

Chapter 108D.
Medicaid and NC Health Choice Managed Care Programs.

Article 1.

General Provisions.

§ 108D-1. Definitions.

The following definitions apply in this Chapter:

- (1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).
- (2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.
- (3) Applicant. – A provider who is seeking to participate in the network of one or more local management entity/managed care organizations or prepaid health plans.
- (4) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD tailored plans.
- (5) Beneficiary. – A person to whom or on whose behalf medical assistance is granted under Article 2 of Chapter 108A of the General Statutes.
- (6) Repealed by Session Laws 2022-74, s. 9D.13(c), effective July 1, 2022.
- (6a) CMS. – The Centers for Medicare and Medicaid Services.
- (7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-5.9 or G.S. 108D-15.
- (8) Department. – The North Carolina Department of Health and Human Services.
- (9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- (12) Emergency services. – As defined in 42 C.F.R. § 438.114.
- (13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care organization or a prepaid health plan.
- (14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).
- (16) Fee-for-service program. – A payment model for the Medicaid program operated by the Department of Health and Human Services pursuant to its authority under Part 6 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.
- (21) Local Management Entity or LME. – As defined in G.S. 122C-3.
- (22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3.
- (23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

- (24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.
- (25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.
- (26) 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 by a local management entity/managed care organization under a contract with the Department of Health and Human Services to operate the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.
- (27) Network provider. – An appropriately credentialed provider that has entered into a contract for participation in the network of one or more local management entity/managed care organizations or prepaid health plans.
- (28) Notice of adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.
- (29) OAH. – The North Carolina Office of Administrative Hearings.
- (30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, that is under a capitated contract with the Department for the delivery of Medicaid and NC Health Choice services, or a local management entity/managed care organization that is under a capitated contract with the Department to operate a BH IDD tailored plan.
- (31) Provider. – As defined in G.S. 108C-2.
- (32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.
- (36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD tailored plan. (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, ss. 4.6, 4.7(a); 2022-74, ss. 9D.13(c), 9D.15(p)-(r).)

§ 108D-2. Scope; applicability of this Chapter.

This Chapter applies to every managed care entity, applicant, enrollee, provider of emergency services, and network provider of a managed care entity. This Chapter does not apply to Medicaid services delivered through the fee-for-service program. (2013-397, s. 1; 2019-81, s. 1(a); 2022-74, s. 9D.15(s).)

§ 108D-3. Conflicts; severability.

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Parts 438 and 457, federal law prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect. (2013-397, s. 1; 2019-81, s. 1(a).)

§ 108D-4. Reserved for future codification purposes.

§ 108D-5. Reserved for future codification purposes.

Article 1A.

Disenrollment from Prepaid Health Plans.

§ 108D-5.1. General provisions.

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid program or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP, or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program. (2019-81, s. 1(a); 2022-74, s. 9D.15(z); 2023-11, s. 3.2(h).)

§ 108D-5.3. Enrollee requests for disenrollment.

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

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

- (1) Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a).
- (2) Beneficiaries who are enrolled in the foster care system.
- (3) Beneficiaries who are in the former foster care Medicaid eligibility category.
- (4) Beneficiaries who receive Title IV-E adoption assistance.
- (5) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
- (6) Any other beneficiaries who are not required to enroll in a PHP under G.S. 108D-40.

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

- (1) The enrollee moves out of the PHP's service area.
- (2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.

- (3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
- (4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
- (5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
- (6) A family member of the enrollee becomes, or is determined, eligible for Medicaid and the family member is, or becomes, enrolled in a different PHP.
- (7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
- (8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP. For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. (2019-81, s. 1(a); 2021-62, s. 4.8(a); 2022-74, s. 9D.15(z).)

§ 108D-5.5. PHP requests for disenrollment.

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

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

- (1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.
- (2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee. (2019-81, s. 1(a).)

§ 108D-5.7. Notices.

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under

G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

- (1) A statement that, in order to request an appeal, the enrollee must file the form with OAH no later than 30 days after the mailing date of the notice of resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.
 - (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 the specific adverse disenrollment 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.
- (b) Notices Pertaining to Expedited Enrollee Requests for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:
- (1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the denial. The denial is not appealable.
 - (2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section. (2019-81, s. 1(a); 2021-62, ss. 2.1(d), 2.2(e); 2022-74, s. 9D.15(z).)

§ 108D-5.9. Appeals of adverse disenrollment determinations.

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may request a hearing to appeal the determination by filing the appeal request form provided under G.S. 108D-5.7(a) with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section. (2019-81, s. 1(a); 2021-62, s. 2.1(e).)

§ 108D-6. Reserved for future codification purposes.

§ 108D-7. Reserved for future codification purposes.

§ 108D-8. Reserved for future codification purposes.

§ 108D-9. Reserved for future codification purposes.

§ 108D-10. Reserved for future codification purposes.

Article 2.

Enrollee Grievances and Appeals.

§ 108D-11. Managed care entity grievance and appeal procedures, generally.

(a) Each managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) An enrollee, or the enrollee's authorized representative, may file grievances and managed care entity level appeals orally or in writing.

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

- (1) Offering an enrollee alternative services.
- (2) Engaging in clinical or educational discussions with enrollees or providers.
- (3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) A managed care entity shall not take punitive action against a provider for any of the following:

- (1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.
- (2) Requesting a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for a managed care entity level appeal.
- (3) Requesting an expedited managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for a managed care entity level expedited appeal.
- (4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries. (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, s. 2.1(f).)

§ 108D-12. Managed care entity grievances.

(a) Filing of Grievance. – An enrollee, or the enrollee's authorized representative, has the right to file a grievance with a managed care entity at any time to express dissatisfaction about any matter other than an adverse benefit determination. Upon receipt of a grievance, a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by mail.

(b) Notice of Grievance Disposition. – The managed care entity shall resolve the grievance and cause a notice of grievance resolution to be sent by mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than 30 days after

receipt of the grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum. (2013-397, s. 1; 2019-81, s. 1(a).)

§ 108D-13. Standard managed care entity level appeals.

(a) Notice of Adverse Benefit Determination. – A managed care entity shall provide an enrollee with a written notice of an adverse benefit determination by mail as required under 42 C.F.R. § 438.404. The notice will employ a standardized form included as a provision in the contract between the managed care entity and the Department.

(b) Request for Appeal. – An enrollee, or the enrollee's authorized representative, has the right to file a request for a managed care entity level appeal of a notice of adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. Upon receipt of a request for a managed care entity level appeal, a managed care entity shall acknowledge receipt of the request for appeal in writing by mail.

(c) Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of a managed care entity level appeal to the same extent required under 42 C.F.R. § 438.420.

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

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

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the managed care entity 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). (2013-397, s. 1; 2019-81, s. 1(a); 2022-74, s. 9D.15(t).)

§ 108D-14. Expedited managed care entity level appeals.

(a) Request for Expedited Appeal. – When the time limits for completing a standard managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the enrollee's authorized representative, has the right to file a request for an expedited appeal of an adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request for an expedited managed care entity level appeal, then (i) the managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and

follow up with a written notice of denial by mail no later than 72 hours after receiving the request for an expedited appeal and (ii) the managed care entity shall resolve the appeal within the time limits established for standard managed care entity level appeals in G.S. 108D-13. The denial is not appealable.

(c) Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an expedited managed care entity level appeal to the extent required under 42 C.F.R. § 438.420.

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

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

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

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the managed care entity 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). (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, s. 2.2(f), (g); 2022-74, s. 9D.15(u).)

§ 108D-15. Contested case hearings on disputed adverse benefit determinations.

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning 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 of an adverse benefit determination issued by a managed care entity. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file a request for an appeal by filing an appeal request form that meets the requirements of subsection (f)

of this section with OAH by no later than 120 days after the mailing date of the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

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

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the managed care entity 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 with OAH no later than 120 days after the mailing date of the notice of resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.
- (2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.
- (3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse benefit determination identified in the notice of resolution.
- (3a) The option for the enrollee to request an expedited appeal.
- (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.

(g) Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

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

- (1) OAH shall schedule and hear cases by no later than 55 days after receipt of a request for a contested case hearing.
- (2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the managed

care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

- (3) The administrative law judge assigned to hear the case shall consider and rule on all prehearing motions prior to the scheduled date for a hearing on the merits.
- (4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.
- (5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:
 - a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the managed care entity in the hearing before the administrative law judge.
 - b. The enrollee's right to an interpreter during the hearing process.
 - c. The circumstances in which a medical assessment may be obtained at the managed care entity's expense and made part of the record, including all of the following:
 1. A hearing involving medical issues, such as a diagnosis, an examining physician's report, or a decision by a medical review team.
 2. A hearing in which the administrative law judge considers it necessary to have a medical assessment other than the medical assessment performed by an individual involved in any previous level of review or decision making.

(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 managed care entity 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 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.

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

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the managed care entity's adverse benefit determination and regardless of whether the managed care entity had an opportunity to consider the evidence in resolving the managed care entity level appeal. Upon the receipt of new evidence and at the request of the managed care entity, 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 managed care entity to review the evidence. Upon reviewing the evidence, if the managed care entity decides to reverse the adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(l) Issue for Hearing. – For each adverse benefit determination, the administrative law judge shall determine whether the managed care entity substantially prejudiced the rights of the enrollee and whether the managed care entity, based upon evidence at the hearing, did any of the following:

- (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.

(m) To the extent that anything in this Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with rights that are no less than those provided under federal law. (2013-397, s. 1; 2014-100, s. 12H.27(c); 2019-81, s. 1(a); 2021-62, ss. 2.1(g), (h), 2.2(h); 2022-74, s. 9D.15(v).)

§ 108D-15.1. Expedited contested case hearings on disputed adverse benefit determinations.

In accordance with 42 C.F.R. § 431.224, an enrollee, or an enrollee's authorized representative, may request that an appeal under G.S. 108D-15(d) be expedited if the time otherwise permitted for a hearing could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

- (1) The enrollee shall submit any additional documentation from a licensed health care professional with relevant excerpts from the enrollee's medical record that was not already provided with regard to the adverse benefit determination to demonstrate the need for an expedited appeal.
- (2) The Department shall determine if the enrollee's request meets the criteria for an expedited appeal.

- (3) If the Department determines that the enrollee's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the enrollee, or the enrollee's authorized representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the enrollee's appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.
- (4) If the Department determines that the enrollee's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108D-15(i) shall not apply to the appeal request and (ii) the decision required under G.S. 108D-16 shall be made as expeditiously as possible. (2021-62, s. 2.2(i).)

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

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes. (2013-397, s. 1; 2019-81, s. 1(a).)

§ 108D-17. Reserved for future codification purposes.

§ 108D-18. Reserved for future codification purposes.

§ 108D-19. Reserved for future codification purposes.

§ 108D-20. Reserved for future codification purposes.

Article 3.

Managed Care Entity Provider Networks.

§ 108D-21. LME/MCO provider networks.

Each LME/MCO operating the combined 1915(b) and (c) waivers shall develop and maintain a closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees. A closed network is the network of providers that have contracted with the local management entity/managed care organization operating the combined 1915(b) and (c) waivers. (2019-81, s. 1(a); 2022-74, s. 9D.13(d).)

§ 108D-22. PHP provider networks.

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP 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, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

- (1) Federally qualified health centers.
- (2) Rural health centers.
- (3) Free clinics.
- (4) Local health departments.
- (5) State Veterans Homes. (2019-81, s. 1(a); 2022-74, s. 9D.15(z).)

§ 108D-23. BH IDD tailored plan networks.

Each entity operating a BH IDD tailored plan shall develop and maintain a closed network of providers only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services. A closed network is the network of providers that have contracted with the entity operating a BH IDD tailored plan to furnish these services to enrollees. A closed network must include all essential providers, as designated in accordance with G.S. 108D-22(b), that (i) are located within the region for which the entity holds a BH IDD tailored plan contract and (ii) provide any covered behavioral health, intellectual and developmental disability, or traumatic brain injury service in that region. (2019-81, s. 1(a); 2021-62, s. 4.7(b); 2022-74, s. 9D.13(e).)

§ 108D-24. Reserved for future codification purposes.

§ 108D-25. Reserved for future codification purposes.

§ 108D-26. Reserved for future codification purposes.

§ 108D-27. Reserved for future codification purposes.

§ 108D-28. Reserved for future codification purposes.

§ 108D-29. Reserved for future codification purposes.

Article 4.
Prepaid Health Plans.

§ 108D-30. Intent and Goals.

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

- (1) Ensure budget predictability through shared risk and accountability.
- (2) Ensure balanced quality, patient satisfaction, and financial measures.
- (3) Ensure efficient and cost-effective administrative systems and structures.

- (4) Ensure a sustainable delivery system. (2015-245, s. 1; 2019-81, s. 14(a); 2022-74, s. 9D.15(z); 2023-11, s. 3.2(e).)

§ 108D-35. Services covered by PHPs.

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

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

- (1) Medicaid services covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under a standard benefit plan, except that all capitated PHP contracts shall cover the following services:

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

In accordance with this subdivision, 1915(b)(3) services shall not be covered under a standard benefit plan.

- (2) Dental services.
- (3) Services provided through the Program of All-Inclusive Care for the Elderly (PACE).
- (4) Services documented in an individualized education program, as defined in G.S. 115C-106.3, or other document described in the Medicaid State Plan, and provided or billed by a local education agency, as defined in G.S. 115C-106.3.
- (5) Services documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by a Children's Developmental Services Agency or by a provider contracted with a Children's Developmental Services Agency to provide those services.
- (6) Services for Medicaid program applicants during the period of time prior to eligibility determination.

- (7) The fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. (2015-245, s. 4; 2016-121, s. 2(b); 2017-57, s. 11H.17(a); 2017-186, s. 4; 2018-48, s. 1; 2019-81, ss. 12, 14(a); 2021-62, ss. 3.2, 4.9(a); 2021-180, s. 9F.11(c); 2022-74, s. 9D.15(w).)

§ 108D-40. Populations covered by PHPs.

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

- (1) Recipients who are enrolled in both Medicare and Medicaid for whom Medicaid coverage is limited to the coverage of Medicare premiums and cost sharing.
- (2) Qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611.
- (3) Undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611.
- (4) Medically needy Medicaid recipients.
- (5) Recipients who meet the definition of Indian under 42 C.F.R. § 438.14(a) shall have the option to enroll voluntarily in PHPs.
- (5a) Repealed by Session Laws 2021-62, s. 4.8(c), effective July 1, 2021.
- (6) Presumptively eligible recipients, during the period of presumptive eligibility.
- (7) Recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.
- (8) Recipients enrolled under the Medicaid Family Planning program.
- (9) Recipients who are inmates of prisons.
- (10) Recipients being served through the Community Alternatives Program for Children (CAP/C).
- (11) Recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
- (12) Recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact, until BH IDD tailored plans become operational, at which time this population will be enrolled with a BH IDD tailored plan in accordance with G.S. 108D-60(a)(10). Recipients in this category shall have the option to voluntarily enroll with a PHP, provided that (i) a recipient electing to enroll with a PHP would only have access to the behavioral health services covered by PHPs according to G.S. 108D-35(1) and would no longer have access to the behavioral health services excluded under G.S. 108D-35(1) and (ii) the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP. Recipients in this category shall include, at a minimum, recipients who meet any of the following criteria:
 - a. Individuals with a serious emotional disturbance or a diagnosis of severe substance use disorder or traumatic brain injury.

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

behavioral health crisis services. If the result of the assessment is that the individual does not meet the criteria for disenrolling from the PHP, then the individual shall not be included in the category of recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact for purposes of this subsection, unless the individual has a subsequent episode using behavioral health crisis services within 12 months after completion of the assessment.

2. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered through a standard benefit plan in accordance with G.S. 108D-35(1).
 3. Individuals who are currently receiving or need to be receiving behavioral health, intellectual and developmental disability, or traumatic brain injury services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
 4. Children with complex needs, as that term is defined in the 2016 settlement agreement between the Department and Disability Rights of North Carolina.
 5. Children aged zero to three years old with, or at risk for, developmental delay or disability.
 6. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by the Department of Health and Human Services.
- (13) Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by the Department that shall not exceed five years after the date that capitated PHP contracts begin:
- a. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by the Department in accordance with this subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

- b. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
- c. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

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

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

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

- (1) Four contracts between the Division of Health Benefits and PHPs to provide coverage to Medicaid recipients statewide.
- (2) Up to 12 contracts between the Division of Health Benefits and PLEs for coverage of regions specified by the Division of Health Benefits pursuant to G.S. 108D-65(2). Regional contracts shall be in addition to the four statewide contracts required under subdivision (1) of this section. Each regional contract shall provide coverage throughout the entire region for the Medicaid services required by G.S. 108D-35. A PLE may bid for more than one regional contract, provided that the regions are contiguous.
- (3) The limitations on the number of contracts established in this section shall not apply to BH IDD tailored plans described in G.S. 108D-60.
- (4) Initial capitated PHP contracts may be awarded on staggered terms of three to five years in duration to ensure against gaps in coverage that may result from termination of a contract by the PHP or the State. (2015-245, s. 4; 2016-121, s. 2(b); 2018-48, s. 1; 2019-81, s. 14(a); 2022-74, s. 9D.15(z).)

§ 108D-50. Defined measures and goals.

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

§ 108D-55. Administrative functions.

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

§ 108D-60. BH IDD tailored plans.

(a) BH IDD tailored plans shall be defined as capitated PHP contracts that meet all requirements in this Article pertaining to capitated PHP contracts, except as specifically provided in this section. With regard to BH IDD tailored plans, the following shall occur:

- (1) In the event of the discontinuation of the 1915(b)/(c) Waivers, the following essential components of the 1915(b)/(c) Waivers shall be included in the 1115 Waiver:
 - a. Entities operating BH IDD tailored plans shall authorize, pay for, and manage services offered under the 1915(b)/(c) Waivers, including coverage of 1915(b)(3) services, within their capitation payments.
 - b. Entities operating BH IDD tailored plans shall operate care coordination functions.
 - c. Entities operating BH IDD tailored plans shall oversee home and community based services.
 - d. Repealed by Session Laws 2022-74, s. 9D.13(f), effective July 1, 2022.
 - e. Entities operating BH IDD tailored plans shall manage provider rates.
 - f. Entities operating BH IDD tailored plans shall provide Local Business Plans.
 - g. The State Consumer and Family Advisory Committees shall continue to operate and advise the Department and entities operating the BH IDD tailored plans.
- (2) During the initial contract term for BH IDD tailored plans, an LME/MCO shall be the only entity that may operate a BH IDD tailored plan. LME/MCOs operating BH IDD tailored plans shall receive all capitation payments under the BH IDD tailored plan contracts. Entities operating BH IDD tailored plan contracts shall conduct care coordination administrative functions for all services offered through the BH IDD tailored plans, and shall bear all risk for service utilization. This subdivision shall not be construed to preclude an entity operating a BH IDD tailored plan from engaging in incentives, risk sharing, or other contractual arrangements.
- (3) During the initial contract term for BH IDD tailored plans, BH IDD tailored plans shall be operated only by LME/MCOs that meet certain criteria established by the Department. Any LME/MCO desiring to operate a BH IDD tailored plan shall make an application to the Department in response to this set of criteria. Approval to operate a BH IDD tailored plan will be contingent upon a comprehensive readiness review. The constituent counties of the existing LME/MCOs may change, or existing LME/MCOs may merge or be acquired by another LME/MCO, as allowed under Chapter 122C of the General Statutes, prior to operating a BH IDD tailored plan, provided that the Department ensures every county in the State is covered by an LME/MCO that operates a BH IDD tailored plan. The Department shall issue no more than seven and no fewer than five regional BH IDD tailored plan contracts and shall not issue any statewide BH IDD tailored plan contracts.
- (4) After the term of the initial contracts for BH IDD tailored plans, BH IDD tailored plan contracts shall be the result of requests for proposals issued by the

- Department and the submission of competitive bids from nonprofit PHPs and entities operating the initial BH IDD tailored plan contracts.
- (5) LME/MCOs operating BH IDD tailored plans shall contract with an entity that holds a PHP license and that covers the services required to be covered under a standard benefit plan contract.
 - (6) [Reserved for future codification.]
 - (7) Entities authorized to operate BH IDD tailored plans shall be in compliance with applicable State law, regulations, and policy and shall meet certain criteria established by the Department. These criteria shall include the ability to coordinate activities with local governments, county departments of social services, the Division of Juvenile Justice of the Department of Public Safety, and other related agencies.
 - (8) BH IDD tailored plans shall cover the behavioral health, intellectual and developmental disability, and traumatic brain injury services excluded from standard benefit plan coverage under G.S. 108D-35(1) in addition to the services required to be covered by all PHPs under G.S. 108D-35.
 - (9) Entities authorized to operate BH IDD tailored plans shall continue to manage non-Medicaid behavioral health services funded with federal, State, and local funding in accordance with Chapter 122C of the General Statutes and other applicable State and federal law, rules, and regulations.
 - (10) Recipients described in G.S. 108D-40(a)(12) shall be automatically enrolled with an entity operating a BH IDD tailored plan and shall have the option to enroll with a PHP operating a standard benefit plan, provided that a recipient electing to enroll with a PHP operating a standard benefit plan would only have access to the behavioral health services covered by the standard benefit plans and would no longer have access to the behavioral health services excluded from standard benefit plan coverage under G.S. 108D-35(1) and provided that the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP operating a standard benefit plan.

(b) The Department may contract with entities operating BH IDD tailored plans under a capitated or other arrangement for the management of behavioral health, intellectual and developmental disability, and traumatic brain injury services for any recipients who are not enrolled in a BH IDD tailored plan. (2015-245, s. 4; 2018-48, s. 1; 2019-81, s. 14(a); 2021-62, s. 3.4A(a); 2022-74, ss. 9D.7(c), 9D.13(f); 2023-65, s. 5.1(b).)

§ 108D-65. Role of the Department.

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

- (1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this Article within the required time frames.
- (2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in G.S. 108D-30. Every county in the State must be assigned to a region.

- (3) Oversee, monitor, and enforce capitated PHP contract performance.
- (4) Ensure sustainability of the transformed Medicaid program.
- (5) Set rates, including the following:
 - a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments, provided that capitated PHP contracts shall not require any withhold arrangements, as defined in 42 C.F.R. § 438.6, during the first 18 months of the demonstration. Any withhold arrangements required under a capitated PHP contract after the first 18 months of the demonstration shall not withhold an amount of a PHP's capitation payment that exceeds three and one-half percent (3.5%) of the PHP's total capitation payment. The Department shall not require community reinvestment as a condition for a PHP's receipt of any at-risk portion of the capitation rate.
 - b. Appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.
 - c. Rates for services in the remaining fee-for-service programs.
- (6) Enter into capitated PHP contracts for the delivery of the Medicaid services described in G.S. 108D-35. All contracts shall be the result of requests for proposals (RFPs) issued by the Department and the submission of competitive bids by PHPs. The Department shall develop standardized contract terms, to include at a minimum, the following:
 - a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary.
 - b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by the Department.
 - c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by the Department. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). The Department shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.
 - d. [Reserved for future codification.]
 - e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.
 - f. Terms that, to the extent not inconsistent with federal law or regulations, or State law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these requirements shall be overseen

and enforced by the Department. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

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

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

- g. A requirement that all participation agreements between a PHP and a health care provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.
- (7) Prior to issuing the RFPs [requests for proposals] required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint Legislative Oversight Committee on Medicaid on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

- (8) Develop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.
- (9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels. (2015-245, s. 5; 2016-121, s. 2(c); 2018-49, s. 6(b); 2019-81, ss. 13, 14(a), (b); 2022-74, s. 9D.15(z), (bb); 2023-7, s. 1.7(o); 2023-11, s. 3.2(h).)

§ 108D-70. Advanced Medical Homes.

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