

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 656*
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19
Senate Health Care Committee Substitute Adopted 6/13/19
Fifth Edition Engrossed 6/19/19

Short Title: Medicaid Changes for Transformation.

(Public)

Sponsors:

Referred to:

April 10, 2019

1 A BILL TO BE ENTITLED
2 AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH
3 CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID
4 TRANSFORMATION.

5 The General Assembly of North Carolina enacts:

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

7 "Chapter 108D.

8 "Medicaid and NC Health Choice Managed Care for Behavioral Health
9 Services.Programs.

10 "Article 1.

11 "General Provisions.

12 "§ 108D-1. Definitions.

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

- 15 (1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In
16 accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health
17 Choice beneficiaries in the same manner as it applies to Medicaid
18 beneficiaries.
- 19 (2) Adverse disenrollment determination. – A determination by the Department
20 of Health and Human Services or the enrollment broker to (i) deny a request
21 made by an enrollee, or the enrollee's authorized representative, to disenroll
22 from a prepaid health plan or (ii) approve a request made by a prepaid health
23 plan to disenroll an enrollee from a prepaid health plan.
- 24 (3) Applicant. – A provider of mental health, intellectual or developmental
25 disabilities, and substance abuse services who is seeking to participate in the
26 closed network of one or more local management entity/managed care
27 organizations or prepaid health plans.
- 28 (4) Behavioral health and intellectual/developmental disabilities tailored plan or
29 BH IDD tailored plan. – A capitated prepaid health plan contract under the
30 Medicaid transformation demonstration waiver that meets all of the
31 requirements of Article 4 of this Chapter, including the requirements
32 pertaining to BH IDD tailored plans.



- 1 (5) Beneficiary. – A person to whom or on whose behalf medical assistance or
2 assistance through the North Carolina Health Choice for Children program is
3 granted under Article 2 of Chapter 108A of the General Statutes.
- 4 ~~(2)~~(6) Closed network. – The network of providers that have contracted with a local
5 management entity/managed care organization to furnish mental health,
6 intellectual or developmental disabilities, and substance abuse services to
7 enrollees.
- 8 ~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of
9 Administrative Hearings under ~~G.S. 108D-15~~ to resolve a dispute between an
10 enrollee and a local management entity/managed care organization about a
11 ~~managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.
- 12 ~~(4)~~(8) Department. – The North Carolina Department of Health and Human
13 Services.
- 14 ~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- 15 ~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.
- 16 ~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently
17 enrolled with a local management entity/managed care
18 ~~organization.~~organization or a prepaid health plan.
- 19 (14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).
- 20 (16) Fee-for-service program. – A payment model for the Medicaid and NC Health
21 Choice programs operated by the Department of Health and Human Services
22 pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A
23 of the General Statutes in which the Department pays enrolled providers for
24 services provided to Medicaid and NC Health Choice beneficiaries rather than
25 contracting for the coverage of services through a capitated payment
26 arrangement.
- 27 ~~(8)~~(21) Local Management Entity or LME. – As defined in
28 ~~G.S. 122C-3(20b).~~G.S. 122C-3.
- 29 ~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As
30 defined in ~~G.S. 122C-3(20e).~~G.S. 122C-3.
- 31 (10) ~~Managed care action.~~ – An action, as defined in 42 C.F.R. § 438.400(b).
- 32 (11) ~~Managed Care Organization or MCO.~~ – As defined in 42 C.F.R. § 438.2.
- 33 (23) Mail. – United States mail or, if the enrollee or the enrollee's authorized
34 representative has given written consent to receive electronic
35 communications, electronic mail.
- 36 (24) Managed care entity. – A local management entity/managed care organization
37 or a prepaid health plan.
- 38 (25) Medicaid transformation demonstration waiver. – The waiver agreement
39 entered into between the State and the Centers for Medicare and Medicaid
40 Services under Section 1115 of the Social Security Act for the transition to
41 prepaid health plans.
- 42 ~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance
43 abuse services or MH/IDD/SA services. – Those mental health, intellectual or
44 developmental disabilities, and substance abuse services covered by a local
45 management entity/managed care organization under a contract in effect
46 between with the Department of Health and Human Services and a local
47 management entity to operate a managed care organization or prepaid
48 inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved
49 by the federal Centers for Medicare and Medicaid Services (CMS); the
50 combined Medicaid waiver program authorized under Section 1915(b) and
51 Section 1915(c) of the Social Security Act.

(13)(27) 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)(28) 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(e).~~

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

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

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

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

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

(36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a 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, 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,

1 or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from
2 disenrolling from a PHP and receiving services through the fee-for-service program.

3 **"§ 108D-5.3. Enrollee requests for disenrollment.**

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

7 (b) Without Cause Enrollee Requests for Disenrollment. – An enrollee shall be allowed
8 to disenroll from the PHP without cause only during the times specified in 42 C.F.R. §
9 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any
10 time:

11 (1) Members of federally recognized tribes.

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

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

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

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

17 (6) Any other beneficiaries who are not required to enroll in a PHP under
18 G.S. 108D-40.

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

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

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

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

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

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

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

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

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

49 (d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's
50 authorized representative, may submit an expedited request for disenrollment to the enrollment
51 broker when the enrollee has an urgent medical need that requires disenrollment from the PHP.

1 For purposes of this subsection, an urgent medical need means that continued enrollment in the
2 PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum
3 function.

4 **"§ 108D-5.5. PHP requests for disenrollment.**

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

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

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

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

15 **"§ 108D-5.7. Notices.**

16 (a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the
17 Department shall issue a written notice of resolution approving or denying the request by mail to
18 the enrollee before the first day of the second month following the month in which the enrollee
19 or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under
20 G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or
21 denying the expedited request within three calendar days of receipt of the request. In the same
22 mailing as the notice, the Department shall also provide the enrollee with an appeal request form
23 that includes all of the following:

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

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

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

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

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

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

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

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

45 **"§ 108D-5.9. Appeals of adverse disenrollment determinations.**

46 (a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied
47 with an adverse disenrollment determination may file an appeal for a hearing with the Office of
48 Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request
49 for a hearing to appeal an adverse disenrollment determination of the Department under this
50 section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General

1 Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article
 2 2 of Chapter 108A of the General Statutes.

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

5 "Article 2.

6 "Enrollee Grievances and Appeals.

7 **"§ 108D-11. LME/MCO-Managed care entity grievance and appeal procedures, generally.**

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

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

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

22 (1) Offering an enrollee alternative services.

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

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

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

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

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

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

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

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

41 **"§ 108D-12. LME/MCO-Managed care entity grievances.**

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

48 (b) Notice of Grievance Disposition. – The LME/MCO-managed care entity shall resolve
 49 the grievance and cause a notice of grievance ~~disposition-resolution~~ to be sent by ~~United States~~
 50 mail to the enrollee and all other affected parties as expeditiously as the enrollee's health
 51 condition requires, but no later than ~~90-30~~ days after receipt of the ~~grievance-grievance, provided~~

1 that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R.
2 § 438.408(c).

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

5 **"§ 108D-13. Standard LME/MCO-managed care entity level appeals.**

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

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

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

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

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

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

39 **"§ 108D-14. Expedited LME/MCO-managed care entity level appeals.**

40 (a) Request for Expedited Appeal. – When the time limits for completing a standard
41 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or
42 regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on~~
43 ~~behalf of an enrollee, the enrollee's authorized representative,~~ has the right to file a request for
44 an expedited appeal of a ~~managed care action-an adverse benefit determination no later than 30~~
45 60 days after the mailing date of the notice of managed care action-adverse benefit determination.
46 For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee
47 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
48 behalf of enrollees, the LME/MCO In determining whether the enrollee qualifies for an expedited
49 appeal, the managed care entity shall presume an expedited appeal is necessary-necessary when
50 the expedited appeal is made by a network provider as an enrollee's authorized representative or

1 when a network provider has otherwise indicated to the managed care entity that an expedited
2 appeal is necessary.

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

10 (c) Continuation of Benefits. – ~~An LME/MCO-A managed care entity~~ shall continue the
11 enrollee's benefits of a Medicaid enrollee during the pendency of an expedited LME/MCO
12 managed care entity level appeal to the extent required under 42 C.F.R. § 438.420. In accordance
13 with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of
14 benefits.

15 (d) Notice of Resolution. – If the ~~LME/MCO-managed care entity~~ grants a request for an
16 expedited ~~LME/MCO-managed care entity level appeal~~, the ~~LME/MCO-managed care entity~~
17 shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later
18 than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal,
19 provided that the managed care entity may extend such time frame as permitted under 42 C.F.R.
20 § 438.408. The LME/MCO-managed care entity shall provide the enrollee and all other affected
21 parties with a written notice of resolution by United States mail within this ~~three day~~ 72-hour
22 period.

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

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

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

37 **"§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~ adverse benefit**
38 **determinations.**

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

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

47 (c) Request for Contested Case Hearing. – A request for an administrative hearing to
48 appeal a notice of resolution of an adverse benefit determination issued by an LME/MCO-a
49 managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of
50 the General Statutes. An enrollee, or a ~~network provider authorized in writing to act on behalf of~~
51 an enrollee, the enrollee's authorized representative, has the right to file a request for appeal to

1 contest a notice of resolution as long as (i) ~~the enrollee-enrollee, or network provider~~ the enrollee's
2 authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or
3 ~~G.S. 108D-14.~~ G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. §
4 438.408(c)(3), to have exhausted the managed care entity level appeals process.

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

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

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

- 24 (1) A statement that in order to request an appeal, the enrollee must file the form
25 in accordance with OAH rules, by mail or fax to the address or fax number
26 listed on the form, ~~by no later than 30-120~~ days after the mailing date of the
27 notice of resolution.
- 28 (2) The enrollee's name, address, telephone number, and Medicaid or NC Health
29 Choice identification number.
- 30 (3) A preprinted statement that indicates that the enrollee would like to appeal a
31 the specific ~~managed care action~~ adverse benefit determination identified in
32 the notice of resolution.
- 33 (4) A statement informing the enrollee of the right to be represented at the
34 contested case hearing by a lawyer, a relative, a friend, or other spokesperson.
- 35 (5) A space for the enrollee's signature and date.

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

43 (h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
44 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify
45 the administrative hearing procedures that apply to contested case hearings conducted under this
46 section in order to complete these cases as expeditiously as possible. Any simplified hearing
47 procedures approved by the chief administrative law judge under this subsection must comply
48 with all of the following requirements:

- 49 ...
- 50 (2) OAH shall conduct all contested case hearings telephonically or by video
51 technology with all parties, unless the enrollee requests that the hearing be

1 conducted in person before the administrative law judge. An in-person hearing
2 shall be conducted in the county that contains the headquarters of the
3 ~~LME/MCO-managed care entity~~ unless the enrollee's impairments limit travel.
4 For enrollees with impairments that limit travel, an in-person hearing shall be
5 conducted in the enrollee's county of residence. OAH shall provide written
6 notice to the enrollee of the use of telephonic hearings, hearings by video
7 conference, and in-person hearings before the administrative law judge, as
8 well as written instructions on how to request a hearing in the enrollee's county
9 of residence.

10 ...

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

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

- 25 a. The enrollee's right to examine at a reasonable time before and during
26 the hearing the contents of the enrollee's case file and any documents
27 to be used by the ~~LME/MCO-managed care entity~~ in the hearing before
28 the administrative law judge.
- 29 b. The enrollee's right to an interpreter during the hearing process.
- 30 c. The circumstances in which a medical assessment may be obtained at
31 the ~~LME/MCO's-managed care entity's~~ expense and made part of the
32 record, including all of the following:

33 ...

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

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

1 (k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of
2 whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care
3 entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed
4 care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed
5 care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~
6 managed care entity, the administrative law judge shall continue the hearing for a minimum of
7 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to
8 review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity
9 decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit
10 determination, it shall immediately inform the administrative law judge of its decision.

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

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

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

29 **"§ 108D-16. Notice of final decision and right to seek judicial review.**

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

36 "Article 3.

37 "Managed Care Entity Provider Networks.

38 **"§ 108D-21. LME/MCO provider networks.**

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

42 **"§ 108D-22. PHP provider networks.**

43 (a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider
44 network that meets access to care requirements for its enrollees. A PHP may not exclude
45 providers from their networks except for failure to meet objective quality standards or refusal to
46 accept network rates. Notwithstanding the previous sentence, a PHP must include all providers
47 in its geographical coverage area that are designated essential providers by the Department in
48 accordance with subdivision (b) of this section, unless the Department approves an alternative
49 arrangement for securing the types of services offered by the essential providers.

50 (b) The Department shall designate Medicaid and NC Health Choice providers as
51 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 develop and maintain 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;~~ 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.~~ Part:

- (1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a

1 ~~Medicaid service~~.service through the fee-for-service program. An adverse
 2 benefit determination as defined in G.S. 108D-1 is not an adverse
 3 determination for purposes of this Part.

4 (1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

5 (1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient
 6 appealing an adverse determination under this Part or (ii) a Medicaid or a NC
 7 Health Choice recipient appealing an adverse disenrollment determination
 8 under G.S. 108D-5.9.

9 (2) OAH. – The Office of Administrative Hearings.

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

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

17 ...

18 **"§ 108A-70.9B. Contested Medicaid cases.**

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

28 (b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
 29 150B of the General Statutes, the chief administrative law judge may limit and simplify the
 30 procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice
 31 recipient in order to complete the case as quickly as possible.

32 ...

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

39 ...

40 (c) Mediation. – Upon receipt of an appeal request form as provided by
 41 G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice
 42 recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall
 43 contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If
 44 mediation is accepted, the mediation must be completed within 25 days of submission of the
 45 request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the
 46 Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties
 47 have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a
 48 hearing of any contested Medicaid case until it has received notice from the mediator assigned
 49 that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of
 50 mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. ~~If the recipient~~

1 ~~accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall~~
 2 ~~dismiss the contested case.~~

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

7 ...

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

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

17 ...

18 **"§ 108A-70.9C. Informal review permitted.**

19 Nothing in this Part shall prevent the Department from engaging in an informal review of a
 20 contested Medicaid case with a recipient prior to issuing a notice of adverse determination as
 21 ~~provided by G.S. 108A-70.9A(e)~~ under G.S. 108A-70.9A(c) or a notice of resolution under
 22 G.S. 108D-5.7."

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

24 **"§ 108A-70.29. Program review process.**

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

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

37"

38 **SECTION 9.** G.S. 122C-3 reads as rewritten:

39 **"§ 122C-3. Definitions.**

40 The following definitions apply in this Chapter:

41 ...

42 (2a) "Area director" means the administrative head of the area authority program
 43 appointed pursuant to G.S. 122C-121.

44 (2b) "Behavioral health and intellectual/developmental disabilities tailored plan"
 45 or "BH IDD tailored plan" has the same meaning as in G.S. 108D-1.

46 (2c) "Board of county commissioners" includes the participating boards of county
 47 commissioners for multicounty area authorities and multicounty programs.

48 ...

49 (20c) "Local management entity/managed care organization" or "LME/MCO"
 50 means a local management entity that is under contract with the Department
 51 to operate the combined Medicaid Waiver program authorized under Section

1 1915(b) and Section 1915(c) of the Social Security Act. ~~Act or to operate a BH~~
 2 IDD tailored plan.

3 ...

4 (29b) "Prepaid health plan" has the same meaning as in G.S. 108D-1.

5"

6 **SECTION 9A.(a)** G.S. 122C-55, as amended by Section 5 of S.L. 2018-33, reads as
 7 rewritten:

8 **"§ 122C-55. Exceptions; care and treatment.**

9 (a) Any facility may share confidential information regarding any client of that facility
 10 with any other facility when necessary to coordinate appropriate and effective care, treatment or
 11 habilitation of the client. For the purposes of this section, the following definitions apply:

12 (1) "Client" includes an enrollee as defined in G.S. 108D-1.

13 (1a) "Coordinate" means the provision, coordination, or management of mental
 14 health, developmental disabilities, and substance abuse services and other
 15 health or related services by one or more facilities and includes the referral of
 16 a client from one facility to another.

17 (2) "Facility" and "area facility" include an area ~~authority.~~authority or a prepaid
 18 health plan.

19 (3) "Secretary" includes any primary care case management programs that
 20 contract with the Department to provide a primary care case management
 21 program for recipients of publicly funded health and related services.

22 ...

23 (a2) ~~Any or State facility or the psychiatric service of the University of North Carolina~~
 24 ~~Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility
 25 with any other ~~area facility or State facility or the psychiatric service of the University of North~~
 26 ~~Carolina Hospitals at Chapel Hill~~ when necessary to conduct payment activities relating to an
 27 individual served by the facility. Payment activities are activities undertaken by a facility to
 28 obtain payment or receive reimbursement for the provision of services and may include, but are
 29 not limited to, determinations of eligibility or coverage, coordination of benefits, determinations
 30 of cost-sharing amounts, claims management, claims processing, claims adjudication, claims
 31 appeals, billing and collection activities, medical necessity reviews, utilization management and
 32 review, precertification and preauthorization of services, concurrent and retrospective review of
 33 services, and appeals related to utilization management and review.

34 (a3) Whenever there is reason to believe that a client is eligible for benefits through a
 35 Department program, any ~~State or facility or the psychiatric service of the University of North~~
 36 ~~Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that
 37 facility with the Secretary, and the Secretary may share confidential information regarding any
 38 client with an ~~area facility or State facility or the psychiatric services of the University of North~~
 39 ~~Carolina Hospitals at Chapel Hill.~~ a facility. Disclosure is limited to that information necessary
 40 to establish initial eligibility for benefits, determine continued eligibility over time, and obtain
 41 reimbursement for the costs of services provided to the client.

42 (a4) An area authority or ~~county program~~ prepaid health plan may share confidential
 43 information regarding any client with any area facility, and any area facility may share
 44 confidential information regarding any client of that facility with the area authority or ~~county~~
 45 ~~program,~~ prepaid health plan, when the area authority or ~~county program~~ prepaid health plan
 46 determines the disclosure is necessary to develop, manage, monitor, or evaluate the area
 47 authority's or ~~county program's~~ prepaid health plan's network of qualified providers as provided
 48 in G.S. 122C-115.2(b)(1)b., G.S. 122C-141(a), Article 3 of Chapter 108D of the General
 49 Statutes, the State Plan, ~~and rules of the Secretary.~~ Secretary, and contracts between the facility
 50 and the Department. For the purposes of this subsection, the purposes or activities for which
 51 confidential information may be disclosed include, but are not limited to, quality assessment and

1 improvement activities, provider accreditation and staff credentialing, developing contracts and
 2 negotiating rates, investigating and responding to client grievances and complaints, evaluating
 3 practitioner and provider performance, auditing functions, on-site monitoring, conducting
 4 consumer satisfaction studies, and collecting and analyzing performance data.

5"

6 **SECTION 10.** G.S. 150B-1 reads as rewritten:

7 "**§ 150B-1. Policy and scope.**

8 ...

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

12 ...

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

18 ...

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

22"

23 **SECTION 11.** G.S. 150B-23 reads as rewritten:

24 "**§ 150B-23. Commencement; assignment of administrative law judge; hearing required;**
 25 **notice; intervention.**

26 ...

27 (a3) A Medicaid or NC Health Choice enrollee, or network provider authorized in writing
 28 to act on behalf of the enrollee, the enrollee's authorized representative, who appeals a notice of
 29 resolution issued by an LME/MCO-a managed care entity under Chapter 108D of the General
 30 Statutes may commence a contested case under this Article in the same manner as any other
 31 petitioner. The case shall be conducted in the same manner as other contested cases initiated by
 32 Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of
 33 contested cases commenced as Medicaid managed care enrollee appeals under Chapter 108D of
 34 the General Statutes, pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of
 35 resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in
 36 G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When
 37 a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract
 38 with the Department of Health and Human Services to issue notices of resolution under Article
 39 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested
 40 cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid
 41 health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a).
 42 The prepaid health plan shall not be considered an agency for any other purpose.

43"

44 **SECTION 12.** Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L.
 45 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of
 46 S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

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

50 ...

(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, a standard benefit 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,~~ a standard benefit plan.

...

d. Services documented in an ~~Individualized Education Program (IEP)~~ individualized education program, as defined in G.S. 115C-106.3, or other document described in the Medicaid State Plan, and provided or billed by Local Education Agencies, a local education agency, as defined in G.S. 115C-106.3.

...

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

...

l. Recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact, until BH IDD Tailored Plans become operational, at which time this population will be enrolled with a BH IDD Tailored Plan in accordance with sub-sub-subdivision 10. of sub-subdivision a. of subdivision (10) of this section. Recipients in this category shall have the option to voluntarily enroll with a PHP, provided that (i) a recipient electing to enroll with a PHP would only have access to the behavioral health services covered by PHPs according to sub-subdivision a. of subdivision (4) of this section and would no longer have access to the behavioral health services excluded under sub-subdivision a. of

- 1 subdivision (4) of this section and (ii) the recipient's informed consent
 2 shall be required prior to the recipient's enrollment with a PHP.
 3 Recipients in this category shall include, at a minimum, recipients who
 4 meet any of the following criteria:
 5 ...
 6 4. Individuals who, regardless of diagnosis, meet any of the
 7 following criteria:
 8 ...
 9 II. Individuals receiving any of the behavioral health,
 10 intellectual and developmental disability, or traumatic
 11 brain injury services that are ~~currently~~ covered by
 12 LME/MCOs under the combined 1915(b) and (c)
 13 waivers and that shall not be covered through ~~any~~
 14 ~~capitated PHP contract other than a BH IDD Tailored~~
 15 ~~Plan—a standard benefit plan~~ in accordance with
 16 sub-subdivision a. of subdivision (4) of this section.
 17 ...
 18 m. Recipients in the following categories shall not be covered by PHPs
 19 for a period of time to be determined by DHHS that shall not exceed
 20 five years after the date that capitated PHP contracts begin:
 21 1. Recipients who (i) reside in a nursing facility and have so
 22 resided, or are likely to reside, for a period of 90 days or longer
 23 and (ii) are not being served through the Community
 24 Alternatives Program for Disabled Adults (CAP/DA). During
 25 the period of exclusion from PHP coverage for this population
 26 as determined by DHHS in accordance with this
 27 sub-subdivision, if an individual enrolled in a PHP resides in a
 28 nursing facility for 90 days or more, then that individual shall
 29 be excluded from PHP coverage on the first day of the month
 30 following the ninetieth day of the stay in the nursing facility
 31 and shall be disenrolled from the PHP.
 32 2. Recipients who are enrolled in both Medicare and Medicaid
 33 and for whom Medicaid coverage is not limited to the coverage
 34 of Medicare premiums and cost sharing. This
 35 sub-sub-subdivision shall not include recipients being served
 36 through the Community Alternatives Program for Disabled
 37 Adults (CAP/DA).
 38 3. Recipients who are (i) enrolled in the foster care system, (ii)
 39 receiving Title IV-E adoption assistance, (iii) under the age of
 40 26 and formerly were in the foster care system, or (iv) under
 41 the age of 26 and formerly received adoption assistance.
 42 ...
 43 (9) LME/MCOs. – Beginning on the date that capitated contracts begin,
 44 LME/MCOs shall cease managing Medicaid services for all Medicaid
 45 recipients other than recipients described in sub-subdivisions a., d., e., f., g.,
 46 j., k., ~~and l., and m.~~ of subdivision (5) of this section. Until BH IDD Tailored
 47 Plans become operational, all of the following shall occur:
 48 a. LME/MCOs shall continue to manage the Medicaid services that are
 49 ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and
 50 (c) waivers for Medicaid recipients described in sub-subdivisions a.,
 51 d., e., f., g., j., k., ~~and l., and m.~~ of subdivision (5) of this section.

- 1 b. The Division of Health Benefits shall negotiate actuarially sound
2 capitation rates directly with the LME/MCOs based on the change in
3 composition of the population being served by the LME/MCOs.
4 c. Capitation payments under contracts between the Division of Health
5 Benefits and the LME/MCOs shall be made directly to the LME/MCO
6 by the Division of Health Benefits.

7 "

8 **SECTION 13.** Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L.
9 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

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

12 ...

- 13 (6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC
14 Health Choice services described in subdivision (4) of Section 4 of this act.
15 All contracts shall be the result of requests for proposals (RFPs) issued by
16 DHHS and the submission of competitive bids by PHPs. DHHS shall develop
17 standardized contract terms, to include at a minimum, the following:

18 ...

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

25 "

26 **SECTION 13A.** Section 6 of S.L. 2015-245 reads as rewritten:

27 **"SECTION 6.** Role of the Department of Insurance. – The transformed Medicaid and NC
28 Health Choice system shall include the licensing of ~~PHPs~~-PHPs, as required by subdivision (2)
29 of Section 4 of this act, based on solvency requirements established and implemented by the
30 Department of Insurance. The Commissioner of Insurance, in consultation with the Director of
31 the Division of Health Benefits, shall develop recommended solvency requirements that are
32 similar to the solvency requirements for similarly situated regulated entities and recommended
33 licensing procedures that include an annual review by the Commissioner and reporting of
34 changes in licensure to the Division of Health Benefits. The Commissioner shall report the
35 recommendations as well as proposed fees to offset the cost of licensure and any necessary
36 statutory changes to the Joint Legislative Oversight Committee on Medicaid and NC Health
37 Choice by March 1, 2016."

38 **SECTION 14.(a)** The portions of S.L. 2015-245, as amended, specified in this
39 section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled
40 "Prepaid Health Plans," as follows:

- 41 (1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.
42 (2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of
43 S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186,
44 Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as
45 G.S. 108D-35.
46 (3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of
47 S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and
48 Section 12 of this act, is codified as G.S. 108D-40.
49 (4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of
50 S.L. 2018-49, is codified as G.S. 108D-40.

- 1 (5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of
2 S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and
3 the words "(statewide contracts)" and "(regional contracts)" shall be removed.
4 (6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.
5 (7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.
6 (8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of
7 S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e),
8 except that the tag line shall not be codified, and the words "under Article 4
9 of Chapter 108D of the General Statutes" shall be inserted after the words
10 "capitated contracts".
11 (9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of
12 S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not
13 codified:
14 a. The first and third sentences of subdivision (10).
15 b. The language in sub-subdivision a. appearing before
16 sub-sub-subdivision 1.
17 c. The word "currently" shall be removed from sub-sub-sub-subdivision
18 I. of sub-sub-subdivision 1. of sub-subdivision a.
19 d. Sub-sub-subdivision 6. of sub-subdivision a.
20 e. Sub-subdivisions b., c., and d.
21 (10) Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121,
22 Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as
23 G.S. 108D-65, except that the following are not codified:
24 a. Sub-subdivision d. of subdivision (6).
25 b. Subdivisions (10), (11), (12), and (13).
26 (11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is
27 codified as G.S. 108D-70.

28 **SECTION 14.(b)** In codifying the portions of S.L. 2015-245, as amended, that are
29 specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the
30 following:

- 31 (1) Replace references to DHHS with references to the Department or the
32 Department of Health and Human Services, as appropriate.
33 (2) Revise references to subdivision (3) of Section 4 of the session law to instead
34 reference the codified location of the language in subdivision (3) of Section 5
35 of the session law.

36 **SECTION 15.(a)** References to the Division of Medical Assistance, and any
37 derivatives thereof, in the General Statutes are replaced with references to the Division of Health
38 Benefits, except that references to the Division of Medical Assistance are not replaced in
39 G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

40 **SECTION 15.(b)** This section becomes effective July 1, 2019.

41 **SECTION 16.(a)** Except as otherwise provided, this act becomes effective October
42 1, 2019.

43 **SECTION 16.(b)** This section is effective when it becomes law.