§ 108D-65. (Effective until contingency met – see note) Role of the Department.

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

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this Article within the required time frames.

(2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in G.S. 108D-30. Every county in the State must be assigned to a region.

(3) Oversee, monitor, and enforce capitated PHP contract performance.

(4) Ensure sustainability of the transformed Medicaid and NC Health Choice programs.

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments, provided that capitated PHP contracts shall not require any withhold arrangements, as defined in 42 C.F.R. § 438.6, during the first 18 months of the demonstration. Any withhold arrangements required under a capitated PHP contract after the first 18 months of the demonstration shall not withhold an amount of a PHP's capitation payment that exceeds three and one-half percent (3.5%) of the PHP's total capitation payment. The Department shall not require community reinvestment as a condition for a PHP's receipt of any at-risk portion of the capitation rate.

b. Appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.

c. Rates for services in the remaining fee-for-service programs.

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in G.S. 108D-35. All contracts shall be the result of requests for proposals (RFPs) issued by the Department and the submission of competitive bids by PHPs. The Department shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by the Department.

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by the Department. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). The

Department shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

d. [Reserved for future codification.]

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

f. Terms that, to the extent not inconsistent with federal law or regulations, or State law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these requirements shall be overseen and enforced by the Department. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

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

g. A requirement that all participation agreements between a PHP and a health care provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.

(7) Prior to issuing the RFPs [requests for proposals] required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint

Legislative Oversight Committee on Medicaid and NC Health Choice on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

(8) Develop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.

(9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels.

This sub-subdivision shall not be construed to require the Department to utilize contract terms that would require PHPs to cover services that are not covered by the Medicaid program. (2015-245, s. 5; 2016-121, s. 2(c); 2018-49, s. 6(b); 2019-81, ss. 13, 14(a), (b).)

§ 108D-65. (Effective once contingency met – see note) Role of the Department.

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

(1) Submit to CMS a demonstration waiver application pursuant to Section 1115 of the Social Security Act and any other waivers and State Plan amendments necessary to accomplish the requirements of this Article within the required time frames.

(2) Define six regions comprised of whole contiguous counties that reasonably distribute covered populations across the State to ensure effective delivery of health care and achievement of the goals of Medicaid transformation set forth in G.S. 108D-30. Every county in the State must be assigned to a region.

(3) Oversee, monitor, and enforce capitated PHP contract performance.

(4) Ensure sustainability of the transformed Medicaid programs.

(5) Set rates, including the following:

a. Capitation rates that are actuarially sound. Actuarial calculations must include utilization assumptions consistent with industry and local standards. Capitation rates shall be risk adjusted and shall include a portion that is at risk for achievement of quality and outcome measures, including value-based payments, provided that capitated PHP contracts shall not require any withhold arrangements, as defined in 42 C.F.R. § 438.6, during the first 18 months of the demonstration. Any withhold arrangements required under a capitated PHP contract after the first 18 months of the demonstration shall not withhold an amount of a PHP's capitation payment that exceeds three and one-half percent (3.5%) of the PHP's total capitation payment. The Department shall not require community reinvestment as a condition for a PHP's receipt of any at-risk portion of the capitation rate.

b. Appropriate rate floors for in-network primary care physicians, specialist physicians, and pharmacy dispensing fees to ensure the achievement of transformation goals.

c. Rates for services in the remaining fee-for-service programs.

(6) Enter into capitated PHP contracts for the delivery of the Medicaid services described in G.S. 108D-35. All contracts shall be the result of requests for proposals (RFPs) issued by the Department and the submission of competitive bids by PHPs. The Department shall develop standardized contract terms, to include at a minimum, the following:

a. Risk-adjusted cost growth for its enrollees must be at least two percentage (2%) points below national Medicaid spending growth as

documented and projected in the annual report prepared for CMS by the Office of the Actuary for nonexpansion states.

b. A requirement that PHP spending for prescribed drugs, net of rebates, ensures the State realizes a net savings for the spending on prescription drugs. All PHPs shall be required to use the same drug formulary, which shall be established by the Department.

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by the Department. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). The Department shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

d. [Reserved for future codification.]

e. A requirement that all PHPs assure that enrollees who do not elect a primary care provider will be assigned to one.

f. Terms that, to the extent not inconsistent with federal law or regulations, or State law or rule, ensure PHPs will be subject to certain requirements of Chapter 58 of the General Statutes in accordance with this sub-subdivision. Compliance with these requirements shall be overseen and enforced by the Department. The requirements to be incorporated in the terms of the capitated PHP contracts are in the following sections of Chapter 58, and the requirements in these sections shall be applicable to PHPs in the manner in which these sections are applicable to insurers and health benefits plans, as the context requires:

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15. G.S. 58-51-37, Pharmacy of choice. The requirements of this statute to be incorporated into capitated PHP contracts shall apply to all PHPs regardless of whether a PHP has its own facility, employs or contracts with physicians, pharmacists,

nurses, or other health care personnel, and dispenses prescription drugs from its own pharmacy to enrollees.

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g. A requirement that all participation agreements between a PHP and a health care provider incorporate specific terms implementing sub-sub-subdivisions 3, 5, 6, 10, 11, 12, and 13 of sub-subdivision f. of this subdivision.

(7) Prior to issuing the RFPs [requests for proposals] required by subdivision (6) of this section, consult, in accordance with G.S. 12-3(15), with the Joint Legislative Oversight Committee on Medicaid on the terms and conditions of the requests for proposals (RFPs) for the solicitation of bids for statewide and regional capitated PHP contracts.

(8) Develop and implement a process for recipient assignment to PHPs. Criteria for assignment shall include at least the recipient's family unit, including foster family and adoptive placement, quality measures, and primary care physician.

(9) Define methods to ensure program integrity against provider fraud, waste, and abuse at all levels. (2015-245, s. 5; 2016-121, s. 2(c); 2018-49, s. 6(b); 2019-81, ss. 13, 14(a), (b); 2022-74, s. 9D.15(z), (bb).)