§ 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, in accordance with G.S. 122C-125.3, is either (i) not required to be under a corrective action plan or (ii) in compliance with a corrective action plan.

(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 direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5 after the Department fulfills any contractual obligations regarding the noncompliance.

(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 direct the dissolution of the LME/MCO in accordance with G.S. 122C-115.5 after the Department fulfills any contractual obligations regarding the noncompliance.

(e) Repealed by Session Laws 2023-134, s. 9G.7A(a8), effective October 3, 2023.

(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. – A contract between the Department of Health and Human Services and a local management entity for the operation of the 1915(b)/(c) Medicaid Waiver or a BH IDD tailored plan. (2013-85, s. 2; 2018-5, s. 11F.10(d); 2023-134, s. 9G.7A(a8).)