HOUSE BILL 656:
Medicaid Changes for Transformation.

2019-2020 General Assembly

Committee:	House Health. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	April 30, 2019
Introduced by:	Reps. Lambeth, Dobson, Murphy, Sasser	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition H656-CSTR-5		

OVERVIEW: HB 656 makes changes to the Medicaid and Health Choice appeals statutes, and to other laws pertaining to Medicaid and Health Choice, that are necessary to implement Medicaid Transformation and contracts with Prepaid Health Plans on November 1, 2019.

The PCS adds Section 8 and makes technical changes.

CURRENT LAW: S.L. 2015-245, as amended, requires transition of the current Medicaid and Health Choice programs to capitated contracts with prepaid health plans (PHPs) under an 1115 waiver that was recently approved by the Centers for Medicare and Medicaid Services (CMS). Under the waiver, the Department of Health and Human Services (DHHS) has entered into contracts to pay PHPs a monthly per-person capitated rate to cover all Medicaid and Health Choice services for their enrollees. DHHS has also contracted with an enrollment broker to assist beneficiaries with enrolling in a PHP. The waiver directs that capitation payments to PHPs for enrolled beneficiaries will begin November 1, 2019.

BILL ANALYSIS: HB 656 makes changes to Medicaid and Health Choice laws that are necessary (i) to comply with federal law and regulations; (ii) for consistency with the Medicaid Transformation legislation, S.L. 2015-245, as amended; and (iii) for consistency with the PHP contracts that have been awarded. The bill has the following components:

- **Sections 1 and 6** establish a process for beneficiaries to appeal adverse decisions regarding disenrollment from a PHP in new Article 1A of Chapter 108D of the General Statutes. A Medicaid or Health Choice beneficiary may use this process to appeal decisions by DHHS or the enrollment broker regarding the beneficiary's disenrollment from a PHP. Key features of the process include the following:
    - The circumstances when disenrollment from a PHP is allowed, with or without cause, whether initiated by the enrollee or the PHP, are set out in G.S. 108D-5.3 and 108D-5.5.
    - The process for an enrollee to make an expedited request for disenrollment when the enrollee has an urgent medical need is set out in G.S. 108D-5.3(d).
    - Beneficiaries may appeal (i) the denial of their request to disenroll from a PHP or (ii) the approval by DHHS or by the enrollment broker of a PHP's request to disenroll the enrollee, under G.S. 108D-5.9.
    - The appeals process will be the same as the existing process for fee-for-service beneficiary appeals at the Office of Administrative Hearings under Part 6A of Article 2 of Chapter 108A of the General Statutes. DHHS is the respondent in these contested cases.

- **Section 1** establishes processes for beneficiaries to file grievances and appeals of adverse decisions by PHPs regarding service coverage. The processes will be the same as the existing grievance and appeals processes in Article 2 of Chapter 108D of the General Statutes, which govern grievances and appeals of actions by local management entities/managed care organizations (LME/MCOs), with the following exceptions:
    - Health Choice beneficiaries will use this process for PHP determinations. Currently, Health Choice beneficiaries are not enrolled in LME/MCOs and do not engage in the LME/MCO appeals process. Health Choice beneficiaries will use the existing process in G.S. 108A-70.29 for appeals not related to PHPs, as set forth in **Section 7**.
    - The length of time in which a LME/MCO must respond to a grievance is shortened from 90 days to 30 days under G.S. 108D-12(b), and the 30-day timeframe also applies to PHPs.
    - PHP enrollees, but not LME/MCO enrollees, who are Medicaid recipients must be granted reinstatement of benefits if requested within 30 days after the adverse benefit determination notice was sent and certain other conditions are met under G.S. 108D-13(c1), 108D-14(c1), and G.S. 108D-15(g).
- **Section 1** also makes conforming changes to existing grievance and appeals processes in accordance with changes in federal law that have recently occurred.
- **Sections 4 and 5** add references to PHPs in the General Statutes.
- **Section 10** exempts contract disputes between PHPs and DHHS from Chapter 150B contested case hearings at the Office of Administrative Hearings under G.S. 150B-1.
- **Section 11** allows a PHP to be named as the sole respondent in a contested case at the Office of Administrative Hearings related to a notice of resolution issued by the PHP, under G.S. 150B-23. The circumstances when a PHP may be named as a respondent are the same as when an LME/MCO may be named as a respondent under current law.
- **Section 14** directs the codification of the Medicaid Transformation legislation, S.L. 2015-245, as amended, into the General Statutes. **Sections 2, 3, 9, 12, and 13** make technical changes related to codification.
- **Section 15** replaces references to the Division of Medical Assistance in the General Statutes with references to the Division of Health Benefits.

The PCS adds **Section 8** which establishes that DHHS may require a PHP or an LME/MCO, on behalf of DHHS, to suspend payments to a provider in accordance with the existing requirements for payment suspension in G.S. 108C-5 and upon notice to the provider. This requirement is consistent with the PHP contracts that have been awarded.

The PCS also makes technical changes, including: (i) modifying the instructions regarding codification of S.L. 2015-245, as amended; (ii) correcting the effective date of Section 16; and (iii) renumbering as appropriate.

EFFECTIVE DATE: The changing of references in the statutes to the Division of Medical Assistance to instead reference the Division of Health Benefits is effective July 1, 2019. The remainder of the PCS is effective October 1, 2019. The changes to the LME/MCO grievance and appeals processes apply to (i) appeals arising from LME/MCO notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.