GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023

S **D**

SENATE BILL 425
PROPOSED COMMITTEE SUBSTITUTE S425-PCS45329-TR-3

Short Title: Medicaid Agency Omnibus.-AB (Public)

Sponsors:

Referred to:

March 30, 2023

A BILL TO BE ENTITLED

AN ACT TO UPDATE LAWS PERTAINING TO MEDICAID AND BEHAVIORAL HEALTH.

The General Assembly of North Carolina enacts:

ACCOUNT FOR DELAY OF BH IDD TAILORED PLANS

SECTION 1.(a) Section 9D.7(a) of S.L. 2022-74 is repealed.

SECTION 1.(b) The Division of Health Benefits, Department of Health and Human Services (DHHS), shall implement BH IDD tailored plans, as defined under G.S. 108D-1, no later than October 1, 2023. The initial term of the BH IDD tailored plan shall end December 1, 2026, in alignment with the ending of the initial term of the standard benefit plan prepaid health plan capitated contracts. If DHHS extends the standard benefit plan contracts, as authorized by Section 7(b) of S.L. 2020-88, then DHHS shall offer to extend the initial term of the BH IDD tailored plan contracts an equivalent amount of time.

REVISE MEDICAID PRESCRIPTION DRUG LOCK-IN PROGRAM

SECTION 2.(a) G.S. 108A-68.2 reads as rewritten:

"**§ 108A-68.2. Beneficiary lock-in program for certain controlled substances.**

(a) The following definitions apply in this section:

…

(2) Lock-in program. – ~~A requirement that a Medicaid beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.~~A requirement, consistent with 42 C.F.R. § 431.54(e), that restricts the number of prescribers from whom, and the number of pharmacies from which, a Medicaid beneficiary may obtain covered substances.

(3) Prepaid health plan or PHP. – As defined in G.S. 108D-1.

…

~~(d) This section does not apply to any lock-in program for Medicaid beneficiaries who are not enrolled in a Prepaid Health Plan.~~

(e) A ~~Prepaid Health Plan may~~ PHP shall develop a lock-in program for Medicaid beneficiaries who meet ~~any of the following criteria:~~the criteria established in the Department's Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2.

~~(1) Have filled six or more prescriptions for covered substances in a period of two consecutive months.~~

~~(2) Have received prescriptions for covered substances from three or more providers in a period of two consecutive months.~~

~~(3) Are recommended as a candidate for the lock-in program by a provider.~~

(f) A lock-in program developed pursuant to subsection (e) of this section shall comply with all of the following:

(1) A beneficiary shall not be subject to the lock-in program until the ~~Prepaid Health Plan~~ PHP has notified the beneficiary in writing that the beneficiary will be subject to the lock-in program.

(2) A beneficiary subject to the lock-in program shall be given the opportunity to select a single prescriber and a single pharmacy from a list of prescribers and pharmacies in the ~~Prepaid Health Plan's~~ PHP's provider network. The beneficiary may be allowed to select up to two prescribers and two pharmacies when medically necessary, as designated by the State, in accordance with 42 C.F.R. § 431.54(e). For any beneficiary who fails to select ~~a single prescriber, the Prepaid Health Plan shall use algorithmic guidelines to assign the beneficiary a single prescriber from a list of prescribers in the Prepaid Health Plan's network. For any beneficiary who fails to select a single pharmacy,~~ prescribers or pharmacies, the ~~Prepaid Health Plan~~ PHP shall use algorithmic guidelines to assign the beneficiary ~~a single pharmacy from a list of~~ prescribers or pharmacies enrolled in the ~~Prepaid Health Plan's~~ PHP's network.

(3) A beneficiary shall not be required to use the single prescriber or single pharmacy selected for the lock-in program to obtain prescriptions drugs covered by the Medicaid program or the ~~Prepaid Health Plan~~ PHP that are not covered substances.

(f1) If a PHP finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the restrictions in subsection (f) of this section may be imposed for a period of two years.

(g) A ~~Prepaid Health Plan's~~ PHP's use of a lock-in program developed pursuant to subsection (e) of this section shall not constitute a violation of the terms of a contract between the ~~Prepaid Health Plan~~ PHP and the Department that relate to a beneficiary's ability to utilize a prescriber or pharmacy of choice."

SECTION 2.(b) G.S. 58-51-37(*l*) reads as rewritten:

"(*l*) An insurer's use of a lock-in program developed pursuant to G.S. 58-51-37.1 or G.S. 108A-68.2 is not a violation of this section."

SECTION 2.(c) This section is effective on the later of the date this act becomes law or the date that the NC Health Choice program is eliminated, as approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with Section 9D.15(a) of S.L. 2022-74.

ADD BEHAVIORAL HEALTH SERVICES COVERED BY STANDARD BENEFIT PLANS

SECTION 3.(a) G.S. 108D-35(b) reads as rewritten:

"(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~~ waivers, 1915(b)(3) services, and any services approved under the 1915(i) option 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.
q. Substance abuse comprehensive outpatient treatment program services.
r. Substance abuse intensive outpatient program services.
s. Social settings detoxification services.
~~In accordance with this subdivision, 1915(b)(3) services shall not be covered under a standard benefit plan.~~

…."

SECTION 3.(b) This section is effective October 1, 2023.

CLARIFY ACTIONS TO BE TAKEN UPON TERMINATION OF LME/MCO CONTRACTS

SECTION 4.(a) Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding the following new sections to read:

"**§ 122C-115.5. Alignment of counties with an area authority.**

(a) No county shall withdraw from an area authority nor shall an area authority be dissolved without prior approval of the Secretary.

(b) A county that wishes to disengage from one area authority and realign with another area authority operating a Medicaid waiver contract may do so with the approval of the Secretary. The Secretary shall adopt rules to establish a process for county disengagement that shall ensure, at a minimum, the following:

(1) Provision of services is not disrupted by the disengagement.
(2) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.
(3) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.
(4) Provisions exist for the distribution of any real property no longer within the catchment area of the area authority.

(c) Area authorities may add one or more additional counties to their existing catchment area upon the adoption of a resolution to that effect by a majority of the members of the area board and the approval of the Secretary.

(d) The Secretary shall direct the dissolution of an area authority upon any of the following:

(1) The termination of a BH IDD tailored plan contract with an area authority.
(2) The Secretary's delivery of a notice of noncompliance to an area authority under G.S. 122C-124.2(c)(2) or G.S. 122C-124.2(d)(4).
(3) The Secretary's assumption of full control of all powers of an area authority under G.S. 122C-125.

(e) When an area authority is dissolved at the direction of the Secretary, the following shall occur:

(1) The Secretary shall deliver a notice of dissolution to the board of county commissioners of each of the counties in the dissolved area authority.

(2) An area authority that is dissolved by the Secretary in accordance with the provisions of this section shall be dissolved on a time line established by the Department.

(3) The area authority being dissolved shall cooperate with the Secretary in order to ensure the uninterrupted provision of services to Medicaid recipients and the other individuals who received services through the area authority.

(4) The Secretary shall reassign the counties aligned with the area authority being dissolved to one or more area authorities that are under contract for the operation of a BH IDD tailored plan.

(5) The Secretary shall reassign the State-funded services contract between the area authority being dissolved and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to the area authorities receiving the realigned counties.

(6) The Secretary shall effectuate and oversee the orderly transfer of all management responsibilities, operations, and contracts of the area authority being dissolved, including the responsibility of paying providers for covered services that are subsequently rendered.

(7) The Secretary shall arrange for the providers of services to be reimbursed from the remaining fund balance or risk reserve of the area authority being dissolved, or from other funds of the Department if necessary, for proper, authorized, and valid claims for services rendered that were not previously paid by the area authority being dissolved. In the event there are insufficient assets to satisfy the liabilities of the area authority being dissolved, it shall be the responsibility of the Secretary to satisfy the liabilities of the area authority being dissolved.

(8) Effective until the date that BH IDD tailored plans begin operating, risk reserve funds of the area authority being dissolved may be used only to pay authorized and approved provider claims. Any funds remaining in the risk reserve transferred under this subdivision shall become part of the risk reserve of the area authorities receiving the realigned counties and shall be subject to the same restrictions on the use of the risk reserve applicable to those area authorities.

(9) The Secretary may assume control, in part or in full, of the financial affairs of the area authority and appoint an administrator to exercise the powers assumed by the Secretary. This assumption of control shall have the effect of divesting the area authority of its authority as to the powers assumed, including service delivery, adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority by law.

(10) County funding of the area authority shall continue and shall not be reduced as a result of the dissolution. A county shall not withdraw funds previously obligated or appropriated to the area authority.

(11) Any fund balance or risk reserve available to an area authority at the time of its dissolution that is not utilized to pay liabilities shall be transferred to one or more area authorities contracted to operate the 1915(b)/(c) Medicaid Waiver or a BH IDD tailored plan in all or a portion of the catchment area of the dissolved area authority, as directed by the Department in accordance with G.S. 122C-115.6.

(12) Effective until the date that BH IDD tailored plans begin operating, if the fund balance transferred from the dissolved area authority under subdivision (11) of this subsection is insufficient to constitute fifteen percent (15%) of the anticipated operational expenses arising from assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%) operational reserves.

"**§ 122C-115.6. Transfer of area authority fund balance upon county realignment.**

(a) When a county disengages from one area authority and realigns with another area authority under G.S. 122C-115.5, regardless of whether the realignment was due to reassignment by the Secretary or another process, a portion of the risk reserve and other funds of the area authority from which the county is disengaging shall be transferred to the area authority with which the county is realigning. The amount of risk reserve and other funds to be transferred shall be determined by the Department in accordance with a formula or formulas developed in accordance with this section.

(b) Any formula developed by the Department under this section shall consider the stability of both the area authority from which the county is disengaging and the area authority with which the county is realigning. The formula shall support (i) the ability for each area authority to carry out its responsibilities under State law, (ii) the successful operation of the 1915(b)/(c) waivers, (iii) the capitated arrangements authorized by G.S. 108D-60(b), and (iv) the successful operation of BH IDD tailored plans under G.S. 108D-60. The formula shall assure that the area authority from which the county is disengaging retains sufficient funds to pay any outstanding liabilities to healthcare providers, staff-related expenses, and other liabilities.

(c) The area authority from which the county is disengaging and the area authority with which the county is realigning shall provide the Department with all financial information requested by the Department that is necessary to determine the amount of funds to be transferred using the formula or formulas developed under this section, upon any of the following:

(1) The Secretary's approval of a county disengagement under G.S. 122C-115.5.

(2) The Secretary's delivery of a notice of dissolution to the area authority under G.S. 122C-115.5(e)(1).

(d) Prior to finalizing any formula developed under this section, the Department shall post the proposed formula on its website and provide notice of the proposed formula to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. The Department shall accept public comment on the proposed formula. The Department shall post the final version of the formula on its website.

(e) The Department may amend the formula as needed to ensure the requirements of subsection (b) of this section are met. Prior to finalizing any amended formula developed under this section, the Department shall post the proposed formula on its website and provide notice of the proposed formula to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. The Department shall accept public comment on the proposed formula. The Department shall post the final version of the formula on its website.

(f) Beginning July 15, 2023, and quarterly thereafter, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division on any funds transferred as a result of disengagements during the previous quarter.

(g) The development and application of the formula or formulas under this section shall be exempt from the rulemaking requirements and contested case provisions of Chapter 150B of the General Statutes, as provided in G.S. 150B-1(d)(33) and G.S. 150B-1(e)(27)."

SECTION 4.(b) G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

…

(2b) ~~"Behavioral~~ Behavioral health and intellectual/developmental disabilities tailored ~~plan"~~ plan or ~~"BH~~ BH IDD tailored ~~plan" has the same meaning as~~ plan. – As defined in G.S. 108D-1.

…

(29b) ~~"Prepaid~~ Prepaid health ~~plan" has the same meaning as~~ plan. – As defined in G.S. 108D-1.

…

(35b) Specialty services. – Services that are provided to consumers from low-incidence populations.

~~(35c) State or Local Consumer Advocate. The individual carrying out the duties of the State or Local Consumer Advocacy Program Office in accordance with Article 1A of this Chapter.~~

(35d) Standard benefit plan. – As defined in G.S. 108D-1.

(35e) State Plan. – The State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services.

~~(35e)~~(35f) State resources. – State and federal funds and other receipts administered by the Division.

…."

SECTION 4.(c) G.S. 122C-112.1(a)(25) is repealed.

SECTION 4.(d) G.S. 122C-115 reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders ~~under a 1915(b)/(c) Medicaid Waiver~~ through an area authority. ~~Beginning July 1, 2012, the catchment area of an area authority shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority shall contain a minimum population of at least 500,000.~~ To the extent this section conflicts with G.S. 153A-77 or G.S. 122C-115.1, the provisions of this section control.

~~(a1) Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to a rate consistent with the funding rate provided to LMEs with a population of 300,000.~~

~~(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.~~

~~(a3) A county that wishes to disengage from a local management entity/managed care organization and realign with another multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver may do so with the approval of the Secretary. The Secretary shall adopt rules to establish a process for county disengagement that shall ensure, at a minimum, the following:~~

~~(1) Provision of services is not disrupted by the disengagement.~~

~~(2) The disengaging county either is in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-115(a) of this section.~~

~~(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.~~

~~(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.~~

~~(5) Provision for distribution of any real property no longer within the catchment area of the area authority.~~

…

~~(c1) Area authorities may add one or more additional counties to their existing catchment area upon the adoption of a resolution to that effect by a majority of the members of the area board and the approval of the Secretary.~~

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities ~~or county programs~~ because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area ~~authority or county program.~~ authority. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area ~~authority or county program.~~authority.

(e) Beginning ~~on the date that capitated contracts under Article 4 of Chapter 108D of the General Statutes begin,~~ July 1, 2021, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients ~~other than recipients described in G.S. 108D-40(a)(1), (4), (5), (6), (7), (10), (11), (12), and (13).~~ who are enrolled in a standard benefit plan.

(e1) Until BH IDD tailored plans become operational, all of the following shall occur:

(1) LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients ~~described in G.S. 108D-40(a)(1), (4), (5), (6), (7), (10), (11), (12), and (13).~~who are covered by the those waivers and who are not enrolled in a standard benefit plan.

(2) The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

(3) 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.

(f) ~~Entities~~ LME/MCOs operating the BH IDD tailored plans under G.S. 108D-60 may continue to manage the behavioral health, intellectual and developmental disability, and traumatic brain injury services for any Medicaid recipients ~~described in G.S. 108D-40(a)(4), (5), (7), (10), (11), (12), and (13) under any contract with the Department in accordance with G.S. 108D-60(b).~~who are not enrolled in a BH IDD tailored plan."

SECTION 4.(e) G.S. 122C-115.3 is repealed.

SECTION 4.(f) G.S. 122C-124.1 is repealed.

SECTION 4.(g) G.S. 122C-124.2 reads as rewritten:

"**§ 122C-124.2. Actions by the Secretary to ensure effective management of behavioral health services under the 1915(b)/(c) Medicaid Waiver.**

…

(b) The Secretary's certification under subsection (a) of this section shall be in writing and signed by the Secretary and shall contain a clear and unequivocal statement that the Secretary has determined the local management entity/managed care organization to be in compliance with all of the following requirements:

(1) The LME/MCO has made adequate provision against the risk of insolvency ~~and~~ and, in accordance with G.S. 122C-125.3, is either (i) ~~is~~ not required to be under a corrective action plan ~~in accordance with G.S. 122C-125.2~~ or (ii)

~~is~~ in compliance with a corrective action ~~plan required under G.S. 122C-125.2.~~plan.

…

(c) If the Secretary does not provide a local management entity/managed care organization with the certification of compliance required by this section based upon the LME/MCO's failure to comply with any of the requirements specified in subdivisions (1) through (3) of subsection (b) of this section, the Secretary shall do the following:

…

~~(3) Not later than 10 days after the Secretary's notice of noncompliance is provided to the LME/MCO, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.~~

~~(4) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (e) of this section.~~

(5) Direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5(d).

(d) If, at any time, in the Secretary's determination, a local management entity/managed care organization is not in compliance with a requirement of the Contract other than those specified in subdivisions (1) through (3) of subsection (b) of this section, then the Secretary shall do all of the following:

…

~~(5) Upon a final determination that an LME/MCO is noncompliant, allow no more than 30 days following the date of notification of the final determination of noncompliance for the noncompliant LME/MCO to complete negotiations for a merger or realignment with a compliant LME/MCO that is satisfactory to the Secretary.~~

~~(6) If the noncompliant LME/MCO does not successfully complete negotiations with a compliant LME/MCO as described in subdivision (5) of this subsection, assign the Contract of the noncompliant LME/MCO to a compliant LME/MCO.~~

~~(7) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to the compliant LME/MCO in accordance with the provisions in subsection (e) of this section.~~

(8) Upon a final determination that an LME/MCO is noncompliant, direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5(d).

~~(e) If the Secretary assigns the Contract of a noncompliant local management entity/managed care organization to a compliant LME/MCO under subdivision (3) of subsection (c) of this section, or under subdivision (6) of subsection (d) of this section, the Secretary shall oversee the orderly transfer of all management responsibilities, operations, and contracts of the noncompliant LME/MCO to the compliant LME/MCO. The noncompliant LME/MCO shall cooperate with the Secretary in order to ensure the uninterrupted provision of services to Medicaid recipients. In making this transfer, the Secretary shall do all of the following:~~

~~(1) Arrange for the providers of services to be reimbursed from the remaining fund balance or risk reserve of the noncompliant LME/MCO, or from other funds of the Department if necessary, for proper, authorized, and valid claims for services rendered that were not previously paid by the noncompliant LME/MCO.~~

~~(2) Effectuate an orderly transfer of management responsibilities from the noncompliant LME/MCO to the compliant LME/MCO, including the responsibility of paying providers for covered services that are subsequently rendered.~~

~~(3) Oversee the dissolution of the noncompliant LME/MCO, including transferring to the compliant LME/MCO all assets of the noncompliant LME/MCO, including any balance remaining in its risk reserve after payments have been made under subdivision (1) of this subsection. Risk reserve funds of the noncompliant LME/MCO may be used only to pay authorized and approved provider claims. Any funds remaining in the risk reserve transferred under this subdivision shall become part of the compliant LME/MCO's risk reserve and subject to the same restrictions on the use of the risk reserve applicable to the compliant LME/MCO. If the risk reserves transferred from the noncompliant LME/MCO are insufficient, the Secretary shall guarantee any needed risk reserves for the compliant LME/MCO arising from the additional risks being assumed by the compliant LME/MCO until the compliant LME/MCO has established fifteen percent (15%) risk reserves. All other assets shall be used to satisfy the liabilities of the noncompliant LME/MCO. In the event there are insufficient assets to satisfy the liabilities of the noncompliant LME/MCO, it shall be the responsibility of the Secretary to satisfy the liabilities of the noncompliant LME/MCO.~~

~~(4) Following completion of the actions specified in subdivisions (1) through (3) of this subsection, direct the dissolution of the noncompliant LME/MCO and deliver a notice of dissolution to the board of county commissioners of each of the counties in the dissolved LME/MCO. An LME/MCO that is dissolved by the Secretary in accordance with the provisions of this section may be dissolved at any time during the fiscal year.~~

…

(g) As used in this section, the following terms mean:

…

(2) Contract. – The contract between the Department of Health and Human Services and a local management entity for the operation of the 1915(b)/(c) Medicaid ~~Waiver.~~waiver or a BH IDD tailored plan."

SECTION 4.(h) G.S. 122C-125 reads as rewritten:

"**§ 122C-125. Area ~~Authority financial~~ authority failure; State assumption of ~~financial~~ control.**

(a) At any time that the Secretary of the Department of Health and Human Services determines that an area authority is in imminent danger of failing ~~financially and~~ financially, of failing to provide ~~direct~~ minimally adequate services to ~~clients,~~ clients in need in a timely manner, or failing to execute on priority infrastructure, services, and supports that are needed across the State related to mental health, intellectual or other developmental disabilities, and substance use disorder, the Secretary, after providing written notification of the Secretary's intent to the area board and after providing the area authority an opportunity to be heard, may assume ~~control of the financial affairs~~ control, in part or in full, of the area authority and appoint an administrator to exercise the powers ~~assumed.~~ assumed by the Secretary. This assumption of control shall have the effect of divesting the area authority of its ~~powers~~ authority as to the powers assumed, which may include service delivery, adoption of budgets, expenditures of money, and all other financial powers conferred ~~in~~ on the area authority by law.

(b) County funding of the area authority shall continue when the ~~State~~ Secretary has assumed control ~~of the financial affairs~~ of the area ~~authority.~~ authority under this section. At no time after the ~~State~~ Secretary has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority. ~~The Secretary shall adopt rules to define imminent danger of failing financially and of failing to provide direct services to clients.~~

(c) Upon the Secretary's assumption of ~~financial control,~~ partial control of an area authority under this section, the Department shall, in conjunction with the area authority, develop

and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's finances.

(d) Upon the Secretary's assumption of full control of all powers of an area authority under this section, the Secretary shall direct the dissolution of the area authority in accordance with G.S. 122C-115.5(d)(3).

(e) The Department shall develop definitions of the following terms used in this section: "imminent danger of failing financially," "failing to provide minimally adequate services to clients in need in a timely manner," and "failing to execute on priority infrastructure, services, and supports that are needed across the State related to mental health, intellectual or other developmental disabilities, and substance use disorder." The Department may amend the definitions developed under this section. Prior to implementing a definition, whether initial or amended, the Department shall do all of the following:

(1) Post the proposed definition on its website and provide notice of the proposed definition to all area authorities, the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Medicaid.

(2) Accept public comment on the proposed definition.

(3) Post the final version of the definition on its website.

(f) The development of definitions under subsection (e) of this section shall be exempt from the rulemaking requirements of Chapter 150B of the General Statutes, as provided in G.S. 150B-1(d)(34)."

SECTION 4.(i) G.S. 122C-125.2 is repealed.

SECTION 4.(j) Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-125.3. LME/MCO solvency; corrective action plan.**

(a) The Department shall establish, in its contracts with LME/MCOs, solvency standards based on industry-standard financial accounting measures, such as the current ratio of assets to liabilities, defensive interval ratio of current assets to average monthly expenditure, capital reserves, and profit and loss. The contracts shall require the development of a corrective action plan when an LME/MCO does not meet the solvency standards specified in the contract.

(b) Each LME/MCO shall provide the Department with monthly financial reports containing the data needed to calculate the financial accounting measures and assess the LME/MCO's adherence to the solvency standards established in contract.

(c) On a quarterly basis, beginning on April 1, 2024, the Department shall publish to its website a dashboard reporting all of the following information for each LME/MCO for the previous quarter:

(1) Each solvency standard applicable to the LME/MCO under its contracts with the Department, including any applicable minimum or maximum threshold.

(2) The financial position of the LME/MCO relative to each solvency standard applicable to the LME/MCO under its contracts with the Department.

(3) Whether the LME/MCO is under any corrective action plan related to the solvency standards applicable to the LME/MCO under its contracts with the Department, and whether the LME/MCO is in compliance with any such corrective action plan.

(d) The Department shall notify the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division when the information required under subsection (c) of this section has been published to the Department's website."

SECTION 4.(k) G.S. 108D-60(b) reads as rewritten:

"(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 ~~excluded from PHP coverage under G.S. 108D-40(a)(4), (5), (7), (10), (11), (12), and (13).~~who are not enrolled in a BH IDD tailored plan."

SECTION 4.(*l*) G.S. 108D-60 is amended by adding a new subsection to read:

"(c) Notwithstanding G.S. 108D-40(a)(12) and subdivision (10) of subsection (a) of this section, upon the dissolution of an area authority under G.S. 122C-115.5 and as part of the orderly transfer of operations of the area authority being dissolved, the enrollees of the area authority being dissolved temporarily may be served through one or any combination of the following delivery systems:

(1) The fee-for-service program.

(2) An arrangement authorized under subsection (b) of this section.

(3) A standard benefit plan.

(4) Any other system allowed under State law for the delivery of Medicaid services or mental health, intellectual and developmental disabilities, and substance use disorder services."

SECTION 4.(m) G.S. 150B-1(d) is amended by adding two new subdivisions to read:

"(33) The Department of Health and Human Services with respect to the development and application of any formula under G.S. 122C-115.6.

(34) The Department of Health and Human Services with respect to the development of definitions under G.S. 122C-125(e)."

SECTION 4.(n) G.S. 150B-1(e)(21) reads as rewritten:

"(21) The Department of Health and Human Services for actions taken under ~~G.S. 122C-124.2.~~G.S. 122C-124.2 and G.S. 122C-115.5(d)."

SECTION 4.(o) G.S. 150B-1(e) is amended by adding a new subdivision to read:

"(27) The Department of Health and Human Services with respect to the development and application of any formula under G.S. 122C-115.6."

SECTION 4.(p) Section 3.5A of S.L. 2021-62 is repealed.

SECTION 4.(q) Section 9D.13(b) of S.L. 2022-74 is repealed.

DEPARTMENTAL AUTHORITY OVER SINGLE STREAM FUNDS

SECTION 5.(a) G.S. 122C-102(b) is amended by adding a new subdivision to read:

"(13) Identification of priority infrastructure, services, and supports that are needed across the State related to mental health, intellectual or other developmental disabilities, and substance use disorder."

SECTION 5.(b) G.S. 122C-112.1(a) is amended by adding a new subdivision to read:

"(40) Direct and oversee the allocation and use of single-stream funding to support priority infrastructure, services, and supports, including those identified in the State Plan under G.S. 122C-102(b)."

SECTION 5.(c) G.S. 122C-112.1(b) reads as rewritten:

"(b) The Secretary may do the following:

…

(4) Accept, allocate, and spend any federal funds for mental health, intellectual or other developmental disabilities, ~~and~~ or substance ~~abuse~~ use disorder activities that may be made available to the State by the federal ~~government.~~ Government for purposes of funding the priority infrastructure, services, and supports identified in the State Plan under G.S. 122C-102(b)(13). This Chapter shall be liberally construed in order that the State and its citizens may

benefit fully from these funds. Any federal funds received shall be deposited with the Department of State Treasurer and shall be appropriated by the General Assembly for the mental health, intellectual or other developmental disabilities, or substance ~~abuse~~ use disorder purposes specified.

(4a) Spend any State funds allocated for mental health, intellectual or other developmental disabilities, and substance use disorder services and supports to contract for the provision of priority infrastructure, services, and supports identified in the State Plan under G.S. 122C-102(b)(13).

…."

SECTION 5.(d) G.S. 122C-117(a)(1) reads as rewritten:

"(1) Engage in comprehensive planning, budgeting, implementing, and monitoring of community-based mental health, intellectual or other developmental disabilities, and substance ~~abuse services.~~use disorder services in coordination with the Secretary and in accordance with direction from the Secretary regarding the use or allocation of single-stream funding to support priority infrastructure, services, and supports identified in the State Plan under G.S. 122C-102(b)(13)."

DEPARTMENTAL AUTHORITY OVER LME/MCO SUBCONTRACTS

SECTION 6.(a) G.S. 122C-112.1(a)(6) reads as rewritten:

"(6) Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities, ~~county programs,~~ third-party contractors of area authorities, and all providers of public services with State and federal policy, law, and standards. The procedures shall include the development and use of critical performance measures and report cards for each area ~~authority and county program.~~authority."

SECTION 6.(b) G.S. 122C-112.1(a)(9) reads as rewritten:

"(9) Provide ongoing and focused technical assistance to area authorities ~~and county programs~~ in the implementation of the LME functions and the establishment and operation of community-based programs. ~~The technical assistance required under this subdivision includes, but is not limited to, the technical assistance required under G.S. 122C-115.4(d)(2).~~ The Secretary shall include in the State Plan a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities ~~and county programs~~ in achieving these functions."

SECTION 6.(c) G.S. 122C-115.4(c) reads as rewritten:

"(c) Subject to subsection (b) of this ~~section and~~ section, all applicable State and federal laws and ~~rules~~ rules, and contractual requirements established by the Secretary, an LME may contract with a public or private entity for the implementation of LME functions designated under subsection (b) of this section. An LME shall cancel any such contract when directed by the Secretary under G.S. 122C-142(a)."

SECTION 6.(d) Subsections (d) and (e) of G.S. 122C-115.4 are repealed.

SECTION 6.(e) G.S. 122C-115.4(f)(3) is repealed.

SECTION 6.(f) G.S. 122C-142(a) reads as rewritten:

"(a) When ~~the~~ an area authority contracts with persons for the provision of services, it shall use the standard contract adopted by the Secretary and shall assure that these contracted services meet the requirements of applicable State ~~statutes and the rules of the Commission and the Secretary. However, an~~ and federal laws and rules. An area authority may amend the contract to comply with any court-imposed duty or responsibility. An area authority that is operating under a Medicaid waiver may amend the contract subject to the approval of the Secretary. Terms

of the standard contract shall require the area authority to monitor the contract to assure that State and federal laws and rules ~~and State statutes~~ are met. It shall also place an obligation upon the entity providing services to provide to the area authority timely data regarding the clients being served, the services provided, and the client outcomes. The Secretary may also monitor contracted services ~~to assure that rules and State statutes are met.~~for compliance with the area authority's contractual requirements with the Department and State and federal law. If an area authority's oversight of a contract for services results in noncompliance, the Secretary may direct the area authority to cancel the contract for services."

EXEMPT LME/MCO EMPLOYEES FROM THE STATE HUMAN RESOURCES ACT

SECTION 7.(a) G.S. 126-5 reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) This Chapter applies to all of the following:

(1) All State employees not exempted by this section.

(2) All employees of the following local entities:

~~a. Area mental health, developmental disabilities, and substance abuse authorities, except as otherwise provided in Chapter 122C of the General Statutes.~~

b. Local social services departments.

c. County health departments and district health departments.

d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

…

(c1) Except as to Articles 6 and 7 of this Chapter, this Chapter does not apply to any of the following:

…

(39) All employees of area authorities, as defined under G.S. 122C-3.

…."

SECTION 7.(b) This section applies to employees of area mental health, developmental disabilities, and substance abuse authorities, defined as area authorities under G.S. 122C-3, hired after the date this act becomes law.

CONFORM CONTESTED CASE HEARING EXEMPTION FOR VARIOUS MANAGED CARE ENTITIES

SECTION 8. G.S. 150B-1(e)(25) reads as rewritten:

"(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and ~~a~~ any of the following:

a. A prepaid health plan, as defined in G.S. 108D-1.

b. A prepaid inpatient health plan, as defined in 42 C.F.R. § 438.2.

c. A primary care case management entity, as defined in 42 C.F.R. § 438.2."

TECHNICAL CORRECTION REGARDING TIMING OF ANNUAL UPDATES

SECTION 9.(a) G.S. 108A-54.3A reads as rewritten:

"**§ 108A-54.3A. Eligibility categories and income thresholds.**

(a) The Department shall provide Medicaid coverage for individuals in accordance with federal statutes and regulations and specifically shall provide coverage for the following populations:

…

(b) The applicable federal poverty guidelines for the eligibility categories in subsection (a) of this section shall be updated annually on April 1 immediately following publication of the federal poverty guidelines."

SECTION 9.(b) The Revisor of Statutes shall replace all references to "G.S. 108A-54.3A(24)" with "G.S. 108A-54.3A(a)(24)" throughout the General Statutes.

SECTION 9.(c) Subsection (a) of this section is effective retroactively to June 26, 2020.

CONFORM WITH FEDERAL LEGISLATION REGARDING THIRD PARTY PRIOR AUTHORIZATIONS

SECTION 10.(a) G.S. 108A-55.4 reads as rewritten:

"**§ 108A-55.4. ~~Insurers to provide certain information to~~ Requirements related to insurers and the Department of Health and Human Services.**

…

(b) Health insurers, and pharmacy benefit managers regulated as third-party administrators under Article 56 of Chapter 58 of the General Statutes, shall provide, with respect to a subscriber upon request of the Division or its authorized contractor, information to determine during what period the individual or the individual's spouse or dependents may ~~be (or~~ be or may have ~~been)~~ been covered by a health insurer and the nature of the coverage that is or was provided by the health ~~insurer (including~~ insurer, including the subscriber's name, address, identification number, social security number, date of birth and identifying number of the ~~plan)~~ insurance policy, in a manner prescribed by the Division or its authorized contractor. Notwithstanding any other provision of law, every health insurer shall provide, not more frequently than twelve times in a year and at no cost, to the Department of Health and Human Services, Division of Health Benefits, or the Department's or Division's authorized contractor, upon its request, information as necessary so that the Division may (i) identify applicants or recipients who may also be subscribers covered under the benefit plans of the health insurer; (ii) determine the period during which the individual, the individual's spouse, or the individual's dependents may be or may have been covered by the health benefit plan; and (iii) determine the nature of the coverage. To facilitate the Division or its authorized contractor in obtaining this and other related information, every health insurer ~~shall:~~shall do all of the following:

…

(4) ~~Respond~~ With regard to any inquiry by the Division or its authorized contractor regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or ~~service.~~service, respond within 60 days of receipt of the inquiry.

…

(e) All third parties, as defined under 42 U.S.C. § 1396a(a)(25), requiring prior authorization of an item or service furnished to an individual eligible to receive medical assistance shall accept an authorization provided by the Department that the item or service for which third-party reimbursement is being sought is a covered service or item for that individual under the North Carolina Medicaid State Plan, or under a relevant waiver of the State Plan, as if that authorization is the prior authorization made by the third party for the item or service."

SECTION 10.(b) This section is effective January 1, 2024.

EFFECTIVE DATE

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.