

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2017

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HOUSE BILL 403  
Committee Substitute Favorable 3/29/17  
Senate Health Care Committee Substitute Adopted 6/15/17  
Senate Rules and Operations of the Senate Committee Substitute Adopted 6/28/17  
Proposed Conference Committee Substitute H403-PCCS10514-TR-21

Short Title: Medicaid and Behavioral Health Modifications.

(Public)

Sponsors:

Referred to:

March 20, 2017

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE MEDICAID TRANSFORMATION LEGISLATION.

The General Assembly of North Carolina enacts:

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

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

...

(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this ~~section~~section, or a local management entity/managed care organization (LME/MCO) that operates or will operate a BH IDD Tailored Plan pursuant to subdivision (10) of this section. For purposes of this act, the terms "commercial plan" and "provider-led entity" are defined as follows:

- a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.
- b. Provider-led entity or PLE. – An entity that meets all of the following criteria:
  1. A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section or Medicaid and NC Health Choice providers.
  2. A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and



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- 1 (ii) have experience treating beneficiaries of the North  
 2 Carolina Medicaid program.  
 3 3. Holds a PHP license issued by the Department of Insurance.  
 4 ...  
 5 (4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid  
 6 and NC Health Choice services, including physical health services,  
 7 prescription drugs, long-term services and supports, and behavioral health  
 8 services for NC Health Choice recipients, except as otherwise provided in this  
 9 subdivision. The capitated contracts required by this subdivision shall not  
 10 cover:  
 11 a. ~~Behavioral health services for Medicaid recipients services~~ currently  
 12 covered by the local management entities/managed care organizations  
 13 (LME/MCOs) ~~for four years after the date capitated contracts~~  
 14 ~~begin~~ shall not be covered under any capitated PHP contract other than  
 15 a BH IDD Tailored Plan, except that all capitated PHP contracts shall  
 16 cover the following services: inpatient behavioral health services,  
 17 outpatient behavioral health emergency room services, outpatient  
 18 behavioral health services provided by direct-enrolled providers,  
 19 mobile crisis management services, facility-based crisis services for  
 20 children and adolescents, professional treatment services in a  
 21 facility-based crisis program, outpatient opioid treatment services,  
 22 ambulatory detoxification services, nonhospital medical  
 23 detoxification services, partial hospitalization, medically supervised or  
 24 alcohol and drug abuse treatment center detoxification crisis  
 25 stabilization, research-based intensive behavioral health treatment,  
 26 diagnostic assessment services, and Early and Periodic Screening,  
 27 Diagnosis, and Treatment services. In accordance with this  
 28 sub-subdivision, 1915(b)(3) services shall not be covered under any  
 29 capitated PHP contract other than a BH IDD Tailored Plan.  
 30 ...  
 31 (5) Populations covered by PHPs. – Capitated PHP contracts shall cover all  
 32 Medicaid and NC Health Choice program aid categories except for the  
 33 following categories:  
 34 ...  
 35 h. Recipients enrolled under the Medicaid Family Planning program.  
 36 i. Recipients who are inmates of prisons.  
 37 j. Recipients being served through the Community Alternatives Program  
 38 for Children (CAP/C).  
 39 k. Recipients being served through the Community Alternatives Program  
 40 for Disabled Adults (CAP/DA).  
 41 l. Recipients with a serious mental illness, a serious emotional  
 42 disturbance, a severe substance use disorder, an  
 43 intellectual/developmental disability, or who have survived a  
 44 traumatic brain injury and who are receiving traumatic brain injury  
 45 services, who are on the waiting list for the Traumatic Brain Injury  
 46 waiver, or whose traumatic brain injury otherwise is a knowable fact,  
 47 until BH IDD Tailored Plans become operational, at which time this  
 48 population will be enrolled with a BH IDD Tailored Plan in  
 49 accordance with sub-sub-subdivision 10. of sub-subdivision a. of  
 50 subdivision (10) of this section. Recipients in this category shall have  
 51 the option to voluntarily enroll with a PHP, provided that (i) a recipient

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

9 1. Individuals with a serious emotional disturbance or a diagnosis  
10 of severe substance use disorder or traumatic brain injury.

11 2. Individuals with a developmental disability as defined in  
12 G.S. 122C-3(12a).

13 3. Individuals with a mental illness diagnosis who also meet any  
14 of the following criteria:

15 I. Individuals with serious mental illness or serious and  
16 persistent mental illness, as those terms are defined in  
17 the 2012 settlement agreement between DHHS and the  
18 United States Department of Justice, including  
19 individuals enrolled in and served under the Transition  
20 to Community Living Initiative settlement agreement.

21 II. Individuals with two or more psychiatric  
22 hospitalizations or readmissions within the prior 18  
23 months.

24 III. Individuals who have had two or more visits to the  
25 emergency department for a psychiatric problem within  
26 the prior 18 months, except as provided in this  
27 sub-sub-sub-subdivision. After any individual who is  
28 enrolled with a PHP has a second visit to the emergency  
29 department for a psychiatric problem within the prior  
30 18 months, the individual shall remain enrolled with  
31 the PHP until DHHS provides a comprehensive  
32 assessment to determine whether the individual should  
33 be disenrolled from the PHP and receive more  
34 comprehensive care through an LME/MCO or an entity  
35 operating a BH IDD Tailored Plan. This assessment  
36 shall be completed within 14 calendar days following  
37 discharge after the second visit. If the result of the  
38 assessment is that the individual does not meet the  
39 criteria for disenrolling from the PHP, then the  
40 individual shall not be included in the category of  
41 recipients with a serious mental illness for purposes of  
42 this subdivision, unless the individual has a subsequent  
43 visit to the emergency department for a psychiatric  
44 problem within 12 months after completion of the  
45 assessment.

46 IV. Individuals known to DHHS or an LME/MCO to have  
47 had one or more involuntary treatment episodes within  
48 the prior 18 months.

49 4. Individuals who, regardless of diagnosis, meet any of the  
50 following criteria:

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- I. Individuals who have had two or more episodes using behavioral health crisis services within the prior 18 months, except as provided in this sub-sub-sub-subdivision. After any individual who is enrolled with a PHP experiences a second episode of behavioral health crisis, the individual shall remain enrolled with the PHP until DHHS provides a comprehensive assessment to determine whether the individual should be disenrolled from the PHP and receive more comprehensive care through an LME/MCO or an entity operating a BH IDD Tailored Plan. This assessment shall be completed within 14 calendar days following discharge after the second episode using behavioral health crisis services. If the result of the assessment is that the individual does not meet the criteria for disenrolling from the PHP, then the individual shall not be included in the category of recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact for purposes of this subdivision, unless the individual has a subsequent episode using behavioral health crisis services within 12 months after completion of the assessment.
  - II. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are currently covered by LME/MCOs and that shall not be covered through any capitated PHP contract other than a BH IDD Tailored Plan in accordance with sub-subdivision a. of subdivision (4) of this section.
  - III. Individuals who are currently receiving or need to be receiving behavioral health, intellectual and developmental disability, or traumatic brain injury services funded with State, local, federal, or other non-Medicaid funds, or any combination of non-Medicaid funds, in addition to the services covered by Medicaid.
  - IV. Children with complex needs, as that term is defined in the 2016 settlement agreement between DHHS and Disability Rights of North Carolina.
  - V. Children aged zero to three years old with, or at risk for, developmental delay or disability.
  - VI. Children and youth involved with the Division of Juvenile Justice of the Department of Public Safety and Delinquency Prevention Programs who meet criteria established by DHHS.

- 1 (6) Number and nature of capitated PHP contracts. – The number and nature of  
2 the contracts required under subdivision (3) of this section shall be as follows:  
3 a. ~~Three~~Four contracts between the Division of Health Benefits and  
4 PHPs to provide coverage to Medicaid and NC Health Choice  
5 recipients statewide (statewide contracts).  
6 b. Up to 12 contracts between the Division of Health Benefits and PLEs  
7 for coverage of regions specified by the Division of Health Benefits  
8 pursuant to subdivision (2) of Section 5 of this act (regional contracts).  
9 Regional contracts shall be in addition to the ~~three~~four statewide  
10 contracts required under sub-subdivision a. of this subdivision. Each  
11 regional contract shall provide coverage throughout the entire region  
12 for the Medicaid and NC Health Choice services required by  
13 subdivision (4) of this section. A PLE may bid for more than one  
14 regional contract, provided that the regions are contiguous.  
15 b1. The limitations on the number of contracts established in this  
16 subdivision shall not apply to BH IDD Tailored Plans described in  
17 subdivision (10) of this section.  
18 c. Initial capitated PHP contracts may be awarded on staggered terms of  
19 three to five years in duration to ensure against gaps in coverage that  
20 may result from termination of a contract by the PHP or the State.  
21 ...  
22 (9) ~~LME/MCOs. – LME/MCOs shall continue to manage the behavioral health~~  
23 ~~services currently covered for their enrollees under all existing waivers,~~  
24 ~~including the 1915(b) and (c) waivers, for four years after the date capitated~~  
25 ~~PHP contracts begin. During this four year period, the~~Beginning on the date  
26 that capitated contracts begin, LME/MCOs shall cease managing Medicaid  
27 services for all Medicaid recipients other than recipients described in  
28 sub-subdivisions a., d., e., f., g., j., k., and l. of subdivision (5) of this section.  
29 Until BH IDD Tailored Plans become operational, all of the following shall  
30 occur:  
31 a. LME/MCOs shall continue to manage the Medicaid services that are  
32 currently covered by the LME/MCOs for Medicaid recipients  
33 described in sub-subdivisions a., d., e., f., g., j., k., and l. of subdivision  
34 (5) of this section.  
35 b. The Division of Health Benefits shall ~~continue to negotiate~~ actuarially  
36 sound capitation rates directly with the LME/MCOs ~~in the same~~  
37 ~~manner as currently utilized.~~ based on the change in composition of the  
38 population being served by the LME/MCOs.  
39 c. Capitation payments under contracts between the Division of Health  
40 Benefits and the LME/MCOs shall be made directly to the LME/MCO  
41 by the Division of Health Benefits ~~during the four year~~  
42 ~~period.~~ Benefits.  
43 (10) BH IDD Tailored Plans. – DHHS shall not begin any application process to  
44 implement, establish rules for, or begin any contracting or procurement  
45 process with respect to BH IDD Tailored Plans, as defined in this subdivision,  
46 until August 31, 2018, or until authorized to do so in a subsequent act of the  
47 General Assembly, whichever comes first. BH IDD Tailored Plans shall be  
48 defined as capitated PHP contracts that meet all requirements in this act  
49 pertaining to capitated PHP contracts, except as specifically provided in this  
50 subdivision. Capitated PHP contracts that are not BH IDD Tailored Plans shall

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

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

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

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

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

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

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

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

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

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

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

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

- 1 contingent upon a comprehensive readiness review. The  
2 constituent counties of the existing LME/MCOs may change,  
3 or existing LME/MCOs may merge or be acquired by another  
4 LME/MCO, as allowed under Chapter 122C of the General  
5 Statutes, prior to operating a BH IDD Tailored Plan, provided  
6 that DHHS ensures every county in the State is covered by an  
7 LME/MCO that operates a BH IDD Tailored Plan. DHHS shall  
8 issue no more than seven and no fewer than five regional BH  
9 IDD Tailored Plan contracts and shall not issue any statewide  
10 BH IDD Tailored Plan contracts.
- 11 4. After the term of the initial contracts for BH IDD Tailored  
12 Plans to last four years, BH IDD Tailored Plan contracts will  
13 be the result of RFPs issued by DHHS and the submission of  
14 competitive bids from nonprofit PHPs and entities operating  
15 the initial BH IDD Tailored Plan contracts.
- 16 5. LME/MCOs operating BH IDD Tailored Plans shall contract  
17 with an entity that holds a PHP license and that covers the  
18 services required to be covered under a Standard Benefit Plan  
19 contract.
- 20 6. Entities operating BH IDD Tailored Plans shall utilize closed  
21 provider networks only for the provision of behavioral health,  
22 intellectual and developmental disability, and traumatic brain  
23 injury services, notwithstanding sub-subdivision d. of  
24 subdivision (6) of Section 5 of this act.
- 25 7. Entities authorized to operate BH IDD Tailored Plans shall be  
26 in compliance with applicable State law, regulations, and  
27 policy and shall meet certain criteria established by DHHS.  
28 These criteria shall include the ability to coordinate activities  
29 with local governments, county departments of social services,  
30 the Division of Juvenile Justice of the Department of Public  
31 Safety, and other related agencies.
- 32 8. BH IDD Tailored Plans shall cover the behavioral health,  
33 intellectual and developmental disability, and traumatic brain  
34 injury services excluded from Standard Benefit Plan coverage  
35 under sub-subdivision a. of subdivision (4) of this section, in  
36 addition to the services required to be covered by all PHPs  
37 under subdivision (4) of this section.
- 38 9. Entities authorized to operate BH IDD Tailored Plans shall  
39 continue to manage non-Medicaid behavioral health services  
40 funded with federal, State, and local funding in accordance  
41 with Chapter 122C of the General Statutes and other applicable  
42 State and federal law, rules, and regulations.
- 43 10. Recipients described in sub-subdivision l. of subdivision (5) of  
44 this section shall be automatically enrolled with an entity  
45 operating a BH IDD Tailored Plan and shall have the option to  
46 enroll with a PHP operating a Standard Benefit Plan, provided  
47 that a recipient electing to enroll with a PHP operating a  
48 Standard Benefit Plan would only have access to the  
49 behavioral health services covered by the Standard Benefit  
50 Plans and would no longer have access to the behavioral health  
51 services excluded from Standard Benefit Plan coverage under

- 1                                    sub-subdivision a. of subdivision (4) of this section, and  
2                                    provided that the recipient's informed consent shall be required  
3                                    prior to the recipient's enrollment with a PHP operating a  
4                                    Standard Benefit Plan.
- 5                    b.    No later than June 22, 2018, DHHS shall report to the Joint Legislative  
6                    Oversight Committee on Medicaid and NC Health Choice with a plan  
7                    for the implementation of BH IDD Tailored Plans. At a minimum, the  
8                    report shall contain the following:
- 9                    1.    The date when BH IDD Tailored Plans are planned to be  
10                    operational.
- 11                    2.    The proposed parameters for contracts between LME/MCOs  
12                    and partnering entities to operate a BH IDD Tailored Plan,  
13                    including, but not limited to, incentive arrangements for  
14                    providing integrated care and for achieving measurable  
15                    outcomes, and strategies to minimize cost-shifting between the  
16                    LME/MCO and the partnering entity.
- 17                    3.    Proposed language for any legislative changes needed to  
18                    implement the plan.
- 19                    4.    A detailed description of the process by which recipients will  
20                    be able to transition between BH IDD Tailored Plans and  
21                    Standard Benefit Plans. At a minimum, this process must  
22                    include the following:
- 23                    I.    The proposed definition for a qualifying event, after  
24                    which a Standard Benefit Plan enrollee would be  
25                    eligible to enroll with a BH IDD Tailored Plan, and the  
26                    proposed process for rapid enrollment in a BH IDD  
27                    Tailored Plan after a qualifying event.
- 28                    II.   A process for the periodic evaluation of BH IDD  
29                    Tailored Plan enrollees with criteria to determine  
30                    whether enrollees continue to require the  
31                    comprehensive services managed by the BH IDD  
32                    Tailored Plans or whether their needs can be adequately  
33                    met through coverage by a Standard Benefit Plan.
- 34                    III.   A detailed description of the process and criteria to be  
35                    used for the assessments that are required under  
36                    sub-subdivision l. of subdivision (5) of this section of  
37                    individuals after their second visit to an emergency  
38                    department for a psychiatric problem within the prior  
39                    18 months or after their second episode using  
40                    behavioral health crisis services within the prior 18  
41                    months.
- 42                    IV.   The manner by which a recipient's continuation of care  
43                    shall be ensured when the recipient transitions between  
44                    BH IDD Tailored Plans and Standard Benefit Plans or  
45                    between Standard Benefit Plans and BH IDD Tailored  
46                    Plans. This process should include a consideration of  
47                    the maintenance of the recipient's care providers as well  
48                    as any prior authorization approvals existing prior to  
49                    the recipient transitioning between these two plans.
- 50                    5.    An estimate of State spending under the 1115 Waiver if BH  
51                    IDD Tailored Plans are implemented compared to an estimate



- 1 of State spending under the 1115 Waiver if BH IDD Tailored  
2 Plans are not implemented.
- 3 6. Specific measureable outcomes, along with a time frame for  
4 the achievement of each measureable outcome, to be included  
5 in the capitated PHP contracts for BH IDD Tailored Plans.
- 6 7. A description of the solvency requirements for LME/MCOs  
7 operating BH IDD Tailored Plans describing how the solvency  
8 requirements relate to the solvency standards for PHPs set by  
9 the Department of Insurance under Section 6 of this act and  
10 how they relate to the solvency standards for LME/MCOs.
- 11 8. Any anticipated barriers to the ability of BH IDD Tailored  
12 Plans to meet the standardized contract terms described in  
13 subdivision (6) of Section 5 of this act.
- 14 9. Justification and proposed guidelines for the management of  
15 the closed provider networks utilized by the BH IDD Tailored  
16 Plans as required by sub-sub-subdivision 6. of sub-subdivision  
17 a. of this subdivision.
- 18 10. A plan for adding recipients who are being served through the  
19 CAP/C program to the populations covered by BH IDD  
20 Tailored Plans.
- 21 11. A plan for transitioning children aged zero to three years old  
22 with, or at risk for, developmental delay or disability.
- 23 12. A plan for adding coverage, under BH IDD Tailored Plans or  
24 another specialty plan, of all recipients who are enrolled in the  
25 foster care system, who are enrolled in Medicaid under the  
26 former foster care eligibility category, who receive Title IV-E  
27 Adoption Assistance, or who are under the age of 26 and  
28 formerly received Title IV-E Adoption Assistance. This plan  
29 shall include assurances that these recipients will be supported  
30 in instances when they have a change in residence.
- 31 c. After receiving the report required by sub-subdivision b. of this  
32 subdivision, the Joint Legislative Oversight Committee on Medicaid  
33 and NC Health Choice may recommend that the General Assembly  
34 consider proposed legislation during the 2018 Regular Session  
35 containing any modifications to the law that are necessary to  
36 implement BH IDD Tailored Plans.
- 37 d. Beginning August 31, 2018, or when authorized by a subsequent act  
38 of the General Assembly, whichever comes first, DHHS is authorized  
39 to take any actions necessary to implement BH IDD Tailored Plans in  
40 accordance with all the requirements in this act, including all the  
41 requirements enumerated under sub-subdivision a. of this  
42 subdivision."

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