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

2021-2022 General Assembly

Committee:		**Date:**	July 14, 2021
Introduced by:		**Prepared by:**	Jennifer Hillman
Analysis of:	S.L. 2021-62		Staff Attorney

OVERVIEW: S.L. 2021-62 makes various technical and other changes to laws related to the NC Medicaid program and local management entities/managed care organizations (LME/MCOs) as follows:

- ***Part I makes modifications to two Medicaid-related provisions of the 2020 COVID-19 Recovery Act, S.L. 2020-4.***
- ***Part II makes modifications to the existing Medicaid beneficiary appeals statutes in Chapters 108A and 108D of the General Statutes to allow certain appeals to be filed by telephone and to provide an expedited hearing option for certain appeals.***
- ***Part III makes various changes to laws related to the Medicaid program, including (i) allowing additional days of therapeutic leave from an intermediate care facility, (ii) specifying changes to the coverage of behavioral health services in the managed care environment, (iii) specifying procedures related to the dissolution of LME/MCOs and the transfer of assets by LME/MCOs, and (iv) establishing a fixed reimbursement rate for durable medical equipment for the first five years of standard benefit plan contracts.***
- ***Part IV makes various technical corrections to laws related to the Medicaid program.***

This act has various effective dates. See full summary for details.

BILL ANALYSIS:

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

- **Section 1.1** excludes 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 became effective July 1, 2021.
- **Section 1.2** reinstates 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 became effective July 29, 2021.

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

- **Section 2.1** allows 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 must provide instructions for filing the form by telephone.

- **Section 2.2** provides 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 is allowed if the normal timeframe for the hearing could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. The Department of Health and Human Services (DHHS) will determine whether the criteria for an expedited appeal was met, and a denial of an expedited appeal is not appealable. Appeal request forms for these appeals must inform the Medicaid beneficiary of the option to request an expedited appeal.

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

- **Section 3.1** increases the number of Medicaid-covered therapeutic leave days to 90 (from 60) for a Medicaid beneficiary in an intermediate care facility. This section also adds 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** clarifies the codification of the behavioral health services that are covered by standard benefit plans under G.S. 108D-35(1) and requires standard benefit plans to cover peer support services in addition to other behavioral health services specified in the statute.

- **Section 3.4A** specifically restates 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 contract, 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** requires 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 clarifies 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** directs DHHS to develop a formula or formulas to be used whenever a county disengages from an area authority. The formula(s) will determine the amount of risk reserve and

other funds that the area authority must transfer to the area authority that the county is joining and are subject to all of the following:

- The formula(s) must consider the stability of both impacted area authorities and must 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) must assure that the area authority that loses the county keeps sufficient funds to pay its liabilities.
- Prior to finalizing the formula(s), DHHS must post the proposed 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. The final formula(s) must be posted on DHHS's website by August 1, 2021.
- Beginning with disengagements that occur on or after September 1, 2021, when a county disengages, DHHS must determine the amount of funds to be transferred according to the formula(s). The area authorities involved must 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 are exempt from a hearing at the Office of Administrative Hearings.
- DHHS must 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 were transferred during the prior quarter.
- This section expires June 30, 2026.

- **Section 3.6** replaces 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 became effective July 1, 2021.

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

- **Section 4.1** replaces the phrase "the mentally retarded" with "individuals with intellectual disabilities" throughout Chapter 108A of the General Statutes.
- **Section 4.2** removes 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** corrects 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** clarifies 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** replaces the term "recredentialing" with "revalidation" to conform with the defined term in G.S. 108C-2(11).
- **Section 4.6** defines the acronym "CMS", as used in Chapter 108D, as the Center for Medicare and Medicaid Services.

- **Section 4.7** updates the definition of "closed network" in G.S. 108D-1 to align with the use of that term in G.S. 108D-21 and 108D-23.
- **Section 4.8** replaces the reference to "members of federally recognized tribes" with the term "Indians" in accordance with the updated federal definition in 42 C.F.R. § 438.50(d). This section became effective July 1, 2021.
- **Section 4.9** clarifies that certain services provided through a contractor with a Children's Developmental Services Agency (CDSA) are 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 became effective July 1, 2021.
- **Section 4.10** repeals Article 17 of Chapter 131E pertaining to Provider Sponsored Organizations (PSOs).

EFFECTIVE DATE: Sections 1.1, 3.6, 4.8, and 4.9 became effective July 1, 2021. The repeal of Section 4.7 of S.L. 2020-4 in Section 1.2 of the act became effective July 29, 2021. The remainder of the act became effective June 29, 2021.