GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

S **D**

SENATE BILL 594
Health Care Committee Substitute Adopted 5/6/21
PROPOSED HOUSE COMMITTEE SUBSTITUTE S594-PCS45442-TR-9

Short Title: Medicaid Admin. Changes & Tech. Corrections. (Public)

Sponsors:

Referred to:

April 7, 2021

A BILL TO BE ENTITLED

AN ACT MODIFYING CERTAIN MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT, UPDATING THE MEDICAID PROGRAM BENEFICIARY APPEALS PROCESSES, INCREASING THE AMOUNT OF ALLOWABLE THERAPEUTIC LEAVE UNDER THE MEDICAID PROGRAM, CLARIFYING THE CODIFICATION OF BEHAVIORAL HEALTH SERVICES COVERED BY STANDARD BENEFIT PLANS, AUTHORIZING COVERAGE OPTIONS FOR BEHAVIORAL HEALTH SERVICES FOR POPULATIONS NOT COVERED BY PREPAID HEALTH PLAN CONTRACTS, REVISING THE TRANSFER OF AREA AUTHORITY FUND BALANCES, REMOVING THE RATE FLOOR FOR DURABLE MEDICAL EQUIPMENT, AND MAKING VARIOUS TECHNICAL CORRECTIONS TO THE STATUTES GOVERNING THE NORTH CAROLINA MEDICAID PROGRAM.

The General Assembly of North Carolina enacts:

PART I. MODIFICATIONS TO MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT

EXCLUDE THE COVID-19 TESTING COVERAGE GROUP FROM MEDICAID MANAGED CARE

SECTION 1.1.(a) Section 4.5 of S.L. 2020-4 reads as rewritten:

"**PROVIDE MEDICAID COVERAGE FOR COVID-19 TESTING TO UNINSURED INDIVIDUALS IN NORTH CAROLINA DURING THE NATIONWIDE PUBLIC HEALTH EMERGENCY**

"**SECTION 4.5.** The Department of Health and Human Services, Division of Health Benefits (DHB), is authorized to provide the Medicaid coverage described in 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XXIII), which covers COVID-19 testing for certain uninsured individuals during the period in which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus, and for which the federal medical assistance percentage is one hundred percent (100%). DHB is authorized to provide this medical assistance retroactively to the earliest date allowable. Notwithstanding G.S. 108D-40, individuals receiving this Medicaid coverage shall not be covered by capitated prepaid health plan contracts under Article 4 of Chapter 108D of the General Statutes."

SECTION 1.1.(b) This section becomes effective July 1, 2021.

END TEMPORARY MEDICAID PROVIDER CHANGES IMPLEMENTED DUE TO THE PUBLIC HEALTH EMERGENCY

SECTION 1.2. Effective 30 days after this act becomes law, Section 4.7 of S.L. 2020-4 is repealed.

PART II. MEDICAID BENEFICIARY APPEALS MODIFICATIONS

ALLOW MEDICAID BENEFICIARIES TO FILE APPEALS BY TELEPHONE

SECTION 2.1.(a) G.S. 108A-70.9A is amended by adding a new subsection to read:

"(c1) Notice Availability. – The Department shall make available to OAH a copy of the notice of adverse determination required under subsection (c) of this section. The information contained in the notice is confidential unless the recipient appeals the adverse determination under subsection (d) of this section. OAH may dispose of these records after one year."

SECTION 2.1.(b) G.S. 108A-70.9A(d) reads as rewritten:

"(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse 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 recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by ~~sending~~ filing an appeal request ~~form to OAH and the Department.~~ with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. ~~The Department shall immediately forward a copy of the notice to OAH electronically. The information contained in the notice is confidential unless the recipient appeals. OAH may dispose of the records after one year.~~ The Department may not influence, limit, or interfere with the recipient's decision to request a hearing."

SECTION 2.1.(c) G.S. 108A-70.9A(e)(1) reads as rewritten:

"(1) A statement ~~that~~ that, in order to request an appeal, the recipient must ~~send~~ file the form ~~by mail or fax to the address or fax number listed on the form~~ with OAH within 30 days of mailing of the ~~notice.~~notice, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form."

SECTION 2.1.(d) G.S. 108D-5.7(a)(1) reads as rewritten:

"(1) A statement ~~that~~ 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.~~resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form."

SECTION 2.1.(e) G.S. 108D-5.9(a) reads as rewritten:

"(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~~ request a hearing to appeal the determination by filing the appeal request form provided under G.S. 108D-5.7(a) with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. 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."

SECTION 2.1.(f) G.S. 108D-11(b) reads as rewritten:

"(b) An enrollee, or the enrollee's authorized representative, may file grievances and managed care entity level appeals orally or in writing. ~~However, unless the enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral appeal must be followed by a written, signed appeal.~~"

SECTION 2.1.(g) G.S. 108D-15(d) reads as rewritten:

"(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file a request for an appeal by ~~sending~~ filing an appeal request form that meets the requirements of subsection ~~(e)~~ (f) of this section ~~to~~ with OAH ~~and the affected managed care entity~~ by no later than 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.~~ The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the 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."

SECTION 2.1.(h) G.S. 108D-15(f)(1) reads as rewritten:

"(1) A statement ~~that~~ 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 120 days after the mailing date of the notice of ~~resolution.~~resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form."

SECTION 2.1.(i) This section is effective when it becomes law and applies to (i) appeal request forms under G.S. 108A-70.9A(e), 108D-5.7(a), and 108D-15(f) issued on or after that date and (ii) appeals requested on or after that date.

EXPEDITED PROCESS FOR MEDICAID BENEFICIARY APPEALS

SECTION 2.2.(a) G.S. 108A-70.9A(e) is amended by adding a new subdivision to read:

"(3a) The option for the recipient to request an expedited appeal."

SECTION 2.2.(b) G.S. 108A-70.9A is amended by adding a new subsection to read:

"(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may request that an appeal under subsection (d) of this section be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The recipient shall submit any additional documentation from a licensed health care professional with relevant excerpts from the recipient's medical record that was not already provided with regard to the adverse determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the recipient's request meets the criteria for an expedited appeal.

(3) If the Department determines that the recipient's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the recipient, or the recipient's parent, guardian, or legal

representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the recipient's appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the recipient's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision required under G.S. 108A-70.9B(g) shall be made as expeditiously as possible."

SECTION 2.2.(c) G.S. 108A-79(c) is amended by adding a new subdivision to read:

"(4a) With regard to the Medicaid and NC Health Choice programs only, the option to request an expedited appeal in accordance with subsection (j1) of this section."

SECTION 2.2.(d) G.S. 108A-79 is amended by adding a new subsection to read:

"(j1) In accordance with 42 C.F.R. § 431.224, a Medicaid or NC Health Choice applicant or recipient may request that an appeal from the local appeal hearing decision under subsection (g) of this section or an appeal of a case involving disability be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The appellant shall submit any documentation that was not previously submitted to demonstrate the need for an expedited appeal. For cases not involving disability, this documentation shall include documentation from a licensed health care professional. For cases involving disability, this documentation shall include relevant excerpts from the appellant's medical record, including physical examinations, signs, symptoms, and laboratory findings.

(2) The Department shall determine if the appellant's request meets the criteria for an expedited appeal.

(3) If the Department determines that the appellant's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the appellant, or the appellant's authorized representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the appellant's request meets the criteria for an expedited appeal, both the proposal for decision and the final decision required under subsection (j) of this section shall be made as expeditiously as possible.

(5) This subsection does not grant an appellant any greater assistance than the appellant is otherwise entitled to under this section while the appellant's appeal is pending."

SECTION 2.2.(e) G.S. 108D-5.7(b)(1) reads as rewritten:

"(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.~~denial. The denial is not appealable."

SECTION 2.2.(f) G.S. 108D-14(a) reads as rewritten:

"(a) Request for Expedited Appeal. – When the time limits for completing a standard managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the

enrollee's authorized representative, has the right to file a request for an expedited appeal of an adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary."

SECTION 2.2.(g) G.S. 108D-14(b) reads as rewritten:

"(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request for an expedited managed care entity level appeal, then (i) the 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 mail no later than 72 hours after receiving the request for an expedited ~~appeal. In addition,~~ appeal and (ii) the managed care entity shall resolve the appeal within the time limits established for standard managed care entity level appeals in G.S. 108D-13. The denial is not appealable."

SECTION 2.2.(h) G.S. 108D-15(f) is amended by adding a new subdivision to read:

"(3a) The option for the enrollee to request an expedited appeal."

SECTION 2.2.(i) Article 2 of Chapter 108D of the General Statutes is amended by adding a new section to read:

"**§ 108D-15.1. Expedited contested case hearings on disputed adverse benefit determinations.**

In accordance with 42 C.F.R. § 431.224, an enrollee, or an enrollee's authorized representative, may request that an appeal under G.S. 108D-15(d) be expedited if the time otherwise permitted for a hearing could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The enrollee shall submit any additional documentation from a licensed health care professional with relevant excerpts from the enrollee's medical record that was not already provided with regard to the adverse benefit determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the enrollee's request meets the criteria for an expedited appeal.

(3) If the Department determines that the enrollee's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the enrollee, or the enrollee's authorized representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the enrollee's appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the enrollee's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108D-15(i) shall not apply to the appeal request and (ii) the decision required under G.S. 108D-16 shall be made as expeditiously as possible."

SECTION 2.2.(j) This section is effective when it becomes law and applies to (i) notices of action under G.S. 108A-79(c) and appeal request forms under G.S. 108A-70.9A(e) and G.S. 108D-15(f) issued on or after that date and (ii) requests to expedite an appeal made on or after that date.

PART III. MISCELLANEOUS CHANGES RELATED TO THE MEDICAID PROGRAM

INCREASE ALLOWABLE AMOUNT OF MEDICAID-COVERED THERAPEUTIC LEAVE

SECTION 3.1.(a) G.S. 108A-62 reads as rewritten:

"**§ 108A-62. Therapeutic leave for medical assistance patients.**

(a) ~~Patients~~ A medical assistance beneficiary at an intermediate care facility or skilled nursing facility may take ~~up to 60 days of~~ therapeutic leave ~~in any one calendar year~~ in accordance with this section without the facility losing reimbursement under the medical assistance ~~program, provided, however, no more than 15 consecutive days may be taken without approval of the Department of Health and Human Services, Division of Health Benefits. Under no circumstances shall the number of Medicaid covered therapeutic leave days exceed 60 days per patient per calendar year.~~program.

(b) The maximum amount of therapeutic leave days that may be taken in a calendar year by a medical assistance beneficiary are as follows:

(1) Ninety days for a beneficiary in an intermediate care facility.

(2) Sixty days for a beneficiary in a skilled nursing facility.

(c) No more than 15 consecutive days of therapeutic leave may be taken by a medical assistance beneficiary without the approval of one of the following:

(1) The Division of Health Benefits of the Department.

(2) The local management entity/managed care organization with which the beneficiary is enrolled under Chapter 122C of the General Statutes.

(3) The prepaid health plan with which the beneficiary is enrolled under Chapter 108D of the General Statutes."

SECTION 3.1.(b) This section is effective when it becomes law, and individuals who had exhausted the amount of therapeutic leave prior to that date shall be entitled to any additional leave for the calendar year allowed under G.S. 108A-62, as amended by this section.

CLARIFY CODIFICATION OF BEHAVIORAL HEALTH SERVICES COVERED BY STANDARD BENEFIT PLANS

SECTION 3.2. G.S. 108D-35(1) reads as rewritten:

"(1) Medicaid services covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under a standard benefit plan, except that all capitated PHP contracts shall cover the following services: ~~inpatient~~

a. Inpatient behavioral health ~~services, outpatient~~ services.

b. Outpatient behavioral health emergency room ~~services, outpatient~~ services.

c. Outpatient behavioral health services provided by direct-enrolled ~~providers, mobile~~ providers.

d. Mobile crisis management ~~services, facility-based~~ services.

e. Facility-based crisis services for children and ~~adolescents, professional~~ adolescents.

f. Professional treatment services in a facility-based crisis ~~program, outpatient~~ program.

g. Outpatient opioid treatment ~~services, ambulatory~~ services.

h. Ambulatory detoxification ~~services, nonhospital~~ services.

i. Nonhospital medical detoxification ~~services, partial hospitalization, medically~~ services.

j. Partial hospitalization.

k. Medically supervised or alcohol and drug abuse treatment center detoxification crisis ~~stabilization, research-based~~ stabilization.

l. Research-based intensive behavioral health ~~treatment, diagnostic~~ treatment.
m. Diagnostic assessment ~~services, and~~ services.
n. Early and Periodic Screening, Diagnosis, and Treatment services.

In accordance with this subdivision, 1915(b)(3) services shall not be covered under a standard benefit plan."

BEHAVIORAL HEALTH SERVICES FOR POPULATIONS NOT COVERED BY PREPAID HEALTH PLAN CONTRACTS

SECTION 3.4A.(a) G.S. 108D-60 reads as rewritten:

"**§ 108D-60. BH IDD tailored plans.**

(a) BH IDD tailored plans shall be defined as capitated PHP contracts that meet all requirements in this Article pertaining to capitated PHP contracts, except as specifically provided in this section. With regard to BH IDD tailored plans, the following shall occur:

…

(b) The Department may contract with entities operating BH IDD tailored plans under a capitated or other arrangement for the management of behavioral health, intellectual and developmental disability, and traumatic brain injury services for any recipients excluded from PHP coverage under G.S. 108D-40(a)(4), (5), (7), (10), (11), (12), and (13)."

SECTION 3.4A.(b) G.S. 122C-115 is amended by adding a new subsection to read:

"(f) Entities operating the BH IDD tailored plans under G.S. 108D-60 may continue to manage the behavioral health, intellectual and developmental disability, and traumatic brain injury services for any Medicaid recipients described in G.S. 108D-40(a)(4), (5), (7), (10), (11), (12), and (13) under any contract with the Department in accordance with G.S. 108D-60(b)."

TRANSFER OF AREA AUTHORITY FUND BALANCES/AREA AUTHORITY DISSOLUTION

SECTION 3.5.(a) G.S. 122C-115.3 is amended by adding a new subsection to read:

"(b1) The Secretary shall, prior to the date that BH IDD tailored plans begin operating, direct the dissolution of any area authority that does not receive an initial contract to operate a BH IDD tailored plan. The Secretary shall deliver a notice of dissolution to the board of county commissioners of each of the counties in the dissolved LME/MCO."

SECTION 3.5.(b) G.S. 122C-115.3(e) reads as rewritten:

"(e) Any fund balance or risk reserve available to an area authority at the time of its dissolution that is not utilized to pay liabilities shall be transferred to ~~the area authority~~ one or more area authorities contracted to operate the 1915(b)/(c) Medicaid Waiver or a BH IDD tailored plan in all or a portion of the catchment area of the dissolved area ~~authority. If the fund balance transferred from the dissolved area authority is insufficient to constitute fifteen percent (15%) of the anticipated operational expenses arising from assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%) operational reserves.~~authority, as directed by the Department."

SECTION 3.5.(c) G.S. 122C-115.3 is amended by adding a new subsection to read:

"(e1) Effective until the date that BH IDD tailored plans begin operating, if the fund balance transferred from the dissolved area authority under subsection (e) of this section is insufficient to constitute fifteen percent (15%) of the anticipated operational expenses arising from assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%) operational reserves."

TRANSFER OF AREA AUTHORITY FUND BALANCES/COUNTY DISENGAGEMENT

SECTION 3.5A.(a) When a county disengages from one area authority and realigns with another area authority under G.S. 122C-115, a portion of the risk reserve and other funds of the area authority from which the county is disengaging shall be transferred to the area authority with which the county is realigning. The amount of risk reserve and other funds to be transferred shall be determined by the Department of Health and Human Services (DHHS) in accordance with a formula or formulas developed in accordance with this section.

SECTION 3.5A.(b) Any formula developed by DHHS under this section shall consider the stability of both the area authority from which the county is disengaging and the area authority with which the county is realigning. The formula shall support the ability for each area authority to carry out its responsibilities under State law and shall support the successful operation of BH IDD tailored plans under G.S. 108D-60. The formula shall assure that the area authority from which the county is disengaging retains sufficient funds to pay any outstanding liabilities to health care providers, staff-related expenses, and other liabilities.

SECTION 3.5A.(c) Upon the Secretary's approval of a disengagement under G.S. 122C-115(a3), the area authority from which the county is disengaging and the area authority with which the county is realigning shall provide DHHS with all financial information requested by DHHS that is necessary to determine the amount of funds to be transferred using the formula or formulas developed under this section.

SECTION 3.5A.(d) DHHS shall post on its website any formula developed under this section and provide notice of the formula to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. DHHS shall accept public comment on the proposed formula.

SECTION 3.5A.(e) No later than October 15, 2021, DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division on any formulas developed under this section and any funds transferred during the previous quarter. Beginning January 15, 2022, and quarterly thereafter through April 15, 2026, DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division on any funds transferred as a result of disengagements during the previous quarter. A final quarterly report shall be due June 30, 2026, for the quarter ending on that date.

SECTION 3.5A.(f) Notwithstanding any provision of law to the contrary, the development and application of the formula or formulas under this section shall be exempt from the rulemaking requirements under Article 2A of Chapter 150B of the General Statutes and the contested case provisions of Chapter 150B of the General Statutes.

SECTION 3.5A.(g) This section is effective when it becomes law and applies to disengagements approved by DHHS with an effective date on or after September 1, 2021.

SECTION 3.5A.(h) This section shall expire on June 30, 2026.

REMOVE RATE FLOOR FOR DME

SECTION 3.6.(a) Section 11 of S.L. 2020-88 reads as rewritten:

"**DURABLE MEDICAL EQUIPMENT RATE ~~FLOOR~~**

"**SECTION 11.** For the first ~~three~~ five years of the initial standard benefit plan prepaid health plan capitated contracts required under Article 4 of Chapter 108D of the General Statutes, the ~~rate floor~~ reimbursement for durable medical equipment and supplies, orthotics, and prosthetics under managed care shall be set at one hundred percent (100%) of the lesser of the supplier's

usual and customary rate or the maximum allowable Medicaid fee-for-service rates for durable medical ~~equipment.~~equipment and supplies, orthotics, and prosthetics."

SECTION 3.6.(b) This section becomes effective July 1, 2021.

PART IV. TECHNICAL CORRECTIONS

SECTION 4.1. The Revisor of Statutes shall replace the phrase "the mentally retarded" with the phrase "individuals with intellectual disabilities" in the following statutes: G.S. 108A-58.2, 108A-61.1, and 108A-70.5.

SECTION 4.2.(a) G.S. 90-21.50(1) reads as rewritten:

"(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a self-insured indemnity program or prepaid hospital and medical benefits plan offered under the State Health Plan for Teachers and State Employees and subject to the requirements of Article 3 of Chapter 135 of the General Statutes, a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. ~~Except for the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes,~~ "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any of the following kinds of insurance:
…."

SECTION 4.2.(b) G.S. 90-21.50(7) reads as rewritten:

"(7) "Managed care entity" means an insurer that:
…
Except for the State Health Plan for Teachers and State ~~Employees and the Health Insurance Program for Children,~~ Employees, "managed care entity" does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider."

SECTION 4.3. G.S. 108A-54.3A(5) reads as rewritten:

"(5) Children under the age of ~~19~~ 21 who are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, without regard to income."

SECTION 4.4. G.S. 108A-68.2 reads as rewritten:

"**§ 108A-68.2. Beneficiary lock-in program for certain controlled substances.**

(a) ~~As used in this section, "covered substances" means any~~ The following definitions apply in this section:

(1) Covered substances. – Any controlled substance identified as an opioid or benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in Article 5 of Chapter 90 of the General Statutes, unless one of the following conditions are met:

~~(1)~~a. If the Department of Health and Human Services specifically identifies the opioid or benzodiazepine as a substance excluded from coverage by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in

accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is not a covered substance under this section.

~~(2)~~b. If the Department of Health and Human Services specifically identifies a controlled substance contained in Article 5 of Chapter 90 of the General Statutes other than an opioid or benzodiazepine as a controlled substance covered by the Medicaid Beneficiary Management Lock-In Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(2) Lock-in program. – A requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.

(3) Prepaid health plan or PHP. – As defined in G.S. 108D-1.

~~(b) As used in this section, "lock-in program" means a requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.~~

~~(c) As used in this section, "Prepaid Health Plan" or "PHP" means an entity holding a PHP license under Article 93 of Chapter 58 of the General Statutes.~~

…."

SECTION 4.5. G.S. 108C-2.1 reads as rewritten:

"**§ 108C-2.1. Provider application and ~~recredentialing~~ revalidation fee.**

(a) Each provider that submits an application to enroll in the Medicaid program shall submit an application fee. The application fee shall be the sum of the amount federally required and one hundred dollars ($100.00).

(b) The fee required under subsection (a) of this section shall be charged to all providers at ~~recredentialing~~ revalidation every five years."

SECTION 4.6. G.S. 108D-1 is amended by adding a new subdivision to read:

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

SECTION 4.7.(a) G.S. 108D-1(6) reads as rewritten:

"(6) Closed network. – The network of providers that have contracted with (i) a local management entity/managed care organization operating the combined 1915(b) and (c) waivers or (ii) an entity operating a BH IDD tailored plan to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees."

SECTION 4.7.(b) G.S. 108D-23 reads as rewritten:

"**§ 108D-23. BH IDD tailored plan networks.**

Entities operating BH IDD tailored plans shall develop and maintain a closed ~~provider networks~~ network of providers only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 4.8.(a) G.S. 108D-5.3(b)(1) reads as rewritten:

"(1) ~~Members of federally recognized tribes.~~Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a)."

SECTION 4.8.(b) G.S. 108D-40(a)(5) reads as rewritten:

"(5) ~~Members of federally recognized tribes. Members of federally recognized tribes~~ Recipients who meet the definition of Indian under 42 C.F.R. § 438.14(a) shall have the option to enroll voluntarily in PHPs."

SECTION 4.8.(c) G.S. 108D-40(a)(5a) is repealed.

SECTION 4.8.(d) G.S. 122C-115(e) reads as rewritten:

"(e) Beginning on the date that capitated contracts under Article 4 of Chapter 108D of the General Statutes begin, LME/MCOs shall cease managing Medicaid services for all Medicaid

recipients other than recipients described in G.S. 108D-40(a)(1), (4), (5), ~~(5a),~~ (6), (7), (10), (11), (12), and (13). Until BH IDD tailored plans become operational, all of the following shall occur:

(1) LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in G.S. 108D-40(a)(1), (4), (5), ~~(5a),~~ (6), (7), (10), (11), (12), and (13).

…."

SECTION 4.8.(e) This section becomes effective July 1, 2021.

SECTION 4.9.(a) G.S. 108D-35(5) reads as rewritten:

"(5) Services documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by a Children's Developmental Services Agency ~~(CDSA) that are included on the child's Individualized Family Service Plan.~~or by a provider contracted with a Children's Developmental Services Agency to provide those services."

SECTION 4.9.(b) This section becomes effective July 1, 2021.

SECTION 4.10. Article 17 of Chapter 131E of the General Statutes is repealed.

PART V. EFFECTIVE DATE

SECTION 5. Except as otherwise provided, this act is effective when it becomes law.