This Bill Analysis reflects the contents of the bill as it was presented in committee.

SENATE BILL 425: Medicaid Agency Omnibus.

2023-2024 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	April 26, 2023
Introduced by:	Sens. Krawiec, Burgin, Corbin	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 425 would make updates to various laws relating to Medicaid and behavioral health services.

BACKGROUND: Medicaid transformation legislation enacted in 2015 (S.L. 2015-245, as amended) directed the transition of the NC Medicaid program to a managed care model. Under the managed care model, the Department of Health and Human Services, Division of Health Benefits, pays monthly, per-person, capitated rates to cover the physical and behavioral health services of the Medicaid beneficiaries who are enrolled with a prepaid health plan (PHP). A PHP may be a commercial insurer, a provider-led entity, or a local management entity/managed care organizations (LME/MCOs). Article 4 of Chapter 108D of the General Statutes establishes two benefit coverage plans: standard benefit plans (Standard Plans) and behavioral health and intellectual/developmental disabilities (BH IDD) tailored plans (Tailored Plans). Tailored Plans cover the same benefits as Standard Plans and additionally cover more intensive behavioral health and developmental disabilities services that Standard Plans do not cover. Standard Plans launched July 1, 2021. Current law required Tailored Plans to launch on December 1, 2022, but the launch was delayed and is now anticipated to occur on October 1, 2023. Under current law, the initial Standard Plan contracts and the initial Tailored Plan contracts both end on December 1, 2026 with the option to extend up to one additional year. During the initial Tailored Plan contracts, an LME/MCO is the only entity that can operate a Tailored Plan.

BILL ANALYSIS: Section 1 would update the launch date of Tailored Plans from December 1, 2022, to October 1, 2023, to conform with the timeline anticipated by the Department of Health and Human Services (DHHS). The language would further ensure that the initial Tailored Plan contracts would end simultaneously with the end of the initial Standard Plan contracts.

Section 2 would revise the Medicaid prescription drug lock-in statute (G.S. 108A-68.2) to address issues identified in a recent decision[1] of the Office of Administrative Hearings. The statute establishes the criteria for when a Medicaid beneficiary's choice of prescriber and choice of pharmacy may be limited, also referred to as "lock-in". Key changes to the statute include:

- The prescription drug lock-in statute would apply to the Medicaid fee-for-service program in addition to PHPs, which are currently covered by the statute.
- PHPs would be required to develop a lock-in program. Currently, PHPs have the option to use a lock-in program.
- The beneficiaries who would be subject to lock-in would be defined by DHHS in clinical coverage policy instead of statute.

[1] *Jeffrey W. Martin v. N.C. Department of Health and Human Services*, 21 MED 03861, N.C. Office of Administrative Hearings (February 23, 2022).

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- A beneficiary would be able to select two prescribers and pharmacies, instead of one, when medically necessary.
- The lock-in could last for two years upon certain findings by a PHP.

Section 3 would adjust the behavioral health services covered by Standard Plans under G.S. 108D-35(b)(1). Behavioral health services provided under a future 1915(i) option would not be covered by Standard Plans. The following services would be covered by Standard Plans:

- Substance abuse comprehensive outpatient treatment program services.
- Substance abuse intensive outpatient program services.
- Social setting detoxification services.

Section 4 would amend numerous laws to clarify the actions to be taken in the event that DHHS's Tailored Plan contract with a local management entity/managed care organization (LME/MCO) is terminated. This section would reorganize various laws pertaining to the authority of the Secretary of DHHS to dissolve an LME/MCO and the procedures that apply when a county disengages with one LME/MCO and aligns with another LME/MCO, regardless of whether the disengagement was the result of an LME/MCO's dissolution. Authorities that currently appear in G.S. 122C-115, G.S. 122C-115.3, G.S. 122C-124.2, G.S. 122C-125 and Section 3.5A of S.L. 2021-62 would be reorganized into new G.S. 122C-115.5 and G.S. 122C-115.6.

Section 4 would also make the following substantive changes to existing law:

- Make permanent the currently temporary language stating that the Secretary shall dissolve an LME/MCO upon termination of its Tailored Plan contract. (G.S. 122C-115.5(d))
- Allow the Secretary of DHHS the authority to establish the timeline for a Secretary-directed dissolution of an LME/MCO. (G.S. 122C-115.5(e)(2))
- Direct that when a contract with an LME/MCO for operation of a Tailored Plan is terminated, the Tailored Plan contract and the State-funded services contract will be assigned to one or more LME/MCOs with a Tailored Plan contract. (G.S. 122C-115.5(e)(5))
- Codify the existing law that directs the transfer of fund balance from an LME/MCO when a county disengages from that LME/MCO, and clarify that the law applies when an LME/MCO is dissolved. (G.S. 122C-115.6)
- Eliminate the minimum population threshold for LME/MCOs. (G.S. 122C-115)
- Prohibit counties from withdrawing funding for mental health, developmental disabilities, and substance abuse services upon dissolution of an LME/MCO. (G.S. 122C-115.5(e)(10))
- Allow Tailored Plan enrollees of an LME/MCO to be temporarily enrolled in service delivery options other than a Tailored Plan during the dissolution of the LME/MCO. (G.S. 108D-60)
- Update the statutory solvency standards for LME/MCOs by replacing the statutory formula with a requirement that DHHS establish solvency standards in the LME/MCO contracts. The contractual solvency standards would be based on industry-standard financial accounting measures and the contracts would require corrective action plans for noncompliant LME/MCOs. DHHS would report quarterly on each LME/MCO's compliance with the contractual solvency standards by publishing data on their website and notifying the General Assembly. (G.S. 122C-125.3)

Section 5 would direct DHHS to identify, in the Mental Health, Developmental Disabilities, and Substance Abuse Services State Plan required under G.S. 122C-102, priority infrastructure, services, and supports that are needed across the State related to mental health, developmental disabilities, and substance abuse services. DHHS would oversee the use of single-stream funding for these priorities and would be authorized to spend single-stream funding for these priorities, resulting in a reduced allocation of single-stream funding to LME/MCOs.

Section 6 would require an LME/MCO to cancel a subcontract at DHHS's direction if the subcontract results in the LME/MCO's noncompliance with contractual requirements.

Section 7 would exempt prospectively hired employees of LME/MCOs from most provisions of the State Human Resources Act.

Section 8 would extend the Office of Administrative Hearings contested case hearings exemption that exists for PHPs to also apply to prepaid inpatient health plans and primary care case management entities.

Section 9 would correct a technical deficiency in the statute around the timing of the applicability of new federal poverty level figures each year.

EFFECTIVE DATE: Except as otherwise provided, the bill would be effective when it becomes law.