HOUSE BILL 403:
LME/MCO Claims Reporting/Mental Health Amdts.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 14, 2017
Introduced by:	Reps. Dollar, Lambeth, Dobson, White	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition H403-CSTR-6		

OVERVIEW: The PCS to House Bill 403 would make various modifications to laws pertaining to local management entities/managed care organizations (LME/MCOs) and to the Medicaid program, as follows:

- ***Part I modifies certain requirements pertaining to LME/MCOs, which manage the provision of publicly-funded behavioral health services throughout the State.***
- ***Part II modifies the Medicaid transformation legislation, enacted in 2015 and amended in 2016, requiring transition of the Medicaid delivery system to capitated contracts with Prepaid Health Plans.***
- ***Part III requires the Department of Health and Human Services (DHHS) to notify the General Assembly every time DHHS submits a Medicaid State Plan amendment for federal approval and every time DHHS decides not to submit a proposed State Plan amendment that was posted to DHHS's website.***
- ***Part IV amends the statutes that govern Medicaid enrollees' appeals and grievances related to actions taken by LME/MCOs to make these statutes conform to changes in the Medicaid federal regulations that recently took effect.***

PART I. LME/MCO MODIFICATIONS

CURRENT LAW/BACKGROUND: S.L. 2011-264 (HB 916), as amended by Section 13, S.L. 2012-151 (SB 191), directed the Department of Health and Human Services (DHHS) to proceed with statewide restructuring of management responsibilities for the delivery of services to individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders, through the statewide expansion of the Section 1915(b)/(c) Medicaid Waiver and the operation of the waiver by regional LME/MCOs. As directed in the law, statewide expansion was completed by July 2013. LME/MCO operations are governed by Chapter 122C of the General Statutes.

Originally, 11 LME/MCOs were formed, and those have consolidated to the 7 LME/MCOs that currently exist in the State, which include Vaya Health, Partners Behavioral Health, Cardinal Innovations Healthcare Solutions, Sandhills Center, Alliance Behavioral Health, Eastpointe, and Trillium Health Resources.

LME/MCOs originated from area authorities, county programs, and consolidated human services agencies, which later became local management entities (LMEs). Today, all LME/MCOs are structured

as area authorities, and county programs and consolidated human services agencies no longer operate. The terms "area authority," "LME," and "LME/MCO" all refer to the same entities.

The LME/MCOs manage funding from 4 primary sources: State-only (single-stream) funding, State and federal Medicaid funds, federal block grant funds, and county funds.

BILL ANALYSIS: **Part I** of the PCS amends several sections of Chapter 122C, The Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, and other provisions of law pertaining to LME/MCOs.

Section 1 directs that on the date when Medicaid capitated contracts with Prepaid Health Plans (PHPs) begin: (1) PHPs shall manage all publicly-funded behavioral health services, (2) the LME/MCOs shall be dissolved, and (3) all remaining LME/MCO assets shall be transferred to DHHS and used to satisfy LME/MCO liabilities or to pay for the cost of contracts with PHPs. If the assets transferred to DHHS are insufficient to cover the LME/MCOs' liabilities, the State shall satisfy the liabilities or arrange to transfer the liabilities to the PHPs.

Section 2 of the PCS requires DHHS to specify a standardized electronic format that all LME/MCOs must use to submit data to DHHS regarding claims billed for Medicaid and State-funded services and to work with LME/MCOs to ensure the success of the process for submitting this data. This section lists permissible uses of the data by DHHS and requires DHHS to report on the status of this requirement by February 1, 2018.

Section 3 of the PCS amends the statute pertaining to the powers and duties of the Secretary of DHHS relevant to the mental health, developmental disabilities, and substance abuse services system to require DHHS to use contracts with LME/MCOs for the management of State-only funding, federal block grant funding, and Medicaid funding that include quality outcome measures for covered services. This section is effective January 1, 2018 and applies to contracts entered into on or after the bill becomes law.

Section 4 of the PCS amends various definitions pertaining to the State's mental health, developmental disabilities, and substance abuse services system, including amending the definition of "area director" to clarify that the term refers to the administrative head of the LME/MCO, regardless of the title that individual uses. This section amends other definitions for clarity and to remove obsolete references.

Section 5 of the PCS amends the statute pertaining to the powers and duties of an area authority to codify certain powers and duties that were enacted in uncodified language in S.L. 2011-264.

Section 6 of the PCS amends the statute pertaining to processes that may occur when an area authority is not providing minimally adequate services to specify that those processes may apply when the Secretary of DHHS determines that an area authority or area director has failed to comply with any requirement of State or federal law, rule, or regulation, or any requirement of the area authority's contract with DHHS. The process allows the Secretary to withhold funding from an area authority or assume control of an area authority's management functions after giving the area authority notice and an opportunity to be heard. If the Secretary either withholds funding or assumes control of management functions, the Secretary must develop and oversee a corrective action plan for the area authority. If the area authority does not comply with the corrective action plan, the Secretary, upon notice to the area authority, may appoint a caretaker board and terminate the area director.

Section 7 of the PCS amends the statute pertaining to the area authorities' responsibilities related to their funding to specify that area authorities shall not expend any resources on alcohol, first-class airfare, charter flights, holiday parties or similar social gatherings, or meetings outside the State.

Section 8 of the PCS requires the Office of State Human Resources (OSHR), in collaboration with the Secretary of DHHS and the LME/MCO boards, to take certain actions to revise the job description and salary range for LME/MCO area directors. **Section 8(b)** imposes the following requirements:

- Requires OSHR to update the job description for area directors by September 1, 2017.
- Requires OSHR to recommend a revised salary range to the State Human Resources Commission by December 1, 2017. The recommendation must be based upon a market compensation study of public and not-for-profit organizations nationwide with similar functions to the LME/MCOs and of similar size, including number of covered lives, annual service expenditures, and geographical service areas.
- Requires the State Human Resources Commission to revise the salary range based on this recommendation by March 1, 2018.

Section 8(c) voids the current salary range for area directors and prohibits area authorities from increasing any area director's salary until the new salary range is established, except that vacant area director positions may be filled. **Section 8(d)** requires LME/MCO boards to reestablish the salary for their area director upon the establishment of the new salary range. This requirement would apply to contracts with area directors beginning on or after the date that this act becomes law. **Section 8(e)** authorizes OSHR to recommend to the State Human Resources Commission revisions the salary range for area directors until LME/MCOs are dissolved under **Section 1** of the PCS. Recommendations must be based a market compensation study meeting the same criteria as required for **Section 8(b)**.

Section 9 of the PCS removes obsolete references from Chapter 122C.

EFFECTIVE DATE: Part I of the PCS would be effective when it becomes law.

PART II. MEDICAID TRANSFORMATION MODIFICATIONS

CURRENT LAW: S.L. 2015-245, An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs, became law on September 23, 2015, and provided a legislative framework for the transformation of North Carolina's Medicaid program to provide budget predictability for the taxpayers of the State while ensuring quality care to those in need. S.L. 2015-245 requires transition of the current Medicaid and NC Health Choice programs to capitated (per person per month) contracts with Prepaid Health Plans (PHPs) under an 1115 waiver approved by the Centers for Medicare and Medicaid Services (CMS).

BILL ANALYSIS: **Part II** of the PCS makes various changes to the Medicaid transformation legislation, as follows:

- Clarifies rule-making authority pertaining to licensure of PHPs and other aspects of Medicaid transformation.
- Clarifies the definitions of the terms "commercial plan" and "provider-led entity" (PLE).
- Eliminates the exclusion of behavioral health services from PHP coverage for four years after capitated contracts begin.
- Eliminates the exclusion of dental services from PHP coverage.
- Adds an exclusion for the coverage of eyeglasses from PHP coverage.

- Requires Medicare and Medicaid dually-eligible recipients to be covered by PHPs beginning two years after captitated contracts begin, and allows their enrollment to be phased in over a period of up to two years.
- Adds to the list of populations excluded from PHP coverage recipients who are enrolled under the Medicaid Family Planning program and recipients who are inmates of prisons.
- Changes the number of statewide PHP contracts that may be awarded from three to at least three but no more than five.
- Changes the number of regional PLE contracts that may be awarded from 12 to four and allows DHHS to specify any number of regions (current legislation requires six regions).
- Replaces the requirement that PHPs must comply with Chapter 58 of the General Statutes with a requirement to comply with recently-amended federal Medicaid managed care regulations.
- Clarifies that DHHS is authorizes to submit modifications to the 1115 waiver submission to CMS and requires notice to the General Assembly of the submission of any modifications.
- Requires PHPs and hospitals to negotiate mutually acceptable rates.
- Requires that PHP payments to hospitals may not exceed 125% of the fee-for-service rate unless a higher rate is approved by DHHS.
- Requires providers enrolling or reenrolling as a Medicaid provider to agree to accept 90% of the Medicaid fee-for-service rate for the services they provide to PHP enrollees if the provider has been offered a contract with the PHP but is not under a contract with the PHP or has been excluded from a contract with the PHP for failing to meet quality standards.

EFFECTIVE DATE: Part II of the PCS is effective when it becomes law.

PART III. NOTICE OF MEDICAID STATE PLAN AMENDMENT SUBMISSIONS

CURRENT LAW: G.S. 108A-54.1A(d) requires DHHS to post amendments to the Medicaid State Plan, including Medicaid waivers and waiver amendments, at least 10 days prior to submitting the amendment to the federal government for approval. The statute requires DHHS to notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division when an amendment is posted to DHHS's website. Current law does not require DHHS to provide notice to the General Assembly when a State Plan amendment has been submitted for federal approval.

BILL ANALYSIS: **Section 12** of the PCS adds requirements for DHHS to give notice to the Joint Legislative Oversight Committee and Medicaid and NC Health Choice and the Fiscal Research Division regarding the submission of State Plan amendments that are posted to DHHS's website in accordance with G.S. 108A-54.1A(d). The PCS requires DHHS to give notice when a State Plan amendment is submitted for federal approval and to give notice when DHHS decides not to submit a proposed State Plan amendment that was posted. The PCS also requires DHHS to give notice upon submission of a modification to a previously-submitted State Plan amendment.

EFFECTIVE DATE: Part III of the PCS is effective when it becomes law and applies to State Plan amendments posted on DHHS's website on or after that date.

PART IV. CONFORMING CHANGES TO LME/MCO APPEALS

CURRENT LAW: Chapter 108D of the General Statutes governs the process for Medicaid beneficiaries who are enrolled with an LME/MCO to appeal decisions made by LME/MCOs and to file grievances with LME/MCOs. Medicaid beneficiaries enroll with an LME/MCO in order to receive behavioral health services. The statutes in Chapter 108D allow enrollees to appeal certain LME/MCO actions through an LME/MCO level (first-level) appeal and to appeal the LME/MCO's resolution of the first-level appeal by requesting a contested case hearing with the Office of Administrative Hearings. The statutes also allow enrollees to file grievances with LME/MCOs related to matters that are not subject to appeal.

The State is required to establish procedures for Medicaid enrollee appeals and grievances in accordance with federal managed care regulations in Part 438 of Title 42 of the Code of Federal Regulations. Effective July 5, 2016, changes were made to these federal regulations that conflict with certain provisions in Chapter 108D.

BILL ANALYSIS: **Section 14** of the PCS amends the definitions pertaining to LME/MCO grievances and appeals by replacing the term "managed care action" with the term "adverse benefit determination" in accordance with a change to that terminology in the federal regulations. Conforming changes are made in **Section 15** of the PCS and throughout the **Part IV** of the PCS.

Section 16 of the PCS amends the statute governing standard LME/MCO level enrollee appeals to do the following:

- Allows enrollees 60 days instead of 30 days to request an LME/MCO level appeal after receiving a notice of adverse benefit determination.
- Requires LME/MCOs to resolve an LME/MCO level appeal and send a notice of resolution to the enrollee within 30 days instead of 45 days after receiving the request for appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 17 of the PCS amends the statute governing expedited LME/MCO level appeals to do the following:

- Requires LME/MCOs to resolve expedited LME/MCO level appeals within 72 hours instead of three working days after receiving the request for expedited appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 18 of the PCS amends the statute governing enrollee contested case hearings to allow enrollees 120 days instead of 30 days after the mailing date of the notice of resolution to file a request for an appeal at the Office of Administrative Hearings.

EFFECTIVE DATE: **Part IV** of the PCS is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.

PART V. EFFECTIVE DATE

EFFECTIVE DATE: **Section 3** of the PCS would become effective January 1, 2018. The remainder of the PCS would become effective when the bill becomes law.