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GENERAL ASSEMBLY OF NORTH CAROLINA
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S **D**

SENATE BILL DRS55053-MR-91C*

Short Title:	Medicaid Changes for Transformation.	(Public)
Sponsors:	Senators Krawiec and Bishop (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"**Chapter 108D.**

"**Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~ Programs.**

"Article 1.

"General Provisions.

"**§ 108D-1. Definitions.**

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

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(1a) 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.

(1b) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(1c) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

(1d) Behavioral Health and Individuals with 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.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health,

intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.5 or G.S. 108D-15.

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

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

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

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

(7a) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(7b) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

(8) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

(10a) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(10b) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

~~(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.~~

(11b) 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.

(12) 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 ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

(13) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(14) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(c).~~

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

(16a) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, or a local management entity/managed care organization operating a BH IDD Tailored Plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.~~

(17a) Provider. – As defined in G.S. 108C-2.

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

(19) Standard 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 to BH IDD Tailored Plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP, or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.2. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests or Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.

(2) Beneficiaries who are enrolled in the foster care system.

(3) Beneficiaries who are in the former foster care Medicaid eligibility category.

(4) Beneficiaries who receive Title IV-E adoption assistance.

(5) Beneficiaries under the age of 26 who formerly received Title IV-E adoption assistance.

(6) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.

(7) Any other beneficiaries who are not required to enroll in a PHP under State law.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.

(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.

(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.

(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.

(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.

(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.

(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP. For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.3. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.4. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.2(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

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

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

(b) Notices Pertaining to Expedited Enrollee Request for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.5. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"**§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.**

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an ~~LME/MCO~~ managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"**§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.**

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

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"**§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.**

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

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

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee if all of the following occur:

(1) The Medicaid enrollee, or the enrollee's authorized representative, files the appeal within the required time frames.

(2) The Medicaid enrollee, or the enrollee's authorized representative, files for continuation of benefits within 30 calendar days of the mailing date of the notice of adverse benefit determination, except that a request for continuation of benefits filed by a provider does not meet the requirement of this subdivision, in accordance with 42 C.F.R. § 438.402(c)(ii).

(3) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(4) The service was ordered by an authorized provider.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

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

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

"**§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for

an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by ~~enrollees,~~ an enrollee, or the enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by ~~network providers on behalf of enrollees,~~ a network provider as an enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee who is a Medicaid beneficiary in accordance with G.S. 108D-13(c1).

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three-day~~ 72-hour period.

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

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

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

"**§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.**

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

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity.

G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

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

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

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

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

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

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

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under ~~42 C.F.R. § 438.420.~~42 C.F.R. § 438.420, G.S. 108D-13, and G.S. 108D-14. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420, except to the extent required by G.S. 108D-13(c1) and G.S. 108D-14(c1).

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

…

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

…

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

…

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has

received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

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

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

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

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"**§ 108D-16. Notice of final decision and right to seek judicial review.**

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"**§ 108D-21. LME/MCO provider networks.**

Each LME/MCO operating the combined 1915(b) and (c) waivers shall maintain and utilize a closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"**§ 108D-22. PHP provider networks.**

(a) Except as provided in G.S. 108D-23, 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 for failure to meet objective quality standards or refusal to accept network rates. 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 and NC Health Choice 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 and NC Health Choice 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 and NC Health Choice 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.

"**§ 108D-23. BH IDD Tailored Plan networks.**

Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

…

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients

rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e)~~ ~~"FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

…

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid Health Plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

…."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

…."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this Part, unless the context clearly requires otherwise.

(1) Adverse disenrollment decision. – As defined in G.S. 108D-1.

~~(1)~~(2) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(3) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.5.

~~(2)~~(4) OAH. – The Office of Administrative Hearings.

~~(3)~~(5) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

…

"**§ 108A-70.9B. Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

…

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

…

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall

contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the recipient accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

…

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

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

…

"**§ 108A-70.9C. Informal review permitted.**

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.4."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"**§ 108A-70.29. Program review process.**

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

…."

SECTION 8. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

…

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

…

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD Tailored Plan.

…."

SECTION 9. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

…

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

…

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

…

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a Prepaid Health Plan, as defined in G.S. 108D-1.

…."

SECTION 10. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

…

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

…."

SECTION 11. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

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

…

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan.

…

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

…

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

…

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are currently covered by the LME/MCOs for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section.
b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.
c. 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.

…."

SECTION 12. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

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

…

(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:

…

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

…."

SECTION 13.(a) The Revisor of Statutes shall codify the portions of S.L. 2015-245, as amended, specified in this section. These specified portions of S.L. 2015-245, as amended, shall be codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans." The new Article 4 of Chapter 108D of the General Statutes shall have the following structure:

(1) Section 1 of S.L. 2015-245 shall be codified as G.S. 108D-30.

(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 1 of S.L. 2018-48, and Section 11 of this act, shall be codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 11 of this act, shall be codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, shall be codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, shall be codified as G.S. 108D-45.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 shall be codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 shall be codified as G.S. 108D-55.

(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 11 of this act, shall be codified as G.S. 122C-115(e), except that the tag line shall not be codified.

(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, shall be codified as G.S. 108D-60, except that the following shall not be codified:

a. The first and third sentences of the subdivision (10).

b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.

c. Sub-sub-subdivision 6. of sub-subdivision a. of subdivision (10).

d. Sub-subdivisions b., c., and d. of subdivision (10).

(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 12 of this act, shall be codified as G.S. 108D-65, except that the following shall not be codified:

a. Sub-subdivision d. of subdivision (6) of Section 5.

b. Subdivisions (10), (11), (12), and (13) of Section 5.

(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, shall be codified as G.S. 108D-70.

SECTION 13.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this Section, the Revisor of Statutes is authorized to do all of the following:

(1) Make codification-related substitutions for statutory citations and internal cross-references that appear throughout the session law as needed, including references to an act, section, subdivision, or other elements of the session law.

(2) Make codification-related substitutions for acronyms or abbreviations that appear throughout the session law as needed and for clarity.

(3) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

(4) Insert a cross-reference to the new Article 4 of Chapter 108D after the reference to capitated contracts in subdivision (9) of Section 4 of the session law.

SECTION 14.(a) The Revisor of Statutes is authorized to replace references to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes with

references to the Division of Health Benefits, except that references to the Division of Medical Assistance shall not be changed in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 14.(b) The changes authorized by subsection (a) of this section shall be effective July 1, 2019.

SECTION 15. Except as otherwise provided, this act is effective October 1, 2019.