

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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HOUSE BILL 403
Committee Substitute Favorable 3/29/17
Senate Health Care Committee Substitute Adopted 6/15/17
Senate Rules and Operations of the Senate Committee Substitute Adopted 6/28/17

Short Title: Behavioral Health and Medicaid Modifications.

(Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO MODIFY CERTAIN REQUIREMENTS PERTAINING TO LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, TO MODIFY THE MEDICAID TRANSFORMATION LEGISLATION, TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO NOTIFY THE GENERAL ASSEMBLY UPON THE SUBMISSION OR NONSUBMISSION OF A MEDICAID STATE PLAN AMENDMENT, AND TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH RECENT CHANGES TO FEDERAL LAW.

The General Assembly of North Carolina enacts:

PART I. LME/MCO MODIFICATIONS

SECTION 1.(a) The Department of Health and Human Services (DHHS) shall specify a single, nationally recognized, standardized electronic format to be used by all local management entities/managed care organizations (LME/MCOs) when submitting encounter data to DHHS. LME/MCOs must submit to DHHS encounter data, consisting of records of claims payments made to providers, for Medicaid and State-funded mental health, intellectual and developmental disabilities, and substance abuse disorder services utilizing the single, nationally recognized, standardized electronic format specified by DHHS.

SECTION 1.(b) DHHS may use encounter data submitted by LME/MCOs for all of the following purposes:

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

SECTION 1.(c) DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

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

SECTION 2.(a) G.S. 122C-112.1(a)(39) reads as rewritten:

"(39) Develop and use a standard ~~contract~~ contracts for all local management entity/managed care organizations for operation of the 1915(b)/(c) Medicaid



1 Waiver and management of State appropriations and federal block grant
 2 funds that requires compliance by each LME/MCO with all provisions of the
 3 ~~contract~~ contracts to operate the 1915(b)/(c) Medicaid Waiver and manage
 4 State appropriations and federal block grant funds and with all applicable
 5 provisions of State and federal law. Each of these standard contracts must
 6 include quality outcome measures for mental health, developmental
 7 disabilities, and substance use disorders."

8 **SECTION 2.(b)** This section becomes effective January 1, 2018, and applies to
 9 contracts entered into on or after that date.

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

11 **"§ 122C-3. Definitions.**

12 The following definitions apply in this Chapter:

- 13 (1) "Area authority" means the area mental health, developmental disabilities,
 14 and substance abuse authority.
- 15 (2) "Area board" means the area mental health, developmental disabilities, and
 16 substance abuse ~~board~~ board that is the governing body for the area
 17 authority, local management entity, or local management entity/managed
 18 care organization.
- 19 (2a) "Area director" means the administrative head of the area ~~authority program~~
 20 authority, local management entity, or local management entity/managed
 21 care organization appointed pursuant to G.S. 122C-121. All provisions of
 22 Chapter 122C of the General Statutes that apply to the area director also
 23 apply to the administrative head of the area authority, LME, or LME/MCO,
 24 regardless of whether (i) the administrative head uses the title "CEO" or any
 25 other name or title assigned to him or her by the area authority, LME, or
 26 LME/MCO and (ii) a contract, memorandum of understanding, or other
 27 agreement in effect between the Department and the area authority, LME, or
 28 LME/MCO refers to the administrative head as the "CEO" or any other
 29 name or title.
- 30 (2b) "Board of county commissioners" includes the participating boards of county
 31 commissioners for multicounty area ~~authorities~~ and ~~multicounty~~
 32 ~~programs~~ authorities.
- 33 ...
- 34 (5) "Catchment area" means the geographic part of the State served by a specific
 35 area ~~authority or county program~~ authority.
- 36 ...
- 37 (10a) ~~"County program" means a mental health, developmental disabilities, and~~
 38 ~~substance abuse services program established, operated, and governed by a~~
 39 ~~county pursuant to G.S. 122C-115.1.~~
- 40 ...
- 41 (14) "Facility" means any person at one location whose primary purpose is to
 42 provide services for the care, treatment, habilitation, or rehabilitation of the
 43 mentally ill, the developmentally disabled, or substance abusers, and
 44 includes:
 - 45 a. An "area facility", which is a facility that is operated by or under
 46 contract with the area ~~authority or county program~~ authority. For the
 47 purposes of this subparagraph, a contract is a contract, memorandum
 48 of understanding, or other written agreement whereby the facility
 49 agrees to provide services to one or more clients of the area ~~authority~~
 50 ~~or county program~~ authority. Area facilities may also be licensable

1 facilities in accordance with Article 2 of this Chapter. A State facility
 2 is not an area facility;

3 ...
 4 (20b) "Local management entity" or "LME" means an area ~~authority, county~~
 5 ~~program, or consolidated human services agency. It is a collective term that~~
 6 ~~refers to functional responsibilities rather than governance~~
 7 ~~structure.~~authority.

8 ...
 9 (29a) ~~"Program director" means the director of a county program established~~
 10 ~~pursuant to G.S. 122C-115.1.~~

11"
 12 **SECTION 4.** G.S. 122C-117 reads as rewritten:

13 **"§ 122C-117. Powers and duties of the area authority.**

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

15 ...
 16 (7) Appoint an area director in accordance with
 17 ~~G.S. 122C-121(d).~~G.S. 122C-121.

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

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

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

27 **SECTION 5.** G.S. 122C-124.1 reads as rewritten:

28 **"§ 122C-124.1. Actions by the Secretary upon area authority or area director failure to**
 29 **comply or when area authority or county program is not providing minimally**
 30 **adequate services.**

31 (a) Notice of Likelihood of Action. – When the Secretary determines that there is a
 32 likelihood of suspension of funding, assumption of service delivery or management functions,
 33 or appointment of a caretaker board under this section within the ensuing 60 days, the Secretary
 34 shall so notify in writing the area authority board ~~or the county program~~ and the board of
 35 county commissioners of the area ~~authority or county program~~authority. The notice shall state
 36 the particular deficiencies in program services or administration that must be remedied to avoid
 37 action by the Secretary under this section. The area authority board ~~or county program~~ shall
 38 have 60 days from the date it receives notice under this subsection to take remedial action to
 39 correct the deficiencies. The Secretary shall provide technical assistance to the area authority ~~or~~
 40 ~~county program~~ in remedying deficiencies.

41 (b) Suspension of Funding; Assumption of Service Delivery or Management Functions.
 42 – If the Secretary determines that ~~a county, through (i) an area authority or county program,~~
 43 area director has failed to comply with any requirement of State or federal law, rule, or
 44 regulation, or any requirement of the area authority's contract with the Department, or (ii) an
 45 area authority is not providing minimally adequate services to persons in need in a timely
 46 manner, or fails to demonstrate reasonable efforts to do so, then the Secretary, after providing
 47 written notification of the Secretary's intent to the area authority or county program and to the
 48 board of county commissioners of the area ~~authority or county program~~authority, and after
 49 providing the area authority ~~or county program~~ and the boards of county commissioners of the
 50 area authority ~~or county program~~ an opportunity to be heard, may:

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

5 Upon suspension of funding, the Department shall direct the
6 development and oversee implementation of a corrective plan of action and
7 provide notification to the area authority ~~or county program~~ and the board of
8 county commissioners of the area authority ~~or county program~~ of any
9 ongoing concerns or problems with the area authority's ~~or county program's~~
10 finances or delivery of services.

- 11 (2) Assume control of the particular service or management functions in
12 question or of the area authority ~~or county program~~ and appoint an
13 administrator to exercise the powers assumed. This assumption of control
14 shall have the effect of divesting the area authority ~~or county program~~ of its
15 powers in G.S. 122C-115.1 and G.S. 122C-117 and all other service delivery
16 powers conferred on the area authority ~~or county program~~ by law as they
17 pertain to this service or management function. County funding of the area
18 authority ~~or county program~~ shall continue when the State has assumed
19 control of the catchment area or of the area ~~authority or county~~
20 ~~program authority~~. At no time after the State has assumed this control shall a
21 county withdraw funds previously obligated or appropriated to the area
22 ~~authority or county program authority~~.

23 Upon assumption of control of service delivery or management
24 functions, the Department shall, in conjunction with the area ~~authority or~~
25 ~~county program authority~~, develop and implement a corrective plan of action
26 and provide notification to the area authority ~~or county program~~ and the
27 board of county commissioners of the area authority ~~or county program~~ of
28 the plan. The Department shall also keep the area authority board and the
29 board of county commissioners informed of any ongoing concerns or
30 problems with the delivery of services.

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

38 The Secretary may assign any of the powers and duties of the area director or program
39 director or of the area authority board or board of county commissioners of the area authority ~~or~~
40 ~~county program~~ pertaining to the operation of mental health, developmental disabilities, and
41 substance abuse services to the caretaker board or to the caretaker administrator as it deems
42 necessary and appropriate to continue to provide direct services to clients, including the powers
43 as to the adoption of budgets, expenditures of money, and all other financial powers conferred
44 on the area authority ~~or county program~~ by law pertaining to the operation of mental health,
45 developmental disabilities, and substance abuse services. County funding of the area authority
46 ~~or county program~~ shall continue when the State has assumed control of the financial affairs of
47 the program. At no time after the State has assumed this control shall a county withdraw funds
48 previously obligated or appropriated to the area ~~authority or county program authority~~. The
49 caretaker administrator and the caretaker board shall perform all of these powers and duties.
50 The Secretary may terminate the area director ~~or program director~~ when it appoints a caretaker
51 administrator. Chapter 150B of the General Statutes shall apply to the decision to terminate the

1 area ~~director or program~~ director. Neither party to any such contract shall be entitled to
2 damages. After a caretaker board has been appointed, the General Assembly shall consider, at
3 its next regular session, the future governance of the identified area ~~authority or county~~
4 ~~program authority.~~"

5 **SECTION 6.** G.S. 122C-151 reads as rewritten:

6 "**§ 122C-151. Responsibilities of those receiving appropriations.**

7 (a) All resources allocated to and received by any area authority and used for programs
8 of mental health, developmental disabilities, substance abuse or other related services are
9 subject to the conditions specified in this Article and to the rules of the Commission and the
10 Secretary and to the conditions of the ~~Memorandum of Agreement specified in G.S.~~
11 ~~122C-143.2, memorandum of agreement with the Secretary specified in G.S. 122C-115.2(d).~~
12 Area authorities shall not use any resources for any of the following expenses:

13 (1) Alcohol.

14 (2) First-class airfare.

15 (3) Charter flights.

16 (4) Holiday parties or similar social gatherings.

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

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

23 (1) Delay payments; and

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

27 **SECTION 7.(a)** The definitions in G.S. 122C-3 apply to this section.

28 **SECTION 7.(b)** The salary range for area directors, which was last updated by the
29 State Human Resources Commission in 2010, is void. The Office of State Human Resources
30 and the State Human Resources Commission shall revise and update the job description and
31 salary range for area directors as follows:

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

38 (2) No later than December 1, 2017, the Office of State Human Resources shall
39 recommend to the State Human Resources Commission a revision to the
40 salary range for area directors. In forming its recommendation, the Office of
41 State Human Resources shall conduct a market compensation study of
42 organizations nationwide with similar functions as the LME/MCOs and of
43 similar size, including number of covered lives, annual service expenditures,
44 and geographic service areas. The market compensation study shall include
45 both public and not-for-profit managed care organizations. In forming its
46 recommendation, the Office of State Human Resources shall seek input from
47 the Secretary of the Department of Health and Human Services and the
48 LME/MCO area boards.

49 (3) No later than March 1, 2018, the State Human Resources Commission shall
50 revise the salary range for area directors based on the recommendation of the
51 Office of State Human Resources. Once a new salary range for area directors

1 is adopted, the State Human Resources Commission shall inform each
2 LME/MCO's area board of the new salary range.

3 **SECTION 7.(c)** Beginning on the date this act becomes law, and until the Office of
4 State Human Resources and the State Human Resources Commission complete a revision and
5 update of the job description and salary range of the area directors as required by subsection (b)
6 of this section, the following shall occur:

7 (1) The LME/MCO area boards shall not authorize any increase in the salaries
8 of an area director. This section shall not be construed to prohibit an
9 LME/MCO from authorizing a salary pursuant to G.S. 122C-121(a1) to be
10 paid to an area director filling a vacant position after the date this act
11 becomes law.

12 (2) An LME/MCO area board shall not pay an area director a salary that
13 exceeds by more than thirty percent (30%) the average salary of the area
14 directors of the remaining LME/MCOs. For area directors who are under an
15 employment contract with an LME/MCO area board at the time this act
16 becomes law, the salary limitation required by this subdivision applies after
17 the end of the current contract period or upon amendment of the contract and
18 applies to extensions of those contracts.

19 **SECTION 7.(d)** After completion of the revision and update required by
20 subsection (b) of this section, each LME/MCO area board shall reestablish the salary for its
21 area director in accordance with G.S. 122C-121(a1). For area directors who are under an
22 employment contract with an LME/MCO area board at the time this act becomes law, any
23 salary reduction required by this subsection applies after the end of the current contract period
24 or upon amendment of the contract and applies to contract extensions.

25 **SECTION 7.(e)** After the date that the State Human Resources Commission
26 revises the salary range for area directors as required by subdivision (3) of subsection (b) of this
27 section and until four years after the date, Medicaid capitated contracts with Prepaid Health
28 Plans begin in accordance with S.L. 2015-245, as amended, the Office of State Human
29 Resources, at the discretion of the Director of the Office of State Human Resources, may
30 recommend to the State Human Resources Commission adjustments to the salary range for area
31 directors. In forming a recommendation under this subsection, the Office of State Human
32 Resources shall conduct a market compensation study of organizations nationwide with similar
33 functions as the LME/MCOs and of similar size, including number of covered lives, annual
34 service expenditures, and geographic service areas. The market compensation study shall
35 include both public and not-for-profit managed care organizations. In forming a
36 recommendation under this subsection, the Office of State Human Resources shall seek input
37 from the Secretary of the Department of Health and Human Services and the LME/MCO area
38 boards.

39 **SECTION 8.(a)** G.S. 122C-141(d)(1) reads as rewritten:

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

44 **SECTION 8.(b)** G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the
45 General Statutes are repealed.

46 **SECTION 8.(c)** The Revisor of Statutes shall delete every reference to
47 G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human
48 services agency" wherever they occur in Chapter 122C of the General Statutes.

49
50 **PART II. MEDICAID TRANSFORMATION MODIFICATIONS**

1 **SECTION 9.** Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L.
2 2016-121, reads as rewritten:

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

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

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

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

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

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

36 2. A majority of the entity's governing body is composed of
37 individuals who (i) are licensed in the State as physicians,
38 physician assistants, nurse practitioners, or psychologists and
39 (ii) have experience treating beneficiaries of the North
40 Carolina Medicaid program.

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

42 ...
43 (4) Services covered by PHPs. – Capitated PHP contracts shall cover all
44 Medicaid and NC Health Choice services, including physical health services,
45 prescription drugs, long-term services and supports, and behavioral health
46 services for NC Health Choice recipients, except as otherwise provided in
47 this subdivision. The capitated contracts required by this subdivision shall
48 not cover:

49 a. ~~Behavioral health—Medicaid services for Medicaid recipients~~
50 currently covered by the local management entities/managed care
51 organizations (LME/MCOs) for Medicaid recipients with a serious

- 1 mental illness, a serious emotional disturbance, a substance use
 2 disorder, an intellectual/developmental disability, or who have
 3 survived a traumatic brain injury for four years after the date
 4 capitated contracts begin.
- 5 ...
- 6 g. The fabrication of eyeglasses, including complete eyeglasses,
 7 eyeglass lenses, and ophthalmic frames."
- 8 (5) Populations covered by PHPs. – Capitated PHP contracts shall cover all
 9 Medicaid and NC Health Choice program aid categories except for the
 10 following categories:
- 11 a. Recipients who are dually eligible for Medicaid and ~~Medicare-~~
 12 Medicare for two years after the date capitated contracts begin.
 13 Recipients in the aged program aid category that are eligible for
 14 Medicare shall be considered recipients who are dually eligible for
 15 Medicaid and Medicare. ~~The Division of Health Benefits shall~~
 16 ~~develop a long term strategy to cover dual eligibles through capitated~~
 17 ~~PHP contracts, as required by subdivision (11) of Section 5 of this~~
 18 ~~act.~~ As recommended by DHHS in its "Report to the Joint Legislative
 19 Oversight Committee on Medicaid and NC Health Choice on the
 20 Managed Care Strategy for North Carolina Medicare-Medicaid Dual
 21 Eligible Beneficiaries" dated January 31, 2017, enrollment of dually
 22 eligible recipients shall begin two years after the date capitated
 23 contracts begin, may be phased as described in DHHS's January 31,
 24 2017, report, and shall be completed within two years after the date
 25 that dually eligible recipients are first enrolled with PHPs.
- 26 ...
- 27 h. Recipients enrolled under the Medicaid Family Planning program.
- 28 i. Recipients who are inmates of prisons.
- 29 (6) Number and nature of capitated PHP contracts. – The number and nature of
 30 the contracts required under subdivision (3) of this section shall be as
 31 follows:
- 32 a. ~~Three~~ No less than three and no more than five contracts between the
 33 Division of Health Benefits and PHPs to provide coverage to
 34 Medicaid and NC Health Choice recipients statewide (statewide
 35 contracts).
- 36 b. Up to ~~424~~ contracts between the Division of Health Benefits and
 37 PLEs for coverage of regions specified by the Division of Health
 38 Benefits pursuant to subdivision (2) of Section 5 of this act (regional
 39 contracts). Regional contracts shall be in addition to the three
 40 statewide contracts required under sub-subdivision a. of this
 41 subdivision. Each regional contract shall provide coverage
 42 throughout the entire region for the Medicaid and NC Health Choice
 43 services required by subdivision (4) of this section. A PLE may bid
 44 for more than one regional contract, provided that the regions are
 45 contiguous.
- 46 ...
- 47 (9) LME/MCOs. – LME/MCOs shall continue to manage the behavioral health
 48 services currently covered for their enrollees under all existing waivers,
 49 including the 1915(b) and (e) waivers, for ~~for~~ four years after the date
 50 capitated PHP contracts begin. ~~begin,~~ LME/MCOs shall continue to manage
 51 the Medicaid services that are currently covered by the LME/MCOs for

1 Medicaid recipients with a serious mental illness, a serious emotional
 2 disturbance, a substance use disorder, an intellectual/developmental
 3 disability, or who have survived a traumatic brain injury. Beginning on the
 4 date that capitated contracts begin, LME/MCOs shall cease managing
 5 Medicaid services for all other Medicaid recipients. During ~~this~~ the four-year
 6 period, period described in this subdivision, the Division of Health Benefits
 7 shall continue to negotiate actuarially sound capitation rates directly with the
 8 LME/MCOs in the same manner as currently utilized. LME/MCOs.
 9 Capitation payments under contracts between the Division of Health
 10 Benefits and the LME/MCOs shall be made directly to the LME/MCO by
 11 the Division of Health Benefits during the four-year period. No later than
 12 November 1, 2017, DHHS shall report to the Joint Legislative Oversight
 13 Committee on Medicaid and NC Health Choice with a plan for defining and
 14 determining whether a Medicaid recipient has a serious mental illness, a
 15 serious emotional disturbance, a substance use disorder, an
 16 intellectual/developmental disability, or has survived a traumatic brain
 17 injury. The report shall also include a plan for ensuring that recipients who
 18 experience a change in status appropriately transition between the
 19 LME/MCO delivery system and the PHP delivery system. No later than
 20 March 1, 2018, DHHS shall report to the Joint Legislative Oversight
 21 Committee on Medicaid and NC Health Choice with a plan for providing
 22 coordinated Medicaid services to the recipients described in sub-subdivision
 23 a. of subdivision (4) of this section."

24 **SECTION 10.** Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L.
 25 2016-121, reads as rewritten:

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

- 28 (1) Submit to CMS a demonstration waiver application pursuant to Section 1115
 29 of the Social Security Act and any other waivers and State Plan
 30 ~~amendments~~ amendments, as well as any modifications to these submissions,
 31 necessary to accomplish the requirements of this act within the required time
 32 frames. If DHHS submits any modification to these submissions, DHHS
 33 shall provide notice in accordance with G.S. 108A-54.1A(d1).
 34 (2) Define ~~six~~ regions comprised of whole contiguous counties that reasonably
 35 distribute covered populations across the State to ensure effective delivery of
 36 health care and achievement of the goals of Medicaid transformation set
 37 forth in Section 1 of this act. Every county in the State must be assigned to a
 38 region.
 39 ...
 40 (14) Study options for capitating Medicaid payments for dental services as part of
 41 the transformed Medicaid delivery system, including adding dental services
 42 coverage to capitated contracts or entering into capitated contracts with
 43 prepaid dental plans. No later than March 1, 2018, DHHS shall report
 44 findings and recommendations on the options considered as well as any
 45 proposed legislation related to the findings and recommendations."

46
 47 **PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS**

48 **SECTION 11.** G.S. 108A-54.1A reads as rewritten:

49 **"§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

50 (a) The Department of Health and Human Services is expressly authorized and required
 51 to take any and all necessary action to amend the State Plan and waivers in order to keep the

1 program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of
 2 this section, the term "amendments to the State Plan" includes State Plan amendments,
 3 Waivers, and Waiver amendments.

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

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

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

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

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

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

27 **SECTION 12.** This Part is effective when it becomes law and applies to
 28 amendments to the State Plan posted on the Department of Health and Human Services Web
 29 site on or after that date.

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

32 **SECTION 13.** G.S. 108D-1 reads as rewritten:

33 **"§ 108D-1. Definitions.**

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

36 (1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

37 ~~(1)~~(1a) Applicant. – A provider of mental health, intellectual or developmental
 38 disabilities, and substance abuse services who is seeking to participate in the
 39 closed network of one or more local management entity/managed care
 40 organizations.

41 (2) Closed network. – The network of providers that have contracted with a
 42 local management entity/managed care organization to furnish mental
 43 health, intellectual or developmental disabilities, and substance abuse
 44 services to enrollees.

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

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

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

- 1 (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
 2 (7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local
 3 management entity/managed care organization.
 4 (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
 5 (9) Local Management Entity/Managed Care Organization or LME/MCO. – As
 6 defined in G.S. 122C-3(20c).
 7 ~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~
 8 (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
 9 (12) Mental health, intellectual or developmental disabilities, and substance abuse
 10 services or MH/IDD/SA services. – Those mental health, intellectual or
 11 developmental disabilities, and substance abuse services covered under a
 12 contract in effect between the Department of Health and Human Services
 13 and a local management entity to operate a managed care organization or
 14 prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver
 15 approved by the federal Centers for Medicare and Medicaid Services (CMS).
 16 (13) Network provider. – An appropriately credentialed provider of mental
 17 health, intellectual or developmental disabilities, and substance abuse
 18 services that has entered into a contract for participation in the closed
 19 network of one or more local management entity/managed care
 20 organizations.
 21 (14) Notice of ~~managed care action~~adverse benefit determination. – The notice
 22 required by 42 C.F.R. § 438.404.
 23 (15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).
 24 (16) OAH. – The North Carolina Office of Administrative Hearings.
 25 (17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.
 26 (18) Provider of emergency services. – A provider that is qualified to furnish
 27 emergency services to evaluate or stabilize an enrollee's emergency medical
 28 condition."

29 **SECTION 14.** G.S. 108D-12(a) reads as rewritten:

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

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

36 **"§ 108D-13. Standard LME/MCO level appeals.**

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

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

48 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
 49 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
 50 § 438.420.

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

5 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
6 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
7 hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the
8 appeal procedures described in this section or ~~G.S. 108D-14~~.G.S. 108D-14 or (ii) the enrollee
9 has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. §
10 438.408(c)(3).

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

14 **SECTION 16.** G.S. 108D-14 reads as rewritten:

15 "**§ 108D-14. Expedited LME/MCO level appeals.**

16 (a) Request for Expedited Appeal. – When the time limits for completing a standard
17 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or
18 regain maximum function, an enrollee, or a network provider authorized in writing to act on
19 behalf of an enrollee, has the right to file a request for an expedited appeal of ~~a managed care~~
20 ~~action-an adverse benefit determination~~ no later than 30 days after the mailing date of the notice
21 of ~~managed care action-adverse benefit determination~~. For expedited appeal requests made by
22 enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For
23 expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO
24 shall presume an expedited appeal is necessary.

25 ...

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

32 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
33 authorized in writing to act on behalf of an enrollee, may file a request for a contested case
34 hearing under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the
35 appeal procedures described in G.S. 108D-13 or this ~~section-section~~ or (ii) the enrollee has been
36 deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. §
37 438.408(c)(3).

38"

39 **SECTION 17.** G.S. 108D-15 reads as rewritten:

40 "**§ 108D-15. Contested case hearings on disputed managed care actions.**

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

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

48 ...

49 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
50 on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that
51 meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by

1 no later than ~~30~~120 days after the mailing date of the notice of resolution. A request for appeal
2 is deemed filed when a completed and signed appeal request form has been both submitted into
3 the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings
4 clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of
5 resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of
6 the notice of resolution to OAH electronically. OAH may dispose of these records after one
7 year.

8 ...

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

- 13 (1) A statement that in order to request an appeal, the enrollee must file the form
14 in accordance with OAH rules, by mail or fax to the address or fax number
15 listed on the form, by no later than 30 days after the mailing date of the
16 notice of resolution.
- 17 (2) The enrollee's name, address, telephone number, and Medicaid identification
18 number.
- 19 (3) A preprinted statement that indicates that the enrollee would like to appeal a
20 specific ~~managed care action~~adverse benefit determination identified in the
21 notice of resolution.
- 22 (4) A statement informing the enrollee of the right to be represented at the
23 contested case hearing by a lawyer, a relative, a friend, or other
24 spokesperson.
- 25 (5) A space for the enrollee's signature and date.

26 ...

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

40 ...

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

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

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

9"

10 **SECTION 18.** This Part is effective when it becomes law and applies to notices of
11 adverse benefit determination and notices of resolution mailed on or after that date and to
12 requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

13
14 **PART V. EFFECTIVE DATE**

15 **SECTION 19.** Except as otherwise provided, this act is effective when it becomes
16 law.