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

2021-2022 General Assembly

Committee:	House Rules, Calendar, and Operations of the House	**Date:**	June 23, 2021
Introduced by:	Sens. Krawiec, Burgin, Perry	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition S594-CSTR-9		

OVERVIEW: The proposed committee substitute (PCS) to Senate Bill 594 makes various technical and other changes to laws related to the NC Medicaid program and local management entities/managed care organizations (LME/MCOs). The PCS removes Sections 3.3 and 3.4, modifies Sections 3.2 and 3.6, adds Section 3.4A and 3.5A, and makes technical and conforming changes.

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. This section would be effective July 1, 2021.
- **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 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 would clarify the codification of the behavioral health services that are covered by standard benefit plans under G.S. 108D-35(1).
- **Section 3.4A** would specifically restate DHHS's authority to contract with entities operating behavioral health and intellectual/developmental disabilities (BH IDD) tailored plans through a contract other than a BH IDD tailored plan for the management of behavioral health, intellectual and developmental disability, and traumatic brain injury services provided to the following populations of Medicaid recipients who are excluded from coverage by prepaid health plans: foster care or adoption assistance recipients, the medically needy, Indians, Health Insurance Premium Payment (HIPP) participants, community alternatives program for children (CAP/C) participants, community alternatives program for disabled adults (CAP/DA) participants, nursing facility residents, and Medicare/Medicaid dual-eligibles who receive full Medicaid coverage.
- **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 area authority 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 3.5A** would direct DHHS to develop a formula or formulas to be used whenever a county disengages from an area authority that would determine the amount of risk reserve and other funds that the area authority must transfer to the area authority that the county is joining.
    - The formula(s) would consider the stability of both impacted area authorities and would support their ability to carry out their responsibilities under State law, as well as the successful operation of BH IDD tailored plans. The formula(s) would assure that the area authority that loses the county keeps sufficient funds to pay its liabilities.
    - DHHS would post the formula(s) on its website, notify the area authorities, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division, and accept public comment.
    - Beginning with disengagements that occur on or after September 1, 2021, when a county disengages, DHHS would determine the amount of funds to be transferred according to the formula(s). The area authorities involved would provide DHHS with the financial

information necessary to apply the formula(s). Any appeal of DHHS's determination of the risk reserve and other funds to be transferred would be exempt from a hearing at the Office of Administrative Hearings.

- DHHS would report quarterly to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division on funds that had been transferred during the prior quarter.
- The section would expire June 30, 2026.

- **Section 3.6** would replace the rate floor for durable medical equipment established by Section 11 of S.L. 2020-88 with a fixed reimbursement rate for durable medical equipment and supplies, orthotics, and prosthetics, for the first five years of standard benefit plan contracts. This section would be effective July 1, 2021.

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). This section would be effective July 1, 2021.
- **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). This section would be effective July 1, 2021.
- **Section 4.10** would repeal Article 17 of Chapter 131E pertaining to Provider Sponsored Organizations (PSOs), none of which exist.

EFFECTIVE DATE: Sections 1.1, 3.6, 4.8, and 4.9 would be effective July 1, 2021. 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.