LME/MCO Contract Termination Legislative Proposal

Session Law 2022-74, SECTION 9D.13.(h)

Report to

Joint Legislative Oversight Committee on Medicaid

By

North Carolina Department of Health and Human Services

May 18, 2023

Background:

Section 9D.13.(h) of S.L. 2022-74 (see Appendix A) directs the Division of Health Benefits (DHB) to submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing proposed legislative language regarding actions to be taken upon the termination of a contract operated by an LME/MCO with respect to four specific domains.

DHB evaluated Chapter 122C and Chapter 108D of the General Statues for the report. The current LME/MCO contract under which 1915(b)/(c) waiver services will be administered until BH IDD tailored plans begin, the BH IDD tailored plan contract and the draft of the contract for a capitated arrangement authorized by G.S. 108D-60(b)[1] were also reviewed. In preparing recommended legislative amendments, DHB focused primarily on the BH IDD tailored plan contract and the capitated arrangement authorized by G.S. 108D-60(b) because 1915(b)/(c) waiver services will be transitioned to those contracts.[2] Many of the detailed, logistical administrative requirements to ensure a smooth transition of a terminated contract will be addressed in a "transition agreement" between the impacted parties and Department. Legislating this level of detail does not lend itself to addressing the variables of the situation surrounding a termination of the contract(s).

Based on this assessment, DHB recommends the amendments discussed in the body of this report.

[1] Section 9D.13.(h) of S.L. 2022-74 erroneously refers to the legislation authorizing a capitated arrangement with LME/MCOs to manage services for beneficiaries who are carved out of managed care as G.S. 108D-60(d). This report uses the correct citation of G.S. 108D-60(b) instead.

[2] G.S. 108D-60(a) already specifies transitioning essential services to the 1115 waiver in the event the 1915(b)/(c) waiver were discontinued. 1915(b)(3) services are being transitioned to a 1915(i) State Plan option which will be administered under BH IDD tailored plan contracts and under contracts awarded pursuant to contract pursuant to G.S. 108D-60(b).

TRANSFER OF LME/MCO RISK RESERVE AND FUND BALANCES UPON MEDICAID CONTRACT TERMINATION

DHB recommends the language in a new section (see at lines 1-32 of Appendix B) to codify the transfer of risk reserve and fund balances in the event of a contract termination. G.S. 122C-115.3(e), which addresses dissolution of area authority, must be revised to address that fund balance or risk reserve of an area authority operating a BH IDD Tailored Plan and contract pursuant to G.S. 108D-60(b) must also be transferred in the event of a dissolution. Proposed language to address transfer of funds for the additional types of contracts is at lines 87-88 of Appendix B.

Additionally, DHB recommends that termination of either the BH IDD tailored plan contract or the contract pursuant to G.S. 108D-60(b) result in dissolution of the LME/MCO whose contract(s) are terminated. Removing the expiration of Secretarial authority in G.S. 122C-115.3(h) and clarifying that the authority is not limited to BH IDD Tailored Plans addresses this need (see lines 91-92 of Appendix B). Due to the complexity of transitioning Medicaid coverage after a contract termination, DHB seeks flexibility on the timing of the dissolution as outlined in lines 209-210.

TRANSITION OF MEDICAID COVERAGE TO ONE OR MORE ENTITIES

DHB envisions that the activities necessary to implement the transition of Medicaid coverage after a Contract termination will be governed by a transition agreement between impacted parties and the Department. Currently G.S. 122C-124.2 governs which LME/MCO takes responsibility for the beneficiaries affected by the contract termination. However, this statute is limited to the 1915(b)/(c) waiver only. For consistency across the potential contracts an LME/MCO may hold with the Department, DHB recommends Secretarial authority to assign a contract when the conditions specified in G.S. 122C-124.2 are met should be extended to BH IDD Tailored Plan contract and the capitated arrangement authorized by G.S. 108D-60(b). This change is reflected in lines 97, and 221-222 of Appendix B.

Currently, under G.S. 122C-124.2(c)(3), the Secretary assigns the contract only if an LME/MCO is not complying with requirements pertaining to solvency, timely provider payments or the exchange of billing, payment and transaction information with the Department. But, under G.S. 122C-124.2(d), upon final determination that an LME/MCO is not compliant with *some other requirement of* its contract, the noncompliant LME/MCO has no more than 30 days to or from the time the date of notification to complete negotiations for a merger or realignment with a compliant LME/MCO that is satisfactory to the Secretary. Only after negotiations are unsuccessful is the Secretary authorized to assign the contract.

DHB recommends that the Secretary have immediate authority to assign the contract regardless of the cause for termination. Pursuant to G.S. 122C-115 (a3), counties can still seek disengagement if they wish to realign using the process codified in 10 NCAC 26C .0703. This approach provides uniformity, eliminates the uncertainty of negotiations, and provides beneficiaries and providers faster, more predictable transition away from the noncompliant LME/MCO. This approach builds in time before BH IDD Tailored Plan launch for counties to assess whether the LME/MCO to which they were assigned is meeting the needs of their residents while allowing continued authority to seek realignment if the Secretary's assignment is not satisfactory. Language to address these needs appears at lines 163-170 of

Appendix B. To align with Secretarial authority to assign a terminated contract regardless of the underlying reasons, conforming changes will be necessary to G.S. 122C-124.2(e) to ensure authority to oversee an orderly transfer of responsibilities. Activities include provider reimbursement from fund balance/risk reserve, effectuating orderly transfer of management responsibilities, oversee dissolution of non-compliant LME/MCO including transfer of assets, direct the dissolution of the LME/MCO. DHB suggests the conforming language at lines 174-183 of Appendix B.

Additionally, while these transition activities are being assessed and executed, the Department may need flexibility to temporarily move recipients who were to receive services in the BH IDD Tailored Plan contract being terminated to another health care delivery model. The Department needs authority to potentially permit the LME/MCO whose BH IDD Tailored Plan contract is being terminated to continue managing services for the enrollees under its the capitated arrangement authorized by G.S. 108D-60(b) or to allow another PHP or the Department to temporarily manage services until the LME/MCO(s) to which the recipient will be assigned can assume the responsibilities. Language to provide this flexibility and authority is suggested at lines 226-241. This provision requires conforming changes to G.S. 122C-115. Lines 71-72 and 78-81 of Appendix B address these changes.

Finally, DHB recommends clarifying that the terminated contract could be split between more than one LME/MCO. Language to make this clarification is provided at lines 4, 7-8, 19, 145-148, 172, 180, 192, 197, and 199-200 of Appendix B.

FUTURE ALIGNMENT OF COUNTIES COVERED BY THE LME/MCO WHOSE CONTRACT WAS TERMINATED

DHB does not recommend changes on this topic currently.

REVISIONS TO THE DEFINITION OF CATCHMENT AREA IN CHAPTER 122C

DHB recommends specifying in G.S. 122C-3 that LME/MCOs serve the geographic area of the State approved and assigned by the Department in the applicable contract as proposed in lines 37-38 of Appendix B. DHB recommends that the population size requirements of catchment areas in G.S. 122C-115 be repealed because the population requirements no longer serve a purpose and because behavioral health needs of lesser acuity will be served by PHPs offering standard benefit plans. See suggested language at lines 54-64 of Appendix B.

OTHER CONSIDERATIONS

1. The proposed changes require that the definition of LME/MCO in G.S. 122C-3(20c) be revised to be more general and inclusive of all LME/MCO contracts and decoupling from the specific CMS authority the contract operationalizes. This change is addressed in lines 41-44 of Appendix B. Similarly, DHB recommends elimination of specific CMS authorities throughout Chapter 122C and 108D because the authority under which services are provided can shift over time (see lines 53 and 97 of Appendix B). For example 1915(b)(3) services are being transitioned to a 1915)(i) State Plan option. The 1915(i) services will

be administered under the BH IDD tailored plan contract, and the capitated arrangement authorized by G.S. 108D-60(b), not a specific contract as the 1915(b)/(c) waiver was.

2. DHB has identified certain sections of Chapter 122C that should be repealed regardless of whether a contract is terminated because they do not align requirements of the BH IDD Tailored Plan contract, and the capitated arrangement authorized by G.S. 108D-60(b). In the event repeal of the sections below is not enacted, these sections would need significant amendments to align with the contracts. The language in the contracts aligns with federal regulations that guard against member harm, risk of failure and maintaining public trust, establish remedies, sanctions, and procedural steps in the event of noncompliance and govern termination.
    a. G.S. 122C-124.1 should be repealed once BH IDD tailored plans and the capitated arrangement authorized by G.S. 108D-60(b) begin. These soon to be implemented contracts with LME/MCOs address corrective action plans, withholding of funding, expectations regarding delivery of services, and temporary management making G.S. 122C-124.1 unnecessary.
    b. G.S. 122C-125 should be repealed for similar reasons as G.S. 122C-124.1. The contracts address financial viability requirements, measures to be taken if the requirements are not met and addresses termination for noncompliance.
3. While not related to the termination of contracts for BH IDD tailored plans and the capitated arrangement authorized by G.S. 108D-60(b), DHB recommends consideration of empowering the Secretary of DHHS with respect to the topics listed in subsections a-c of this section. Preliminary legislative proposals to address these requirements are provided in Appendix C.
    a. Retain single stream funding to support programs and contracts that support mental health across multiple catchment areas of LME/MCOs.
    b. Exempt staff of LME/MCOs exempt from the State Personnel Act.
    c. Direct LME/MCOs to cancel sub contractual relationships when there is noncompliance with State, federal and contractual requirements.
4. DHB envisions proposing a statewide catchment area for the Children and Families Specialty Plan and encourages LME/MCOs to collaborate in a manner to achieve state wideness in every sense of the word.

Appendix A:

S.L. 2022-74, SECTION 9D.13.(h)

SECTION 9D.13.(h) No later than January 10, 2023, DHHS shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing proposed legislative language regarding actions to be taken upon the termination of a contract operated by an LME/MCO for (i) a BH IDD Tailored Plan, (ii) a capitated arrangement authorized by G.S. 108D-60(d), or (iii) the 1915(b)/(c) combined Medicaid waiver. The proposed legislation shall address at least all of the following:

(1) The transition of the Medicaid coverage under the terminated contract to one or more other entities.

(2) The transfer of all or a portion of any fund balance or risk reserve balance from the LME/MCO that held the contract that was terminated to one or more other entities.

(3) For counties in the catchment area of the LME/MCO that held the contract that was terminated, the future alignment of those counties with one or more LME/MCOs.

(4) Any revisions to the definition of catchment area in Chapter 122C of the General Statutes that are needed.

Appendix B

Proposed Mark Up of Statute for Contract Termination

SECTION xx.(a) When the Department of Health and Human Services (DHHS) terminates a Contract held by an LME/MCO under G.S. 122C-124.2, the balance of the risk reserve, fund balance, and other funds of the LME/MCO whose Contract is terminated shall be transferred to the LME/MCO(s) to which the Contract is being assigned. The amount of risk reserve, fund balance and other funds to be transferred shall be determined by DHHS in accordance with the formula posted at https://medicaid.ncdhhs.gov/media/10048/download?attachment.

SECTION xx.(b) DHHS may amend the formula to support the ability for the LME/MCO(s) receiving the contract(s) to carry out responsibilities under State law and shall support the successful operation of 1915(b)/(c) waiver until services have been transitioned to another authority approved by CMS, BH IDD Tailored Plans under G.S. 108D-60 and the capitated arrangement authorized by G.S. 108D-60(b). The formula shall assure that the LME/MCO contract is terminated retains sufficient funds to pay any outstanding liabilities to health care providers, staff-related expenses, and other liabilities.

SECTION xx.(c) Within 30 days of Secretary's notification of noncompliance pursuant to G.S. 124.2(c)(2) or G.S. 124.2(d)(4), the LME/MCO whose Contract is being terminated shall provide DHHS with all financial information requested by DHHS that is necessary to determine the amount of funds to be transferred using the formula or formulas developed under this section.

SECTION xx.(d) Within 30 days of the Secretary's assignment of the Contract pursuant to G.S. 124.2(c)(3) or G.S. 124.2(d)(5), the LME/MCO(s) receiving the Contract shall provide DHHS with all financial information requested by DHHS that is necessary to determine the amount of funds to be transferred using the formula or formulas developed under this section.

SECTION xx.(e) Prior to finalizing any change in the formula pursuant to subsection (b) of this section, DHHS shall post the proposed formula on its website and provide notice of the proposed formula to all LME/MCOs, 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. DHHS shall accept public comment on the proposed formula. DHHS shall post the final version of the formula on its website within 30 days of the Contract being assigned.

SECTION xx.(f) Notwithstanding any provision of law to the contrary, the development and application of the formula or formulas under this section shall be exempt from the rulemaking requirements under Article 2A of Chapter 150B of the General Statutes and the contested case provisions of Chapter 150B of the General Statutes.

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

"§ 122C-3. Definitions.

…

(4) Catchment area. – The geographic part of the State served by a specific area authority ~~or county program~~ via a contract for a Medicaid managed care program authorized by CMS. The geographic area shall be specified in the contract.

…

(20c) Local management entity/managed care organization (LME/MCO). – A local management entity that is under contract with the Department under Article 4 of Chapter 108D of the General Statutes to operate one or more ~~the combined~~ Medicaid ~~Waiver~~ managed care programs ~~program~~ authorized by the Centers for Medicare and Medicaid Services. ~~under Section 1915(b) and~~

~~Section 1915(c) of the Social SecurityAct or to operate a BH IDD tailored plan.~~
…"

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 managed care program authorized by CMS ~~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.~~

…

(e) Beginning on the date that capitated contracts under Article 4 of Chapter 108D of the General Statutes begin, 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). 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) or the <u>prepaid inpatient health plan authorized by G.S 108D-60(b)</u> for Medicaid recipients described in G.S. 108D-40(a)(1), (4), (5), (6), (7), (10), (11), (12), and (13).

…

(f) Entities 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). <u>In the event the entity no longer operates a BH IDD tailored plan, the entity is authorized to continue the temporary management of the services in this subsection for a period of time established by the Department as provided in G.S. 108D-60(c)(1).</u>"

G.S. 122C-115.3 reads as rewritten:

§ 122C-115.3. Dissolution of area authority.

…

(e) 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~~ <u>Waiver, ~~or~~</u> a BH IDD Tailored Plan <u>or a capitated arrangement authorized by G.S. 108D-60(b)</u> in all or a portion of the catchment area of the dissolved area authority, as directed by the Department.

…

(h) ~~Effective until December 1, 2023, upon~~ Upon the termination of a ~~BH IDD tailored plan~~ contract with an area authority as defined in G.S. 122C-124.2(g)(2), the Secretary shall direct the dissolution of that area authority. The Secretary shall deliver a notice of dissolution to the board of county commissioners of each of the counties in the dissolved area authority."

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~~.

(a) For all local management entity/managed care organizations, the Secretary shall certify whether the LME/MCO is in compliance or is not in compliance with all requirements of subdivisions (1) through (3) of subsection (b) of this section. The Secretary's certification shall be made every six months beginning August 1, 2013. In order to ensure accurate evaluation of administrative, operational, actuarial and financial components, and overall performance of the LME/MCO, the Secretary's certification shall be based upon an internal and external assessment made by an independent external review agency in accordance with applicable federal and State laws and regulations. Beginning on February 1, 2014, and for all subsequent assessments for certification, the independent review will be made by an External Quality Review Organization approved by the Centers for Medicare and Medicaid Services and in accordance with applicable federal and State laws and regulations.

(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 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.

(2) The LME/MCO is making timely provider payments. The Secretary shall certify that an LME/MCO is making timely provider payments if there are no consecutive three-month periods during which the LME/MCO paid less than ninety percent (90%) of clean claims for covered services within the 30-day period following the LME/MCO's receipt of these claims during that three-month period. As used in this subdivision, a "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse or a claim under review for medical necessity.

(3) The LME/MCO is exchanging billing, payment, and transaction information with the Department and providers in a manner that complies with all applicable federal standards, including all of the following:

a. Standards for information transactions and data elements specified in 42 U.S.C. § 1302d-2 of the Healthcare Insurance Portability and Accountability Act (HIPAA), as from time to time amended.

b. Standards for health care claims or equivalent encounter information transactions specified in HIPAA regulations in 45 C.F.R. § 162.1102, as from time to time amended.

c. Implementation specifications for Electronic Data Interchange standards published and maintained by the Accredited Standards Committee (ASC X12) and referenced in HIPAA regulations in 45 C.F.R. § 162.920, as from time to time amended.

(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:
(1) Prepare a written notice informing the LME/MCO of the provisions of subdivision (1), (2), or (3) of subsection (b) of this section with which the LME/MCO is deemed not to be in compliance and the reasons for the determination of noncompliance.
(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.
(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~~ one or more compliant ~~LME/MCO~~ LME/MCOs.
(4) Oversee the transfer of the operations and contracts from the noncompliant LME/MCO to ~~the~~ one or more compliant ~~LME/MCO~~ LME/MCOs in accordance with the provisions in subsection (e) of this section.
(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:
(1) Prepare a written notice informing the LME/MCO of the provisions of the Contract with which the LME/MCO is deemed not to be in compliance and the reasons therefor.
(2) Cause the notice of the noncompliance to be delivered to the LME/MCO.
(3) Allow the noncompliant LME/MCO 30 calendar days from the date of receipt of the notice to respond to the notice of noncompliance and to demonstrate compliance to the satisfaction of the Secretary.
(4) Upon the expiration of the period allowed under subdivision (3) of this subsection, make a final determination on the issue of compliance and promptly notify the LME/MCO of the determination.
(5) Upon a final determination that an LME/MCO is noncompliant, assign the Contract of the noncompliant LME/MCO to one or more compliant LME/MCOs. ~~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~~ LME/MCO(s) in accordance with the provisions in subsection (e) of this section.
(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~~, In the event a Contract is terminated, the noncompliant LME/MCO shall cooperate with the Secretary in order to ensure the uninterrupted provision of services to Medicaid recipients. ~~the~~ The Secretary shall oversee the orderly transfer of all management responsibilities, operations, and contracts of the noncompliant LME/MCO to the compliant LME/MCO(s) as follows: ~~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(s) 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~~ shall be dissolved on a timeline established by the Department. ~~dissolved at any time during the fiscal year.~~

(f) The Secretary shall provide a copy of each written, signed certification of compliance or noncompliance completed in accordance with this section to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

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

(1) Compliant local management entity/managed care organization. – An LME/MCO that has undergone an independent external assessment and been determined by the Secretary to be operating successfully and to have the capability of expanding.

(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, the BH IDD Tailored Plan or the contract pursuant to G.S. 108D-60(b)."

G.S. 108D-60 is amended by adding a new subsection to read:

"BH IDD tailored plans.

…

(c) Notwithstanding G.S. 108D-40(a)(12) and G.S. 108D-60(a)(10), in the event a BH IDD tailored plan contract is terminated, the Department is authorized to temporarily enroll recipients as follows:

1. In Medicaid Direct which includes the fee for service program described in G.S. 108D-1(16) and the prepaid inpatient health plan authorized by G.S 108D-60(b) of the LME/MCO whose BH IDD tailored plan contract is being terminated for the management of behavioral health, intellectual disability, and traumatic brain injury services including the services described in G.S. 108D-35(b); or

2. in a standard benefit plan as defined in G.S. 108D-1(36) for the management of the services described in G.S. 108D-35(a) and in the prepaid inpatient health plan authorized by G.S 108D-60(b)
of the LME/MCO whose BH IDD tailored plan contract is being terminated for the management of behavioral health, intellectual disability, and traumatic brain injury services including the services described in G.S. 108D-35(b) ; or

3. Any other service delivery system or combination of delivery systems available to the Department, until an orderly transfer to an alternate BH IDD tailored plan can be effectuated."

G.S. 122C-124.1 and G.S. 122C-125 are repealed in their entirety.

Appendix C

Proposed Mark Up of Statute Regarding Additional Secretarial Authority

Legislative Proposals to Authorize DHHS to Cancel An LME/MCO's Subcontract

Section xx.(a). G.S. 122C-112.1 reads as rewritten:

§ 122C-112.1. Powers and duties of the Secretary.

(a) The Secretary shall do all of the following:

…

(6)Establish comprehensive, cohesive oversight and monitoring procedures and processes to ensure continuous compliance by area authorities and their third party subcontractors, county programs, 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.

…"

Section xx.(b). G.S. 122C-115.4 reads as rewritten:

§ 122C-115.4. Functions of local management entities.

…

(c) Subject to subsection (b) of this section and all applicable State and federal laws, ~~laws and~~ rules of the Commission, 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. In accordance with G.S. 122C-142, an area authority shall cancel any third party subcontract at the direction of the Secretary when the area authority's management of its subcontractor results in the area authority's failure to comply with all statutory and contractual obligations.

…"

Section xx.(c). G.S. 122C-142 reads as rewritten:

§ 122C-142. Contract for services.

(a) When the 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 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 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 and federal statutes, rules of the Commission and contractual requirements are met and direct the area authority to cancel any third party subcontract when the area authority's oversight of the third party contract results in noncompliance.

…"

Legislative Proposals to Exempt LME/MCO Employees from the State Human Resources Act

Section xx.(a). G.S. 126-5(2)(a) is repealed in its entirety.

Section xx.(b). G.S. 126-5 reads as rewritten:

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

…

(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 mental health, developmental disabilities, and substance abuse authorities.

…"

Legislative Proposals to Adjust Use of Single Stream Funding[3]

Section xx. ~~During each year of the 2023-205 fiscal biennium, DMH/DD/SAS shall ensure that LME/MCOs fund, in total, at least ninety percent (90%) of the level of single-stream services provided across the State during the 2014-2015 fiscal year~~. No LME/MCO shall reduce funding for (i) home and community-based services or (ii) services paid for with single-stream funding that support the 2012 settlement agreement entered into between the United States Department of Justice and the State of North Carolina to ensure that the State will willingly meet the requirements of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, and the United States Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999). This subsection shall not be construed to require an LME/MCO to authorize or maintain the same level of services for any specific individual whose services were paid for with single-stream funding. This subsection shall not be construed to create a private right of action for any person or entity against the State of North Carolina or the Department of Health and Human Services or any of its divisions, agents, or contractors and shall not be used as authority in any contested case brought pursuant to Chapter 108C of the General Statutes or Chapter 108D of the General Statutes. DMH/DD/SAS shall have the authority to use or allocate single stream dollars to support statewide behavioral health or intellectual/developmental disability (I/DD) infrastructure or supports; to approve LME/MCO use of single stream dollars; or to direct single stream dollars to another LME/MCO if an LME/MCO dissolves or if two or more consolidate.

3 Additional inspection of the General Statutes is necessary to fully align with this proposal. Preliminary inspection indicates the following sections of Chapters 143B and 122C of the General Statutes may require conforming changes: . G.S. 122C-112.1(a)(3), (5), (6), (7), (9), (11), (14), (31)-(34) (Secretary authority re LME/MCOs); 122C-20.6, 20.9, 20.10, 20.11, 20.12 and 20.15 (LME/MCO responsibilities re TCL supportive housing program);.122C-114 (single portal of entry); 122C-115.4 (LME/MCO functions); 122C-117 (LME/MCO powers and duties); 122C-124.1 (actions by Secretary when LME/MCO fails to provide minimally adequate services); 122C-124.2 (effective management of behavioral health services under 1915(b)/(c) Medicaid waiver) 122C-131 (composition of public behavioral health system); Part 4 of Article 4 of Chapter 122C regarding area service providers; 122C-141 (LME/MCO authority pertaining to provision of services); 122C-142 (LME/MCO authority pertaining to contracting for services); 122C-143.1 (LME/MCO compliance with DHHS policy guidance); 122C-191 (area authority quality assurance duties); 143B-139.3 (DHHS authority to contract with other entities); 143B-147(a)(4) and (9) (MH/DD/SAS Commission authority re LME/MCOs).