Chapter 108D.

Medicaid and NC Health Choice Managed Care Programs.

Article 1.

General Provisions.

§ 108D-1. Definitions.

The following definitions apply in this Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider who is seeking to participate in the network of one or more local management entity/managed care organizations or prepaid health plans.

(4) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD tailored plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

(6) Closed network. – The network of providers that have contracted with (i) a local management entity/managed care organization operating the combined 1915(b) and (c) waivers or (ii) an entity operating a BH IDD tailored plan to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(6a) CMS. – The Centers for Medicare and Medicaid Services.

(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-5.9 or G.S. 108D-15.

(8) Department. – The North Carolina Department of Health and Human Services.

(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than

contracting for the coverage of services through a capitated payment arrangement.

(21) Local Management Entity or LME. – As defined in G.S. 122C-3.

(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3.

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract with the Department of Health and Human Services to operate the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

(27) Network provider. – An appropriately credentialed provider that has entered into a contract for participation in the network of one or more local management entity/managed care organizations or prepaid health plans.

(28) Notice of adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, that is under a capitated contract with the Department for the delivery of Medicaid and NC Health Choice services, or a local management entity/managed care organization that is under a capitated contract with the Department to operate a BH IDD tailored plan.

(31) Provider. – As defined in G.S. 108C-2.

(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD tailored plan. (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, ss. 4.6, 4.7(a).)

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

This Chapter applies to every managed care entity, applicant, enrollee, provider of emergency services, and network provider of a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this

Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21. (2013-397, s. 1; 2019-81, s. 1(a).)

§ 108D-3. Conflicts; severability.

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

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

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

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

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