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SENATE BILL DRS35233-MR-92A

Short Title: Medicaid Admin. Changes & Tech. Corrections.-AB (Public)

Sponsors: Senators Krawiec, Burgin, and Perry (Primary Sponsors).

Referred to:

A BILL TO BE ENTITLED

AN ACT MODIFYING CERTAIN MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT, UPDATING THE MEDICAID PROGRAM BENEFICIARY APPEALS PROCESSES, INCREASING THE AMOUNT OF ALLOWABLE THERAPEUTIC LEAVE UNDER THE MEDICAID PROGRAM, REVISING THE TRANSFER OF AREA AUTHORITY FUND BALANCES, AND MAKING VARIOUS TECHNICAL CORRECTIONS TO THE STATUTES GOVERNING THE NORTH CAROLINA MEDICAID PROGRAM, AS REQUESTED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

PART I. MODIFICATIONS TO MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT

EXCLUDE THE COVID-19 TESTING COVERAGE GROUP FROM MEDICAID MANAGED CARE

SECTION 1.1. Section 4.5 of S.L. 2020-4 reads as rewritten:

"PROVIDE MEDICAID COVERAGE FOR COVID-19 TESTING TO UNINSURED INDIVIDUALS IN NORTH CAROLINA DURING THE NATIONWIDE PUBLIC HEALTH EMERGENCY

"SECTION 4.5. The Department of Health and Human Services, Division of Health Benefits (DHB), is authorized to provide the Medicaid coverage described in 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XXIII), which covers COVID-19 testing for certain uninsured individuals during the period in which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus, and for which the federal medical assistance percentage is one hundred percent (100%). DHB is authorized to provide this medical assistance retroactively to the earliest date allowable. Notwithstanding G.S. 108D-40, individuals receiving this Medicaid coverage shall not be covered by capitated prepaid health plan contracts under Article 4 of Chapter 108D of the General Statutes."

END TEMPORARY MEDICAID PROVIDER CHANGES IMPLEMENTED DUE TO THE PUBLIC HEALTH EMERGENCY

SECTION 1.2. Effective 30 days after this act becomes law, Section 4.7 of S.L. 2020-4 is repealed.

PART II. MEDICAID BENEFICIARY APPEALS MODIFICATIONS



ALLOW MEDICAID BENEFICIARIES TO FILE APPEALS BY TELEPHONE

SECTION 2.1.(a) G.S. 108A-70.9A is amended by adding a new subsection to read:

"(c1) Notice Availability. – The Department shall make available to OAH a copy of the notice of adverse determination required under subsection (c) of this section. The information contained in the notice is confidential unless the recipient appeals the adverse determination under subsection (d) of this section. OAH may dispose of these records after one year."

SECTION 2.1.(b) G.S. 108A-70.9A(d) reads as rewritten:

"(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by ~~sending~~ filing an appeal request form to OAH and the Department with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. ~~The Department shall immediately forward a copy of the notice to OAH electronically. The information contained in the notice is confidential unless the recipient appeals. OAH may dispose of the records after one year.~~ The Department may not influence, limit, or interfere with the recipient's decision to request a hearing."

SECTION 2.1.(c) G.S. 108A-70.9A(e)(1) reads as rewritten:

"(1) A statement ~~that that~~, in order to request an appeal, the recipient must ~~send file the form by mail or fax to the address or fax number listed on the form with OAH~~ within 30 days of mailing of the notice. notice, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form."

SECTION 2.1.(d) G.S. 108D-5.7(a)(1) reads as rewritten:

"(1) A statement ~~that that~~, in order to request an appeal, the enrollee must file the form ~~in accordance with OAH rules, by mail or fax to the address or fax number listed on the form,~~ no later than 30 days after the mailing date of the notice of ~~resolution~~ resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form."

SECTION 2.1.(e) G.S. 108D-5.9(a) reads as rewritten:

"(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may ~~file an appeal for a hearing~~ request a hearing to appeal the determination by filing the appeal request form provided under G.S. 108D-5.7(a) with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes."

SECTION 2.1.(f) G.S. 108D-11(b) reads as rewritten:

"(b) An enrollee, or the enrollee's authorized representative, may file grievances and managed care entity level appeals orally or in writing. ~~However, unless the enrollee, or the~~

1 enrollee's authorized representative, requests an expedited appeal, the oral appeal must be
2 followed by a written, signed appeal."

3 **SECTION 2.1.(g)** G.S. 108D-15(d) reads as rewritten:

4 "(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file
5 a request for an appeal by sending-filing an appeal request form that meets the requirements of
6 subsection ~~(e)-(f)~~ of this section ~~to-with~~ OAH ~~and the affected managed care entity~~ by no later
7 than 120 days after the mailing date of the notice of resolution. ~~A request for appeal is deemed~~
8 ~~filed when a completed and signed appeal request form has been both submitted into the care and~~
9 ~~eustody of the chief hearings clerk of OAH and accepted by the chief hearings clerk.~~ The form
10 may be filed by either (i) sending the form by mail or fax to the address or fax number listed on
11 the form or (ii) calling the telephone number on the form and providing the information requested
12 on the form. Upon receipt of a timely filed appeal request form, information contained in the
13 notice of resolution is no longer confidential, and the managed care entity shall immediately
14 forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these
15 records after one year."

16 **SECTION 2.1.(h)** G.S. 108D-15(f)(1) reads as rewritten:

17 "(1) A statement ~~that that~~, in order to request an appeal, the enrollee must file the
18 form ~~in accordance with OAH rules, by mail or fax to the address or fax~~
19 ~~number listed on the form~~, no later than 120 days after the mailing date of the
20 notice of ~~resolution~~-resolution, and the form may be filed by either (i) sending
21 the form by mail or fax to the address or fax number listed on the form or (ii)
22 calling the telephone number on the form and providing the information
23 requested on the form."

24 **SECTION 2.1.(i)** This section is effective when it becomes law and applies to (i)
25 appeal request forms under G.S. 108A-70.9A(e), 108D-5.7(a), and 108D-15(f) issued on or after
26 that date and (ii) appeals requested on or after that date.

27 **EXPEDITED PROCESS FOR MEDICAID BENEFICIARY APPEALS**

28 **SECTION 2.2.(a)** G.S. 108A-70.9A(e) is amended by adding a new subdivision to
29 read:
30

31 "(3a) The option for the recipient to request an expedited appeal."

32 **SECTION 2.2.(b)** G.S. 108A-70.9A is amended by adding a new subsection to read:

33 "(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may
34 request that an appeal under subsection (d) of this section be expedited if the time otherwise
35 permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain,
36 or regain maximum function. With regard to a request for an expedited appeal, all of the
37 following apply:

38 (1) The recipient shall submit any additional documentation from a licensed
39 health care professional with relevant excerpts from the recipient's medical
40 record that was not already provided with regard to the adverse determination
41 to demonstrate the need for an expedited appeal.

42 (2) The Department shall determine if the recipient's request meets the criteria for
43 an expedited appeal.

44 (3) If the Department determines that the recipient's request does not meet the
45 criteria for an expedited appeal, then (i) the Department shall make reasonable
46 efforts to give the recipient, or the recipient's parent, guardian, or legal
47 representative, oral notice of the denial as expeditiously as possible and shall
48 follow up with a written notice of denial and (ii) the recipient's appeal shall
49 not be subject to the expedited time frame in subdivision (4) of this subsection.
50 The denial is not appealable.

1 (4) If the Department determines that the recipient's request meets the criteria for
2 an expedited appeal, then (i) the mediation procedure under
3 G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision
4 required under G.S. 108A-70.9B(g) shall be made as expeditiously as
5 possible."

6 **SECTION 2.2.(c)** G.S. 108A-79(c) is amended by adding a new subdivision to read:

7 "(4a) With regard to the Medicaid and NC Health Choice programs only, the option
8 to request an expedited appeal in accordance with subsection (j1) of this
9 section."

10 **SECTION 2.2.(d)** G.S. 108A-79 is amended by adding a new subsection to read:

11 "(j1) In accordance with 42 C.F.R. § 431.224, a Medicaid or NC Health Choice applicant
12 or recipient may request that an appeal from the local appeal hearing decision under subsection
13 (g) of this section or an appeal of a case involving disability be expedited if the time otherwise
14 permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain,
15 or regain maximum function. With regard to a request for an expedited appeal, all of the
16 following apply:

17 (1) The appellant shall submit any documentation that was not previously
18 submitted to demonstrate the need for an expedited appeal. For cases not
19 involving disability, this documentation shall include documentation from a
20 licensed health care professional. For cases involving disability, this
21 documentation shall include relevant excerpts from the appellant's medical
22 record, including physical examinations, signs, symptoms, and laboratory
23 findings.

24 (2) The Department shall determine if the appellant's request meets the criteria
25 for an expedited appeal.

26 (3) If the Department determines that the appellant's request does not meet the
27 criteria for an expedited appeal, then (i) the Department shall make reasonable
28 efforts to give the appellant, or the appellant's authorized representative, oral
29 notice of the denial as expeditiously as possible and shall follow up with a
30 written notice of denial and (ii) the appeal shall not be subject to the expedited
31 time frame in subdivision (4) of this subsection. The denial is not appealable.

32 (4) If the Department determines that the appellant's request meets the criteria for
33 an expedited appeal, both the proposal for decision and the final decision
34 required under subsection (j) of this section shall be made as expeditiously as
35 possible.

36 (5) This subsection does not grant an appellant any greater assistance than the
37 appellant is otherwise entitled to under this section while the appellant's
38 appeal is pending."

39 **SECTION 2.2.(e)** G.S. 108D-5.7(b)(1) reads as rewritten:

40 "(1) No later than three calendar days after receiving the enrollee's request for
41 disenrollment, make reasonable efforts to give the enrollee and all other
42 affected parties oral notice of the denial and follow up with a written notice of
43 the ~~determination by mail denial~~. The denial is not appealable."

44 **SECTION 2.2.(f)** G.S. 108D-14(a) reads as rewritten:

45 "(a) Request for Expedited Appeal. – When the time limits for completing a standard
46 managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's
47 life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the
48 enrollee's authorized representative, has the right to file a request for an expedited appeal of an
49 adverse benefit determination no later than 60 days after the mailing date of the notice of adverse
50 benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the
51 managed care entity shall presume an expedited appeal is necessary when the expedited appeal

1 is made by a network provider as an enrollee's authorized representative or when a network
2 provider has otherwise indicated to the managed care entity that an expedited appeal is
3 necessary."

4 **SECTION 2.2.(g)** G.S. 108D-14(b) reads as rewritten:

5 "(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request
6 for an expedited managed care entity level appeal, then (i) the managed care entity shall make
7 reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and
8 follow up with a written notice of denial by mail no later than 72 hours after receiving the request
9 for an expedited appeal. ~~In addition, appeal and~~ (ii) the managed care entity shall resolve the
10 appeal within the time limits established for standard managed care entity level appeals in
11 G.S. 108D-13. The denial is not appealable."

12 **SECTION 2.2.(h)** G.S. 108D-15(f) is amended by adding a new subdivision to read:

13 "(3a) The option for the enrollee to request an expedited appeal."

14 **SECTION 2.2.(i)** Article 2 of Chapter 108D of the General Statutes is amended by
15 adding a new section to read:

16 **§ 108D-15.1. Expedited contested case hearings on disputed adverse benefit**
17 **determinations.**

18 Expedited Contested Case Hearing Requests. – In accordance with 42 C.F.R. § 431.224, an
19 enrollee, or an enrollee's authorized representative, may request that an appeal under
20 G.S. 108D-15(d) be expedited if the time otherwise permitted for a hearing could jeopardize the
21 enrollee's life, health, or ability to attain, maintain, or regain maximum function. With regard to
22 a request for an expedited appeal, all of the following apply:

23 (1) The enrollee shall submit any additional documentation from a licensed health
24 care professional with relevant excerpts from the enrollee's medical record
25 that was not already provided with regard to the adverse benefit determination
26 to demonstrate the need for an expedited appeal.

27 (2) The Department shall determine if the enrollee's request meets the criteria for
28 an expedited appeal.

29 (3) If the Department determines that the enrollee's request does not meet the
30 criteria for an expedited appeal, then (i) the Department shall make reasonable
31 efforts to give the enrollee, or the enrollee's authorized representative, oral
32 notice of the denial as expeditiously as possible and shall follow up with a
33 written notice of denial and (ii) the enrollee's appeal shall not be subject to the
34 expedited time frame in subdivision (4) of this subsection. The denial is not
35 appealable.

36 (4) If the Department determines that the enrollee's request meets the criteria for
37 an expedited appeal, then (i) the mediation procedure under G.S. 108D-15(i)
38 shall not apply to the appeal request and (ii) the decision required under
39 G.S. 108D-16 shall be made as expeditiously as possible."

40 **SECTION 2.2.(j)** This section is effective when it becomes law and applies to (i)
41 notices of action under G.S. 108A-79(c) and appeal request forms under G.S. 108A-70.9A(e) and
42 G.S. 108D-15(f) issued on or after that date and (ii) requests to expedite an appeal made on or
43 after that date.

44 **PART III. MISCELLANEOUS CHANGES RELATED TO THE MEDICAID PROGRAM**

45 **INCREASE ALLOWABLE AMOUNT OF MEDICAID-COVERED THERAPEUTIC** 46 **LEAVE**

47 **SECTION 3.1.(a)** G.S. 108A-62 reads as rewritten:

48 **§ 108A-62. Therapeutic leave for medical assistance patients.**
49
50

1 (a) ~~Patients~~ A medical assistance beneficiary at an intermediate care facility or skilled
2 nursing facility may take ~~up to 60 days of therapeutic leave in any one calendar year in~~
3 accordance with this section without the facility losing reimbursement under the medical
4 assistance program, ~~provided, however, no more than 15 consecutive days may be taken without~~
5 approval of the Department of Health and Human Services, Division of Health Benefits. Under
6 no circumstances shall the number of Medicaid-covered therapeutic leave days exceed 60 days
7 per patient per calendar year program.

8 (b) The maximum amount of therapeutic leave days that may be taken in a calendar year
9 by a medical assistance beneficiary are as follows:

10 (1) Ninety days for a beneficiary in an intermediate care facility.

11 (2) Sixty days for a beneficiary in a skilled nursing facility.

12 (c) No more than 15 consecutive days of therapeutic leave may be taken by a medical
13 assistance beneficiary without the approval of one of the following:

14 (1) The Division of Health Benefits of the Department.

15 (2) The local management entity/managed care organization with which the
16 beneficiary is enrolled under Chapter 122C of the General Statutes.

17 (3) The prepaid health plan with which the beneficiary is enrolled under Chapter
18 108D of the General Statutes."

19 **SECTION 3.1.(b)** This section is effective when it becomes law, and individuals
20 who had exhausted the amount of therapeutic leave prior to that date shall be entitled to any
21 additional leave for the calendar year allowed under G.S. 108A-62, as amended by this section.
22

23 **TRANSFER OF LME/MCO FUND BALANCES**

24 **SECTION 3.2.(a)** G.S. 122C-115.3 is amended by adding a new subsection to read:

25 "**(b1)** The Secretary shall, prior to the date that BH IDD tailored plans begin operating,
26 direct the dissolution of any authority that does not receive an initial contract to operate a BH
27 IDD tailored plan. The Secretary shall deliver a notice of dissolution to the board of county
28 commissioners of each of the counties in the dissolved LME/MCO."

29 **SECTION 3.2.(b)** G.S. 122C-115.3(e) reads as rewritten:

30 "**(e)** Any fund balance or risk reserve available to an area authority at the time of its
31 dissolution that is not utilized to pay liabilities shall be transferred to the area authority one or
32 more area authorities contracted to operate the 1915(b)/(c) Medicaid Waiver or a BH IDD
33 tailored plan in all or a portion of the catchment area of the dissolved area authority. If the fund
34 balance transferred from the dissolved area authority is insufficient to constitute fifteen percent
35 (15%) of the anticipated operational expenses arising from assumption of responsibilities from
36 the dissolved area authority, the Secretary shall guarantee the operational reserves for the area
37 authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming
38 area authority has reestablished fifteen percent (15%) operational reserves authority, as directed
39 by the Department."

40 **SECTION 3.2.(c)** G.S. 122C-115.3 is amended by adding a new subsection to read:

41 "**(e1)** Effective until the date that BH IDD tailored plans begin operating, if the fund balance
42 transferred from the dissolved area authority under subsection (e) of this section is insufficient
43 to constitute fifteen percent (15%) of the anticipated operational expenses arising from
44 assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the
45 operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c)
46 Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%)
47 operational reserves."

48 **PART IV. TECHNICAL CORRECTIONS**

49

1 **SECTION 4.1.** The Revisor of Statutes shall replace the phrase "the mentally
2 retarded" with the phrase "individuals with intellectual disabilities" in the following statutes:
3 G.S. 108A-58.2, 108A-61.1, and 108A-70.5.

4 **SECTION 4.2.(a)** G.S. 90-21.50(1) reads as rewritten:

5 "(1) "Health benefit plan" means an accident and health insurance policy or
6 certificate; a nonprofit hospital or medical service corporation contract; a
7 health maintenance organization subscriber contract; a self-insured indemnity
8 program or prepaid hospital and medical benefits plan offered under the State
9 Health Plan for Teachers and State Employees and subject to the requirements
10 of Article 3 of Chapter 135 of the General Statutes, a plan provided by a
11 multiple employer welfare arrangement; or a plan provided by another benefit
12 arrangement, to the extent permitted by the Employee Retirement Income
13 Security Act of 1974, as amended, or by any waiver of or other exception to
14 that act provided under federal law or regulation. ~~Except for the Health
15 Insurance Program for Children established under Part 8 of Article 2 of
16 Chapter 108A of the General Statutes,~~ "Health benefit plan" does not mean
17 any plan implemented or administered by the North Carolina or United States
18 Department of Health and Human Services, or any successor agency, or its
19 representatives. "Health benefit plan" does not mean any of the following
20 kinds of insurance:

21 "

22 **SECTION 4.2.(b)** G.S. 90-21.50(7) reads as rewritten:

23 "(7) "Managed care entity" means an insurer that:

24 ...

25 Except for the State Health Plan for Teachers and State ~~Employees and the
26 Health Insurance Program for Children, Employees,~~ "managed care entity"
27 does not include: (i) an employer purchasing coverage or acting on behalf of
28 its employees or the employees of one or more subsidiaries or affiliated
29 corporations of the employer, or (ii) a health care provider."

30 **SECTION 4.3.** G.S. 108A-54.3A(5) reads as rewritten:

31 "(5) Children under the age of ~~19-21~~ who are receiving foster care or adoption
32 assistance under Title IV-E of the Social Security Act, without regard to
33 income."

34 **SECTION 4.4.** G.S. 108A-68.2 reads as rewritten:

35 "**§ 108A-68.2. Beneficiary lock-in program for certain controlled substances.**

36 (a) ~~As used in this section, "covered substances" means any~~ The following definitions
37 apply in this section:

38 (1) Covered substances. – Any controlled substance identified as an opioid or
39 benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in
40 Article 5 of Chapter 90 of the General Statutes, unless one of the following
41 conditions are met:

42 ~~(1)~~a. If the Department of Health and Human Services specifically identifies
43 the opioid or benzodiazepine as a substance excluded from coverage
44 by the Medicaid Beneficiary Management Lock-In Program described in
45 its Outpatient Pharmacy Clinical Coverage Policy adopted in
46 accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is
47 not a covered substance under this section.

48 ~~(2)~~b. If the Department of Health and Human Services specifically identifies
49 a controlled substance contained in Article 5 of Chapter 90 of the
50 General Statutes other than an opioid or benzodiazepine as a controlled
51 substance covered by the Medicaid Beneficiary Management Lock-In

Program described in its Outpatient Pharmacy Clinical Coverage Policy adopted in accordance with G.S. 108A-54.2, then the controlled substance is a covered substance under this section.

(2) Lock-in program. – A requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.

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

(b) ~~As used in this section, "lock-in program" means a requirement that a Medicaid or NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining covered substances.~~

(c) ~~As used in this section, "Prepaid Health Plan" or "PHP" means an entity holding a PHP license under Article 93 of Chapter 58 of the General Statutes.~~

...."

SECTION 4.5. G.S. 108C-2.1 reads as rewritten:

"§ 108C-2.1. **Provider application and ~~recredentialing-revalidation~~ fee.**

(a) Each provider that submits an application to enroll in the Medicaid program shall submit an application fee. The application fee shall be the sum of the amount federally required and one hundred dollars (\$100.00).

(b) The fee required under subsection (a) of this section shall be charged to all providers at ~~recredentialing-revalidation~~ every five years."

SECTION 4.6. G.S. 108D-1 is amended by adding a new subdivision to read:

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

SECTION 4.7. G.S. 108D-1(6) reads as rewritten:

"(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."

SECTION 4.8.(a) G.S. 108D-5.3(b)(1) reads as rewritten:

"(1) ~~Members of federally recognized tribes.~~ Beneficiaries who meet the definition of Indian under 42 C.F.R. § 438.14(a)."

SECTION 4.8.(b) G.S. 108D-40(a)(5) reads as rewritten:

"(5) ~~Members of federally recognized tribes. Members of federally recognized tribes~~ Recipients who meet the definition of Indian under 42 C.F.R. § 438.14(a) shall have the option to enroll voluntarily in PHPs."

SECTION 4.8.(c) G.S. 108D-40(a)(5a) is repealed.

SECTION 4.8.(d) G.S. 122C-115(e) reads as rewritten:

"(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), ~~(5a)~~, (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) waivers for Medicaid recipients described in G.S. 108D-40(a)(1), (4), (5), ~~(5a)~~, (6), (7), (10), (11), (12), and (13).

...."

SECTION 4.9. G.S. 108D-35(5) reads as rewritten:

"(5) Services documented in an individualized family service plan under the Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are provided and billed by a Children's Developmental Services Agency (CDSA) ~~that are included on the child's Individualized Family Service Plan~~ or by a

1 provider contracted with a Children's Developmental Services Agency to
2 provide those services."

3 **SECTION 4.10.** Article 17 of Chapter 131E of the General Statutes is repealed.

4

5 **PART V. EFFECTIVE DATE**

6 **SECTION 5.** Except as otherwise provided, this act is effective when it becomes
7 law.