-related services received, including RB-BHT, occupational therapy, speech therapy, HCBS and others. The autism treatment plan will promote coordination across providers and services so that the combined intensity (i.e., number of hours) across services is age appropriate and informed by the child's needs and caregiver preferences. Creation of the treatment plan will be the responsibility of a licensed professional who will collaborate with the child's care team, including the primary care provider and care manager (where applicable). NCDHHS will seek additional input from stakeholders on the structure and details of the treatment plan and qualifications of professionals who will create the plan.

- ✓ Require plans to consider the full ASD service array when conducting prior authorization. Specifically, justification for RB-BHT service intensity in the autism treatment plan must reflect all clinically appropriate interventions the member is receiving according to their autism treatment plan (see previous bullet). For example, if an assessment finds a member should receive occupational therapy, that may necessitate a lower intensity of RB-BHT based upon a child's capacity to tolerate and benefit from the intensity of hours across all interventions.
- ✓ Partner with health plans, providers, local advocacy organizations, schools and community centers to increase awareness of available resources and treatment options beyond RB-BHT and ABA.
- ✓ Explore "step-up" therapeutic requirements for older children and adolescents with ASD. This approach would require members to begin with the least intense research-based intervention that is medically necessary. Additional or higher intensity services could only be requested and authorized if the member is not making sufficient progress against goals.

Action 8: Clarify provider types that may make an ASD diagnosis, and assess for and refer to ASD services, including RB-BHT.

The RB-BHT Clinical Coverage Policy requires a provisional ASD diagnosis to be made by a licensed psychologist, physician or licensed clinician with a master's degree for whom the RB-BHT service is within their scope of practice—the policy does not address the provider types that may diagnose ASD on a non-provisional basis. Referrals to RB-BHT must be made by a licensed physician, a licensed psychological associate or a licensed doctorate-level psychologist working within their scope of practice. Some providers have reported to NCDHHS that these requirements in the RB-BHT Clinical Coverage Policy are insufficiently clear on which provider

types may make an ASD diagnosis, referral to RB-BHT, or referrals for other ASD services (see also Action #8). As a result, providers that do not offer RB-BHT sometimes refer an individual to an RB-BHT provider to make an ASD diagnosis, which raises conflict-of-interest concerns. In practice, the same provider may currently function as the diagnosing provider, the referring provider, the assessing provider and the service provider.

Though CMS does not consider RB-BHT to meet the federal definition of HCBS, the principles of how conflict of interest is addressed in HCBS could be applied to RB-BHT. Federal rules require that providers of HCBS for the individual must not provide case management activities or develop a person-centered service plan.[38] When a direct service provider also conducts assessments, can self-refer to services and is the entity case managing those services, it can be more difficult for the individual to make changes to their services. There is also an elevated risk that individuals' choice of provider is not assured or honored, quality and outcomes oversight is compromised, and over- or under-utilization is incentivized.[39]

To mitigate conflict-of-interest risks, states must expand the pool of providers qualified to make an ASD diagnosis and service referral so that providers are not conducting both these functions and service delivery for the same individual. Indiana University's Early Autism Evaluation (EAE) Hub System is one model that is expanding the pool of ASD providers, particularly for very young children (ages 14–48 months). The EAE Hub System is a statewide network of primary care physicians and clinicians with specialized training in ASD diagnosis that train community clinicians in ASD diagnosis and care management, provide longitudinal support to care teams, and maintain a repository of training materials and resources. The EAE Hub System has conducted 6,500 evaluations since 2012. Of these evaluations, 56% of children received an ASD diagnosis and the majority received a diagnosis of developmental delay.[40]

Proposed Policy Actions

- ✓ Clarify requirements for provider types that may make an ASD diagnosis and refer to ASD services, including RB-BHT. NCDHHS will explore funding and partnership opportunities for providing specialized training and consultation to diagnosing providers to ensure ASD diagnoses and service referrals are done in a manner consistent with best practice standards.
- ✓ Pursue funding for a partnership with provider training and capacity building groups in the state (e.g., North Carolina Psychiatry Access Line (NC-PAL)) to expand the network of providers trained and qualified to make an ASD diagnosis and service referrals.
- ✓ Revise the RB-BHT Clinical Coverage Policy to prohibit provider self-referral, meaning the provider that provides case management functions, makes an ASD diagnosis, or

conducts an assessment for service referral, may not also deliver ASD services to that same individual.

NCDHHS specifically seeks feedback from its community partners on the application of HCBS conflict-of-interest principles to RB-BHT, in addition to the specific policy actions proposed above.

C. Driver: The RB-BHT Clinical Coverage Policy can clarify billing requirements to reduce provider confusion.

Action 9: Clarify RB-BHT Clinical Coverage Policy requirements on billing.

In its review of RB-BHT data and discussions with health plans, NCDHHS has identified areas where billing requirements in the RB-BHT Clinical Coverage Policy can be clarified. Clear billing requirements improve monitoring and program oversight by defining details around service delivery that are required to understand the drivers of utilization and spending and program integrity risks. Specific issues identified include:

- The policy identifies the CPT codes that may be billed for RB-BHT but could also provide a description or guidance for what specific activities are allowable under each code or which provider types may bill to each code.[41]
- North Carolina has recently made licensure changes and introduced new provider types (licensed behavior analyst and licensed assistant behavior analyst) that are not addressed in the RB-BHT Clinical Coverage Policy; specifically, the RB-BHT Clinical Coverage Policy does not identify which activities they may bill for.
- NC Medicaid claims data also do not have modifiers to distinguish between RB-BHT delivered by a licensed professional versus a technician, which inhibits monitoring of how services are being rendered (see also Actions #4 and #5).

Audits in multiple other states have identified inaccurate billing practices for ABA associated with overpayment for services. [42,43,44] Those audits also attribute improper payments to documentation requirements not being met, lack of appropriate credentials, and no diagnosis or treatment referral. No similar audit has been completed in North Carolina to date.

Proposed Policy Actions

- ✓ Develop and require use of modifiers for relevant RB-BHT billing code to distinguish the rendering provider type (e.g., technician or licensed professional).
- ✓ Require all providers, regardless of delivery system, use the same billing practices.

- ✓ Update the RB-BHT Clinical Coverage Policy to clarify for health plans and providers when specific codes may be used and which provider types may bill them for reimbursement of RB-BHT services.
- ✓ Develop additional billing guidance for providers to include in the proposed RB-BHT services provider manual (see Action #3) and work with health plans to provide technical assistance to providers to ensure that billing is in line with NCDHHS policy.
- ✓ Along with initiating more robust monitoring, require health plans to conduct post-utilization review to ensure that billing practices are consistent with changes proposed in this paper (see Actions #4 and #5).

Health plans will continue to follow existing requirements detailed in the RB-BHT Clinical Coverage Policy until new requirements are established by NCDHHS.

D. Driver: A significant number of new providers have entered the North Carolina market.

Action 10: Work with the General Assembly to amend state statute to allow health plans to operate a closed provider network for RB-BHT.

North Carolina statute requires Tailored Plans, Standard Plans, NC Medicaid Direct and the CFSP to have an open network for RB-BHT providers, meaning they may not exclude RB-BHT providers except for failure to meet objective quality standards or refusal to accept network rates.[45,46] This limits plans' oversight enforcement mechanisms as well as their ability to base contracting on quality. In contrast, prior to the launch of Standard Plans, NC Medicaid Direct operated a closed network for RB-BHT (the majority of individuals using RB-BHT were enrolled in NC Medicaid Direct until the launch of Tailored Plans in July 2024).

The open provider network is one factor that has allowed an influx of new ABA providers to enter the market. And the influx of new ABA providers is happening at a time when health plans are increasingly raising concerns about the quality of care from some ABA providers, including limited individualization in treatment planning, as noted above (see Action #1). One North Carolina health plan proposed that closing the RB-BHT provider network would foster "effective service management and sustainability as well as enhanced fraud/waste/abuse deterrence." One caution is that closing networks alone will not solve all of the issues in the benefit, and the health plans will have to utilize additional strategies to oversee the benefit.

Like other states, some of the new providers entering North Carolina are for-profit providers—including those backed by private equity—with little in-state experience or integration with the state's health system.[47] As a result, it may be more difficult for these providers to connect individuals with ASD to the full range of whole-person services and supports people with ASD require. Additionally, the Center for Economic and Policy Research has identified that some for-

profit providers, particularly those with funding from private equity firms, are more likely to operate in ways that negatively impact the quality of services, including having high caseloads, organizational churn, and using non-individualized treatment plans with more service hours than are clinically necessary, as opposed to person-centered plans that reflect an individualized assessment.[48] Additional analysis is needed to determine the specific impact of provider ownership type on RB-BHT utilization patterns in North Carolina.

Proposed Policy Actions

- ✓ Work with the General Assembly to amend existing statute for Local Management Entity/Managed Care Organization (LME/MCO), Standard Plan, Behavioral Health I/DD Tailored Plan and CFSP provider networks to allow all health plans to establish a closed network for RB-BHT providers (see Appendix B for sample legislative language).
- ✓ Work with providers, plans, families to determine appropriate network adequacy standards for RB-BHT providers under closed networks and how access will be monitored.

Action 11: Identify strategies to align rate structure with quality.

North Carolina uses a fee schedule for RB-BHT rates paid to providers, which was last updated in October 2025.[xviii, 49] For many Medicaid-covered services, including RB-BHT, health plans must treat the rates in the fee schedule as a rate floor, meaning that plans may not negotiate a rate with providers that is lower than that in the fee schedule. This can potentially hinder a plan's ability to incentivize high quality providers to join their network and use lower rates to "weed out" lower quality providers. Current reimbursement rates do not differentiate by provider licensure, certifications or credentials, which incentivizes providers to hire individuals with less experience and training.

North Carolina's rates are largely in line with those in other states; NCDHHS has identified only one outlier rate to-date, for billing code 97152 (behavior identification supporting assessment, administered by a technician or a licensed supervisor). The rate for 97152 is nearly three times the national average and should be reviewed for appropriate pricing, though it is not among the most frequently used codes for RB-BHT.

Proposed Policy Actions

[xviii] Effective October 1, 2025, NCDHHS reduced rates across all Medicaid services, including RB-BHT, due to funding shortfalls. More information is available at: https://ncnewsline.com/wp-content/uploads/2025/08/Medicaid-Rebase-NCGA-Letter-August-2025_FINAL.pdf

- ✓ Explore developing differential rates for providers based on licensure, certifications and credentials so that rates are commensurate with education and training.
- ✓ Evaluate the impact of removing the rate floor on both quality oversight and enforcement, and network adequacy.
- ✓ Re-evaluate the reimbursement rate for 97152.

Incentivizing Quality in ABA

NCDHHS believes that any changes to the RB-BHT program design must emphasize the provision of high-quality services. In addition to the actions described in this paper, NCDHHS is exploring other strategies for promoting quality in RB-BHT delivery, particularly for ABA. A small number of states and health plans have indicated they have instituted or are exploring implementing a value-based payment model for their ABA benefit.[50] A primary barrier to incentivizing quality in ABA is there are currently no standardized ABA quality metrics, in part due to the variability in ABA service intensity and treatment needs across children with ASD.[51] Collaboration across NCDHHS, families, providers, plans and clinical experts would be needed to develop new statewide quality measures. Possible measures could be based on demonstrated outcomes—such as improvements in adaptive assessment scores that measure daily living skills—family and caregiver involvement, credentialing and staff training, and whole-person treatment planning.[52] Requirements for providers to share data on health outcomes (e.g., assessment scores) with NCDHHS and health plans would also be needed to establish a baseline for performance and target outcomes to define "quality."

Next Steps

NCDHHS is committed to working with its community partners on refining and strengthening its RB-BHT service offerings. To that end, we invite feedback on the proposals detailed in this paper from our members and their families, as well as providers, health plans, and other interested parties. We ask that you kindly submit your feedback at Medicaid.NCEngagement@dhhs.nc.gov by Nov. 27, 2025. Following this process, NCDHHS will assess and communicate to its community partners an approach, estimated timeline, and associated costs for implementing policy changes discussed in this paper.

Appendix A: RB-BHT Service Definition (Clinical Coverage Policy 8F)[53]

Research-Based-Behavioral Health Treatments (RB-BHT) services are research-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary. RB-BHT demonstrates clinical efficacy in treating ASD: prevent or minimizes the adverse effects of ASD; and promote, to the maximum extent possible, the functioning of a beneficiary.

RB-BHT services include, but are not limited to, the following categories of Research-Based interventions:

a. Behavioral, Adaptive or Functional assessment and development of an individualized treatment plan;
b. Delivery of RB-BHT services:
    1. Adapting environments to promote positive behaviors and learning while reducing negative behaviors (antecedent based intervention, visual supports);
    2. Applying treatment procedures to change behaviors and promote learning (reinforcement, differential reinforcement of alternative behaviors, extinction);
    3. Teaching techniques to increase positive behaviors, build motivation, develop social, communication, and adaptive skills (discrete trial teaching, modeling, naturalistic intervention, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting);
    4. Using typically developing peers (individuals who do not have ASD) to teach and interact with children with ASD (peer mediated instruction, structured play groups);
    5. Applying technological tools to change behaviors and teach skills (video modeling, tablet-based learning software);
    6. Training of parents, guardians and caregivers on interventions consistent with the RB-BHT; and
c. Observation and Directing: Provider's observation and direction of the Paraprofessional (Board Certified Assistant Behavior Analyst [BCaBA] or Technician), which is allowed only when:
    1. the Performing Provider is in the same location, or using Telehealth in accordance with section 3.1.1, as both the individual and the paraprofessional (BCaBA or technician); and
    2. the observation is for the benefit of the individual. The Performing Provider delivers observation and direction regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each individual. Observation and direction also inform any

modifications needed to the methods to be implemented to support the accomplishment of outcomes in the Treatment Plan. Observation and direction must be provided on an ongoing basis throughout the time that RB-BHT services are being provided to an individual. 10% of all approved services should be observed by the provider. An excess of percent of observation must be clinically justified; and

d. In addition to the categories of interventions listed above, covered RB-BHT services are any other intervention supported by credible scientific or clinical evidence, as appropriate for the treatment of Autism Spectrum Disorder. An intervention is considered to have credible scientific or clinical evidence if it meets the specific criteria listed below:
    1. Randomized or quasi-experimental design studies. Two high quality experimental or quasi-experimental group design studies conducted by at least two different researchers or research groups;
    2. Single-subject design studies. Five high quality single subject design studies conducted by three different investigators or research groups and having a total of at least 20 participants across studies; or
    3. Combination of evidence. One high quality randomized or quasi-experimental group design study and at least three high quality single subject design studies conducted by at least three different investigators or research groups (across the group and single subject design studies); or
    4. Interventions programs that have a strong evidence base for American Indian youth and Promising Practice interventions that are culturally grounded and community driven programs that are supported by tribal communities.

Appendix B: Proposed Amendments to NC General Statutes (Policy Action #10)

§ 108D-22. PHP provider networks.

a. **Subject to the following sentence,** except as provided in G.S. 108D-23 and G.S. 108D-24, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except **(i)** for **a provider's** failure to meet objective quality standards**,** or **(ii) a provider's** refusal to accept network rates**, or (iii) as required under subdivision (c) of this section**. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

b. The Department shall designate Medicaid providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid beneficiaries within the region

during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes. (2019-81, s. 1(a); 2022-74, s. 9D.15(z); 2023-134, s. 9E.22(e).)

a. **The entity operating the PHP shall develop and maintain a closed network of providers that furnish RB-BHT services.**

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

a. The entity operating the children and families specialty plan shall develop and maintain a closed network of providers only as provided in this section.
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.
   (5) **Research Based-Behavioral Health Treatment.**
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. (2023-134, s. 9E.22(f).)

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