

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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HOUSE BILL 403
Committee Substitute Favorable 3/29/17
Senate Health Care Committee Substitute Adopted 6/15/17

Short Title: Behavioral Health and Medicaid Modifications.

(Public)

Sponsors:

Referred to:

March 20, 2017

1 A BILL TO BE ENTITLED
2 AN ACT TO MODIFY CERTAIN REQUIREMENTS PERTAINING TO LOCAL
3 MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, TO MODIFY THE
4 MEDICAID TRANSFORMATION LEGISLATION, TO REQUIRE THE DEPARTMENT
5 OF HEALTH AND HUMAN SERVICES TO NOTIFY THE GENERAL ASSEMBLY
6 UPON THE SUBMISSION OR NON-SUBMISSION OF A MEDICAID STATE PLAN
7 AMENDMENT, AND TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO
8 ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH
9 RECENT CHANGES TO FEDERAL LAW.

10 The General Assembly of North Carolina enacts:

11
12 **PART I. LME/MCO MODIFICATIONS**

13 **SECTION 1.** On the date when Medicaid capitated contracts with Prepaid Health
14 Plans (PHPs) begin, as required by S.L. 2015-245, all of the following shall occur:

- 15 (1) PHPs shall manage all publicly-funded behavioral health services currently
16 managed by the local management entities/managed care organizations
17 (LME/MCOs) under contracts with the Department of Health and Human
18 Services (DHHS).
19 (2) The LME/MCOs shall be dissolved.
20 (3) All remaining assets of the LME/MCOs, including all funds in the Medicaid
21 risk reserve account shall be transferred to DHHS to be used to satisfy the
22 liabilities of the LME/MCOs and for costs of the contracts with PHPs for the
23 management of publicly funded behavioral health services. In the event there
24 are insufficient assets to satisfy the liabilities of the LME/MCOs, it shall be
25 the responsibility of the Secretary to satisfy the liabilities of the LME/MCOs
26 or arrange for the transfer of those liabilities to PHPs.

27 **SECTION 2.(a)** The Department of Health and Human Services (DHHS) shall
28 specify a single, nationally recognized, standardized electronic format to be used by all local
29 management entities/managed care organizations (LME/MCOs) when submitting encounter
30 data to DHHS. LME/MCOs must submit to DHHS encounter data, consisting of records of
31 claims payments made to providers, for Medicaid and State-funded mental health, intellectual
32 and developmental disabilities, and substance abuse disorder services utilizing the single,
33 nationally recognized, standardized electronic format specified by DHHS.

34 **SECTION 2.(b)** DHHS may use encounter data submitted by LME/MCOs for all
35 of the following purposes:



- 1 (1) Setting LME/MCO capitation rates.
- 2 (2) Measuring the quality of services managed by LME/MCOs.
- 3 (3) Assuring compliance with State and federal regulations.
- 4 (4) Conducting oversight and audit functions.
- 5 (5) Other purposes determined necessary by DHHS.

6 **SECTION 2.(c)** DHHS shall work with LME/MCOs to ensure that the process for
7 submitting encounter claims through NCTracks is successful.

8 **SECTION 2.(d)** DHHS shall report to the Joint Legislative Oversight Committee
9 on Health and Human Services regarding the status of subsection (a) of this section on or
10 before February 1, 2018.

11 **SECTION 3.(a)** G.S. 122C-112.1(a)(39) reads as rewritten:

12 "(39) Develop and use ~~a standard contract~~ contracts for all local management
13 entity/managed care organizations for operation of the 1915(b)/(c) Medicaid
14 Waiver and management of State appropriations and federal block grant
15 funds that requires compliance by each LME/MCO with all provisions of the
16 contract ~~contracts~~ to operate the 1915(b)/(c) Medicaid Waiver and manage
17 State appropriations and federal block grant funds and with all applicable
18 provisions of State and federal law. Each of these standard contracts must
19 include quality outcome measures for mental health, developmental
20 disabilities, and substance use disorders."

21 **SECTION 3.(b)** This section becomes effective January 1, 2018, and applies to
22 contracts entered into on or after that date.

23 **SECTION 4.** G.S. 122C-3 reads as rewritten:

24 **"§ 122C-3. Definitions.**

25 The following definitions apply in this Chapter:

- 26 (1) "Area authority" means the area mental health, developmental disabilities,
27 and substance abuse authority.
- 28 (2) "Area board" means the area mental health, developmental disabilities, and
29 substance abuse ~~board~~ board that is the governing body for the area
30 authority, local management entity, or local management entity/managed
31 care organization.
- 32 (2a) "Area director" means the administrative head of the area ~~authority program~~
33 authority, local management entity, or local management entity/managed
34 care organization appointed pursuant to G.S. 122C-121. All provisions of
35 Chapter 122C of the General Statutes that apply to the area director also
36 apply to the administrative head of the area authority, LME, or LME/MCO,
37 regardless of whether (i) the administrative head uses the title "CEO" or any
38 other name or title assigned to him or her by the area authority, LME, or
39 LME/MCO and (ii) a contract, memorandum of understanding, or other
40 agreement in effect between the Department and the area authority, LME, or
41 LME/MCO refers to the administrative head as the "CEO" or any other
42 name or title.
- 43 (2b) "Board of county commissioners" includes the participating boards of county
44 commissioners for multicounty area ~~authorities~~ and multicounty
45 programs ~~authorities.~~
- 46 ...
- 47 (5) "Catchment area" means the geographic part of the State served by a specific
48 area ~~authority or county program~~ authority.
- 49 ...

(10a) ~~"County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

...

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program~~ authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program~~ authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

...

...

(20b) "Local management entity" or "LME" means an area ~~authority, county program, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure.~~ authority.

...

(29a) ~~"Program director" means the director of a county program established pursuant to G.S. 122C-115.1.~~

...."

SECTION 5. G.S. 122C-117 reads as rewritten:

"§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with ~~G.S. 122C-121(d)~~ G.S. 122C-121.

...

(18) Maintain disability-specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(19) Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(20) Maintain full accountability for all aspects of Medicaid Waiver operations and for meeting all contract requirements specified by the Department."

SECTION 6. G.S. 122C-124.1 reads as rewritten:

"§ 122C-124.1. Actions by the Secretary upon area authority or area director failure to comply or when area authority or county program is not providing minimally adequate services.

(a) Notice of Likelihood of Action. – When the Secretary determines that there is a likelihood of suspension of funding, assumption of service delivery or management functions, or appointment of a caretaker board under this section within the ensuing 60 days, the Secretary shall so notify in writing the area authority board ~~or the county program~~ and the board of county commissioners of the area ~~authority or county program~~ authority. The notice shall state the particular deficiencies in program services or administration that must be remedied to avoid

1 action by the Secretary under this section. The area authority board ~~or county program~~ shall
2 have 60 days from the date it receives notice under this subsection to take remedial action to
3 correct the deficiencies. The Secretary shall provide technical assistance to the area authority ~~or~~
4 ~~county program~~ in remedying deficiencies.

5 (b) Suspension of Funding; Assumption of Service Delivery or Management Functions.
6 – If the Secretary determines that ~~a county, through (i) an area authority or county program,~~
7 area director has failed to comply with any requirement of State or federal law, rule, or
8 regulation, or any requirement of the area authority's contract with the Department, or (ii) an
9 area authority is not providing minimally adequate services to persons in need in a timely
10 manner, or fails to demonstrate reasonable efforts to do so, then the Secretary, after providing
11 written notification of the Secretary's intent to the area authority ~~or county program~~ and to the
12 board of county commissioners of the area ~~authority or county program,~~ authority, and after
13 providing the area authority ~~or county program~~ and the boards of county commissioners of the
14 area authority ~~or county program~~ an opportunity to be heard, may:

- 15 (1) Withhold funding for the particular service or services in question from the
16 area authority ~~or county program~~ and ensure the provision of these services
17 through contracts with public or private agencies or by direct operation by
18 the Department.

19 Upon suspension of funding, the Department shall direct the
20 development and oversee implementation of a corrective plan of action and
21 provide notification to the area authority ~~or county program~~ and the board of
22 county commissioners of the area authority ~~or county program~~ of any
23 ongoing concerns or problems with the area authority's ~~or county program's~~
24 finances or delivery of services.

- 25 (2) Assume control of the particular service or management functions in
26 question or of the area authority ~~or county program~~ and appoint an
27 administrator to exercise the powers assumed. This assumption of control
28 shall have the effect of divesting the area authority ~~or county program~~ of its
29 powers in G.S. 122C-115.1 and G.S. 122C-117 and all other service delivery
30 powers conferred on the area authority ~~or county program~~ by law as they
31 pertain to this service or management function. County funding of the area
32 authority ~~or county program~~ shall continue when the State has assumed
33 control of the catchment area or of the area ~~authority or county~~
34 ~~program.~~ authority. At no time after the State has assumed this control shall a
35 county withdraw funds previously obligated or appropriated to the area
36 ~~authority or county program.~~ authority.

37 Upon assumption of control of service delivery or management
38 functions, the Department shall, in conjunction with the area ~~authority or~~
39 ~~county program,~~ authority, develop and implement a corrective plan of action
40 and provide notification to the area authority ~~or county program~~ and the
41 board of county commissioners of the area authority ~~or county program~~ of
42 the plan. The Department shall also keep the area authority board and the
43 board of county commissioners informed of any ongoing concerns or
44 problems with the delivery of services.

45 (c) Appointment of Caretaker Administrator. – In the event that a county, through an
46 area ~~authority or county program,~~ authority, fails to comply with the corrective plan of action
47 required when funding is suspended or when the State assumes control of service delivery or
48 management functions, the Secretary, after providing written notification of the Secretary's
49 intent to the area authority ~~or county program~~ and the applicable participating boards of county
50 commissioners of the area ~~authority or county program,~~ authority, shall appoint a caretaker
51 administrator, a caretaker board of directors, or both.

1 The Secretary may assign any of the powers and duties of the area director or program
2 director or of the area authority board or board of county commissioners of the area authority or
3 ~~county program~~ pertaining to the operation of mental health, developmental disabilities, and
4 substance abuse services to the caretaker board or to the caretaker administrator as it deems
5 necessary and appropriate to continue to provide direct services to clients, including the powers
6 as to the adoption of budgets, expenditures of money, and all other financial powers conferred
7 on the area authority or ~~county program~~ by law pertaining to the operation of mental health,
8 developmental disabilities, and substance abuse services. County funding of the area authority
9 ~~or county program~~ shall continue when the State has assumed control of the financial affairs of
10 the program. At no time after the State has assumed this control shall a county withdraw funds
11 previously obligated or appropriated to the area ~~authority or county program~~ authority. The
12 caretaker administrator and the caretaker board shall perform all of these powers and duties.
13 The Secretary may terminate the area director or ~~program director~~ when it appoints a caretaker
14 administrator. Chapter 150B of the General Statutes shall apply to the decision to terminate the
15 area ~~director or program~~ director. Neither party to any such contract shall be entitled to
16 damages. After a caretaker board has been appointed, the General Assembly shall consider, at
17 its next regular session, the future governance of the identified area ~~authority or county~~
18 ~~program~~ authority."

19 **SECTION 7.** G.S. 122C-151 reads as rewritten:

20 "**§ 122C-151. Responsibilities of those receiving appropriations.**

21 (a) All resources allocated to and received by any area authority and used for programs
22 of mental health, developmental disabilities, substance abuse or other related services are
23 subject to the conditions specified in this Article and to the rules of the Commission and the
24 Secretary and to the conditions of the ~~Memorandum of Agreement specified in G.S.~~
25 ~~122C-143.2~~ memorandum of agreement with the Secretary specified in G.S. 122C-115.2(d).
26 Area authorities shall not use any resources for any of the following expenses:

27 (1) Alcohol.

28 (2) First-class airfare.

29 (3) Charter flights.

30 (4) Holiday parties or similar social gatherings.

31 (5) Any meeting, whether a formal public meeting or an informal retreat, of the
32 area board outside of the State.

33 (b) If an area authority fails to complete actions necessary for ~~the development of a~~
34 ~~Memorandum of Agreement~~, the memorandum of agreement, fails to file required reports
35 within the time limit set by the Secretary, or fails to comply with any other requirements
36 specified in this Article, the Secretary may:

37 (1) Delay payments; and

38 (2) With written notification of cause and subject to an appeal as provided by
39 G.S. 122C-151.2, reduce or deny payment of funds. Restoration of funds
40 upon compliance is within the discretion of the Secretary."

41 **SECTION 8.(a)** The definitions in G.S. 122C-3 apply to this section.

42 **SECTION 8.(b)** The Office of State Human Resources and the State Human
43 Resources Commission shall revise and update the job description and salary range for area
44 directors as follows:

45 (1) No later than September 1, 2017, the Office of State Human Resources, in
46 collaboration with the Secretary of the Department of Health and Human
47 Services and the LME/MCO area boards, shall revise and update the job
48 description for area directors, taking into account the LME/MCOs' functions
49 and current size, including number of covered lives, annual service and
50 administrative expenditures, and geographic service areas.

1 (2) No later than December 1, 2017, the Office of State Human Resources shall
2 recommend to the State Human Resources Commission a revision to the
3 salary range for area directors. In forming its recommendation, the Office of
4 State Human Resources shall conduct a market compensation study of
5 organizations nationwide with similar functions as the LME/MCOs and of
6 similar size, including number of covered lives, annual service expenditures,
7 and geographic service areas. The market compensation study shall include
8 both public and not-for-profit managed care organizations. In forming its
9 recommendation, the Office of State Human Resources shall seek input from
10 the Secretary of the Department of Health and Human Services and the
11 LME/MCO area boards.

12 (3) No later than March 1, 2018, the State Human Resources Commission shall
13 revise the salary range for area directors based on the recommendation of the
14 Office of State Human Resources. Once a new salary range for area directors
15 is adopted, the State Human Resources Commission shall inform each
16 LME/MCO's area board of the new salary range.

17 **SECTION 8.(c)** The salary range for area directors, which was last updated by the
18 State Human Resources Commission in 2010, is void. Beginning on the date this act becomes
19 law, the LME/MCO area boards shall not authorize any increase in the salaries of an area
20 director until the Office of State Human Resources and the State Human Resources
21 Commission complete a revision and update of the job description and salary range of the area
22 directors as required by subsection (b) of this section. This section shall not be construed to
23 prohibit an LME/MCO from authorizing a salary pursuant to G.S. 122C-121(a1) to be paid to
24 an area director filling a vacant position after the date this act becomes law.

25 **SECTION 8.(d)** After completion of the revision and update required by
26 subsection (b) of this section, each LME/MCO area board shall reestablish the salary for its
27 area director in accordance with G.S. 122C-121(a1). This subsection applies to contracts with
28 area directors beginning on or after the date that the State Human Resources Commission
29 revises the salary range for area directors as required by subdivision (3) of subsection (b) of this
30 section.

31 **SECTION 8.(e)** After the date that the State Human Resources Commission
32 revises the salary range for area directors as required by subdivision (3) of subsection (b) of this
33 section and until the LME/MCOs are dissolved pursuant to Section 1 of this act, the Office of
34 State Human Resources, at the discretion of the Director of the Office of State Human
35 Resources, may recommend to the State Human Resources Commission adjustments to the
36 salary range for area directors. In forming a recommendation under this subsection, the Office
37 of State Human Resources shall conduct a market compensation study of organizations
38 nationwide with similar functions as the LME/MCOs and of similar size, including number of
39 covered lives, annual service expenditures, and geographic service areas. The market
40 compensation study shall include both public and not-for-profit managed care organizations. In
41 forming a recommendation under this subsection, the Office of State Human Resources shall
42 seek input from the Secretary of the Department of Health and Human Services and the
43 LME/MCO area boards.

44 **SECTION 9.(a)** G.S. 122C-141(d)(1) reads as rewritten:

45 "(1) The public provider must meet all the provider qualifications as defined by
46 rules adopted by the Commission. ~~A county that satisfies its duties under~~
47 ~~G.S. 122C-115(a) through a consolidated human services agency may not be~~
48 ~~considered a qualified provider for purposes of this subdivision."~~

49 **SECTION 9.(b)** G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the
50 General Statutes are repealed.

1 **SECTION 9.(c)** The Revisor of Statutes shall delete every reference to
 2 G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human
 3 services agency" wherever they occur in Chapter 122C of the General Statutes.
 4

5 **PART II. MEDICAID TRANSFORMATION MODIFICATIONS**

6 **SECTION 10.** Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L.
 7 2016-121, reads as rewritten:

8 **"SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health
 9 Choice programs described in Section 1 of this act shall be organized according to the
 10 following principles and parameters:

11 (1) DHHS authority. – The Department of Health and Human Services (DHHS)
 12 shall have full authority to manage the State's Medicaid and NC Health
 13 Choice programs provided that the total expenditures, net of agency receipts,
 14 do not exceed the authorized budget for each program, except the General
 15 Assembly shall determine eligibility categories and income thresholds.
 16 DHHS shall be responsible for planning and implementing the Medicaid
 17 transformation required by this act. DHHS shall have the authority to adopt
 18 rules related to the activities listed in this section and the regulation of PHPs,
 19 except that any rules adopted relating to PHP licensure under Chapter 58 of
 20 the General Statutes and Section 6 of this act shall be adopted by the
 21 Department of Insurance.

22 (2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP)
 23 shall be defined as an entity, which may be a commercial plan or
 24 provider-led entity, that holds a PHP license issued by the Department of
 25 Insurance and that operates or will operate a capitated contract for the
 26 delivery of services pursuant to subdivision (3) of this section. For purposes
 27 of this act, the terms "commercial plan" and "provider-led entity" are defined
 28 as follows:

29 a. Commercial plan or CP. – Any person, entity, or organization, profit
 30 or nonprofit, that undertakes to provide or arrange for the delivery of
 31 health care services to enrollees on a prepaid basis except for
 32 enrollee responsibility for copayments and deductibles and ~~holds a~~
 33 ~~PHP license issued by the Department of Insurance.~~ is not a PLE.

34 b. Provider-led entity or PLE. – An entity that meets all of the
 35 following criteria:

36 1. A majority of the entity's ownership is held by an individual
 37 or entity that has as its primary business purpose the
 38 ownership or operation of one or more capitated contracts
 39 described in subdivision (3) of this section or Medicaid and
 40 NC Health Choice providers.

41 2. A majority of the entity's governing body is composed of
 42 individuals who (i) are licensed in the State as physicians,
 43 physician assistants, nurse practitioners, or psychologists and
 44 (ii) have sufficient experience treating beneficiaries of the
 45 North Carolina Medicaid ~~program.~~ program, as determined
 46 by the Secretary of DHHS.

47 ~~3. Holds a PHP license issued by the Department of Insurance.~~

48 ...
 49 (4) Services covered by PHPs. – Capitated PHP contracts shall cover all
 50 Medicaid and NC Health Choice services, including physical health services,
 51 prescription drugs, long-term services and supports, and behavioral health

- 1 services for NC Health Choice recipients, except as otherwise provided in
 2 this subdivision. The capitated contracts required by this subdivision shall
 3 not cover:
- 4 a. ~~Behavioral health services for Medicaid recipients currently covered~~
 5 ~~by the local management entities/managed care organizations~~
 6 ~~(LME/MCOs) for four years after the date capitated contracts begin.~~
 - 7 b. ~~Dental services.~~
 - 8 ...
 - 9 g. The fabrication of eyeglasses, including complete eyeglasses,
 10 eyeglass lenses, and ophthalmic frames."
- 11 (5) Populations covered by PHPs. – Capitated PHP contracts shall cover all
 12 Medicaid and NC Health Choice program aid categories except for the
 13 following categories:
- 14 a. Recipients who are dually eligible for Medicaid and ~~Medicare.~~
 15 Medicare for two years after the date capitated contracts begin.
 16 Recipients in the aged program aid category that are eligible for
 17 Medicare shall be considered recipients who are dually eligible for
 18 Medicaid and Medicare. ~~The Division of Health Benefits shall~~
 19 ~~develop a long term strategy to cover dual eligibles through capitated~~
 20 ~~PHP contracts, as required by subdivision (11) of Section 5 of this~~
 21 ~~act.~~As recommended by DHHS in its "Report to the Joint Legislative
 22 Oversight Committee on Medicaid and NC Health Choice on the
 23 Managed Care Strategy for North Carolina Medicare-Medicaid Dual
 24 Eligible Beneficiaries" dated January 31, 2017, enrollment of dually
 25 eligible recipients shall begin two years after the date capitated
 26 contracts begin, may be phased as described in DHHS's January 31,
 27 2017, report, and shall be completed within two years after the date
 28 that dually eligible recipients are first enrolled with PHPs.
 - 29 ...
 - 30 h. Recipients enrolled under the Medicaid Family Planning program.
 - 31 i. Recipients who are inmates of prisons.
- 32 (6) Number and nature of capitated PHP contracts. – The number and nature of
 33 the contracts required under subdivision (3) of this section shall be as
 34 follows:
- 35 a. ~~Three~~No less than three and no more than five contracts between the
 36 Division of Health Benefits and PHPs to provide coverage to
 37 Medicaid and NC Health Choice recipients statewide (statewide
 38 contracts).
 - 39 b. Up to ~~424~~ contracts between the Division of Health Benefits and
 40 PLEs for coverage of regions specified by the Division of Health
 41 Benefits pursuant to subdivision (2) of Section 5 of this act (regional
 42 contracts). Regional contracts shall be in addition to the three
 43 statewide contracts required under sub-subdivision a. of this
 44 subdivision. Each regional contract shall provide coverage
 45 throughout the entire region for the Medicaid and NC Health Choice
 46 services required by subdivision (4) of this section. A PLE may bid
 47 for more than one regional contract, provided that the regions are
 48 contiguous.
 - 49 ...
- 50 (6a) ~~To the extent allowed by Medicaid federal law and regulations and~~
 51 ~~consistent with the requirements of this act, PHPs shall comply with the~~

requirements of Chapter 58 of the General Statutes. This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations. Part 438 of Title 42 of the Code of Federal Regulations. The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

- a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.
- b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.
- c. Proposed statutory changes necessary to implement this subdivision.

...

(9) ~~LME/MCOs.—LME/MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four year period, the Division of Health Benefits shall continue to negotiate actuarially sound capitation rates directly with the LME/MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits during the four year period."~~

SECTION 11. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

- (1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan ~~amendments~~amendments, as well as any modifications to these submissions, necessary to accomplish the requirements of this act within the required time frames. If DHHS submits any modification to these submissions, DHHS shall provide notice in accordance with G.S. 108A-54.1A(d1).
- (2) Define ~~six~~ regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in Section 1 of this act. Every county in the State must be assigned to a region.
- ...
- (6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

- d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates.

1 Notwithstanding the previous sentence, PHPs must include all
 2 providers in their geographical coverage area that are designated
 3 essential providers by DHHS pursuant to subdivision (13) of this
 4 section, unless DHHS approves an alternative arrangement for
 5 securing the types of services offered by the essential providers.
 6 PHPs and hospitals must negotiate mutually acceptable rates,
 7 methods, and terms of payment.

- 8 d1. A requirement that the negotiated payments to hospitals may not
 9 exceed one hundred twenty-five percent (125%) of the
 10 fee-for-service Medicaid rate unless specifically approved by DHHS.
- 11 e. A requirement that all PHPs assure that enrollees who do not elect a
 12 primary care provider will be assigned to one.

13 ...
 14 (7a) Require providers enrolling or reenrolling as a Medicaid or NC Health
 15 Choice provider to agree to accept ninety percent (90%) of the Medicaid
 16 fee-for-service rate for the services they provide to PHP enrollees if the
 17 provider has been offered a contract with a PHP but the provider is not under
 18 a contract with that PHP, or if the provider is excluded from contracting with
 19 the PHP for failure to meet objective quality standards. DHHS shall
 20 implement this requirement within 30 days after this subdivision becomes
 21 law, unless a waiver by the Centers for Medicare and Medicaid Services is
 22 required as provided in 42 C.F.R. 431.55(f). If a waiver is required, DHHS
 23 shall implement this requirement upon CMS's approval of that waiver.

24"

25
 26 **PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS**

27 **SECTION 12.** G.S. 108A-54.1A reads as rewritten:

28 **"§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

29 (a) The Department of Health and Human Services is expressly authorized and required
 30 to take any and all necessary action to amend the State Plan and waivers in order to keep the
 31 program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of
 32 this section, the term "amendments to the State Plan" includes State Plan amendments,
 33 Waivers, and Waiver amendments.

34 (b), (c) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

35 (d) No fewer than 10 days prior to submitting an amendment to the State Plan to the
 36 federal government, the Department shall post the amendment on its Web site and notify the
 37 members of the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and
 38 the Fiscal Research Division that the amendment has been posted. For any amendments to the
 39 State Plan that add or eliminate an optional service, the notice required by this subsection shall
 40 be 90 days. This notice requirement shall not apply to draft or proposed amendments submitted
 41 to the federal government for comments but not submitted for approval.

42 (d1) Upon the submission of an amendment to the State Plan or a modification to a
 43 previously submitted amendment to the State Plan to the federal government, the Department
 44 shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and
 45 the Fiscal Research Division that the amendment or modification has been submitted.

46 If the Department determines that an amendment posted on its Web site in accordance with
 47 subsection (d) of this section will not be submitted to the federal government, then the
 48 Department shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health
 49 Choice and the Fiscal Research Division upon making that determination.

50 (e) Repealed by Session Laws 2015-245, s. 18, effective September 23, 2015.

1 (f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other
2 posting requirements under federal law, be posted on the Department's Web site. Upon posting
3 such a public notice, the Department shall notify the members of the Joint Legislative
4 Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division
5 that the public notice has been posted. Public notices shall remain posted on the Department's
6 Web site."

7 **SECTION 13.** This Part is effective when it becomes law and applies to
8 amendments to the State Plan posted on the Department of Health and Human Services Web
9 site on or after that date.

10 **PART IV. CONFORMING CHANGES TO LME/MCO APPEALS**

11 **SECTION 14.** G.S. 108D-1 reads as rewritten:

12 **"§ 108D-1. Definitions.**

13 The following definitions apply in this Chapter, unless the context clearly requires
14 otherwise:

- 15 (1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).
16
17 ~~(1)(1a)~~ Applicant. – A provider of mental health, intellectual or developmental
18 disabilities, and substance abuse services who is seeking to participate in the
19 closed network of one or more local management entity/managed care
20 organizations.
21 (2) Closed network. – The network of providers that have contracted with a
22 local management entity/managed care organization to furnish mental
23 health, intellectual or developmental disabilities, and substance abuse
24 services to enrollees.
25 (3) Contested case hearing. – The hearing or hearings conducted at the Office of
26 Administrative Hearings under G.S. 108D-15 to resolve a dispute between
27 an enrollee and a local management entity/managed care organization about
28 ~~a managed care action~~ an adverse benefit determination.
29 (4) Department. – The North Carolina Department of Health and Human
30 Services.
31 (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
32 (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
33 (7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local
34 management entity/managed care organization.
35 (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
36 (9) Local Management Entity/Managed Care Organization or LME/MCO. – As
37 defined in G.S. 122C-3(20c).
38 ~~(10) Managed care action.~~ An action, as defined in 42 C.F.R. § 438.400(b).
39 (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
40 (12) Mental health, intellectual or developmental disabilities, and substance abuse
41 services or MH/IDD/SA services. – Those mental health, intellectual or
42 developmental disabilities, and substance abuse services covered under a
43 contract in effect between the Department of Health and Human Services
44 and a local management entity to operate a managed care organization or
45 prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver
46 approved by the federal Centers for Medicare and Medicaid Services (CMS).
47 (13) Network provider. – An appropriately credentialed provider of mental
48 health, intellectual or developmental disabilities, and substance abuse
49 services that has entered into a contract for participation in the closed
50 network of one or more local management entity/managed care
51 organizations.

- 1 (14) Notice of ~~managed care action~~adverse benefit determination. – The notice
2 required by 42 C.F.R. § 438.404.
- 3 (15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).
- 4 (16) OAH. – The North Carolina Office of Administrative Hearings.
- 5 (17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.
- 6 (18) Provider of emergency services. – A provider that is qualified to furnish
7 emergency services to evaluate or stabilize an enrollee's emergency medical
8 condition."

9 **SECTION 15.** G.S. 108D-12(a) reads as rewritten:

10 "(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to
11 act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to
12 express dissatisfaction about any matter other than a ~~managed care action~~an adverse benefit
13 determination. Upon receipt of a grievance, an LME/MCO shall cause a written
14 acknowledgment of receipt of the grievance to be sent by United States mail."

15 **SECTION 16.** G.S. 108D-13 reads as rewritten:

16 **"§ 108D-13. Standard LME/MCO level appeals.**

17 (a) Notice of ~~Managed Care Action~~Adverse Benefit Determination. – An LME/MCO
18 shall provide an enrollee with a written notice of a ~~managed care action~~adverse benefit
19 determination by United States mail as required under 42 C.F.R. § 438.404. The notice of
20 action will employ a standardized form included as a provision in the contracts between the
21 LME/MCOs and the Department of Health and Human Services.

22 (b) Request for Appeal. – An enrollee, or a network provider authorized in writing to
23 act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a
24 notice of ~~managed care action~~adverse benefit determination no later than ~~30~~60 days after the
25 mailing date of the ~~grievance disposition or notice of managed care action~~adverse benefit
26 determination. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall
27 acknowledge receipt of the request for appeal in writing by United States mail.

28 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
29 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
30 § 438.420.

31 (d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as
32 the enrollee's health condition requires, but no later than ~~45~~30 days after receiving the request
33 for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a
34 written notice of resolution by United States mail within this ~~45-day~~30-day period.

35 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
36 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
37 hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the
38 appeal procedures described in this section or ~~G.S. 108D-14~~G.S. 108D-14 or (ii) the enrollee
39 has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. §
40 438.408(c)(3).

41 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
42 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
43 contested case hearing that meets the requirements of G.S. 108D-15(f)."

44 **SECTION 17.** G.S. 108D-14 reads as rewritten:

45 **"§ 108D-14. Expedited LME/MCO level appeals.**

46 (a) Request for Expedited Appeal. – When the time limits for completing a standard
47 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or
48 regain maximum function, an enrollee, or a network provider authorized in writing to act on
49 behalf of an enrollee, has the right to file a request for an expedited appeal of a ~~managed care~~
50 ~~action~~an adverse benefit determination no later than 30 days after the mailing date of the notice
51 of ~~managed care action~~adverse benefit determination. For expedited appeal requests made by

1 enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For
2 expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO
3 shall presume an expedited appeal is necessary.

4 ...
5 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited
6 LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the
7 enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after
8 receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all
9 other affected parties with a written notice of resolution by United States mail within this
10 ~~three day~~ 72-hour period.

11 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
12 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
13 hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the
14 appeal procedures described in G.S. 108D-13 or this ~~section~~ section or (ii) the enrollee has been
15 deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. §
16 438.408(c)(3).

17"

18 **SECTION 18.** G.S. 108D-15 reads as rewritten:

19 **"§ 108D-15. Contested case hearings on disputed managed care actions.**

20 (a) Jurisdiction of the Office of Administrative Hearings. – The Office of
21 Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care~~
22 ~~action, an adverse benefit determination,~~ except as expressly set forth in this Chapter.

23 (b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or
24 rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of
25 resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not
26 apply to enrollees contesting ~~a managed care action, an adverse benefit determination.~~

27 ...
28 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
29 on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that
30 meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by
31 no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal
32 is deemed filed when a completed and signed appeal request form has been both submitted into
33 the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings
34 clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of
35 resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of
36 the notice of resolution to OAH electronically. OAH may dispose of these records after one
37 year.

38 ...
39 (f) Appeal Request Form. – In the same mailing as the notice of resolution, the
40 LME/MCO shall also provide the enrollee with an appeal request form for a contested case
41 hearing which shall be no more than one side of one page. The form shall include at least all of
42 the following:

- 43 (1) A statement that in order to request an appeal, the enrollee must file the form
44 in accordance with OAH rules, by mail or fax to the address or fax number
45 listed on the form, by no later than 30 days after the mailing date of the
46 notice of resolution.
- 47 (2) The enrollee's name, address, telephone number, and Medicaid identification
48 number.
- 49 (3) A preprinted statement that indicates that the enrollee would like to appeal a
50 specific ~~managed care action~~ adverse benefit determination identified in the
51 notice of resolution.

1 (4) A statement informing the enrollee of the right to be represented at the
 2 contested case hearing by a lawyer, a relative, a friend, or other
 3 spokesperson.

4 (5) A space for the enrollee's signature and date.

5 ...

6 (i) Mediation. – Upon receipt of an appeal request form as provided by
 7 G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately
 8 notify the Mediation Network of North Carolina, which shall contact the enrollee within five
 9 days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the
 10 mediation must be completed within 25 days of submission of the request for appeal. Upon
 11 completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24
 12 hours of the resolution by facsimile or electronic messaging. If the parties have resolved
 13 matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any
 14 contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination
 15 until it has received notice from the mediator assigned that either (i) the mediation was
 16 unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has
 17 failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then
 18 fails to attend mediation without good cause, OAH shall dismiss the contested case.

19 ...

20 (k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of
 21 whether it was obtained before or after the LME/MCO's ~~managed care action~~ adverse benefit
 22 determination and regardless of whether the LME/MCO had an opportunity to consider the
 23 evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the
 24 request of the LME/MCO, the administrative law judge shall continue the hearing for a
 25 minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the
 26 evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the ~~managed care~~
 27 ~~action~~ adverse benefit determination taken against the enrollee, it shall immediately inform the
 28 administrative law judge of its decision.

29 (l) Issue for Hearing. – For each ~~managed care action~~ adverse benefit determination,
 30 the administrative law judge shall determine whether the LME/MCO substantially prejudiced
 31 the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

- 32 (1) Exceeded its authority or jurisdiction.
- 33 (2) Acted erroneously.
- 34 (3) Failed to use proper procedure.
- 35 (4) Acted arbitrarily or capriciously.
- 36 (5) Failed to act as required by law or rule.

37"

38 **SECTION 19.** This Part is effective when it becomes law and applies to notices of
 39 adverse benefit determination and notices of resolution mailed on or after that date and to
 40 requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

41 **PART V. EFFECTIVE DATE**

42 **SECTION 20.** Except as otherwise provided, this act is effective when it becomes
 43 law.
 44