GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

H **D**

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
Proposed Conference Committee Substitute H403-PCCS10514-TR-21

Short Title: Medicaid and Behavioral Health Modifications. (Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

SECTION 1. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, and Section 4 of S.L. 2017-186, 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:

…

(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 operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this ~~section.~~section, or a local management entity/managed care organization (LME/MCO) that operates or will operate a BH IDD Tailored Plan pursuant to subdivision (10) 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.

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 experience treating beneficiaries of the North Carolina Medicaid program.

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~~ services currently covered by the local management entities/managed care organizations (LME/MCOs) ~~for four years after the date capitated contracts begin.~~shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan.

…

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

…

h. Recipients enrolled under the Medicaid Family Planning program.

i. Recipients who are inmates of prisons.

j. Recipients being served through the Community Alternatives Program for Children (CAP/C).

k. Recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).

l. Recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact, until BH IDD Tailored Plans become operational, at which time this population will be enrolled with a BH IDD Tailored Plan in accordance with sub-sub-subdivision 10. of sub-subdivision a. of subdivision (10) of this section. Recipients in this category shall have the option to voluntarily enroll with a PHP, provided that (i) a recipient

electing to enroll with a PHP would only have access to the behavioral health services covered by PHPs according to sub-subdivision a. of subdivision (4) of this section and would no longer have access to the behavioral health services excluded under sub-subdivision a. of subdivision (4) of this section and (ii) the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP. Recipients in this category shall include, at a minimum, recipients who meet any of the following criteria:

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

I. Individuals who have had two or more episodes using behavioral health crisis services within the prior 18 months, except as provided in this sub-sub-sub-subdivision. After any individual who is enrolled with a PHP experiences a second episode of behavioral health crisis, the individual shall remain enrolled with the PHP until DHHS provides a comprehensive assessment to determine whether the individual should be disenrolled from the PHP and receive more comprehensive care through an LME/MCO or an entity operating a BH IDD Tailored Plan. This assessment shall be completed within 14 calendar days following discharge after the second episode using behavioral health crisis services. If the result of the assessment is that the individual does not meet the criteria for disenrolling from the PHP, then the individual shall not be included in the category of recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact for purposes of this subdivision, unless the individual has a subsequent episode using behavioral health crisis services within 12 months after completion of the assessment.

II. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are currently covered by LME/MCOs and that shall not be covered through any capitated PHP contract other than a BH IDD Tailored Plan in accordance with sub-subdivision a. of subdivision (4) of this section.

III. Individuals who are currently receiving or need to be receiving behavioral health, intellectual and developmental disability, or traumatic brain injury services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.

IV. Children with complex needs, as that term is defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina.

V. Children aged zero to three years old with, or at risk for, developmental delay or disability.

VI. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by DHHS.

(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~~Four 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 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~~four 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.

b1. The limitations on the number of contracts established in this subdivision shall not apply to BH IDD Tailored Plans described in subdivision (10) of this section.

c. Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State.

…

(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~~ Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., and *l.* of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are currently covered by the LME/MCOs for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., and *l.* of subdivision (5) of this section.

b. 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.~~based on the change in composition of the population being served by the LME/MCOs.

c. 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.~~Benefits.

(10) BH IDD Tailored Plans. – DHHS shall not begin any application process to implement, establish rules for, or begin any contracting or procurement process with respect to BH IDD Tailored Plans, as defined in this subdivision, until August 31, 2018, or until authorized to do so in a subsequent act of the General Assembly, whichever comes first. BH IDD Tailored Plans shall be defined as capitated PHP contracts that meet all requirements in this act pertaining to capitated PHP contracts, except as specifically provided in this subdivision. Capitated PHP contracts that are not BH IDD Tailored Plans shall

be referred to as Standard Benefit Plans. With regard to BH IDD Tailored Plans, the following shall occur:

a. DHHS shall create a detailed plan for implementation of BH IDD Tailored Plans under the 1115 Waiver in accordance with the following requirements:

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

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

II. Entities operating BH IDD Tailored Plans shall operate care coordination functions.

III. Entities operating BH IDD Tailored Plans shall oversee home and community-based services.

IV. Entities operating BH IDD Tailored Plans shall maintain closed provider networks for behavioral health, intellectual and developmental disability, and traumatic brain injury services and shall ensure network adequacy.

V. Entities operating BH IDD Tailored Plans shall manage provider rates.

VI. Entities operating BH IDD Tailored Plans shall provide Local Business Plans.

VII. The State Consumer and Family Advisory Committees shall continue to operate and advise DHHS and entities operating the BH IDD Tailored Plans.

2. During the contract term of the initial contracts for BH IDD Tailored Plans to begin one year after the implementation of the first contracts for Standard Benefit Plans and to last four years, an LME/MCO shall be the only entity that may operate a BH IDD Tailored Plan. LME/MCOs operating BH IDD Tailored Plans shall receive all capitation payments under the BH IDD Tailored Plan contracts. Entities operating BH IDD Tailored Plan contracts shall conduct care coordination administrative functions for all services offered through the BH IDD Tailored Plans, and shall bear all risk for service utilization. This sub-sub-subdivision shall not be construed to preclude an entity operating a BH IDD Tailored Plan from engaging in incentives, risk sharing, or other contractual arrangements.

3. During the contract term of the initial contracts for BH IDD Tailored Plans to begin one year after the implementation of the first contracts for Standard Benefit Plans and to last four years, BH IDD Tailored Plans shall be operated only by LME/MCOs that meet certain criteria established by DHHS. Any LME/MCO desiring to operate a BH IDD Tailored Plan will make an application to DHHS in response to this set of criteria. Approval to operate a BH IDD Tailored Plan will be

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

4. After the term of the initial contracts for BH IDD Tailored Plans to last four years, BH IDD Tailored Plan contracts will be the result of RFPs issued by DHHS and the submission of competitive bids from nonprofit PHPs and entities operating the initial BH IDD Tailored Plan contracts.

5. LME/MCOs operating BH IDD Tailored Plans shall contract with an entity that holds a PHP license and that covers the services required to be covered under a Standard Benefit Plan contract.

6. Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services, notwithstanding sub-subdivision d. of subdivision (6) of Section 5 of this act.

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

8. BH IDD Tailored Plans shall cover the behavioral health, intellectual and developmental disability, and traumatic brain injury services excluded from Standard Benefit Plan coverage under sub-subdivision a. of subdivision (4) of this section, in addition to the services required to be covered by all PHPs under subdivision (4) of this section.

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

10. Recipients described in sub-subdivision *l.* of subdivision (5) of this section shall be automatically enrolled with an entity operating a BH IDD Tailored Plan and shall have the option to enroll with a PHP operating a Standard Benefit Plan, provided that a recipient electing to enroll with a PHP operating a Standard Benefit Plan would only have access to the behavioral health services covered by the Standard Benefit Plans and would no longer have access to the behavioral health services excluded from Standard Benefit Plan coverage under

sub-subdivision a. of subdivision (4) of this section, and provided that the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP operating a Standard Benefit Plan.

b. No later than June 22, 2018, DHHS shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with a plan for the implementation of BH IDD Tailored Plans. At a minimum, the report shall contain the following:

1. The date when BH IDD Tailored Plans are planned to be operational.
2. The proposed parameters for contracts between LME/MCOs and partnering entities to operate a BH IDD Tailored Plan, including, but not limited to, incentive arrangements for providing integrated care and for achieving measurable outcomes, and strategies to minimize cost-shifting between the LME/MCO and the partnering entity.
3. Proposed language for any legislative changes needed to implement the plan.
4. A detailed description of the process by which recipients will be able to transition between BH IDD Tailored Plans and Standard Benefit Plans. At a minimum, this process must include the following:
   I. The proposed definition for a qualifying event, after which a Standard Benefit Plan enrollee would be eligible to enroll with a BH IDD Tailored Plan, and the proposed process for rapid enrollment in a BH IDD Tailored Plan after a qualifying event.
   II. A process for the periodic evaluation of BH IDD Tailored Plan enrollees with criteria to determine whether enrollees continue to require the comprehensive services managed by the BH IDD Tailored Plans or whether their needs can be adequately met through coverage by a Standard Benefit Plan.
   III. A detailed description of the process and criteria to be used for the assessments that are required under sub-subdivision *l.* of subdivision (5) of this section of individuals after their second visit to an emergency department for a psychiatric problem within the prior 18 months or after their second episode using behavioral health crisis services within the prior 18 months.
   IV. The manner by which a recipient's continuation of care shall be ensured when the recipient transitions between BH IDD Tailored Plans and Standard Benefit Plans or between Standard Benefit Plans and BH IDD Tailored Plans. This process should include a consideration of the maintenance of the recipient's care providers as well as any prior authorization approvals existing prior to the recipient transitioning between these two plans.
5. An estimate of State spending under the 1115 Waiver if BH IDD Tailored Plans are implemented compared to an estimate

of State spending under the 1115 Waiver if BH IDD Tailored Plans are not implemented.

6. Specific measureable outcomes, along with a time frame for the achievement of each measureable outcome, to be included in the capitated PHP contracts for BH IDD Tailored Plans.

7. A description of the solvency requirements for LME/MCOs operating BH IDD Tailored Plans describing how the solvency requirements relate to the solvency standards for PHPs set by the Department of Insurance under Section 6 of this act and how they relate to the solvency standards for LME/MCOs.

8. Any anticipated barriers to the ability of BH IDD Tailored Plans to meet the standardized contract terms described in subdivision (6) of Section 5 of this act.

9. Justification and proposed guidelines for the management of the closed provider networks utilized by the BH IDD Tailored Plans as required by sub-sub-subdivision 6. of sub-subdivision a. of this subdivision.

10. A plan for adding recipients who are being served through the CAP/C program to the populations covered by BH IDD Tailored Plans.

11. A plan for transitioning children aged zero to three years old with, or at risk for, developmental delay or disability.

12. A plan for adding coverage, under BH IDD Tailored Plans or another specialty plan, of all recipients who are enrolled in the foster care system, who are enrolled in Medicaid under the former foster care eligibility category, who receive Title IV-E Adoption Assistance, or who are under the age of 26 and formerly received Title IV-E Adoption Assistance. This plan shall include assurances that these recipients will be supported in instances when they have a change in residence.

c. After receiving the report required by sub-subdivision b. of this subdivision, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice may recommend that the General Assembly consider proposed legislation during the 2018 Regular Session containing any modifications to the law that are necessary to implement BH IDD Tailored Plans.

d. Beginning August 31, 2018, or when authorized by a subsequent act of the General Assembly, whichever comes first, DHHS is authorized to take any actions necessary to implement BH IDD Tailored Plans in accordance with all the requirements in this act, including all the requirements enumerated under sub-subdivision a. of this subdivision."

SECTION 2. This act is effective when it becomes law.