STATE OF NORTH CAROLINA WAKE COUNTY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 25 CV 039433-910

M.Q., by and through parent AKIYA LEWIS; *et al.* Plaintiffs, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES; DEVDUTTA SANGVAI, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendants.	)	**DEFENDANTS BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION**

INTRODUCTION

The North Carolina Department of Health and Human Services is charged with administering the NC Medicaid Program as dictated in the General Statues and within the confines of the funds appropriated to the program by the General Assembly. For Fiscal Year 2025-26, the funds allocated by the General Assembly to NC Medicaid resulted in a $319 million shortfall of the amount needed to maintain the current services and provider payments. As a result of the budget shortfall and the controlling authority for operation of the NC Medicaid program, the Department made reimbursement rate cuts across its array of covered services with the goal of ensuring that all Medicaid beneficiaries continue to have access to covered services.

As part of these carefully considered provider reimbursement rate cuts, DHHS partially reversed a 2024 rate increase for Research-Based Behavioral Health Treatments (RB-BHT). Even after DHHS's decision, the reimbursement rate for RB-BHT services is still higher than it was just

two years ago. Indeed, if the rate cut remains in place, NC Medicaid will still spend $400 million more for RB-BHT services in Fiscal Year 2025-26 than it did in Fiscal Year 2022-23. One consideration for the determination was that on January 1, 2024, RB-BHT received a reimbursement rate increase of 15%. In 2022-23 Fiscal Year, prior to the rate increase, NC Medicaid reimbursed $199 million dollars for the RB-BHT services. After the 15% rate reimbursement increase there was a surge in the number of claims per beneficiary. Spending on RB-BHT service is projected to increase 425% by 2026. The current estimate for reimbursement of RB-BHT in 2025-26 Fiscal Year **with the 10% rate reduction** is $639 million. NC Medicaid estimates to reimburse $440 million more dollars for RB-BHT services than it reimbursed just two years ago even with implementing a 10% cut. These and other factors were taken into consideration when determining rate cut percentages.

DHHS performed well-reasoned, mathematical financial assessments for all NC Medicaid services to determine rate reimbursement reductions to fit the certified budget. DHHS made very difficult decision to ensure that necessary healthcare services continue to be available for North Carolinians throughout the entire fiscal year and did so as required by statute. *N.C. Gen. Stat. §108A-54(e)(1)*. There is no evidence that the provider reimbursement rate cut to the RB-BHT service was discriminatory.

BACKGROUND

NC Medicaid provides health care to eligible low-income adults, children, pregnant women, seniors and people with disabilities. Medicaid covers most health services. It includes doctor visits, check-ups, emergency care, dental care, vision and hearing services, prescription drugs, maternity and postpartum care, hospital services, behavioral health, preventive and wellness services, medical-related devices and more. NC Medicaid provides health coverage to 1 in 4 North

Carolinians—that's more than 3 million children, pregnant women, older adults, people with disabilities and working North Carolinians. This population includes:

- 50% of all births in North Carolina are covered by NC Medicaid.
- 21% of people covered by NC Medicaid are older adults and people with disabilities.
- 67% of North Carolina nursing home residents rely on NC Medicaid to help with the cost of their long-term care.
- More than half of the population has health coverage through NC Medicaid in many rural counties

Medicaid benefits North Carolinians through making people healthier, saving lives and increasing access to behavioral health and substance use treatment. Medicaid provides a major source of funding for the state's rural hospitals, many of which are struggling financially. Rural counties rely on all of the services provided by Medicaid and the rural hospitals rely on Medicaid funding to stay in operation. Additionally, NC Medicaid supports North Carolina's workforce, including workers in childcare, construction, hospitality, home health care and other essential industries.

On May 9, 2025, NC Medicaid alerted the General Assembly's Fiscal Research Division that more money would be needed to fund the program. Since that time, NC Medicaid has consistently provided updates to the General Assembly regarding projected funding needs. These efforts have included sharing detailed documentation and hosting informational briefings to outline the potential effects of insufficient funding. DHHS advocated for the funds necessary to ensure that our health care providers would not take pay cuts, and our beneficiaries would not lose services.

Both the House and Senate introduced proposals aimed at fully funding Medicaid as requested by DHHS, however, no final agreement was reached. DHHS presented the option of utilizing the Medicaid Contingency Reserve, which is established as a reserve to be used for budget shortfalls in the Medicaid program. The General Assembly did not elect to pursue this option and placing DHHS in position that required reconciliation of its budget.

NC Medicaid must operate based on the budget that becomes law. *N.C. Gen. Stat. §108A-54(e)(1)*. No state government agency is allowed to ignore a passed budget and just spend what it wants. As a result of this underfunding, DHHS has made very difficult decisions surrounding reductions in provider reimbursement rates. State lawmakers, not DHHS, hold the authority to make up for the funding shortfall needed for providers reimbursement and beneficiary services that help keep people healthy.

Short of the General Assembly implementing a solution to reconcile the funding shortfall, DHHS is required to make extremely difficult funding decisions to administer the NC Medicaid Program within the confines of the appropriated and allocated budget. If DHHS does not implement cuts, NC Medicaid will run out of funding before the end of the fiscal year and will come to a complete standstill. **None of the services listed above will be available for any of the Medicaid population** – over 3 million children, pregnant women, older adults, people with disabilities and working North Carolinians, including the Plaintiffs.

a. Provider Reimbursement Rate Reduction

Following the $319 million budget shortfall, the Department determined that the options for reducing expenditures were limited to reducing provider rates, eliminating optional services, and/or changing eligibility criteria. *(See Declaration of Jay Ludlam, Deputy Secretary for NC DHHS, NC Medicaid)*. Any adjustments to make up for the $319 million budget shortfall would also have to meet administrative and contractual duties within the Department. *Id.* The Department's goals for implementing options to meet the $319 million budget deficit were to minimize the impact to services for vulnerable populations, minimize the impact to critical behavioral health services, minimize impact to providers, minimize impact to home and community-based services, and make reductions that are more manageable to reverse in case additional funding becomes available. *Id.* Taking the goals and options into consideration, it was

decided to implement provider reimbursement rate reductions as one way to cover the massive budget shortfall.

On August 11, 2025, Secretary of DHHS, Dr. Devdutta Sangvai, sent a letter to legislative leaders notifying them that DHHS would need to begin reducing provider reimbursement rates to meet projections for the 2025-26 Fiscal Year. *Id.* Despite this, still, no additional appropriations by the General Assembly were made to NC Medicaid. *Id.* DHHS is also unable to rely on the promise of future appropriations or the assumption that the North Carolina General Assembly will appropriate sufficient funds at a future date to eliminate the need for reimbursement rate reductions.

When looking at provider reimbursement rates, some provider fee schedules accounted for a larger proportion of Medicaid's expenditure. *Id.* The provider reimbursement rate reductions were made in proportion to the expenditures they accounted for. *Id.* Another factor that was taken into consideration was previous rate increases. Some industries affected by the rate reductions have not seen a rate increase since 2012. *Id.* Those industry provider reimbursement rate reductions were recommended at the 3% reduction. *Id.* The provider reimbursement rate reductions range from 3% to 10%, depending on main factors such as expenditures and previous rate increases.

Services that received 10% provider reimbursement rate reductions include Research-Based Behavioral Health Treatments, ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities. These provider reimbursement rate reductions were made out of a necessity to keep the NC Medicaid program running within the allocated budget.

New provider reimbursements rates for providers billing Medicaid Direct went into effect on October 1, 2025. *Id.* However, Managed Care Entities[1] contracted through the DHHS, delayed

[1] DHHS also contracts with Managed Care Organizations ("MCO's") and Prepaid Inpatient Health Plans ("PIHP's") (collectively "Managed Care Entities") to provide coverage for NC Medicaid beneficiaries pursuant to *N.C. Gen. Stat. §108D-1 et seq.*

the implementation of these provider reimbursement rate reductions until November 1, 2025. *Id.* The fee schedule for RB-BHT services, which identifies the provider reimbursement rates, is a floor that Managed Care Entities are required to pay. *Id.*

b. RB-BHT

As a part of the NC Medicaid Program, Research-Based Behavioral Health Treatments are available for beneficiaries with Autism Spectrum Disorder (ASD) *See NC Medicaid Clinical Coverage Policy 8F.* RB-BHT are behavioral intervention services that prevent or minimize the disabilities and behavioral challenges that may be associated with ASD and may include applied behavior analysis (ABA) therapy.

RB-BHT Current Procedural Terminology (CPT) Codes were one, among other CPT codes, that received a 10% rate reduction in the NC Medicaid fee schedules. Prior to the October 1, 2025 reductions, RB-BHT providers were projected to receive approximately $657 million dollars in claims reimbursements from NC Medicaid. *Id.*

An order to return RB-BHT provider reimbursement rates to September 2025 levels would put the solvency of the NC Medicaid program in danger, which means NC Medicaid may not be able to cover any services for beneficiaries in the Spring 2026. DHHS does not have the fiscal resources available to fund RB-BHT services at the September 2025 level given the current money appropriated by the General Assembly. *(See Declaration of Adam Levinson, Chief Financial Officer for NC DHHS)* If rates were to return to September 2025 levels, it would cause the NC Medicaid Program to be over budget by approximately $17 million and not have sufficient funds to make capitation payments after May of 2026. *Id.* An order to return reimbursement rates to September 2025 levels would also place a large administrative burden on DHHS and would imperil the solvency of the NC Medicaid Program. (*See Declarations of Jay Ludlam and Adam Levinson*)

More specifically, if RB-BHT provider reimbursement rates were to remain at the September 2025 level, NC Medicaid will have to make additional cuts to other provider reimbursement rates. *(See Declaration of Adam Levinson).* Those cuts will have to be higher because of the shorter timeframe to make up for the $17 million shortfall, on top of the $319 million already existing budget gap. *Id.* If the RB-BHT provider reimbursement rates are extended any further, providers that furnish services to other protected classes would be impacted by higher cuts, where RB-BHT would be the only service to remain at the September 2025 level.

STANDARD OF REVIEW

A preliminary injunction is an "extraordinary measure taken by a court to preserve the status quo of the parties during litigation." *DaimlerChrysler Corp. v. Kirkhart*, 148 N.C. App. 572, 577-78, 561 S.E.2d 276, 281 (2002) (quoting *Ridge Community Investors, Inc. v. Berry*, 293 N.C. 688, 701, 239 S.E.2d 566, 574 (1977)). A court may grant a preliminary injunction only when all of three factors are satisfied: (1) the plaintiff has shown a likelihood of success on the merits, (2) the plaintiff will sustain irreparable loss unless the injunction is issued, and (3) a careful balancing of the equities shows that the public interest supports issuing an injunction. *See Ridge Community Investors*, 293 N.C. at 701, 239 S.E.2d at 574; *State v. Fayetteville St. Christian School*, 299 N.C. 351, 357-58, 261 S.E.2d 908, 913 (1980). The party moving for a preliminary injunction bears the burden of establishing entitlement to the relief. *Pruitt v. Williams*, 25 N.C. App. 376, 379, 213 S.E.2d 369, 371 (1975).

Moreover, because Plaintiffs seek a mandatory injunction - an injunction requiring the state to take a particular action - they must satisfy an even higher standard. *See Roberts v. Madison Cty Realtors Assoc.*, 344 N.C. 394, 399–400, 474 S.E.2d 783, 787–88 (1996); *Auto. Dealer Res., Inc. v. Occidental Life Ins. Co.*, 15 N.C. App. 634, 639, 190 S.E.2d 729 (1972). Specifically, Plaintiffs must show that their right to relief is clear, the need for relief is urgent, and their injury is immediate,

pressing, irreparable, and clearly established. *Id.* Additionally, mandatory injunctions are generally disfavored. *Id.*

Plaintiffs rely on *Pashby v. Delia* to assert that their proposed injunction is prohibitory rather than mandatory. *709 F.3d 307 (4th Cir. 2013).* True, *Pashby* explained that a preliminary injunction that restores conditions to their last uncontested status between the parties just before the controversy was prohibitory, not mandatory. But here, there has been no change in the status between Plaintiffs and Defendants. The only change is between Defendants and providers, specifically, how much money NC Medicaid implements as a floor for reimbursement. The providers are not parties to this litigation. Besides, *Pashby* interpreted federal, not state law, so it is inapplicable here.

Plaintiffs, beneficiaries whose services remain intact, request that this Court order Defendants to take the particular action of reinstating outdated and unsustainable provider reimbursement rates. Not only are Plaintiffs not entitled to a preliminary injunction under either standard, but a preliminary injunction forcing Defendants to take the action of reinstating uncut rates would in turn cause NC Medicaid to run out of funding before the end of the fiscal year and may leave the entire 3 million North Carolinians covered by NC Medicaid without coverage or life-saving services, including Plaintiffs.

ARGUMENT

I. PLAINTIFFS ARE UNLIKELY TO SUCCEED ON THE MERITS BECAUSE DEFENDANT'S RATE REDUCTIONS DO NOT VIOLATE NORTH CAROLINA STATUTORY OR CONSTITUTIONAL LAW.

A. NC Medicaid Provider Reimbursement Rate Reductions are not facially discriminatory

Plaintiffs first allege that the Department's action in reducing the provider reimbursement rates for Research Based Behavioral Health Therapy, was on its face discriminatory. This

argument is without support. Plaintiffs cannot show that the group was singled out or that the disability was a motivating factor. The evidence shows that the cuts were made based well-reasoned financial factors and a duty to balance the budget. There is no evidence that the plaintiffs' disability played a role in the rate cuts.

Contrary to Plaintiffs' assertions, individuals with ASD were not singled out and treated differently as a result of their disability. Individuals with ASD may receive a wide range of ASD treatment services beyond RB-BHT therapy. These types of treatment services include speech and language, occupational and physical therapy and Medicaid home and community based services (HCBS). (*See Ex. 4, p. 7*) Individuals with ASD were not discriminated against as a result of the 10% provider reimbursement rate cut for one type of treatment or service they may receive. In fact, they are being treated like all other Medicaid beneficiaries because the Department implemented provider reimbursement rate cuts to most services available to them. When making these cuts, DHHS undertook a detailed analysis of provider reimbursement rates across all services to determine the most limited, yet necessary rate cuts in order to keep the NC Medicaid Program solvent and available to for over 3 million North Carolinians. As stated above, other providers also received a 10% rate cut, including ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities. *(See Declaration of Jay Ludlam)* It is clear from this list that recipients of these services also include other protected classes, such as women, the disabled, and the elderly and as such, Plaintiffs were not singled out or treated differently.

Plaintiffs rely on *Bowers v. National Collegiate Athletic Association,* 563 F. Supp.2d 508 (D. NJ 2008) in support of its erroneous assertion that the rate cuts to RB-BHT therapy were discriminatory on their face. In *Bowers,* the NCAA had a policy which prevented special education courses taken by students in high school from being considered core courses, regardless of course

content. *Id.* at 519. The plaintiff's son, who was subject of the litigation, was an excellent football player but was enrolled in special education classes as a result of a learning disability. *Id.* As a result of the NCAA policy regarding special education courses, the plaintiff's son's ability to obtain an athletic scholarship was negatively impacted. *Id.* at 512-513. The NCAA's policy was found to be discriminatory on its face because it treated those who took special education classes differently than other students. The court found the policy not to be facially neutral because it was premised on a "trait that the handicapped as a class are less capable of meeting or less likely of having." *Id.* at 516.

Here, there is no showing that RB-BHT therapy or ASD individuals have been singled out as a motivating factor for the cut. There is nothing to support that beneficiaries with ASD were facially discriminated against when the DHHS implemented provider reimbursement rate cuts across most services available to Medicaid beneficiaries. Many other service area reimbursement rates were cut by 10%, all of which serve Medicaid beneficiaries that include women, the disabled, and the elderly. By Plaintiffs' logic, all provider reimbursement rate reductions would be considered facially discriminatory because any rate reduction allegedly impact beneficiaries who are in protected classes. Moreover, DHHS set out a detailed analysis on how and why it undertook the reimbursement rate cuts that show well-reasoned factors that support the decisions were not motivated by singling out a group.

It is true that RB-BHT provider reimbursement rates were reduced by 10% along with other services. The determination to make the 10% cuts to RB-BHT, ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities was made to keep the NC Medicaid program within the budget so millions of North Carolinians can continue to receive

services despite the budget shortfall from the General Assembly. The provider reimbursement rate reductions were not taken lightly and were carefully balanced to meet budget shortfalls.

A number of factors went into the decision on how much each provider reimbursement rate needed to be cut, and it should be noted that all but one reimbursement rate was cut in some way. The provider reimbursement rate reductions were made in proportion to the expenditures they accounted for and NC Medicaid is currently experiencing an exponential increase in utilization and spending on RB-BHT. *(See Ex. 4 p. 5-7)* Specifically, total Medicaid spending on RB-BHT is projected to increase by approximately 425% with a projected $639 million dollars in 2026, which includes the rate reductions. *Id.*

Some of the continued and projected increase in spending on RB-BHT may be attributed to the utilization rate, the number of providers, and previous provider rate reimbursement increases. In 2024, RB-BHT providers received a 15% reimbursement rate increase which led to a projected $516 million dollar expenditure in 2025. *Id.* For contrast, in 2023, prior to the 15% rate increase, the total spending on RB-BHT was $199 million. *Id.* This drastic difference in expenditure is also linked to the utilization rate. Between 2022 and 2024, the volume of RB-BHT claims increased 158.4% but the beneficiaries using RB-BHT services only increased by 126.5%. *Id. at 11-12.* The bulk of these increases are being paid out to a small number of providers. From 2023-2024, only 5 RB-BHT providers accounted for 41% of the spending increase. *Id. at 8.* Additionally, 11 providers accounted for 26% of the spending increase. *Id.* The sharp increase in the overall spending in this space, including the vast amount of money into a small number of providers led to the decision to reduce the provider reimbursement rate by 10%.

Plaintiffs have failed to prove that widespread provider reimbursement reductions facially discriminated against people with ASD because many reimbursement rates were reduced by 10%

and because all provider reimbursement rate reductions were carefully balanced to meet budget shortfalls.

B. NC Medicaid Reimbursement Rate Reductions do not violate the NCPDPA because they do not discriminate against children or others with ASD.

Plaintiffs erroneously allege that the Department violated the North Carolina Persons with Disabilities Protection Act ("NCPDPA"). Plaintiffs are unlikely to succeed on these merits because the Department did not discriminate against the Plaintiffs and therefore did not violate the NCPDPA. The NCPDPA states,

> It is a discriminatory practice for a covered governmental entity to exclude a qualified person with a disability from participation in or deny the benefits of services, programs, or activities because of a disability or to refuse to provide reasonable accommodations, including auxiliary aids and services necessary for a known qualified person with a disability to use or benefit from existing public services operated by such entity; provided that the accommodations do not impose an undue hardship on the entity involved.

N.C. Gen. Stat. § 168A-7(a).

For Plaintiffs to succeed in their allegations that the Department violated the NCPDPA, they must show that (1) a covered governmental entity (2) excluded a qualified person with a disability (3) from participation or denied the benefits of services, programs, or activities because of a disability. Here, Plaintiffs are unlikely to succeed on these merits because the Department did not exclude or deny Plaintiff's from participation in services, programs, or activities based on a disability. Plaintiffs erroneously contend that their disability, Autism Spectrum Disorder, ("ASD"), "played a motivating role" in the Medicaid cuts that Department instituted.

Defendants are a covered governmental entity as defined by *N.C. Gen. Stat.* §168A-3(1) and Plaintiffs may be considered a qualified person with a disability as covered by the American with Disabilities Act[2]. However, Plaintiffs fail to meet the remainder of the standard.

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[2] *See* https://www.ada.gov/topics/intro-to-ada/

Defendants did not exclude any of the Plaintiffs from participation in benefits of services, programs, or activities because of a disability. In fact, Plaintiffs do not assert in their declarations that they have been denied any benefits, services, programs, or activities by Defendants. *See P's Exs. 1-20.* To the contrary, the parent declarations provided by Plaintiffs show that 19 out of 22 children are already receiving applied behavior analysis ("ABA") therapy that is being covered by NC Medicaid. *See P's Exs. 3, 5-20.* There were three children where the parents specified that they are currently on a waitlist for ABA therapy. *See P's Exs. 1-2, 4.* Additionally, nothing in the declarations provided by the parents of the children indicate that they were denied any benefit, services, programs, or activities by the Defendants. *Id.* This proves that not only were Plaintiffs not denied any benefits, services, programs, or activities by Defendants, but that Defendants in fact cover and approved Plaintiffs for ABA therapy. *See P's Exs. 1-20.*

Plaintiffs, as such, failed to prove that Defendants denied them of a benefit, service, program, or activity and Plaintiffs also fail to show that the provider reimbursement rate reductions were based on Plaintiffs' disabilities. Plaintiffs again fail to meet this standard and therefore fail to prove that they would likely be successful on the merits.

Under Title II of the ADA, a plaintiff must allege and show that disability "played a motivating factor" in the injury. *Constantine v. Rectors & Visitors of George Mason Univ.*, 411 F.3d 474, 498 n.17 (4th Cir. 2005) (distinguishing the causation requirements) (citing *Baird v. Rose*, 192 F.3d 462, 467-70 (4th Cir. 1999))[3]. A showing of causation requires more than merely "recit[ing] the word 'discrimination'" in the complaint. *Bean v. Perdue*, No. 17-0140, 2017 WL 4005603, at *5 (D.D.C. Sept. 11, 2017). A plaintiff seeking relief must prove that disability played a motivating role in the adverse action. *Constantine,* 411 F.3d at 498 n.17. The failure to allege

[3] Plaintiffs cited to federal ADA decisions as guidance since the NCPDPA is the North Carolina equivalent of the ADA. The Department similarly cites to federal ADA decisions.

causation requires dismissal. *Id.*, *see also Hawkins v. Cohen*, 327 F.R.D. 64, 74 (E.D.N.C. 2018) (dismissing ADA claims for failure to allege that disability "played a motivating role" in the adverse action).

In the present case, Plaintiffs have presented no evidence that disability was a motivating factor in the actions of DHHS in changing the rate for Research Based Behavioral Health Therapy, which encompasses ABA therapy. Plaintiffs' argument is that since the rate for RB-BHT services was cut, it must be motivated by their disability. Plaintiffs incorrectly assert that RB-BHT services were subject to a "disproportionately high cut" and contend that as a result, the Department "facially discriminated against Plaintiffs." First, all but one Medicaid service reimbursement received a rate reduction from 3% to 10%. Other service categories receiving a 10% rate cut included ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities. *(See Declaration of Jay Ludlam)* Further, RB-BHT services received a 15% rate increase that was effective January 1, 2024. This rate increase and the current rate reduction actually balance out to a net increase of 5% for the RB-BHT Services as compared to the rate prior to January 1, 2024. (*See Declaration of Jay Ludlam*) Plaintiffs have failed to demonstrate that their disability played a motivating factor in the provider reimbursement rate reductions and their claim pursuant to NCPDPA fails.

The Plaintiffs have failed to show that the Defendants denied any benefits, services, programs, or activities to Plaintiffs because of their disability; therefore, that the NC Medicaid reimbursement rate reductions do not violate the NCPDPA. Thus, Plaintiffs have not sufficiently shown that they have any likelihood of success on the merits and have not met their burden for a Preliminary Injunction to be issued.

C. NC Medicaid Reimbursement Rate Reductions do not violate the NCPDPA because they do not directly place Plaintiffs at risk for institutionalization.

Plaintiffs next erroneously assert that the NCPDPA was violated because the rate cut for RB-BHT services may put those with ASD at risk for institutionalization. Plaintiffs' reliance on case law concerning the placement of individuals with disabilities in the least restrictive setting is misplaced and not applicable to the case at issue. In each of the cases relied on by Plaintiffs, the NC Medicaid beneficiaries were either institutionalized with no way to be integrated into the community or had their services denied, reduced, or terminated. Here, Plaintiffs are not institutionalized and have not had any interruption in their service made by Defendants.

In *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 592 (1999), the Supreme Court was "confront[ed with] the question [of] whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions." 527 U.S. at 587. The response was "a qualified yes[;]" that is, "[s]uch action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* Here, the Plaintiffs have failed to assert that they are institutionalized and a less restrictive setting is appropriate. *See P's Exs. 1-20.* Instead, Plaintiffs assert that they do not agree with the provider reimbursement rate reductions to RB-BHT, a therapy provided on an outpatient basis.

In *Pashby v. Delia, 709 F.3d 307, 321-323* (4th Cir. 2013), Plaintiffs were denied in-home personal care services ("PCS") but may have been eligible for PCS if they were placed in an institution. Unlike *Pashby*, here, Plaintiffs have failed to show that Defendants denied any benefits, services, activities, or programs to them. Plaintiffs' own declarations prove that Defendants continue to cover their ABA therapy on an outpatient basis. *See P's Exs. 3, 5-20.* There are no allegations that Defendants have discontinued services that Plaintiffs may otherwise be eligible for

if they were institutionalized. Thus, Plaintiffs use of *Pashby*, similar to their use of *Olmstead*, is misplaced.

In *Samantha R.*, Plaintiffs were either institutionalized or had their services denied, reduced, or terminated. *See Samantha R., et al. v. State of North Carolina, et al., Wake County Superior Court, 17CVS006357-910, Amended Complaint, p. 2, 27-34.* Allegations included that Plaintiffs Samantha, Marie, and Jonathan were institutionalized and Plaintiffs Connie, Michael, and Mitchell had services denied, reduced, or terminated which put them at risk of institutionalization. *Id.* Again, unlike *Samantha R.,* the Plaintiffs in this instance are not institutionalized and have not had their services denied, reduced, or terminated by Defendants and Plaintiffs use of *Samantha R.* is misplaced.

Plaintiffs inaccurately allege that the provider reimbursement rate reduction places the Plaintiffs at risk for institutionalization. None of the declarations provided by the Plaintiffs state that the Plaintiffs are institutionalized or are likely to be institutionalized as a result of a minor reduction in a reimbursement rate for one type of therapy for those diagnosed with ASD. Instead, Plaintiffs provided five (5) declarations from parents whose children receive ABA therapy where they indicated that the continuation of ABA therapy may reduce the risk of institutionalization. *See P's Exs. 6,7,8,10,12.* However, the Department has not discontinued providing funding for or offering the RB-BHT services to Plaintiffs. Instead, the Department has insured the continued access to RB-BHT services by providing a minor cut to the provider reimbursement rate, along with the rates of a vast number of other Medicaid services, so that the Medicaid program does not run out funds. (*See Declaration of Adam Levinson*) Because Plaintiffs' amount of authorized services has not been altered due to the provider reimbursement rate reductions, Defendants have not placed Plaintiffs at risk for institutionalization and thus have not violated the NCPDPA.

D. NC Medicaid Reimbursement Rate Reductions do not violate the North Carolina Constitution.

i. **Plaintiffs cannot state a direct claim for injunctive or declaratory relief under the North Carolina Constitution.**

Plaintiffs' state-law due process and equal protection claims are not based on any State statute, but rather, Plaintiffs are trying to bring claims directly under the North Carolina Constitution. In *Corum v. University of North Carolina*, the North Carolina Supreme Court held that in very limited circumstances, a plaintiff may file a direct North Carolina constitutional claim against the State or its agents. 330 N.C. at 782-84, 413 S.E.2d at 289-91. By allowing an otherwise common law or statutory claim to proceed as a direct constitutional claim, the North Carolina Supreme Court fashioned a narrow avenue to bypass certain defenses such as sovereign or governmental immunity. *See, e.g., id.*; *Wilcox v. City of Asheville*, 222 N.C. App. 285, 298 (2012); *Craig v. New Hanover County Bd. of Educ.*, 363 N.C. 334, 340, 678 S.E.2d 351, 355-56 (2009). But these claims are typically allowed only under narrow circumstances. *Corum*; 330 N.C. at 782, 413 S.E.2d at 289. A *Corum* claim is only available to a plaintiff who is able to establish that (1) his state constitutional rights have been violated, (2) he lacks any sort of "adequate state remedy," and (3) the remedy he seeks is "the least intrusive remedy available and necessary to right the wrong." *Corum; 3*30 N.C. at 782, 413 S.E.2d at 289; *see also Craig,* 363 N.C. at 340, 678 S.E.2d at 355-56 (2009); *Taylor v. Wake Cnty*, 258 N.C. App. 178, 183, 811 S.E.2d 648, 652 (2018); *Sanders v. State Personnel Commission*, 183 N.C. App. 15, 17-18, 644 S.E.2d 10, 12 (2007).

As discussed further below, Plaintiffs cannot demonstrate their constitutional rights have been violated. Additionally, Plaintiffs have not demonstrated the lack of an adequate remedy. In order for a remedy to be adequate, "a plaintiff must have at least the opportunity to enter the courthouse doors and present his claim." *Wilkerson v. Duke Univ.*, 229 N.C. App. 670, 676, 748 S.E.2d 154, 159 (2013) (citing *Craig*, 363 N.C. at 339-40, 678 S.E.2d at 355). The available remedy need not guarantee relief, but rather only needs to "provide the possibility of relief under the circumstances." *Craig*, 363 N.C. at 340, 678 S.E2d at 355; *see also Frye v. Brunswick County*

Bd. of Educ., 612 F. Supp. 2d 694, 704 (E.D.N.C. 2009) (an adequate state remedy need not be successful, only available). Indeed, "adequacy is found not in success, but in chance." *Wilcox*, 222 N.C. App. at 299, 730 S.E.2d at 237 (determining that "a state common law claim that may, at trial, ultimately fail based on a defense of public official immunity is an adequate remedy" requiring dismissal of constitutional claims).

Here, Plaintiffs do not lack an adequate remedy as demonstrated by their assertion of two statutory claims in this same case. Even if they are ultimately not successful on these claims, the fact that they were able to assert them in this lawsuit and seek injunctive and declaratory relief based on them, fulfills the adequate state remedy requirement. This bars Plaintiffs' direct assertion of constitutional claims.

ii. NC Medicaid Reimbursement Rate Reductions did not deny Plaintiff's due process.

Assuming *arguendo* that this Court hears Plaintiffs constitutional allegations, Plaintiffs still fail to prove that Defendants denied due process or violated their equal protection. The State's Constitution guarantees that "[n]o person shall be . . . deprived of his life, liberty, or property, but by the law of the land." N.C. Const. art. I, § 19. "The term 'law of the land' . . . is synonymous with 'due process of law' as used in the Fourteenth Amendment to the Federal Constitution." *Rhyne v. K-Mart Corp.*, 358 N.C. 160, 180, 594 S.E.2d 1, 15 (2004) (quoting *In re Moore*, 289 N.C. 95, 98, 221 S.E.2d 307, 309 (1976)). As such, "[o]ur state courts generally treat the corresponding section of the N.C. Constitution as the functional equivalent of its federal counterpart." *Clayton v. Branson*, 170 N.C. App. 438, 451, 613 S.E.2d 259, 269 (2005).

To advance a due process claim, a plaintiff must first demonstrate the existence of a valid liberty or property interest allegedly infringed upon. *See DeBruhl v. Mecklenburg Cty. Sheriff's Office*, 259 N.C. App. 50, 55, 815 S.E.2d 1, 5 (2018) ("[W]hether a state will owe procedural due process protections to an individual depends upon the nature of the individual right that is at stake.

'The requirements of procedural due process apply only to the deprivation of . . . liberty and property' interests.") (quoting *Bd. of Regents v. Roth*, 408 U.S. 564, 569 (1972)); *Ballard v. Shelley*, 257 N.C. App. 561, 568, 811 S.E.2d 603, 608 (2018) ("To state a claim for violation of procedural due process rights, the complainant must allege (1) that 'the State has interfered with a liberty or property interest' . . . .").

Plaintiffs have failed to establish any deprivation of liberty or property interest. As previously mentioned, Plaintiffs have not been denied any services by Defendants and Defendants continue to fund and approve Plaintiffs for services they would otherwise be eligible for. As such, Plaintiffs do not have a liberty or property interest in these services being reimbursed at a particular rate.

Even assuming that Plaintiff has established a cognizable liberty or property interest, their due process claim still fails because generally applicable rules, like the Department's budget, and thus, provider reimbursement rates, do not trigger procedural due process rights. Under well-established federal and state law, an individual plaintiff must be "exceptionally affected, in each case upon individual grounds" by government action to invoke the requirements of procedural due process. *See DeBruhl*, 259 N.C. App. at 55, 815 S.E.2d at 5 (quoting *Bi-Metallic Invest. Co. v. State Bd. of Equalization*, 239 U.S. 441, 446 (1915) (Holmes, J.)).

In *Bi-Metallic*, Justice Holmes noted that "[g]eneral statutes within the state power" may be passed "that affect the person or property of individuals, sometimes to the point of ruin, without giving them a chance to be heard." 239 U.S. at 445. In the context of such general statutes, the affected person's "rights are protected in the only way they can be in a complex society[:] by their power, immediate or remote, over those who make the rule." *Id.*; *see also Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982) (noting that procedural due process rights are not violated by

a law of general applicability because "the legislative determination provides all the process that is due").

Applying the rule articulated in *Bi-Metallic*, courts of this State "evaluat[e] the nature" of the government action by applying "the historic legal distinction ... legislative and adjudicative determinations." *High Rock Lake Ass'n Inc. v. N.C. Env. Mgmt. Comm'n*, 39 N.C. App. 699, 705, 252 S.E.2d 109, 113-14 (1979). "Where the [action] rests on findings of a general nature and not upon 'individual grounds,'" no adjudicative procedure is due. *Id.* (quoting *Bi-Metallic*, 239 U.S. at 446). The "touchstone" for distinguishing between lawmaking and adjudication "is that adjudication involves a specifically named party and a determination of particularized legal issues and facts with respect to that party." *Id.* (quoting Charles E. Daye, *North Carolina's New Administrative Procedure Act: An Interpretive Analysis*, 53 N.C. L. Rev. 833, 868 (1975))[4]; s*ee also State ex rel. Utilities Comm'n v. Nantahala Power & Light Co.*, 326 N.C. 190, 199-203, 388 S.E.2d 118, 123-26 (1990).

Here, the government action was reducing provider reimbursement rates between 3 and 10% for various services and CPT codes. No individual beneficiary was denied any particular service directly and therefore Plaintiffs fail to have grounds where adjudicative procedure is due. Because Plaintiffs have failed to establish any deprivation of liberty or property interest and because Plaintiffs have failed to show where any adjudicative procedure is due, even assuming *arguendo* that Plaintiffs overcome *Corum,* Plaintiffs have advanced unsupported allegations of due process violations.

iii. NC Medicaid Reimbursement Rate Reductions did not deny Plaintiffs' equal protection.

[4] The Court of Appeals in *High Rock Lake* was analyzing a challenge under the Administrative Procedures Act. However, it noted that "our inquiry goes beyond statutory law" and concluded that it was required to determine whether "fundamental concepts of due process entitle plaintiffs to an adjudicatory hearing." *High Rock Lake*, 39 N.C. App. at 705, 252 S.E.2d at 113.

Plaintiffs assert that they are being denied equal protection under the law because they are being treated differently than other Medicaid recipients due to the 10% provider reimbursement rate reduction to RBH-BT services. However, this claim is without basis and is meritless.

The North Carolina Constitution provides that "[n]o person shall be denied the equal protection of the laws." N.C. Const., Art. I, § 1. Since this case does not concern a fundamental right, Plaintiffs concede that the court should apply a rational basis review. Under this standard, a party must establish that "he received treatment different from others similarly situated," *Maines v. City of Greensboro*, 300 N.C. 126, 132, 265 S.E.2d 155(1980), and that the disparate treatment did not "bear some rational relationship to a conceivable legitimate government interest." *Texfi Indus., Inc. v. City of Fayetteville*, 301, N.C. 1,11, 269 S.E.2d 142 (1980).

Here, Plaintiffs cannot demonstrate that they were treated differently than other NC Medicaid recipients because the amount of authorized services for any NC Medicaid recipients have not been altered due to the provider reimbursement rate reductions. These provider reimbursement rate reductions only apply to the amount in which a provider is reimbursed and have no direct correlation to whether a NC Medicaid recipient is approved for services. While RB-BHT services did receive a 10% provider reimbursement rate reduction, numerous other services also received a 10% provider reimbursement rate reduction. Those services include ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities. (*See Declaration of Jay Ludlam* ¶20)

Further, assuming *arguendo* that Plaintiffs were treated different than others similarly situated, there was a rational relationship to a legitimate government interest in the actions of the Department. The Department made thoughtful and precise budget cuts via provider reimbursement rates in an attempt to keep the entire Medicaid program operating in light of its $319 million

shortfall. (*See Declaration of Jay Ludlam* ¶15-17) The analysis undertaken by the Department in arriving at a 10% rate reduction included taking into account the 15% rate increase that occurred for RB-BHT services in 2024, the fact that North Carolina's reimbursement rate for RB-BHT was among the top five highest in the country, and the overall exponential growth of the RB-BHT service. (*See Declaration of Jay Ludlam* ¶18) Clearly, the minor rate reimbursement reduction for the RB-BHT services was only undertaken after thoughtful analysis and it was necessary to shore up the Medicaid program so that services could continue to be provided to the 3.1 million North Carolinians who are Medicaid recipients. Because Plaintiffs cannot demonstrate that they were treated differently than other NC Medicaid recipients and there is a rational relationship to a legitimate government interest in the actions of the Department, Plaintiffs fail to meet the standard required to support any equal protection argument.

II. PLAINTIFFS CANNOT SHOW IMMEDIATE AND IRREPARABLE HARM IF THE PRELMINARY INJUNCTION IS NOT GRANTED.

In their brief, Plaintiffs argue that they will suffer irreparable harm, specifically that they "will be denied necessary and important medical treatment absent injunctive relief." (Plaintiff's Brief pp. 26-27) Plaintiffs support this argument with declarations from both their parents and from several ABA service providers who will be affected by the rate reduction. However, these declarations are insufficient to show that Plaintiffs will suffer the immediate and irreparable harm they hypothesize. The declarations from Plaintiffs' parents provide cursory statements that their children would not be able to continue receiving treatment but do not identify any statements made to them by their providers or any other factual basis to support these conclusions. These speculative and uncertain assertions are insufficient to show a likelihood of harm. The declarations by ABA service providers are no better, providing with no certainty that they would take any particular action should the reimbursement rate cuts remain in place. Declarants make these claims even as they operate practices in other States where reimbursement rates have been and remain lower than

North Carolina's. These assertions of harm are speculative and hypothetical in nature and are insufficient to show that Plaintiffs will suffer immediate and irreparable harm.

To demonstrate irreparable harm, firstly, a plaintiff must show that the harm they will suffer is real and immediate, not merely speculative or hypothetical. "We have held that, in directly attacking the validity of a statute under the constitution, a party must show they suffered a 'direct injury.'" *Comm. to Elect Forest v. Emps. PAC*, 376 N.C. 558, 607, 853 S.E.2d 698, 733 (2021), *quoting State ex rel. Summerell v. Carolina-Virginia Racing Ass'n*, 239 N.C. 591, 594, 80 S.E.2d 638, 640 (1954). A plaintiff must allege and show that the enforcement of a statute will cause individual, direct, and irreparable injury, and a "party who is not personally injured by it may not assail a statute's validity." *D & W, Inc. v. Charlotte*, 268 N.C. 577, 583, 151 S.E.2d 241, 245 (1966); *see also Fox v. Bd. of Comm'rs*, 244 N.C. 497, 500, 94 S.E.2d 482, 485 (1956). Our courts require that the plaintiff set out with particularity the facts supporting the claim of irreparable injury, allowing the court to independently assess whether such injury will indeed occur. *United Tel. Co. v. Universal Plastics, Inc.*, 287 N.C. 232, 236, 214 S.E.2d 49, 52 (1975). This requirement ensures that the court's intervention is justified and necessary to prevent significant harm that cannot be remedied through other means.

Moreover, the harm suffered by the plaintiff must be of such a nature that it cannot be adequately compensated by monetary damages or other legal remedies. *Williams v. Greene*, 36 N.C. App. 80, 85, 243 S.E.2d 156, 159–60 (1978). The injury must be beyond the possibility of repair or compensation in damages, or it must be an injury to which the complainant should not be required to submit, and which the other party should not be permitted to inflict. *Barrier v. Troutman*, 231 N.C. 47, 50, 55 S.E.2d 923, 925 (1949). This standard underscores the necessity of demonstrating that the harm is irreparable and that no adequate remedy at law exists.

Here, Plaintiffs allege that they may be "denied" ABA therapy if the rate reductions are allowed to continue during the pendency of the action. To support this allegation, Plaintiffs argue that they will either be significantly delayed in receiving treatment or suffer a regression in behaviors as a direct result of the rate cuts. However, the only support Plaintiffs provide that they will suffer these injuries are the statements made in the Declarations of the various providers that provide services in the State (hereinafter "Provider Declarations"). These Provider Declarations are self-serving, lack the specific factual assertions necessary to support a preliminary injunction, and are contravened by their willingness to operate in States where reimbursement rates for ABA therapy are lower than the rates complained about in their Declarations.

The Provider Declarations lack an appropriate factual basis for their claims that they will have to scale back or even stop business in North Carolina. Not a single Provider Declaration claims that their business would become unprofitable, simply that they will take in less money from Medicaid beneficiaries. For example, Action Behavior Centers, LLC states that 33% of their current patient population is covered through NC Medicaid. (Declaration of Action Behavior Centers, LLC) This means that they would not see a reduction in revenues of 10%, but more likely 3.3%, hardly the loss of revenue that would trigger action to "not move forward with new clinics" in North Carolina and to "not serve any new N.C. Medicaid patients or commercial patients." (Declaration of Action Behavior Centers, LLC) Further, Action Behavior Centers, LLC states that "North Carolina has a substantial therapist supply-demand gap, with significantly more need than there are providers." (Declaration of Action Behavior Centers, LLC). However, between Fiscal Year 2022 and Fiscal Year 2026, total NC Medicaid spending on this ABA therapy is projected to increase by approximately 425%, from $121.7 million to $639 million which would suggest that North Carolina has made great strides to increase beneficiaries access to ABA therapy. *(Declaration of Jay Ludlam)* Other Provider Declarations also lack the certainty of an outcome

necessary for a preliminary injunction. Centria Healthcare states that the provider "will likely not open any additional clinics" and that they "may be forced to close clinics[.]" (Declaration of Centria Healthcare) Neither statement is conclusive and neither statement is supported by the factual assertions in its own Declaration. Even Plaintiffs' own brief lacks any certainty of the alleged danger they face, instead arguing that they "face substantial concern regarding the loss or reduction of services[.]" (Plaintiffs' Brief p. 31)

Further, many of the Provider Declarations come from providers who operate in states where reimbursement rates for ABA therapies are lower than North Carolina's newly reduced rates, contravening their claims that the new rates in North Carolina will impact care. Action Behavior Centers operates and accepts Medicaid in Arizona and Colorado[5], two States with significantly lower reimbursement rates in all but one CPT code related to ABA therapy: CPT 97151, the initial comprehensive assessment. *(See Declaration of Jay Ludlam)* Blue Sprig Pediatrics, Inc. operates in Georgia, South Carolina, Colorado, and Arizona.[6] In Georgia it receives lower reimbursement rates for two of the seven CPT codes it can bill, in Colorado it receives lower reimbursement rates for three of the four CPT codes it can bill, in Arizona, it receives lower reimbursement rates for four of the five CPT codes it can bill, and in South Carolina it receives lower reimbursement rates for six of the seven CPT codes it can bill. *(See Declaration of Jay Ludlam)* Centria Healthcare operates in North Carolina, Virginia, Georgia, and Arizona.[7] Just as with the others, Centria Healthcare receives lower reimbursement rates for two of the seven CPT codes it can bill in Georgia, four of the seven CPT codes it can bill in Virginia, and four of the five CPT codes it can bill in Arizona. *(See Declaration of Jay Ludlam)* A search of the Secretary of State's website does not show a business entity named "Already Autism Health," however, the signer of its declaration,

[5] https://www.actionbehavior.com/resource/financial-assistance
[6] https://www.bluesprigautism.com/centers/
[7] https://centriahealthcare.com/locations/

Derek Bullard, is the Chief Executive Officer of Autism Behavioral Institute, LLC, a Wyoming limited liability corporation.[8] The website for Already Autism Health shows that they operate in North Carolina, South Carolina, Georgia, and Virginia.[9] Just as with the others, Already Autism Health receives lower reimbursement rates for six of the seven CPT codes it can bill in South Carolina, two of the seven CPT codes it can bill in Georgia, and four out of the seven CPT codes it can bill in Virginia. CompleatKidz has recently begun the process of opening a new location in Danville, Virginia. [10] If it completes this process, CompleatKidz will receive a lower reimbursement from the State of Virginia's Medicaid Program for four out of the seven CPT codes it would be able to bill. *(See Declaration of Jay Ludlam)* But while it is expanding into a State with lower reimbursement rates, it claims that North Carolina's cuts "forced CompleatKidz to put on hold our planning to expand into Goldsboro, Rockingham, Waynesville, Reidsville, Mount Airy, and Kings Mountain."

Finally, the harms identified by the Provider Declarations are the harms any provider would suffer if and when their reimbursement rates are reduced. Plaintiffs may find access to care more difficult, but they will not be alone. Plaintiffs' providers will have to engage in the same belt-tightening that hospitals, nursing facilities, and ambulatory surgical centers are having to do. *(See Declaration of Jay Ludlam)* Medicaid beneficiaries may find it harder to schedule surgery, find a nursing home, or obtain ABA therapy, but the alternative is every beneficiary losing access to Medicaid Benefits. These difficulties, felt by many NC Medicaid providers and beneficiaries, are a natural consequence of running a multi-billion-dollar public assistance program. Plaintiffs have failed to show that they will suffer the immediate and irreparable harm necessary for this Court to enter a preliminary injunction.

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[8] https://sosnc.gov/online_services/search/Business_Registration_profile/17632250
[9] https://alreadyautismhealth.com/locations/
[10] https://wset.com/news/local/compleat-kidz-plan-open-first-virginia-clinic-meeting-pediatric-therapy-needs-in-danville-march-2025

III. THE BALANCE OF THE EQUITIES IS IN FAVOR OF DENYING THE REQUEST FOR A PRELIMINARY INJUNCTION.

In determining whether to issue a preliminary injunction, a court must also engage in a careful balancing of the equities, weighing the potential harm to the plaintiff if the injunction is not issued against the potential harm to the defendant if it is granted. This balancing process ensures that the court's decision to grant injunctive relief is equitable and just, taking into account the interests of both parties. *State ex rel. Edmisten v. Fayetteville St. Christian Sch.*, 299 N.C. 351, 357, 261 S.E.2d 908, 913 (1980).

Moreover, the issuance of an injunction is a matter of discretion to be exercised by the hearing judge. *Id*; *see also A.E.P. Indus., Inc. v. McClure*, 308 N.C. 393, 405, 302 S.E.2d 754, 761 (1983). The judge must carefully consider whether the injunction is necessary to protect the plaintiff's rights during the course of litigation and to preserve the status quo. The court must balance the potential harms to both parties and also the public at large. *See Stout v. City of Durham*, 121 N.C. App. 716, 719, 468 S.E.2d 254, 257 (1996). This discretionary power allows the court to tailor its decision to the specific circumstances of each case, ensuring that injunctive relief is granted only when absolutely necessary.

Here, the balance of the equities must lean in favor of DHHS. Any order by this Court to roll back reimbursement rates to their previous levels would imperil the solvency of the NC Medicaid Program. (*See Declaration of Adam Levinson*) A rollback of all rates would cause the program to be over budget by $319 million and would cause the program to not have sufficient funds to make capitation payments after May 2026. *Id.* RB-BHT services account for 3.4% of all NC Medicaid funds paid to providers and, without the rate reductions, it is projected that RB-BHT providers would receive $657 million of taxpayers' money. *Id.* Even a short rollback would place a large and unnecessary administrative burden on DHHS. DHHS would not just have to stop its work, but redo all of the work it has completed so far, including recalculating capitation rates,

publishing new rates, and reprogramming its fiscal agent claim system. (*See Declaration of Jay Ludlam*) An order rolling back the October 1, 2025 reimbursement rate changes would unbalance the budget of the NC Medicaid program and DHHS would not be in compliance with the law. For Plaintiffs, however, they have yet to suffer any denial or reduction in services and, as explained above, are unlikely to do so, especially in the near term. Finally, the denial of a preliminary injunction would be in the best interest of the public, as a solvent NC Medicaid program is available to provide services, and coverage, to North Carolinians who may yet not be enrolled. An insolvent NC Medicaid, however, would imperil the health and welfare of millions of North Carolinians who rely on NC Medicaid. The balance of the equities is clearly in Defendants' favor, and as such this court should deny Plaintiffs' motion.

CONCLUSION

Plaintiff, as movants, are required to show (1) a likelihood of success on the merits, (2) that they will sustain irreparable loss unless the injunction is issued, and (3) a careful balancing of the equities shows that the public interest supports issuing an injunction. Plaintiffs have failed on both counts. Plaintiffs have failed to prove that the provider reimbursement rate reductions implemented by Defendants violate any North Carolina statutory or constitutional law and, as such, have failed to show a likelihood of success on the merits. Plaintiffs have also failed to identify a specific legitimate harm that they will suffer if the rate cuts are not returned to their September 2025 levels. Furthermore, the balance of the equities is in favor of Defendants. Plaintiffs' arguments to the contrary are without merit and, as such, Plaintiffs' Motion for a Preliminary Injunction must be denied.

Respectfully submitted this the 10th day of November, 2025.

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CERTIFICATE OF SERVICE

THIS IS TO HEREBY CERTIFY that the foregoing BRIEF IN OPPOSITION TO PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION was this day served upon the PLANTIFF'S by electronic mail, addressed to their ATTORNEYS OF RECORD as follows:

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Electronically submitted this the 10th day of November, 2025.

Electronically Submitted
Erin Hukka
Assistant Attorney General

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Assistant Attorney General

Colleen Crowley
Special Deputy Attorney General

Counsel for Defendants

STATE OF NORTH CAROLINA WAKE COUNTY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 25 CV 039433-910

M.Q., by and through parent AKIYA LEWIS; *et al.* Plaintiffs, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES; DEVDUTTA SANGVAI, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendants.	)	DECLARATION OF ADAM LEVINSON

I, Adam Levinson, declare under penalty of perjury, pursuant to N.C.G.S. § 7A-98, as follows:

1. I am a resident of the State of North Carolina. I am over the age of 18 and understand the obligations of an oath.

Professional and Agency Background

2. I am currently the Chief Financial Officer (CFO) for the NC Department of Health & Human Services (NCDHHS) and the acting CFO for the NC Medicaid program (NCDHHS Division of Health Benefits); until June 2025, when I became interim NCDHHS CFO, I had been the Medicaid CFO for six years.

3. I make this declaration based on personal knowledge and on my review of information and records gathered by agency staff.

4. The North Carolina Department of Health and Human Services is one of the largest, most complex agencies in the state of North Carolina, and has approximately 17,000 employees. It is responsible for ensuring the health, safety, and well-being of all North Carolinians, providing human service needs for special populations including individuals who are deaf, blind, developmentally disabled, and mentally ill, and helping low-income North Carolinians achieve economic independence.

5. North Carolina's Medicaid program, one of the programs administered by DHHS, involves the provision of health care coverage for low income and disabled people within the State.

6. As the Chief Financial Officer for the Department of Health and Human Services, I am responsible for overseeing all fiscal and financial management activities for the Department, including forecasting, advising, budgeting, spending, monitoring, reporting, and ensuring compliance with all relevant laws and regulations. As CFO for NC Medicaid, I carry similar responsibilities, focused on the NC Medicaid scope of work.

Local Management Entity/Managed Care Organization (LME/MCO) Coverage of Behavioral Health Services Including RB-BHT

7. NC Medicaid contracts with LME/MCOs for the delivery of behavioral health services to Medicaid beneficiaries through Behavioral Health/IDD Tailored Plans (Tailored Plans; a form of pre-paid health care plan, or PHP) and Prepaid Inpatient Health Plans (PIHP) for individuals enrolled in Medicaid Direct. NC Medicaid pays each LME/MCO a monthly capitation payment generated for each individual Medicaid member enrolled in a Tailored Plan or PIHP that the LME/MCO is financially "at risk" for using to meet all contractual requirements regarding delivery of services to Medicaid beneficiaries enrolled in the respective health care plans. To meet these requirements, each LME/MCO must contract with a network of providers of each covered

Medicaid service covered by the respective health care plans. For some services, including RB-BHT, the LME/MCO's contract with NC Medicaid requires that the LME/MCO reimburse providers at a rate no lower than that found on the Medicaid Direct fee schedule for the service. LME/MCOs may agree to pay providers more than the minimum fee schedule or they may make alternative payment arrangements if mutually agreed upon with the provider. The Medicaid Direct fee schedule is posted on the DHHS website, and the LME/MCOs post their standard fee schedules on their websites, though individual providers could have different rates.

Projected Deficit for NC Medicaid

8. Pursuant to N.C.G.S. § 108A-54(e)(1), DHHS is required to "[a]dminister and operate the Medicaid program, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for the Medicaid program." As such, DHHS may not spend more than the amount appropriated to it by the General Assembly for the purpose of operating N.C. Medicaid. To accomplish this requirement, DHHS is required to "[e]stablish and adjust all program components, except for eligibility categories, resource limits, and income thresholds, of the Medicaid program within the appropriated and allocated budget." N.C.G.S. § 108A-54(e)(4)

9. For State Fiscal Year (SFY) 2026, DHHS forecasted a need for approximately $6.7 billion in state funds to pay for the Medicaid program. This spending was expected to leverage approximately $28 billion in receipts, mostly from federal financial participation, to cover a portion of benefits and anticipated administration costs.

10. During the current fiscal year (SFY 2026), DHHS has spent approximately $1.36 billion in state funds through August to pay for NC Medicaid services.

11. In advance of each SFY, NC Medicaid forecasts required expenditures for Medicaid services, based on historical expenditure data, projected enrollment and service utilization,

changes to state and/or federal requirements, and other factors, such as federal match rate, that affect the non-federal share of cost to deliver Medicaid services. Since NC Medicaid services are now delivered primarily through contracted pre-paid health plans (PHPs), NC Medicaid works closely with actuarial vendor partners who use Medicaid's historical expenditure data to develop PHP capitation rates that meet federal requirements for actuarial soundness. These capitation rates are a key input into the forecasted need for state funding that is known as the annual Medicaid "rebase." The rebase appears as a request in the Governor's Recommended Budget (Governor's Budget) for a given biennium or single SFY.

12. In March of 2025, the Governor's Budget recommended $700 million in additional state appropriations for the Medicaid rebase for SFY 2026. A May 2025 update to the Governor's Office of State Budget and Management and the General Assembly (based on more recent utilization data) amended the need to $819 million. The General Assembly, through House and Senate versions of the SFY 2026 Appropriations Act (but no conference version of that Act) and a later conference "mini-budget," effectively appropriated $500 million toward the $819 million rebase. The resulting gap of approximately $319 million (or approximately 5%) left the Medicaid program at extreme risk of outspending its budget for SFY 2026.

13. Since only the NCGA can change eligibility requirements, NC Medicaid's only levers for reducing expenditures enough to close a budget deficit of $319 million were to reduce or eliminate optional services and/or reduce provider reimbursement for services. In order to best preserve Medicaid members' access to the full range of integrated health care services, NC Medicaid chose to address the majority of the deficit through reductions to provider reimbursement to keep the program going and stay within budget.

14. NCGS 143-4-11 establishes the Medicaid Contingency Reserve (MCR), a non-reverting fund which is to be used only for budget shortfalls in the Medicaid program. The MCR is funded by and must be appropriated by the NCGA. Neither DHHS nor the Governor's Office of State Budget and Management (OSBM) may access the funding without an explicit appropriation by the NCGA. DHHS and OSBM have indicated a readiness to meet all the statutory requirements for accessing funds from the Reserve. The funds in the MCR are non-recurring, meaning that if they were to be appropriated by the NCGA for addressing a budget shortfall, the funding would apply only to the SFY for which the funds were appropriated.

Fiscal Impacts on the State if Reimbursement Rates Reverted back to September Rates

15. An order to return reimbursement rates to September 2025 levels would put the solvency of the NC Medicaid program in danger. If NC Medicaid were to return to the September 2025 reimbursement rates, the program would expect to be over budget by approximately $319 million. In the absence of supplemental state appropriations, NC Medicaid would then expect to not have sufficient funds to make capitation payments in June of 2026.

16. Even an order to return reimbursement rates for only Research Base Behavioral Health Treatment ("RBBHT") providers to September 2025 levels would imperil the solvency of the NC Medicaid program. In SFY 2026, RBBHT providers account for approximately 3.4% percent of all NC Medicaid funds paid to providers. Prior to the October 1, 2025 reductions, RBBHT providers were projected to receive $657 million dollars in claims reimbursements from NC Medicaid. With the rate change, it is projected that RBBHT providers would receive $608 million dollars in claims reimbursements from the NC Medicaid program; the $49 million total reimbursement difference equates to an expected reduction of $17 million in state funds expended in SFY 2026.

17. If RB-BHT reimbursement rates remain at the September 2025 levels, as directed in the TRO, NC Medicaid would expect to see an increase in state fund expenditures of approximately $17 million through SFY 2026, creating a budget deficit of that amount. To address this deficit, NC Medicaid would need to consider implementing additional reductions to reimbursement rates for one or more other Medicaid health care providers. As the window for achieving a different $17 million in reductions would be shorter than the original nine months associated with the October 1 reductions, the new reductions would necessarily be higher on a percentage basis than if they had been implemented as part of the October 1 action. The shifted reductions would have approximately a $49 million additional impact on the newly affected provider(s).

18. DHHS does not have the fiscal resources available to fund RBBHT services at the September 2025 level given the current money appropriated by the North Carolina General Assembly. DHHS is also unable to rely on the promise of future appropriations or the assumption that the North Carolina General Assembly will appropriate sufficient funds at a future date to eliminate the need for these reimbursement rate reductions. The General Assembly has convened several times after the passage of the mini-budget with the intent of appropriating additional money to DHHS for NC Medicaid; however, to date, no additional funds have been appropriated.

19. An order to return reimbursement rates to September 2025 levels would put each and every NC Medicaid beneficiary in danger of losing access to care/services, including Plaintiffs. A return to September 2025 reimbursement levels for RBBHT only would require NC Medicaid to make up for the $17 million in projected additional state expenditure by reducing other services by that amount to still operate within the appropriated budget. This would likely have an effect of

reducing approximately $49 million in reimbursements for the services identified to replace the RBBHT October 1, 2025 reduction.

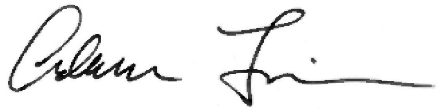
Administrative and Operational Burdens on DHHS if September Reimbursement Rates are Put Back into Effect

20. An order to return reimbursement rates to September 2025 levels would place a large administrative burden on DHHS. NC Medicaid would incur cost for additional staff time and vendor engagement to re-calculate capitation rates to account to the reimbursement changes.

21. Any order to return to the September 2025 rates would also unduly burden DHHS's already limited administrative resources.

I declare under penalty of perjury under the laws of North Carolina that the foregoing is true and correct to the best of my knowledge.

Executed on 7th day of November, 2025, in Raleigh, NC.



Adam Levinson
Chief Financial Officer
N.C. Department of Health and Human Services
Division of Health Benefits

STATE OF NORTH CAROLINA WAKE COUNTY	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 25 CV 039433-910

M.Q., by and through parent AKIYA LEWIS; *et al.* Plaintiffs, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES; DEVDUTTA SANGVAI, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendants.	DECLARATION OF JAY LUDLAM

I, Jay Ludlam, declare under penalty of perjury, pursuant to N.C.G.S. § 7A-98, as follows:

1. I am a resident of the State of North Carolina. I am over the age of 18 and understand the obligations of an oath.

Professional and Agency Background

2. I am the Deputy Secretary for the Department of Health and Human Resources, NC Medicaid, and have approximately 18.5 years of Medicaid experience. As part of my Medicaid experience, I have prosecuted doctors and dentists through the Missouri Attorney General's office, Medicaid Fraud Control Unit; I have worked at Medicaid Managed Care organizations as the Compliance Officer and as the Director of Operations; I have also worked at the Missouri Medicaid program – MO HealthNet – as a Deputy Director over the Missouri managed care program, and responsible for the Information Technology, Provider Relations, Member Services and Financing

units; I served as the Acting Medicaid Director over the MO HealthNet program. In North Carolina, I served as the Assistant Secretary for Transformation overseeing the multi-year transition to Medicaid managed care, the NC Medicaid COVID response, the unwinding of the COVID Public Health Emergency flexibilities, the consolidation of and transition to Tailored Plans, and the implementation of Medicaid Expansion.

3. I make this declaration based on personal knowledge and on my review of information and records gathered by agency staff.

4. The North Carolina Department of Health and Human Services is one of the largest, most complex agencies in the state of North Carolina, and has approximately 17,000 employees. It is responsible for ensuring the health, safety, and well-being of all North Carolinians, providing human service needs for special populations including individuals who are deaf, blind, developmentally disabled, and mentally ill, and helping low-income North Carolinians achieve economic independence.

5. North Carolina's Medicaid program, one of the programs administered by DHHS, involves the provision of health care coverage for low income and disabled people within the State. Medicaid is a joint federal and state program. The federal government regulates the program and provides a federal match to cover a portion of program expenditures. The NCDHHS Division of Health Benefits, administers North Carolina's Medicaid program within federal and state requirements. The North Carolina General Assembly is responsible for defining the eligibility criteria for beneficiary coverage. Federal law defines mandatory and optional benefits as well as a process for states to receive authorization for eligibility criteria, benefit coverage and provider reimbursement. NC Medicaid is delivered through a combination of managed care and fee-for-service.

6. As the Deputy Secretary for the Department of Health and Human Resources, NC Medicaid, I act as the Medicaid Director overseeing the administration of North Carolina's Medicaid program. As part of my duties, I am responsible for working with the Department and Medicaid financing teams to establish a forecasted budget for the NC Medicaid program and once appropriated, operating within that certified budget. I provide public policy and budgetary guidance and direction regarding how to stay within the certified budget and direct changes to the program to meet the fiscal, regulatory and programmatic requirements to stay in compliance.

Medicaid In North Carolina

7. NC Medicaid is a key part of North Carolina's efforts to address the lack of health care coverage for low-income individuals. In October 2025, 3.1 million people were enrolled in NC Medicaid, including approximately 1.5 million children under age 21. NC Medicaid covers beneficiaries for a range of healthcare services to meet their physical and mental health needs. During the state fiscal year between July 1, 2024 and June 30, 2025, the total budgeted expenditures for NC Medicaid were $35.8 billion. Total expenditures were covered by approximately $25.0 billion federal funds, $6.2 billion state appropriations, and $4.6 billion other non-federal funds (these are predominantly provider assessments and intergovernmental transfers).

8. DHHS administers the Medicaid program in North Carolina pursuant to N.C.G.S. § 108A-54 et seq. DHHS also contracts with Managed Care Organizations and Prepaid Inpatient Health Plans (collectively "Managed Care Entities") to provide coverage for NC Medicaid beneficiaries pursuant to N.C.G.S. § 108D-1 et seq. Pursuant to federal law, DHHS administers Medicaid in partnership with United States Department of Health and Human Services (USDHHS) and is responsible for providing coverage, enrolling providers, and supervising local County Department of Social Services offices' application process and enrollment and reenrollment of

beneficiaries. 42 USC § 1396 et seq. For benefits not provided by a Managed Care Entity, DHHS is responsible for paying providers, making coverage decisions, and determining what rate will be paid to providers USDHHS funds a portion of Medicaid benefits and administrative costs in North Carolina.

9. Research-Based Behavioral Health Treatments (RBBHT) are one of the many service categories covered by NC Medicaid. Nationally, RBBHT services are billed under eight Current Procedural Terminology (CPT) Codes: 97151-97158. NC Medicaid covers CPT Codes 97151-97157 at rates comparable with other states.

10. Pursuant to N.C.G.S. § 108A-54(e)(1), DHHS is required to "[a]dminister and operate the Medicaid program, provided that the total expenditures, net of agency receipts, do not exceed the authorized budget for the Medicaid program." As such, DHHS may not spend more than the amount appropriated to it by the General Assembly for the purpose of operating N.C. Medicaid. To accomplish this requirement, DHHS is required to "[e]stablish and adjust all program components, except for eligibility categories, resource limits, and income thresholds, of the Medicaid program within the appropriated and allocated budget." N.C.G.S. § 108A-54(e)(4)

Projected Deficit for NC Medicaid

11. On July 16, 2025, DHHS notified the North Carolina General Assembly that, based on projections for the 2025-26 Fiscal Year, it would need $819 million in State appropriations to maintain current services and provider payments. This adjusted appropriation amount is called a rebase. On July 30, 2025, the General Assembly passed N.C. Session Law 2025-89 which provided $500 million for the NC Medicaid rebase, $319 million less than needed to meet projections.

12. On August 11, 2025, Secretary of Health and Human Services Dr. Devdutta Sangvai sent a letter to legislative leaders notifying them that DHHS would need to begin reducing provider reimbursement rates to meet projections for the 2025-26 Fiscal Year. A copy of the letter is attached hereto as Exhibit 1.

13. On October 30, 2025, DHHS published a policy paper on the treatment of children with Autism Spectrum Disorder in NC Medicaid. In that paper, DHHS found that "[b]etween 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." This policy paper is available at https://medicaid.ncdhhs.gov/policy-paper-ensuring-person-centered-care-children-autism-spectrum-disorder-nc-medicaid-program, and is attached hereto as Exhibit 4.

14. To date, the North Carolina General Assembly has made no additional appropriations for NC Medicaid.

Decision to Reduce Provider Reimbursement Rates

15. With a projected budget shortfall of approximately $319 million, I led the Medicaid Executive Team through an exercise of establishing how the Medicaid program would operate within budget, accounting for the "mini-budget" passage in July 2025 after the state fiscal year had started. As NC Medicaid is a predominately managed care program, the options for reducing forecasted expenditures in the current fiscal year are limited to:

- Reduce Provider Rates
- Eliminate Optional Services
- Change eligibility criteria

Any adjustments would not only have to meet the budget requirements, but would also need to meet the administrative and contractual obligations with CMS, our regulator, and our contractual obligations with vendors, including the health plans. Therefore, I recommended DHHS focus as much as possible the following principles:

- **Minimize impact to services for vulnerable populations** like children and people with disabilities
- **Minimize impact to critical behavioral health services** so the state can continue making progress in addressing the current behavioral health crisis
- **Minimize impact to providers** who have not had rate increases for over a decade
- **Minimize impact to home and community-based services** since the alternative is higher cost care in institutional settings
- **Make reductions that are more easily reversible** (for example: rate cuts versus eliminating whole services) in case additional funding becomes available or utilization trends show a more favorable long-term forecast

By applying these principles to a shortfall as large as $319 million with the administrative timeframes available, it led me to recommend provider rate reductions to all provider fee schedules until the Medicaid program reached its reduction goal. Some provider fee schedules account for a larger proportion of the NC Medicaid expenditure and therefore those provider fee schedules were cut 10%; some provider rate reductions were recommended at 3% because the industries affected were staffed by providers who, for example, have not seen a rate increase since at least 2012 or are staffed by independent or self-employed staff; other provider fee schedules were reduced 8%.

16. In his August 11, 2025 letter to legislative leaders, Secretary Sangvai identified the principles upon which DHHS used to decide which rates to cut:

- Minimizing impact to services for vulnerable populations like children and people with disabilities
- Minimizing impact to critical behavioral health services so the state can continue making progress in addressing the current behavioral health crisis
- Minimizing impact to providers who have not had rate increases for over a decade
- Minimizing impact to home and community-based services, as the alternative is higher cost care in institutional settings
- Making reductions that are more easily reversible, such as implementing provider rate cuts versus eliminating whole service lines, so that if more funds are appropriated to NCDHHS, or utilization pointed to a more favorable forecast over time, the reductions could be more easily reversed

(See Ex. 1)

17. Importantly, Secretary Sangvai identified two areas targeted for enhanced rate reductions:

- Institutional settings: Inpatient and residential services make up a significant share of the overall Medicaid service expenditures. It is impossible to fill the funding gap without making reductions to acute care hospitals, nursing homes, psychiatric residential treatment facilities (PRTFs), and intermediate care facilities (ICFs). They will have rate reductions of 10%, except ICFs which will have an 8% reduction.
- Curbing excessive utilization growth: Researched-based Behavioral Health Therapy/Applied Behavior Analysis (RB-BHT/ABA) is a service primarily for individuals with autism and other related diagnoses. Across the country, utilization of this service in North Carolina has grown much faster than expected. To ensure children who truly need this care can get timely access and high-quality treatment, NCDHHS is more closely evaluating the reasons for rapidly growing utilization of this service. A rate reduction is being implemented to help control costs while exploring and implementing other controls to manage the program. Consequently, this service will have a rate reduction of 10%

(See Ex. 1)

18. Effective January 1, 2024 the RBBHT related fee schedule received a 15% increase in reimbursement rates. As a part of recent reductions for NC Medicaid to operate within its given budget, RBBHT received a 10% rate reduction for several reasons including:

- The RBBHT forecasted service costs increased faster than expected and in May 2025 was adjusted $75.4 million (state share) higher than the original Governor's budget request submitted to the North Carolina General Assembly at the beginning of the biennium;
- The RBBHT related services received a rate increase of 15% on January 1, 2024;
- RB-BHT is one of the fastest growing services currently covered by North Carolina Medicaid. Expenditures for RB-BHT were expected to grow to more than $650 million in state fiscal year 2026;
- The release of the Office of the Inspector General (OIG) December 2024 report regarding lax oversight and an increase in costs of Indiana Medicaid's RBBHT program and subsequent conversations at the national level suggested that some Medicaid RBBHT programs were experiencing uncontrolled growth;
- The Nebraska Medicaid program reduced RBBHT rates in July 2025 and subsequent research showed North Carolina as one of the top 5 highest paying RBBHT Medicaid programs which implied there was room to decrease rates without suppressing access.

19. For the reasons described above, DHHS made the decision to reduce the reimbursement rate for all covered RBBHT services by ten percent (10%), as reflected in this chart:

CPT Code	**Rate Before Reduction**	**Rate After Reduction**
97151	$30.56	$27.50
97152	$61.73	$55.56
97153	$20.81	$18.73
97154	$11.37	$10.23
97155	$32.22	$29.00
97156	$23.70	$21.33
97157	$11.51	$10.36

20. RBBHT was not the only service that had its reimbursement rates reduced by ten percent (10%). Other service categories that received a ten percent reduction include ambulatory surgical centers, anesthesiology providers, freestanding birth centers, hospice room & board, hospitals, nursing facilities, emergency room physician services, and vent facilities. A list of all service categories and their corresponding rate reductions can be found at:

https://medicaid.ncdhhs.gov/blog/2025/09/25/nc-medicaid-rate-reductions-effective-oct-1-2025 and is attached hereto as Exhibit 2.

21. New reimbursements rates for providers billing NC Medicaid's fee-for-service plan, Medicaid Direct, went into effect on October 1, 2025. NC Medicaid is also in the process of adjusting the capitation rate that it paid its Managed Care Entities to reflect the reduced rates. However, Managed Care Entities have some flexibility in setting their own reimbursement rates but, for many services, cannot set a rate lower than the rate set by NC Medicaid for a particular service. The fee schedule issued by DHHS is a floor that MCO's are required to pay.

22. In preparation for this Declaration, I have also analyzed the current reimbursement rates for Virginia, South Carolina, Georgia, Arizona, and Colorado. The following table shows the Medicaid reimbursement rates for RBBHT CPT Codes in those states in comparison to the reimbursement rate in North Carolina after the 10% reduction:

CPT Code	**NC Rate**	**SC Rate**	**VA Rate**	**GA Rate**	**AZ Rate**	**CO Rate**
97151	$27.50	$23.31	$23.58	$30.91	$30.06	$39.61
97152	$55.56	$20.50	$23.58	$30.91	$21.49	(n/a)
97153	$18.73	$14.88	$15.00	$15.58	$17.91	$17.20
97154	$10.23	$9.10	$13.13	$15.58	$4.48	$8.81
97155	$29.00	$21.25	$23.58	$30.91	$25.05	$25.80
97156	$21.33	$21.25	$23.58	$22.56	(n/a)	(n/a)
97157	$10.36	$13.31	$13.13	$26.10	(n/a)	(n/a)

My review shows that North Carolina's new reimbursement rates for RBBHT are comparable with both our neighboring States as well as across the nation.

23. In preparation for this Declaration, I have also reviewed a report published by the Nebraska Department of Health and Human Services entitled "DHHS Explains Medicaid Rate

Adjustment in Response to Provider Misinformation" dated July 18, 2025. The report includes a comparison of all 50 States' Medicaid provider reimbursement rates for CPT Code 97153. North Carolina's reimbursement rate for CPT Code 97153, even with the 10% reduction, is greater than all but six other States in the analysis. A copy of the Nebraska report can be found at: https://dhhs.ne.gov/Pages/DHHS-Gives-Update-on-Medicaid-Rate-Adjustments-Sets-Record-Straight-on-Misinformation.aspx and is attached hereto as Exhibit 3.

Administrative and Operational Burdens on DHHS if September Reimbursement Rates are Put Back into Effect

24. An order to return reimbursement rates to September 2025 levels would place a large administrative burden on DHHS. Such an order does not change DHHS obligation to meet the certified budget and therefore DHHS would have to recalculate and propose other provider rate reductions or optional service benefit cuts. DHHS would need to stop or recalculate capitation rates for 14 health plans, recalculate and publish rate changes for other fee schedules, and communicate those changes to legislators, providers and the general public. There would be administrative requirements that would have to be reviewed to ensure that NC Medicaid remains compliant with its federal and state administrative obligations to provide compliant notice and meet tribal consultation requirements. DHHS would also need to reprogram its fiscal agent claim system based on the new, updated rates and the 14 health plans would need to similarly reprogram their systems and reprocess provider claims. To comply with all of the above would be difficult if not impossible in the short term.

25. Any order to return to the September 2025 rates would also unduly burden DHHS's already limited administrative resources.

I declare under penalty of perjury under the laws of North Carolina that the foregoing is true and correct to the best of my knowledge.

Executed on 3rd day of November, 2025, in Raleigh, NC

DocuSigned by:
Jay Ludlam
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Jay Ludlam
Deputy Secretary
N.C. Department of Health and Human Services
Division of Health Benefits

EXHIBIT
1

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

August 11, 2025

Dear Legislative Leaders,

Thank you for your ongoing partnership and support for the health and well-being of North Carolinians. The North Carolina Department of Health and Human Services (NCDHHS) is proud of the NC Medicaid program we have built together, which now serves over 3 million people.

On July 16, we shared updated projections with the General Assembly for the State Fiscal Year (SFY) 2025–26 Medicaid rebase – the funding needed to maintain current services and provider payments. We shared that following a recent review of updated projections, new forecasts (based on SFY 2026 capitation rates from our contracted actuaries) have indicated that the rebase need is now $819 million, an increase from the $700 million in the Governor's budget, which was developed based on older data from January. We also noted that without full funding for the rebase, we would have to make cuts to the Medicaid program. On July 30, the NC General Assembly passed H125, which includes $600 million for both the Medicaid rebase and the Medicaid Oversight Fund. Given the program's administrative requirements, this appropriation results in only $500 million for the rebase, leaving a $319 million shortfall.

The Medicaid rebase has fallen short in recent years, but the state was able to compensate for that underfunding by using federal COVID (and other) funding. Those funds and options are no longer available. Therefore, the current underfunding of the Medicaid rebase by the General Assembly requires painful cuts to Medicaid. By the end of this month, NCDHHS will begin to cut $319 million from Medicaid by implementing rate reductions of 3% across all providers, as well as rate reductions of 8% or 10% for select providers, and elimination of certain services altogether – all with an effective date of October 1, 2025. These reductions carry serious and far-reaching consequences. Most immediately, reduced rates and the elimination of services could drive providers out of the Medicaid program, threatening access to care for those who need it most.

To meet an effective date of October 1, we must begin several administrative steps now, including notifying providers and beneficiaries, updating contracts and systems, and informing our federal partners at the Centers for Medicare and Medicaid Services (CMS). We have attempted to make these cuts reversible in the event that additional funding is approved. Absent additional appropriations by the General Assembly, however, NCDHHS will proceed with the reductions described herein.

The attached spreadsheet provides additional details about the service and rate cuts that will be required.

Background on Rebase and Guiding Principles for Determining Reductions

Medicaid rebase is the amount of funding required to maintain current service levels for beneficiaries. The primary drivers of the rebase amount are largely medical cost inflation, scheduled changes in the federal medical assistance program (FMAP), and increased service utilization. The request accounts for costs of enrollees in Medicaid Direct (Fee for Service), enrollees in Standard, Tailored, and Medicaid Direct Behavioral Health prepaid health plans, and the Children and Families Specialty Plan (planned to launch in December 2025). Medicaid expansion is not part of the Medicaid rebase funding because it does not utilize state general funds

NCDHHS established principles to guide the approach to cuts that aimed to minimize direct impact on beneficiaries and providers where possible; however, with financial limitations of this magnitude, that is impossible to avoid. NCDHHS prioritized the following principles:

- Minimizing impact to services for vulnerable populations like children and people with disabilities
- Minimizing impact to critical behavioral health services so the state can continue making progress in addressing the current behavioral health crisis
- Minimizing impact to providers who have not had rate increases for over a decade
- Minimizing impact to home and community-based services, as the alternative is higher cost care in institutional settings
- Making reductions that are more easily reversible, such as implementing provider rate cuts versus eliminating whole service lines, so that if more funds are appropriated to NCDHHS, or utilization pointed to a more favorable forecast over time, the reductions could be more easily reversed.

Unfortunately, these principles conflicted with each other at times, or it was unavoidable to impact a prioritized service or population. When that was the case, NCDHHS worked hard to minimize the reduction as much as possible.

Planned Rate and Service Reductions

In a managed care environment, NCDHHS is required by federal regulations to provide actuarially sound capitation rates to managed care organizations. Therefore, there are only two ways to address a shortfall from an insufficient rebase: reduce optional services and/or reduce provider rates. The significant size of the funding gap ($319 million) requires a broad-based approach. Every provider will sustain a minimum of a 3% rate cut, with some services absorbing substantially larger cuts. The attached spreadsheet details the reductions, and key points are below.

- **Enhanced Rate Reductions:**
    - Institutional settings: Inpatient and residential services make up a significant share of the overall Medicaid service expenditures. It is impossible to fill the funding gap without making reductions to acute care hospitals, nursing homes, psychiatric residential treatment facilities (PRTFs), and intermediate care facilities (ICFs). They will have rate reductions of 10%, except ICFs which will have an 8% reduction.
    - Curbing excessive utilization growth: Researched-based Behavioral Health Therapy/Applied Behavior Analysis (RB-BHT/ABA) is a service primarily for individuals with autism and other related diagnoses. Across the country, utilization of this service in North Carolina has grown much faster than expected. To ensure children who truly need this care can get timely access and high-quality treatment, NCDHHS is more closely evaluating the reasons for rapidly growing utilization of this service. A rate reduction is being implemented to help control costs while exploring and implementing other controls to manage the program. Consequently, this service will have a rate reduction of 10%.
- **Pre-paid Health Plans (PHPs)**: The managed care organizations that operate the Standard Plans will sustain a reduction to their capitation rate of 1.5%. CMS requires NCDHHS to pay PHPs an actuarially sound rate. NCDHHS uses the lowest rate possible within an actuarially sound rate range, however, CMS allows states the

flexibility to adjust rates up or down by 1.5% without requiring additional actuarial certification. This gives NCDHHS the flexibility to make the reduction and still comply with federal requirements. This reduction will be retroactive to July 1, 2025. Based on federal managed care requirements, there are no other financial adjustments that can be made that would be directly borne by the PHPs.

- **Optional pharmacy coverage**: NCDHHS will end the optional coverage of GLP-1 drugs for obesity/weight loss. This benefit was added in 2024 with the expectation that by treating obesity, which affects more than one in three North Carolinians, we can reduce future costs because these individuals are less likely to suffer from chronic conditions that are costly to treat (such as diabetes, hypertension, and heart disease) and harmful for their health. This expectation has not changed, but NCDHHS cannot continue to cover these drugs for this purpose at current appropriation levels. GLP-1s would still be covered for other clinical needs like diabetes and heart disease as required by the federal government.

Administrative Reductions

NC Medicaid is also facing significant challenges due to inadequate operational and administrative funding. The allocation provided by H125 fell short of what is needed to support essential Medicaid operations and critical technology investments. As a result, substantial cuts are being made to the operations of the Medicaid program, including ending or reducing contracts, reducing temporary employees who perform critical permanent functions, halting key projects, and scaling back compliance and quality activities. These cuts will significantly impair NC Medicaid's ability to be responsive to emerging needs and inquiries, monitor services for quality and compliance, and continue making timely operational improvements. North Carolina will no longer be able to depend on the level of service that providers and individuals have come to expect – service that is foundational to the success of the intentionally designed managed care program.

Additional Pressures on NC Medicaid

In addition to the Medicaid rebase shortfall, NC Medicaid is confronting several other significant challenges. With multiple fiscal uncertainties and programmatic changes unfolding simultaneously, the full impact of these variables this year and in future years is difficult to predict with certainty. NCDHHS is committed to closely monitoring these developments to understand their effects on the state budget, program operations, and the individuals we serve. We will continue to engage regularly with state leadership, providing timely updates and communicating what resources are necessary to prioritize the health and well-being of North Carolinians.

Key additional budgetary and administrative challenges include:

- The federal reconciliation law (H.R.1) introduces new requirements, including Medicaid work requirements and increased frequency of eligibility determination, without providing sufficient funding for implementation and creating significant administrative strain on counties.
- H125 did not fund the Healthy Opportunities Pilots (HOP), and as a result, DHHS has ended this program. HOP has reduced medical spending by $1,000 per member per year. Without HOP, NC Medicaid loses a critical tool to improve health and generate cost savings to the Medicaid program in future years.
- NC Medicaid had planned to begin working on the re-procurement of Standard Plan contracts and Tailored Plan contracts, which was an opportunity to ensure program sustainability, provide additional value for the state, and most importantly, improve the member and provider experience in ways that lead to better clinical outcomes. However, lack of necessary administrative funding and the scale of ongoing changes makes it impossible to responsibly rewrite the requirements for those contracts now given the uncertainty of what the NC Medicaid program will look like after the implementation of federal and state cuts. NCDHHS will delay these re-procurements by two years.

The below outlines the requested funding for NC Medicaid that was included in the Governor's budget and the funding that was ultimately allocated in H125.

	Requested Funding	Funding in H125	Shortfall
Medicaid Rebase	$819 million*	$600 million	$319 million (=819-500)
Medicaid Managed Care Oversight Fund	$115 million	*$500 million for Rebase $82 million for Oversight $18 million for missing LME/MCO transfer***	$33 million (=115-82)
Technology for NC Medicaid	$13 million	$0	$13 million

*Notice sent to the General Assembly of revision on July 16, 2025. Initial request from the Governor's budget was $700 million.
**By not including this item, H125 effectively reduces $18 million in receipts from the Medicaid budget. Subtracting this $18 million from the $100 million for operations leaves $82 million, approximately the amount that was funded for Medicaid oversight in the earlier House and Senate budget bills.

Conclusion

Over the past decade, NCDHHS has worked in partnership with the North Carolina General Assembly to transform the NC Medicaid program into a national model that comprehensively and strategically addresses the health needs of over 3 million North Carolinians. We remain committed to access, quality, safety, and whole-person health and well-being.

Despite careful efforts to minimize harm, the reductions now required carry serious and far-reaching consequences. Most immediately, reduced rates and the elimination of services could drive providers out of the Medicaid program, threatening access to care for those who need it most. Over time, the combination of underfunding, the loss of key multi-year infrastructure investments like the Healthy Opportunities Pilots, federal mandates that increase administrative burden without necessary resources, and administrative budget shortfalls risks a fundamental erosion of the NC Medicaid program.

NCDHHS remains hopeful that additional appropriations can be made to prevent these reductions. In the absence of additional funding, however, we must take the necessary steps to implement the legislative reductions by October 1, 2025. The NCDHHS team is available to discuss the details of these plans at your convenience.

Sincerely,

Devdutta Sangvai, MD, JD, MBA
Secretary

EXHIBIT 2

NCDHHS
NC Medicaid
Division of Health Benefit

SEPTEMBER 25, 2025

NC Medicaid Rate Reductions – Effective Oct. 1, 2025

Fee schedules impacted by rate reductions will be released Oct. 1 2025, but are subject to change if additional appropriations are made available.

NOTE: This Medicaid Bulletin has been completely replaced by an updated version published on Oct. 30, 2025. Please see the UPDATED: NC Medicaid Rate Reductions – Effective Oct. 1, 2025 bulletin (/blog/2025/10/30/updated-nc-medicaid-rate-reductions-effective-oct-1-2025), for the latest information.

This bulletin communicates the NC Medicaid provider reimbursement rate reductions being implemented by the Division of Health Benefits (DHB) to maintain the NC Medicaid program within the current funding allocated to the Medicaid program by the North Carolina General Assembly (NCGA). Please note that the rate reductions are subject to change if the NCGA provides NC Medicaid with additional appropriations for service programs.

Services to which rate reductions will apply and the corresponding rate reduction percentage that will be applied to the respective fee schedule rates effective Oct. 1, 2025, are listed below. Because reductions apply to procedure codes, impacted procedure codes may appear on more than one fee schedule. Fee schedules impacted by rate reductions will be released on Oct. 1, 2025, and are listed below:

Reductions by State Medicaid Fee Schedule - Program	Applicable Reduction Percentage*
Ambulance Services	3%
Ambulatory Infusion Therapy Centers	Overlapping physician codes only - 8%
Ambulatory Surgical Centers	10%
Anesthesiology Base Units	Anesthesiology codes - 10%, Overlapping physician codes - 8%
Auditory Implants	3%
Children Developmental Services Agency (CDSA)	CDSA codes - 3%, Overlapping physician codes - 8%
Chiropractic Services	Chiropractic codes - 3%, Overlapping physician codes - 8%
Clinical Pharmacist Practitioner (CPP)	CPP codes - 3% Overlapping physician codes - 8%
Community Alternatives Program	Personal Care-like Services - 8%, Non-Personal Care Services (PCS) codes - 3%
Dental	3% Ambulatory Service Center codes - 10%
Dialysis	3%
Dietary and Nutritional Services	Dietary & Nutritional codes - 3%, Overlapping physician codes - 8%
Durable Medical Equipment	3%
Enhanced Mental Health Services	3%

Reductions by State Medicaid Fee Schedule - Program	Applicable Reduction Percentage*
Federally Qualified Health Centers	FQHC - 3%, Overlapping physician codes - 8%
Freestanding Birth Center	10%
Hearing Aid Program	3%
HIV Case Management	3%
Home Health Services	3%
Home Infusion Therapy	3%
Hospice	Room & Board (0658/0659) only - 10%
Hospital Outpatient Laboratory	10%
Hospitals	10%
Indian Tribal (I/T/U) Home Health	3%
Indian Tribal (I/T/U) Pharmacy	0%
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	8%
Laboratory (Independent Diagnostic Testing Facilities)	Lab & X-ray codes - 3%, Overlapping physician codes - 8%
Local Health Departments (LHD)	LHD codes - 3%, Overlapping physician codes - 8%
NC Medicaid State Institutions	8%
Nurse Midwives	8%
Nurse Practitioner and Certified Registered Nurse Anesthetist (CRNA)	8%
Nursing Facility Rates	10%
Optical Program	3%
Optometry Services	Optometry codes - 3%, Overlapping physician codes - 8%
Orthotics and Prosthetics	3%

Reductions by State Medicaid Fee Schedule - Program	Applicable Reduction Percentage*
Other Behavioral Health Services	Research-Based Intensive Behavioral Health Treatment (RBI-BHT) (97151-97157) - 10% Other - 8%
Outpatient Specialized Therapies	3%
Personal Care Services	8%
Pharmacy	0%
Physician Administered Drug Program	0%
Physician Assistant	8%
Physician Services	ER (99281-99285) - 10% Physician codes - 8%
Podiatry Services	3%
Private Duty Nursing	3%
Public Ambulance Provider Managed Care	3%
Radiological/Imaging Services	3%
Rural Health Clinic	RHC codes - 3% Overlapping physician codes - 8%
Targeted Case Management	3%
Vent Facility Rates	10%

* Designation of “overlapping physician codes” indicates that a procedure code on that fee schedule will be reduced at the percentage of reduction applicable to the physician services fee schedule. For example, on the Children Development Services Agency (CDSA) fee schedule, overlapping physician codes means there are codes that appear on both the CDSA fee schedule and physician services fee schedule. The physician services codes appearing on the CDSA fee schedule are subject to the 8% reduction. All non-physician services fee schedule codes appearing on the CDSA fee schedule will be reduced by 3%.

Rate Reductions Applicable to Non-Published State Fee Schedule Service

- NC Medicaid is amending the State Plan effective October 1, 2025, to reduce Medical Home Fees by ninety-seven percent (97%) of the State Plan Medical Home Fee rates in effect on September 30, 2025. Managed Care Plans operating a Standard Benefit Plan are expected to follow the State Plan Amendment in paying Medical Home Fees.

- NC Medicaid intends to amend its Managed Care contracts to add State Directed Payment requirements for the following services and at the following amounts:
  - Innovations Waiver, 1915(i) and Traumatic Brain Injury (TBI) Waiver services furnished on or after Oct. 1, 2025, to be reimbursed at 97% of the Innovations Waiver, 1915(i) and TBI Waiver service reimbursement rates paid on Sept. 30, 2025.
  - Psychiatric Residential Treatment Facilities (PRTFs) as to dates of service on or after Oct. 1, 2025, to be reimbursed at 90% of the reimbursement rate paid to PRTFs on Sept. 30, 2025.
  - Non-Emergency Medical Transportation (NEMT) services furnished on or after Oct. 1, 2025, to be reimbursed at 97% of the reimbursement rates paid for NEMT services in effect on Sept. 30, 2025.
  - Local Health Department payments for Care Management for At-Risk Children (CMARC) and Care Management for High-Risk Pregnant Women (CMHRP) services effective Oct. 1, 2025, to be paid at 97% of the amount paid to LHDs in effect on Sept. 30, 2025.
  - For Behavioral Health Intellectual/ Developmental Disabilities Tailored Plans, Advanced Medical Home Fee(s) paid to Advanced Medical Homes that accrue on or after Oct. 1, 2025, to be reimbursed at no less than $4.85, for each month in which a Member is assigned to the Advanced Medical Home as the Member's primary care provider, which may be prorated for partial months.

- Managed care plans must ensure in lieu of services continue to be cost effective relative to the applicable state plan service, as such, the plans may make changes to in lieu of service offerings or reimbursement rates.

Additional Information

Additional guidance can be found on the NC Medicaid provider bulletin webpage (/providers/medicaid-bulletin) as available. The updated fee schedules will be published to the NC Medicaid Covered Codes and Fee Schedules Portal (https://ncdhhs.servicenowservices.com/fee_schedules) on October 1, 2025.

If you have additional questions regarding the fee schedule changes or the date on which fee schedules will be available, please contact the DHB Provider Reimbursement Team at medicaid.providerreimbursement@dhhs.nc.gov (mailto:medicaid.providerreimbursement@dhhs.nc.gov).

Thank you for your continued partnership and dedication to serving North Carolina's Medicaid beneficiaries.

Contact

medicaid.providerreimbursement@dhhs.nc.gov (mailto:medicaid.providerreimbursement@dhhs.nc.gov)

Related Topics:

- Bulletins (/blog-category/bulletins)
- All Providers (/blog-terms/all-providers)
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EXHIBIT 3

menu

News Release

DHHS Explains Medicaid Rate Adjustment In Response To Provider Misinformation

For Immediate Release: 7/18/2025

Share

MEDIA CONTACT

Jeff Powell, 402-471-6223, jeff.powell@nebraska.gov

Lincoln, NE — Today, Nebraska Department of Health and Human Services (DHHS) CEO Steve Corsi, Medicaid and Long-Term Care Division Director Drew Gonshorowski, and Karoly Mirnics, dean and director of the Munroe-Meyer Institute provided information about the approaching adjustment to Medicaid payment rates for Applied Behavior Analysis (ABA) services to Nebraska families. Rate adjustments will go into effect Aug. 1.

Following months of communication with providers, it became evident that misinformation was being conveyed, including to the public. Those discussions focused on DHHS' need to adjust payment rates to sustainable levels, commensurate with the rates of surrounding states.

At today's news conference, CEO Corsi reiterated that rate modifications would not result in a lapse of care for clients or their families.

“I want to be exceedingly clear, DHHS is fully committed to continuing ABA services to Nebraska families receiving Medicaid," said Corsi. “We will continue to operate in the best interest of children and families."

Currently, Nebraska payment rates for ABA services are the highest of any in the nation. The graph below illustrates Nebraska's expenditure to providers in comparison with other states. Rates have risen dramatically since 2023. Rate increases are enacted by the Legislature.

Per Code of Federal Regulations (CFR) 447.200, payments for services must be consistent with efficiency, economy, and quality of care. Medicaid rates are periodically reviewed for market comparison with respect to other relative payer sources, such as Medicare and other state Medicaid agencies.

DHHS completed a thorough review of Nebraska Medicaid rates for ABA services and observed that Nebraska's rates for these services have been significantly higher, some more than twice as high as those of other state Medicaid programs.

In 2020, Nebraska Medicaid paid approximately $4.6 million for ABA Services. In 2024, Nebraska Medicaid paid approximately $85.6 million for ABA Services. This amounts to an approximate increase of *nearly 2,000%*.

To make sure that these services are available and sustainable going forward, DHHS is adjusting its payment rates to better align with surrounding states. Even after factoring in the rate adjustments Nebraska Medicaid rates for ABA services compare favorably with neighboring states. Also of note, the commonly billed rates will remain higher than the national average and median.

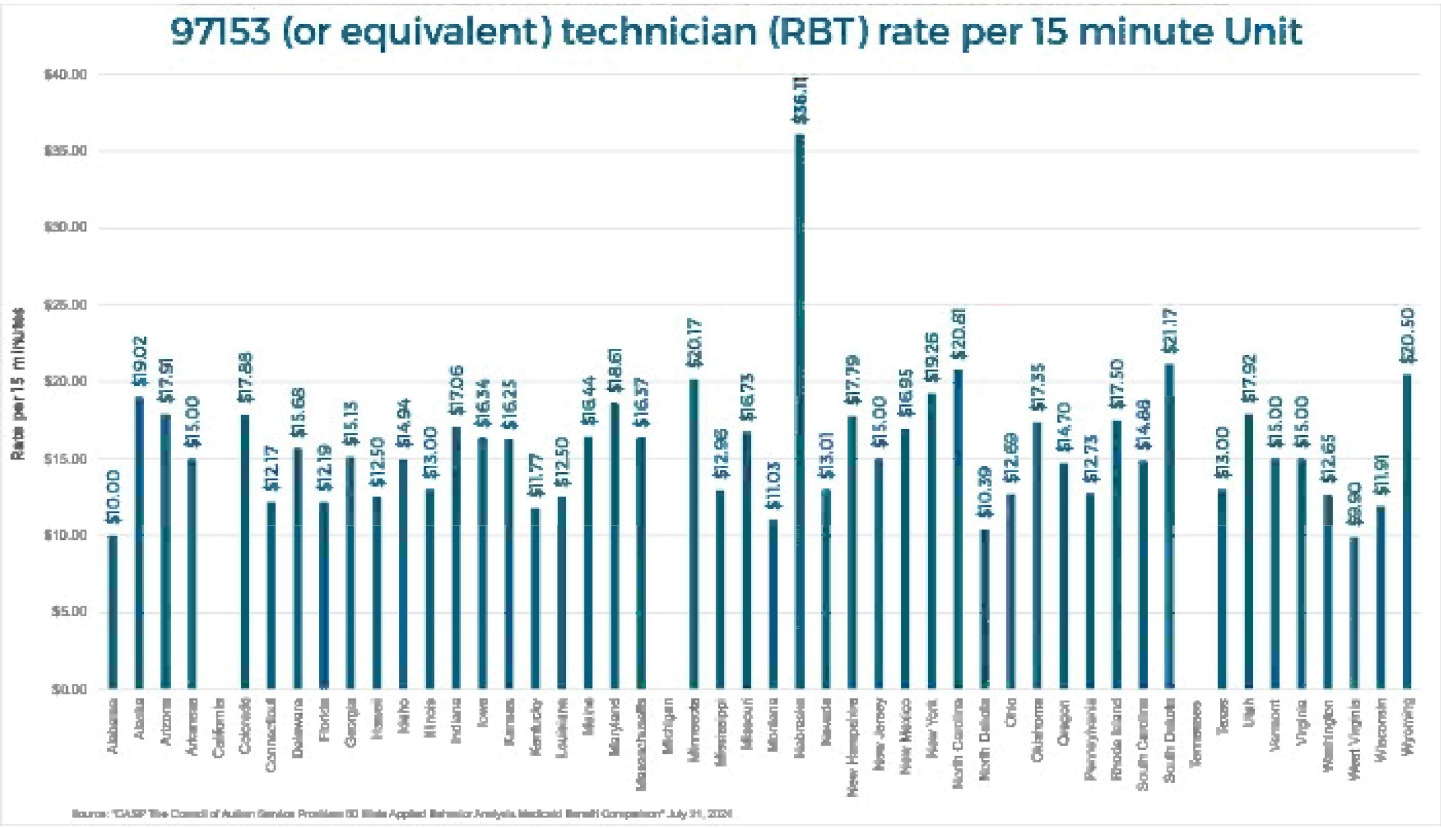
“These changes came as a result of a rate analysis study conducted by Nebraska Medicaid that compared our state to surrounding Medicaid markets," said Gonshorowski. “We found that Nebraska's rates for these services have been significantly higher, some more than twice as high, as those of other

state Medicaid programs. This rate change puts Nebraska more in line with ABA rates, not just in the region, but nationally."

The Munroe-Meyer Institute is one of the biggest and oldest developmental disability centers in the world. The nonprofit organization, an academic unit of the University of Nebraska Medical Center (UNMC), has a 105-year history of caring for vulnerable populations. They provide approximately 120,000 clinical visits a year with approximately 60% of those providing services for individuals and families with Autism Spectrum Disorder (ASD).

Dean and director of Munroe-Meyer, Dr. Karoly Mirnics stated his support for ensuring that rates were managed at a level appropriate to the services provided. “We will continue working with DHHS as close partners to develop evidence-based guardrails to provide the most meaningful, most efficient ABA services for all individuals with autism. This will be done thoughtfully, based on scientific data. We greatly appreciate DHHS's willingness to work with us and soliciting our expert input on this process."

To review the provider bulletin with rate adjustments, please click here.


97153 (or equivalent) technician (RBT) rate per 15 minute Unit
Rate per 15 minutes
$40.00
$35.00
$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$0.00
$10.00
$19.02
$17.91
$15.00
$17.88
$12.17
$15.68
$12.19
$15.13
$12.50
$14.94
$13.00
$17.06
$16.54
$16.25
$11.77
$12.50
$16.44
$18.61
$16.57
$20.17
$12.96
$16.73
$11.03
$36.11
$13.01
$17.79
$15.00
$16.95
$19.26
$20.61
$10.39
$12.69
$17.35
$14.70
$12.73
$17.50
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$21.17
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$17.92
$15.00
$15.00
$12.65
$9.90
$11.91
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Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Illinois
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Iowa
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Louisiana
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Missouri
Montana
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New Hampshire
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South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
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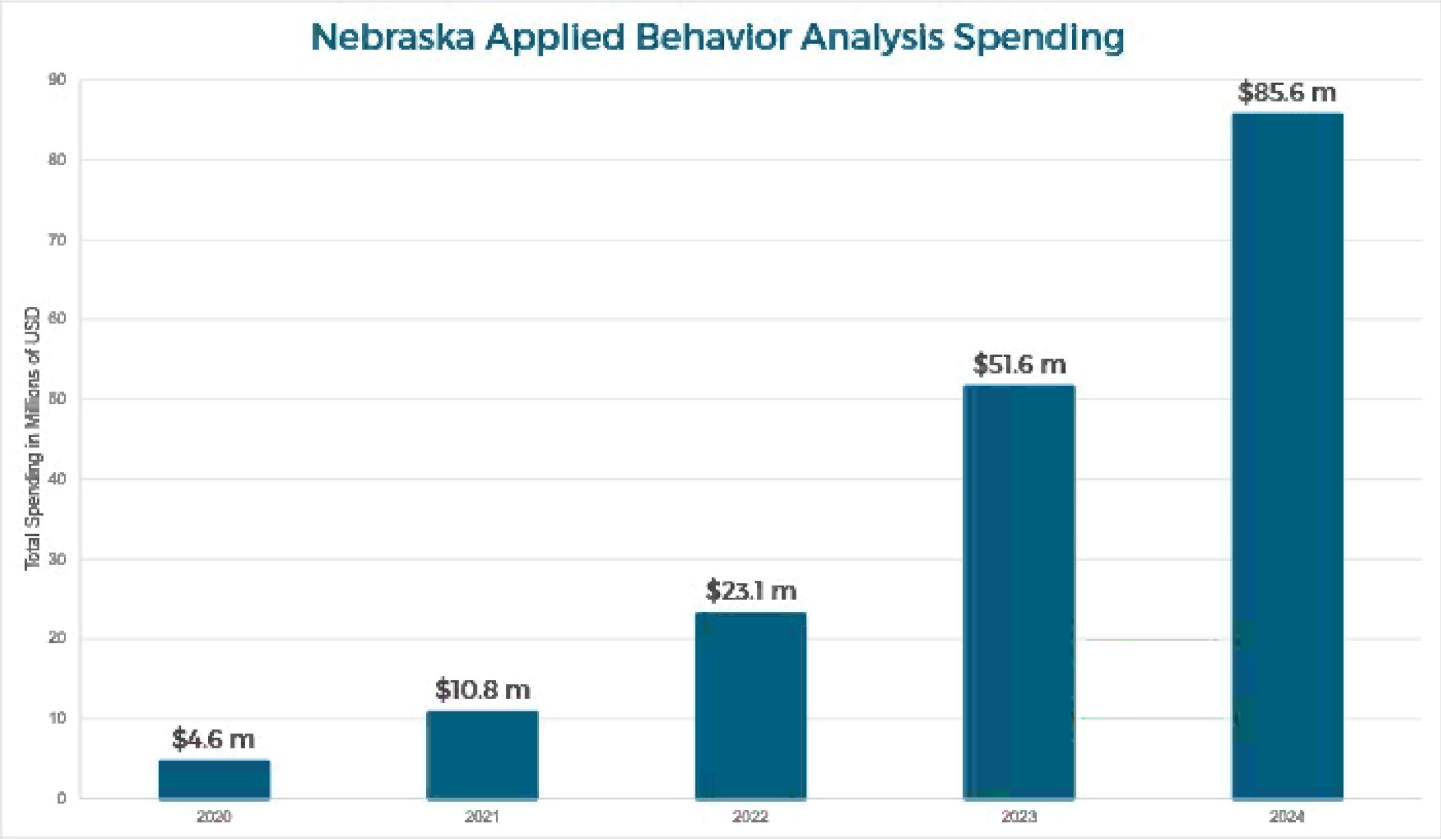
West Virginia
Wisconsin
Wyoming


Nebraska Applied Behavior Analysis Spending
Total Spending in Millions of USD
90
80
70
60
50
40
30
20
10
0
$4.6 m
$10.8 m
$23.1 m
$51.6 m
$85.6 m
2020
2021
2022
2023
2024

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Helping People Live Better Lives

EXHIBIT
4

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

Table of Contents

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.

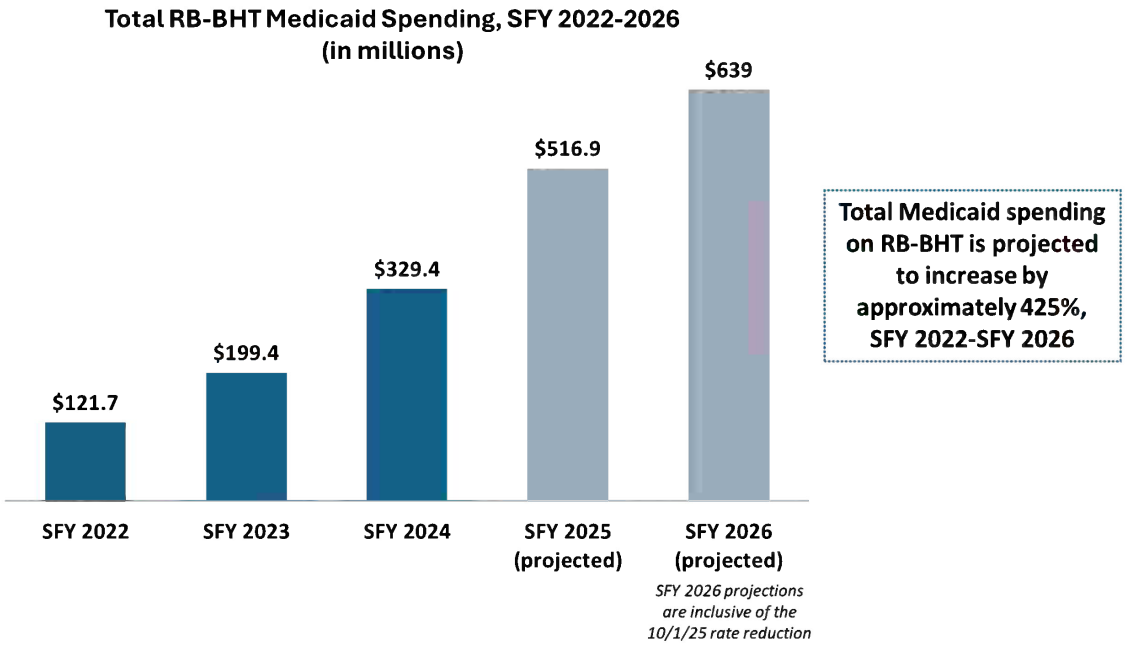
Introduction

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

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[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).

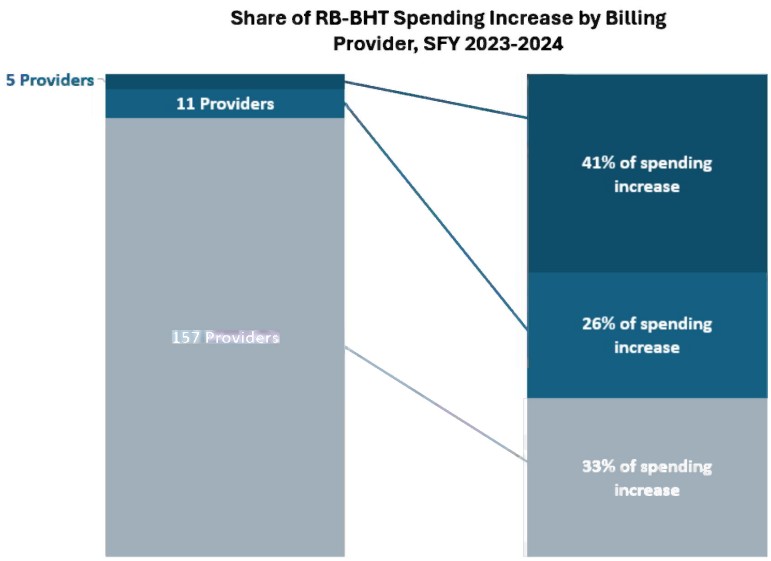
RB-BHT Utilization and Spending Trends

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.

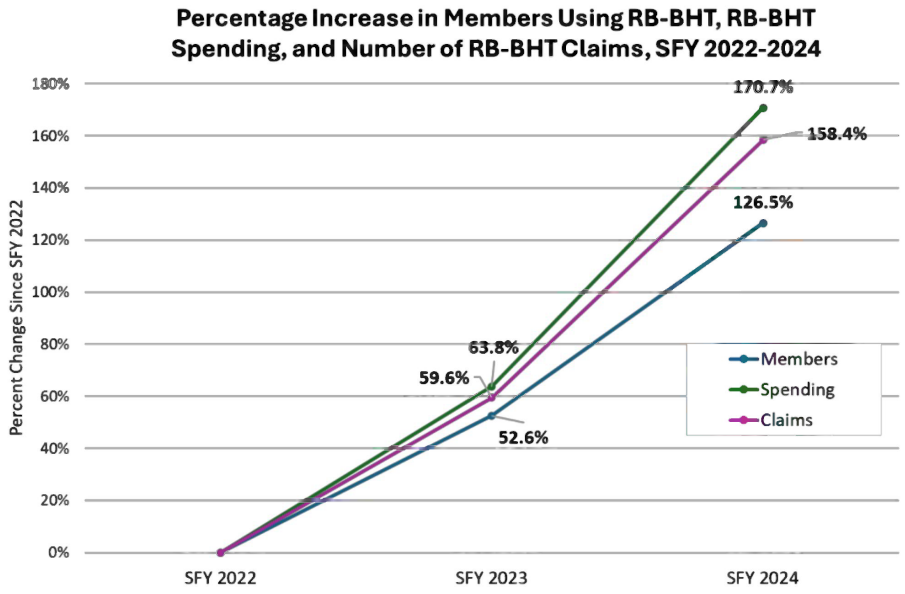
Ultimately, members should receive RB-BHT treatment at the intensity that is medically necessary and most effective to achieve their individualized treatment goals, with ongoing adjustments to the treatment plan based on member progress, including increasing and decreasing intensity as indicated.[13] 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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