Article 4.

Prepaid Health Plans.

§ 108D-30. Intent and Goals.

It is the intent of the General Assembly to transform the State's current Medicaid program in order to provide budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system. (2015-245, s. 1; 2019-81, s. 14(a); 2022-74, s. 9D.15(z); 2023-11, s. 3.2(e).)

§ 108D-35. Services covered by PHPs.

(a) Capitated PHP contracts shall cover all Medicaid services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services, except as otherwise provided in this section.

(b) The capitated contracts required by this section shall not cover any of the following:

(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:
   a. Inpatient behavioral health services.
   b. Outpatient behavioral health emergency room services.
   c. Outpatient behavioral health services provided by direct-enrolled providers.
   d. Mobile crisis management services.
   e. Facility-based crisis services for children and adolescents.
   f. Professional treatment services in a facility-based crisis program.
   g. Outpatient opioid treatment services.
   h. Ambulatory detoxification services.
   i. Nonhospital medical detoxification services.
   j. Partial hospitalization.
   k. Medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization.
   l. Research-based intensive behavioral health treatment.
   m. Diagnostic assessment services.
   n. Early and Periodic Screening, Diagnosis, and Treatment services.
   o. Peer support services.
   p. Behavioral health urgent care services.

   In accordance with this subdivision, 1915(b)(3) services shall not be covered under a standard benefit plan.
(2) Dental services.
(3) Services provided through the Program of All-Inclusive Care for the Elderly (PACE).

(4) Services documented in an 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 a local education agency, as defined in G.S. 115C-106.3.
(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 or by a provider contracted with a Children's Developmental Services Agency to provide those services.
(6) Services for Medicaid program applicants during the period of time prior to eligibility determination.
(7) The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. (2015-245, s. 4; 2016-121, s. 2(b); 2017-57, s. 11H.17(a); 2017-186, s. 4; 2018-48, s. 1; 2019-81, ss. 12, 14(a); 2021-62, ss. 3.2, 4.9(a); 2021-180, s. 9F.11(c); 2022-74, s. 9D.15(w).)

§ 108D-40. Populations covered by PHPs.

(a) Capitated PHP contracts shall cover all Medicaid program aid categories except for the following categories:

(1) Recipients who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing.
(2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.
(3) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.
(4) Medically needy Medicaid recipients.
(5) Recipients who meet the definition of Indian under 42 C.F.R. § 438.14(a) shall have the option to enroll voluntarily in PHPs.
(5a) Repealed by Session Laws 2021-62, s. 4.8(c), effective July 1, 2021.
(6) Presumptively eligible recipients, during the period of presumptive eligibility.
(7) Recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.
(8) Recipients enrolled under the Medicaid Family Planning program.
(9) Recipients who are inmates of prisons.
(10) Recipients being served through the Community Alternatives Program for Children (CAP/C).
(11) Recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
(12) 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 G.S. 108D-60(a)(10).

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 G.S. 108D-35(1) and would no longer have access to the behavioral health services excluded under G.S. 108D-35(1) and (ii) the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP. Recipients in this category shall include, at a minimum, recipients who meet any of the following criteria:

a. Individuals with a serious emotional disturbance or a diagnosis of severe substance use disorder or traumatic brain injury.
b. Individuals with a developmental disability as defined in G.S. 122C-3(12a).
c. Individuals with a mental illness diagnosis who also meet any of the following criteria:
    1. Individuals with serious mental illness or serious and persistent mental illness, as those terms are defined in the 2012 settlement agreement between the Department and the United States Department of Justice, including individuals enrolled in and served under the Transition to Community Living Initiative settlement agreement.
    2. Individuals with two or more psychiatric hospitalizations or readmissions within the prior 18 months.
    3. Individuals who have had two or more visits to the emergency department for a psychiatric problem within the prior 18 months, except as provided in this sub-subdivision. After any individual who is enrolled with a PHP has a second visit to the emergency department for a psychiatric problem within the prior 18 months, the individual shall remain enrolled with the PHP until the Department provides a comprehensive assessment to determine whether the individual should be disenrolled from the PHP and receive more comprehensive care through an LME/MCO or an entity operating a BH IDD tailored plan. This assessment shall be completed within 14 calendar days following discharge after the second visit. If the result of the assessment is that the individual does not meet the criteria for disenrolling from the PHP, then the individual shall not be included in the category of recipients with a serious mental illness for purposes of this subsection, unless the individual has a subsequent visit to the emergency department for a psychiatric problem within 12 months after completion of the assessment.
    4. Individuals known to the Department or an LME/MCO to have had one or more involuntary treatment episodes within the prior 18 months.
d. Individuals who, regardless of diagnosis, meet any of the following criteria:

1. Individuals who have had two or more episodes using behavioral health crisis services within the prior 18 months, except as provided in this sub-sub-subdivision. After any individual who is enrolled with a PHP experiences a second episode of behavioral health crisis, the individual shall remain enrolled with the PHP until the Department provides a comprehensive assessment to determine whether the individual should be disenrolled from the PHP and receive more comprehensive care through an LME/MCO or an entity operating a BH IDD tailored plan. This assessment shall be completed within 14 calendar days following discharge after the second episode using behavioral health crisis services. If the result of the assessment is that the individual does not meet the criteria for disenrolling from the PHP, then the individual shall not be included in the category of 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 for purposes of this subsection, unless the individual has a subsequent episode using behavioral health crisis services within 12 months after completion of the assessment.
2. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered through a standard benefit plan in accordance with G.S. 108D-35(1).
3. Individuals who are currently receiving or need to be receiving behavioral health, intellectual and developmental disability, or traumatic brain injury services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
4. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina.
5. Children aged zero to three years old with, or at risk for, developmental delay or disability.
6. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department of Health and Human Services.

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

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

b. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).

c. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

(b) If a recipient in any of the categories excluded from PHP coverage under G.S. 108D-40 is eligible to receive a service that is not available in the fee-for-service program but is offered by a PHP, the recipient may be enrolled in a PHP. (2015-245, s. 4; 2016-121, s. 2(b); 2018-48, s. 1; 2018-49, s. 5; 2019-81, ss. 12, 14(a); 2020-88, s. 12(b); 2021-62, s. 4.8(b), (c); 2022-74, ss. 9D.14(a), 9D.15(z).)

§ 108D-45. Number and nature of capitated PHP contracts.

The number and nature of the contracts required under G.S. 108D-65(3) shall be as follows:

(1) Four contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid recipients statewide.

(2) Up to 12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to G.S. 108D-65(2). Regional contracts shall be in addition to the four statewide contracts required under subdivision (1) of this section. Each regional contract shall provide coverage throughout the entire region for the Medicaid services required by G.S. 108D-35. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

(3) The limitations on the number of contracts established in this section shall not apply to BH IDD tailored plans described in G.S. 108D-60.

(4) Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State. (2015-245, s. 4; 2016-121, s. 2(b); 2018-48, s. 1; 2019-81, s. 14(a); 2022-74, s. 9D.15(z).)

§ 108D-50. Defined measures and goals.

The new delivery system and capitated PHP contracts shall be built on defined measures and goals for risk-adjusted health outcomes, quality of care, patient satisfaction, access, and cost. Each component shall be subject to specific accountability measures, including penalties. The Division of Health Benefits may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), or any others necessary to develop effective measures for outcomes and quality. (2015-245, s. 4; 2019-81, s. 14(a).)

§ 108D-55. Administrative functions.

PHPs shall be responsible for all administrative functions for recipients enrolled in their plan, including, but not limited to, claims processing, care and case management, grievances and appeals, and other necessary administrative services. (2015-245, s. 4; 2019-81, s. 14(a).)

§ 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:

(1) In the event of the discontinuation of the 1915(b)/(c) Waivers, the following essential components of the 1915(b)/(c) Waivers shall be included in the 1115 Waiver:

a. Entities operating BH IDD tailored plans shall authorize, pay for, and manage services offered under the 1915(b)/(c) Waivers, including coverage of 1915(b)(3) services, within their capitation payments.

b. Entities operating BH IDD tailored plans shall operate care coordination functions.

c. Entities operating BH IDD tailored plans shall oversee home and community based services.

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

e. Entities operating BH IDD tailored plans shall manage provider rates.

f. Entities operating BH IDD tailored plans shall provide Local Business Plans.

g. The State Consumer and Family Advisory Committees shall continue to operate and advise the Department and entities operating the BH IDD tailored plans.

(2) During the initial contract term for BH IDD tailored plans, an LME/MCO shall be the only entity that may operate a BH IDD tailored plan. LME/MCOs operating BH IDD tailored plans shall receive all capitation payments under the BH IDD tailored plan contracts. Entities operating BH IDD tailored plan contracts shall conduct care coordination administrative functions for all services offered through the BH IDD tailored plans, and shall bear all risk for service utilization. This subdivision shall not be construed to preclude an entity operating a BH IDD tailored plan from engaging in incentives, risk sharing, or other contractual arrangements.

(3) During the initial contract term for BH IDD tailored plans, BH IDD tailored plans shall be operated only by LME/MCOs that meet certain criteria established by the Department. Any LME/MCO desiring to operate a BH IDD tailored plan shall make an application to the Department in response to this set

of criteria. Approval to operate a BH IDD tailored plan will be contingent upon a comprehensive readiness review. The constituent counties of the existing LME/MCOs may change, or existing LME/MCOs may merge or be acquired by another LME/MCO, as allowed under Chapter 122C of the General Statutes, prior to operating a BH IDD tailored plan, provided that the Department ensures every county in the State is covered by an LME/MCO that operates a BH IDD tailored plan. The Department shall issue no more than seven and no fewer than five regional BH IDD tailored plan contracts and shall not issue any statewide BH IDD tailored plan contracts.

(4) After the term of the initial contracts for BH IDD tailored plans, BH IDD tailored plan contracts shall be the result of requests for proposals issued by the Department and the submission of competitive bids from nonprofit PHPs and entities operating the initial BH IDD tailored plan contracts.

(5) LME/MCOs operating BH IDD tailored plans shall contract with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract.

(6) [Reserved for future codification.]

(7) Entities authorized to operate BH IDD tailored plans shall be in compliance with applicable State law, regulations, and policy and shall meet certain criteria established by the Department. These criteria shall include the ability to coordinate activities with local governments, county departments of social services, the Division of Juvenile Justice of the Department of Public Safety, and other related agencies.

(8) BH IDD tailored plans shall cover the behavioral health, intellectual and developmental disability, and traumatic brain injury services excluded from standard benefit plan coverage under G.S. 108D-35(1) in addition to the services required to be covered by all PHPs under G.S. 108D-35.

(9) Entities authorized to operate BH IDD tailored plans shall continue to manage non-Medicaid behavioral health services funded with federal, State, and local funding in accordance with Chapter 122C of the General Statutes and other applicable State and federal law, rules, and regulations.

(10) Recipients described in G.S. 108D-40(a)(12) shall be automatically enrolled with an entity operating a BH IDD tailored plan and shall have the option to enroll with a PHP operating a standard benefit plan, provided that a recipient electing to enroll with a PHP operating a standard benefit plan would only have access to the behavioral health services covered by the standard benefit plans and would no longer have access to the behavioral health services excluded from standard benefit plan coverage under G.S. 108D-35(1) and provided that the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP operating a standard benefit plan.

(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 who are not enrolled in a BH IDD tailored plan. (2015-245, s. 4; 2018-48, s. 1; 2019-81, s. 14(a); 2021-62, s. 3.4A(a); 2022-74, ss. 9D.7(c), 9D.13(f); 2023-65, s. 5.1(b).)

§ 108D-65. Role of the Department.

The role and responsibility of the Department during Medicaid transformation shall include the following activities and functions:

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this Article within the required time frames.

(2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in G.S. 108D-30. Every county in the State must be assigned to a region.

(3) Oversee, monitor, and enforce capitated PHP contract performance.

(4) Ensure sustainability of the transformed Medicaid program.

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments, provided that capitated PHP contracts shall not require any withhold arrangements, as defined in 42 C.F.R. § 438.6, during the first 18 months of the demonstration. Any withhold arrangements required under a capitated PHP contract after the first 18 months of the demonstration shall not withhold an amount of a PHP's capitation payment that exceeds three and one-half percent (3.5%) of the PHP's total capitation payment. The Department shall not require community reinvestment as a condition for a PHP's receipt of any at-risk portion of the capitation rate.

b. Appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.

c. Rates for services in the remaining fee-for-service programs.

(6) Enter into capitated PHP contracts for the delivery of the Medicaid services described in G.S. 108D-35. All contracts shall be the result of requests for proposals (RFPs) issued by the Department and the submission of competitive bids by PHPs. The Department shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by the Department.

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to

be defined by the Department. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). The Department shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

d. [Reserved for future codification.]

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

f. Terms that, to the extent not inconsistent with federal law or regulations, or State law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these requirements shall be overseen and enforced by the Department. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

1. G.S. 58-3-190, Coverage required for emergency care, excluding subdivisions (3) and (4) of subsection (g).
2. G.S. 58-3-191, Managed care reporting and disclosure requirements.
3. G.S. 58-3-200(c), Miscellaneous insurance and managed care coverage and network provisions.
4. G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.
5. G.S. 58-3-225, Prompt claim payments under health benefit plans.
6. G.S. 58-3-227, Health plans fee schedules.
7. G.S. 58-3-231, Payment under locum tenens arrangements.
8. G.S. 58-50-26, Physician services provided by physician assistants.
9. G.S. 58-50-30, Right to choose services of certain providers.
10. G.S. 58-50-270, Definitions.
11. G.S. 58-50-275, Notice contact provision.
12. G.S. 58-50-280, Contract amendments.
13. G.S. 58-50-285, Policies and procedures.
14. G.S. 58-50-295, Prohibited contract provisions related to reimbursement rates.
15. G.S. 58-51-37, Pharmacy of choice. The requirements of this statute to be incorporated into capitated PHP contracts shall apply to all PHPs regardless of whether a PHP has its own facility, employs or contracts with physicians, pharmacists, nurses, or other health care personnel, and dispenses prescription drugs from its own pharmacy to enrollees.
16. G.S. 58-51-38, Direct access to obstetrician-gynecologists.
17. G.S. 58-67-88, Continuity of care.

This sub-subdivision shall not be construed to require the Department to utilize contract terms that would require PHPs to cover services that are not covered by the Medicaid program.

g. A requirement that all participation agreements between a PHP and a health care provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.

(7) Prior to issuing the RFPs [requests for proposals] required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint Legislative Oversight Committee on Medicaid on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

(8) Develop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.

(9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels. (2015-245, s. 5; 2016-121, s. 2(c); 2018-49, s. 6(b); 2019-81, ss. 13, 14(a), (b); 2022-74, s. 9D.15(z), (bb); 2023-7, s. 1.7(o); 2023-11, s. 3.2(h).)

§ 108D-70. Advanced Medical Homes.

PHPs shall be required to implement an Advanced Medical Home care management program but shall not be required to contract with any particular entity as an Advanced Medical Home. A PHP may contract with any entity to serve as an Advanced Medical Home or may create its own Advanced Medical Home care management program. (2018-49, s. 7; 2019-81, s. 14(a).)