**GENERAL ASSEMBLY OF NORTH CAROLINA**
**SESSION 2017**

**H** **D**

# HOUSE BILL 403

**Committee Substitute Favorable 3/29/17**
**PROPOSED SENATE COMMITTEE SUBSTITUTE H403-CSTR-6 [v.12]**
**06/13/2017 5:58:12 PM**

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 NON-SUBMISSION 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.** On the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin, as required by S.L. 2015-245, all of the following shall occur:

(1) PHPs shall manage all publicly-funded behavioral health services currently managed by the local management entities/managed care organizations (LME/MCOs) under contracts with the Department of Health and Human Services (DHHS).

(2) The LME/MCOs shall be dissolved.

(3) All remaining assets of the LME/MCOs, including all funds in the Medicaid risk reserve account shall be transferred to DHHS to be used to satisfy the liabilities of the LME/MCOs and for costs of the contracts with PHPs for the management of publicly-funded behavioral health services. In the event there are insufficient assets to satisfy the liabilities of the LME/MCOs, it shall be the responsibility of the Secretary to satisfy the liabilities of the LME/MCOs or arrange for the transfer of those liabilities to PHPs.

**SECTION 2.(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 2.(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 2.(c)** DHHS shall work with LME/MCOs to ensure that the process for submitting encounter claims through NCTracks is successful.

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

**SECTION 3.(b)** This section is effective January 1, 2018 and applies to contracts entered into on or after that date.

**SECTION 4.** G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

(1) "Area authority" means the area mental health, developmental disabilities, and substance abuse authority.
(2) "Area board" means the area mental health, developmental disabilities, and substance abuse ~~board.~~board that is the governing body for the area authority, local management entity, or local management entity/managed care organization.
(2a) "Area director" means the administrative head of the area ~~authority program~~ authority, local management entity, or local management entity/managed care organization appointed pursuant to G.S. 122C-121. All provisions of Chapter 122C of the General Statutes that apply to the area director also apply to the administrative head of the area authority, LME, or LME/MCO, regardless of whether (i) the administrative head uses the title "CEO" or any other name or title assigned to him or her by the area authority, LME, or LME/MCO and (ii) a contract, memorandum of understanding, or other agreement in effect between the Department and the area authority, LME, or LME/MCO refers to the administrative head as the "CEO" or any other name or title.
(2b) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area ~~authorities and multicounty programs.~~authorities.
…
(5) "Catchment area" means the geographic part of the State served by a specific area ~~authority or county program.~~ authority.
…

~~(10a) "County program" means a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county pursuant to G.S. 122C-115.1.~~

…

(14) "Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area ~~authority or county program.~~authority. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more clients of the area ~~authority or county program.~~authority. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

…

…

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

…

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

…."

**SECTION 5.** G.S. 122C-117 reads as rewritten:

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

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

…

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

…

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

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

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

**SECTION 6.** G.S. 122C-124.1 reads as rewritten:

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

(a) Notice of Likelihood of Action. – When the Secretary determines that there is a likelihood of suspension of funding, assumption of service delivery or management functions, or appointment of a caretaker board under this section within the ensuing 60 days, the Secretary shall so notify in writing the area authority board ~~or the county program~~ and the board of county commissioners of the area ~~authority or county program.~~authority. The notice shall state the particular deficiencies in program services or administration that must be remedied to avoid

action by the Secretary under this section. The area authority board ~~or county program~~ shall have 60 days from the date it receives notice under this subsection to take remedial action to correct the deficiencies. The Secretary shall provide technical assistance to the area authority ~~or county program~~ in remedying deficiencies.

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

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

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

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

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

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

The Secretary may assign any of the powers and duties of the area director or program director or of the area authority board or board of county commissioners of the area authority ~~or county program~~ pertaining to the operation of mental health, developmental disabilities, and substance abuse services to the caretaker board or to the caretaker administrator as it deems necessary and appropriate to continue to provide direct services to clients, including the powers as to the adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority ~~or county program~~ by law pertaining to the operation of mental health, developmental disabilities, and substance abuse services. County funding of the area authority ~~or county program~~ shall continue when the State has assumed control of the financial affairs of the program. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area ~~authority or county program.~~ authority. The caretaker administrator and the caretaker board shall perform all of these powers and duties. The Secretary may terminate the area director ~~or program director~~ when it appoints a caretaker administrator. Chapter 150B of the General Statutes shall apply to the decision to terminate the area ~~director or program~~ director. Neither party to any such contract shall be entitled to damages. After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area ~~authority or county program.~~authority."

**SECTION 7.** G.S. 122C-151 reads as rewritten:

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

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

(1) Alcohol.
(2) First-class airfare.
(3) Charter flights.
(4) Holiday parties or similar social gatherings.
(5) Any meeting, whether a formal public meeting or an informal retreat, of the area board outside of the State.

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

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

**SECTION 8.(a)** The definitions in G.S. 122C-3 apply to this section.

**SECTION 8.(b)** The Office of State Human Resources and the State Human Resources Commission shall revise and update the job description and salary range for area directors as follows:

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

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

(3) No later than March 1, 2018, the State Human Resources Commission shall revise the salary range for area directors based on the recommendation of the Office of State Human Resources. Once a new salary range for area directors is adopted, the State Human Resources Commission shall inform each LME/MCO's area board of the new salary range.

**SECTION 8.(c)** The salary range for area directors, which was last updated by the State Human Resources Commission in 2010, is void. Beginning on the date this act becomes law, the LME/MCO area boards shall not authorize any increase in the salaries of an area director until the Office of State Human Resources and the State Human Resources Commission complete a revision and update of the job description and salary range of the area directors as required by subsection (b) of this section. This section shall not be construed to prohibit an LME/MCO from authorizing a salary pursuant to G.S. 122C-121(a1) to be paid to an area director filling a vacant position after the date this act becomes law.

**SECTION 8.(d)** After completion of the revision and update required by subsection (b) of this section, each LME/MCO area board shall reestablish the salary for its area director in accordance with G.S. 122C-121(a1). This subsection applies to contracts with area directors beginning on or after the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section.

**SECTION 8.(e)** After the date that the State Human Resources Commission revises the salary range for area directors as required by subdivision (3) of subsection (b) of this section and until the LME/MCOs are dissolved pursuant to Section 1 of this act, the Office of State Human Resources, at the discretion of the Director of the Office of State Human Resources, may recommend to the State Human Resources Commission adjustments to the salary range for area directors. In forming a recommendation under this subsection, the Office of State Human Resources shall conduct a market compensation study of organizations nationwide with similar functions as the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographic service areas. The market compensation study shall include both public and not-for-profit managed care organizations. In forming a recommendation under this subsection, the Office of State Human Resources shall seek input from the Secretary of the Department of Health and Human Services and the LME/MCO area boards.

**SECTION 9.(a)** G.S. 122C-141(d)(1) reads as rewritten:

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

**SECTION 9(b).** G.S. 122C-115.1 and Part 2A of Article 4 of Chapter 122C of the General Statutes are repealed.

**SECTION 9(c).** The Revisor of Statutes shall delete every reference to G.S. 122C-115.1, G.S. 122C-127, and the phrases "county program" and "consolidated human services agency" wherever they occur in Chapter 122C of the General Statutes.

**PART II. MEDICAID TRANSFORMATION MODIFICATIONS**

**SECTION 10.** Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, reads as rewritten:

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

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

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

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

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

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

2. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have sufficient experience treating beneficiaries of the North Carolina Medicaid ~~program.~~ program, as determined by the Secretary of DHHS.

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

…

(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. Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) for four years after the date capitated contracts begin.~~

~~b. Dental services~~.

…

g. The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames."

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

a. Recipients who are dually eligible for Medicaid and ~~Medicare.~~ Medicare for two years after the date capitated contracts begin. Recipients in the aged program aid category that are eligible for Medicare shall be considered recipients who are dually eligible for Medicaid and Medicare. ~~The Division of Health Benefits shall develop a long-term strategy to cover dual eligibles through capitated PHP contracts, as required by subdivision (11) of Section 5 of this act.~~ As recommended by DHHS in its "Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on the Managed Care Strategy for North Carolina Medicare-Medicaid Dual Eligible Beneficiaries" dated January 31, 2017, enrollment of dually eligible recipients shall begin two years after the date capitated contracts begin, may be phased as described in DHHS's January 31, 2017 report, and shall be completed within two years after the date that dually eligible recipients are first enrolled with PHPs.

…

h. Recipients enrolled under the Medicaid Family Planning program.

i. Recipients who are inmates of prisons.

(6) Number and nature of capitated PHP contracts. – The number and nature of the contracts required under subdivision (3) of this section shall be as follows:

a. ~~Three~~ No less than three and no more than five contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid and NC Health Choice recipients statewide (statewide contracts).

b. Up to ~~12~~ 4 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to subdivision (2) of Section 5 of this act (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for the Medicaid and NC Health Choice services required by subdivision (4) of this section. A PLE may bid for more than one regional contract, provided that the regions are contiguous.

…

(6a) ~~To the extent allowed by Medicaid federal law and regulations and consistent with the requirements of this act,~~ PHPs shall comply with the requirements of ~~Chapter 58 of the General Statutes.~~ of Part 438 of Title 42 of the Code of Federal Regulations.~~This requirement shall not be construed to require PHPs to cover services that are not covered by the Medicaid program pursuant to federal law and regulations.~~ The Department of Health and Human Services, Division of Health Benefits, and the Department of Insurance shall jointly review the applicability of provisions of Chapter 58 of the General Statutes to PHPs, and report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016, on the following:

a. Proposed exceptions to the applicability of Chapter 58 of the General Statutes for PHPs.

b. Recommendations for resolving conflicts between Chapter 58 of the General Statutes and the requirements of Medicaid federal law and regulations.

c. Proposed statutory changes necessary to implement this subdivision.

…

~~(9) LME/MCOs. LME/MCOs shall continue to manage the behavioral health services currently covered for their enrollees under all existing waivers, including the 1915(b) and (c) waivers, for four years after the date capitated PHP contracts begin. During this four-year period, the Division of Health Benefits shall continue to negotiate actuarially sound capitation rates directly with the LME/MCOs in the same manner as currently utilized. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits during the four-year period.~~"

**SECTION 11.** Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS 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~~ amendments, as well as any modifications to these submissions, necessary to accomplish the requirements of this act within the required time frames. If DHHS submits any modification to these submissions, DHHS shall provide notice in accordance with G.S. 108A-54.1A(d1).

(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 Section 1 of this act. Every county in the State must be assigned to a region.

…

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

…

d. A requirement that PHPs develop and maintain provider networks that meet access to care requirements for their enrollees. PHPs may

not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, PHPs must include all providers in their geographical coverage area that are designated essential providers by DHHS pursuant to subdivision (13) of this section, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers. PHPs and hospitals must negotiate mutually acceptable rates, methods, and terms of payment.

d1. A requirement that the negotiated payments to hospitals may not exceed one hundred twenty-five percent (125%) of the fee-for-service Medicaid rate unless specifically approved by DHHS.

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

…

(7a) Require providers enrolling or reenrolling as a Medicaid or NC Health Choice provider to agree to accept ninety percent (90%) of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with a PHP but the provider is not under a contract with that PHP, or if the provider is excluded from contracting with the PHP for failure to meet objective quality standards. DHHS shall implement this requirement within 30 days after this subdivision becomes law, unless a waiver by the Centers for Medicare and Medicaid Services is required as provided in 42 C.F.R. 431.55(f). If a waiver is required, DHHS shall implement this requirement upon CMS's approval of that waiver.

…."

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

**SECTION 12.** G.S. 108A-54.1A reads as rewritten:

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

(a) The Department of Health and Human Services is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget, except as provided in G.S. 108A-54(f). For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.

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

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

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

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

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

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

**SECTION 13.** This Part is effective when it becomes law and applies to amendments to the State Plan posted on the Department of Health and Human Services Web site on or after that date.

## PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

**SECTION 14.** G.S. 108D-1 reads as rewritten:

"**§ 108D-1. Definitions.**

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

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

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

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

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

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

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

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

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local management entity/managed care organization.

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

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

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

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

(12) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed

network of one or more local management entity/managed care organizations.

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

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

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

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

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

**SECTION 15.** G.S. 108D-12(a) reads as rewritten:

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

**SECTION 16.** G.S. 108D-13 reads as rewritten:

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

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

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

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

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

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

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

**SECTION 17.** G.S. 108D-14 reads as rewritten:

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

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

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

...

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

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

...."

**SECTION 18.** G.S. 108D-15 reads as rewritten:

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

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

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

...

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

...

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

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

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

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

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

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

...

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

...

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

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

(1) Exceeded its authority or jurisdiction.

(2) Acted erroneously.

(3) Failed to use proper procedure.

(4) Acted arbitrarily or capriciously.

(5) Failed to act as required by law or rule.

...."

**SECTION 19.** This Part is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

**PART V. EFFECTIVE DATE**

**SECTION 20.** Except as otherwise provided, this act is effective when it becomes law.