SENATE BILL 594: Medicaid Admin. Changes & Tech. Corrections.

2021-2022 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 5, 2021
Introduced by:	Sens. Krawiec, Burgin, Perry	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition S594-CSTR-4		

OVERVIEW: The PCS to Senate Bill 594 makes various technical and other changes to laws related to the NC Medicaid program as requested by the Department of Health and Human Services (DHHS).

BILL ANALYSIS:

Part I would make modifications to two Medicaid-related provisions of the 2020 COVID-19 Recovery Act, S.L. 2020-4, as follows:

- **Section 1.1** would exclude from managed care coverage the population of uninsured individuals who are eligible for Medicaid coverage only for services related to COVID-19 testing.
- **Section 1.2** would reinstate the following provisions of State law that were suspended during the public health emergency:
  - G.S. 108C-2.1, which requires a $100 fee for provider enrollment applications and requires recredentialing every five years.
  - G.S. 108C-4(a), which imposes a State requirement to conduct criminal history record checks.
  - G.S. 108C-9(a) and (c), which requires providers to complete certain trainings prior to initial enrollment as a Medicaid and Health Choice provider,

  This section would be effective 30 days after the bill becomes law.

Part II would make modifications to the existing Medicaid beneficiary appeals statutes in Chapters 108A and 108D of the General Statutes, as follows:

- **Section 2.1** would allow Medicaid beneficiaries to file an appeal of a fee-for-service adverse benefit determination, a prepaid health plan adverse disenrollment determination, a managed care entity level appeal, or a managed care notice of resolution of an adverse benefit determination, or file a managed care grievance, by telephone without following up in writing, in accordance with 42 C.F.R. § 431.221(a)(1)(i). Appeal request forms for these appeals would provide instructions for filing the form by telephone.
- **Section 2.2** would provide an expedited hearing option, in compliance with 42 C.F.R. § 431.224, for the following types of Medicaid beneficiary appeals: fee-for-service adverse benefit determinations, local appeal hearing decisions regarding Medicaid and Health Choice eligibility determinations, and managed care notices of resolution of an adverse benefit determination. An expedited appeal would be allowed if the normal timeframe for the hearing could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. DHHS would determine whether the criteria for an expedited appeal was met, and a denial of an expedited appeal

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

would not be appealable. Appeal request forms for these appeals would inform the Medicaid beneficiary of the option to request an expedited appeal.

Part III would make various changes to laws related to the Medicaid program, as follows:

- **Section 3.1** would increase the number of Medicaid-covered therapeutic leave days to 90 (from 60) for a Medicaid beneficiary in an intermediate care facility. This section also would add local management entities/managed care organizations (LME/MCOs) and prepaid health plans as entities that may approve a Medicaid beneficiary's request for more than 15 consecutive days of therapeutic leave.
- **Sections 3.2** and **3.3** would require standard benefit plans to cover the following additional behavioral health services: peer support services, substance abuse comprehensive outpatient treatment program services, substance abuse intensive outpatient program services, and social setting detoxification or clinically managed residential withdrawal services. The coverage of social setting detoxification or clinically managed residential withdrawal services would only be required if Medicaid coverage for this service is approved by the Centers for Medicare and Medicaid Services.
- **Section 3.4** would allow DHHS to determine whether services provided to Medicaid applicants prior to an eligibility determination may be covered retroactively through the managed care delivery system.
- **Section 3.5** would require the Secretary of DHHS to direct the dissolution of an area authority (also called an LME/MCO) that does not receive an initial contract to operate a BH IDD tailored plan under G.S. 108D-60. This section also would clarify that, upon dissolution of an area authority, (i) the Medicaid risk reserve fund balance of the dissolved area authority must be transferred along with the other fund balance of the dissolved LME/MCO and (ii) these fund balances may be transferred to more than one area authority or BH IDD tailored plan if more than one area authority or BH IDD tailored plan is contracted to operate in the catchment area of the dissolved area authority.
- **Section 3.7** would replace the rate floor for durable medical equipment in the managed care delivery system required by Section 11 of S.L. 2020-88 with a fixed reimbursement rate.

Part IV would make various technical corrections to laws related to the Medicaid program, as follows:

- **Section 4.1** would replace the phrase "the mentally retarded" with "individuals with intellectual disabilities" throughout Chapter 108A of the General Statutes.
- **Section 4.2** would remove the outdated references to the Health Choice program from the "Health Care Liability" statutes in in Chapter 90 of the General Statutes that pertain to insurers.
- **Section 4.3** would correct the age limit for the foster care Medicaid eligibility category from 19 to 21 in accordance with G.S. 108A-48(c) and 108A-49(e).
- **Section 4.4** would clarify that a prepaid health plan operating a BH IDD tailored plan has the same authority to develop and utilize a lock-in program for controlled substances as a prepaid health plan operating a standard benefit plan.
- **Section 4.5** would replace the term "recredentialing" with "revalidation" to conform with the defined term in G.S. 108C-2(11).

- **Section 4.6** would define the acronym "CMS", as used in Chapter 108D, as the Center for Medicare and Medicaid Services.
- **Section 4.7** would update the definition of "closed network" in G.S. 108D-1 to align with the use of the term in G.S. 108D-21 and 108D-23.
- **Section 4.8** would replace the reference to "members of federally recognized tribes" with the term "Indians" in accordance with updated federal definition in 42 C.F.R. § 438.50(d).
- **Section 4.9** would clarify that certain services provided through a contractor with a Children's Developmental Services Agencies (CDSA) will be excluded from the managed care delivery system and will instead be provided through the fee-for-service system. Services provided directly by a CDSA are already excluded from the managed care delivery system under G.S. 108D-35(5).
- **Section 4.10** would repeal Article 17 of Chapter 131E pertaining to Provider Sponsored Organizations (PSOs).

EFFECTIVE DATE: The repeal of Section 4.7 of S.L. 2020-4 in Section 1.2 of the bill would be effective 30 days after the bill becomes law. The remainder of the bill would be effective when it becomes law.