Chapter 108D.

Medicaid Managed Care Program.

Article 1.

General Provisions.

§ 108D-1. Definitions.

The following definitions apply in this Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider who is seeking to participate in the network of one or more local management entity/managed care organizations or prepaid health plans.

(4) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD tailored plans, but excluding the requirements pertaining only to the CAF specialty plan.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance is granted under Article 2 of Chapter 108A of the General Statutes.

(5a) Children and families specialty plan or CAF specialty plan. – A statewide capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to the CAF specialty plan, but excluding the requirements only pertaining to BH IDD tailored plans.

(6) Repealed by Session Laws 2022-74, s. 9D.13(c), effective July 1, 2022.

(6a) CMS. – The Centers for Medicare and Medicaid Services.

(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-5.9 or G.S. 108D-15.

(8) Department. – The North Carolina Department of Health and Human Services.

(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid program operated by the Department of Health and Human Services pursuant to its authority under Part 6 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

(21) Local Management Entity or LME. – As defined in G.S. 122C-3.

(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3.

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract with the Department of Health and Human Services to operate the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

(27) Network provider. – An appropriately credentialed provider that has entered into a contract for participation in the network of one or more local management entity/managed care organizations or prepaid health plans.

(28) Notice of adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, that is under a capitated contract with the Department for the delivery of Medicaid services, or a local management entity/managed care organization that is under a capitated PHP contract with the Department.

(30a) Prepaid inpatient health plan or PIHP. – A prepaid inpatient health plan, as defined in 42 C.F.R. § 438.2.

(31) Provider. – As defined in G.S. 108C-2.

(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(34) RFP. – A request for proposals.

(36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining only to a BH IDD tailored plan and only to the CAF specialty plan. (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, ss. 4.6, 4.7(a); 2022-74, ss. 9D.13(c), 9D.15(p)-(r); 2023-134, ss. 9E.16(b5), 9E.22(c), 9G.7A(b2).)