

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

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SENATE BILL 594
Health Care Committee Substitute Adopted 5/6/21
House Committee Substitute Favorable 6/23/21

Short Title: Medicaid Admin. Changes & Tech. Corrections.

(Public)

Sponsors:

Referred to:

April 7, 2021

A BILL TO BE ENTITLED

AN ACT MODIFYING CERTAIN MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT, UPDATING THE MEDICAID PROGRAM BENEFICIARY APPEALS PROCESSES, INCREASING THE AMOUNT OF ALLOWABLE THERAPEUTIC LEAVE UNDER THE MEDICAID PROGRAM, CLARIFYING THE CODIFICATION OF BEHAVIORAL HEALTH SERVICES COVERED BY STANDARD BENEFIT PLANS, AUTHORIZING COVERAGE OPTIONS FOR BEHAVIORAL HEALTH SERVICES FOR POPULATIONS NOT COVERED BY PREPAID HEALTH PLAN CONTRACTS, REVISING THE TRANSFER OF AREA AUTHORITY FUND BALANCES, REMOVING THE RATE FLOOR FOR DURABLE MEDICAL EQUIPMENT, AND MAKING VARIOUS TECHNICAL CORRECTIONS TO THE STATUTES GOVERNING THE NORTH CAROLINA MEDICAID PROGRAM.

The General Assembly of North Carolina enacts:

PART I. MODIFICATIONS TO MEDICAID-RELATED PROVISIONS OF THE 2020 COVID-19 RECOVERY ACT

EXCLUDE THE COVID-19 TESTING COVERAGE GROUP FROM MEDICAID MANAGED CARE

SECTION 1.1.(a) Section 4.5 of S.L. 2020-4 reads as rewritten:

"PROVIDE MEDICAID COVERAGE FOR COVID-19 TESTING TO UNINSURED INDIVIDUALS IN NORTH CAROLINA DURING THE NATIONWIDE PUBLIC HEALTH EMERGENCY

"SECTION 4.5. The Department of Health and Human Services, Division of Health Benefits (DHB), is authorized to provide the Medicaid coverage described in 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XXIII), which covers COVID-19 testing for certain uninsured individuals during the period in which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus, and for which the federal medical assistance percentage is one hundred percent (100%). DHB is authorized to provide this medical assistance retroactively to the earliest date allowable. Notwithstanding G.S. 108D-40, individuals receiving this Medicaid coverage shall not be covered by capitated prepaid health plan contracts under Article 4 of Chapter 108D of the General Statutes."

SECTION 1.1.(b) This section becomes effective July 1, 2021.



1 **END TEMPORARY MEDICAID PROVIDER CHANGES IMPLEMENTED DUE TO**
2 **THE PUBLIC HEALTH EMERGENCY**

3 **SECTION 1.2.** Effective 30 days after this act becomes law, Section 4.7 of S.L.
4 2020-4 is repealed.

5
6 **PART II. MEDICAID BENEFICIARY APPEALS MODIFICATIONS**

7
8 **ALLOW MEDICAID BENEFICIARIES TO FILE APPEALS BY TELEPHONE**

9 **SECTION 2.1.(a)** G.S. 108A-70.9A is amended by adding a new subsection to read:

10 "(c1) Notice Availability. – The Department shall make available to OAH a copy of the
11 notice of adverse determination required under subsection (c) of this section. The information
12 contained in the notice is confidential unless the recipient appeals the adverse determination
13 under subsection (d) of this section. OAH may dispose of these records after one year."

14 **SECTION 2.1.(b)** G.S. 108A-70.9A(d) reads as rewritten:

15 "(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a
16 hearing to appeal an adverse determination of the Department under this section is a contested
17 case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient
18 shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of
19 this section by ~~sending~~ filing an appeal request form to OAH and the Department. with OAH.
20 Where a request for hearing concerns the reduction, modification, or termination of Medicaid
21 services, including the failure to act upon a timely request for reauthorization with reasonable
22 promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the
23 level or manner prior to action by the Department as permitted by federal law or regulation. ~~The~~
24 ~~Department shall immediately forward a copy of the notice to OAH electronically. The~~
25 ~~information contained in the notice is confidential unless the recipient appeals. OAH may dispose~~
26 ~~of the records after one year.~~ The Department may not influence, limit, or interfere with the
27 recipient's decision to request a hearing."

28 **SECTION 2.1.(c)** G.S. 108A-70.9A(e)(1) reads as rewritten:

29 "(1) A statement ~~that that,~~ in order to request an appeal, the recipient must ~~send~~
30 file the form by mail or fax to the address or fax number listed on the form
31 with OAH within 30 days of mailing of the ~~notice~~ notice, and the form may
32 be filed by either (i) sending the form by mail or fax to the address or fax
33 number listed on the form or (ii) calling the telephone number on the form and
34 providing the information requested on the form."

35 **SECTION 2.1.(d)** G.S. 108D-5.7(a)(1) reads as rewritten:

36 "(1) A statement ~~that that,~~ in order to request an appeal, the enrollee must file the
37 form ~~in accordance with OAH rules, by mail or fax to the address or fax~~
38 ~~number listed on the form,~~ no later than 30 days after the mailing date of the
39 notice of ~~resolution~~ resolution, and the form may be filed by either (i) sending
40 the form by mail or fax to the address or fax number listed on the form or (ii)
41 calling the telephone number on the form and providing the information
42 requested on the form."

43 **SECTION 2.1.(e)** G.S. 108D-5.9(a) reads as rewritten:

44 "(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied
45 with an adverse disenrollment determination may ~~file an appeal for a hearing~~ request a hearing
46 to appeal the determination by filing the appeal request form provided under G.S. 108D-5.7(a)
47 with the Office of Administrative Hearings within 30 calendar days of the date on the notice of
48 resolution. The form may be filed by either (i) sending the form by mail or fax to the address or
49 fax number listed on the form or (ii) calling the telephone number on the form and providing the
50 information requested on the form. A request for a hearing to appeal an adverse disenrollment
51 determination of the Department under this section is a contested case subject to the provisions

1 of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance
2 with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes."

3 **SECTION 2.1.(f)** G.S. 108D-11(b) reads as rewritten:

4 "(b) An enrollee, or the enrollee's authorized representative, may file grievances and
5 managed care entity level appeals orally or in writing. ~~However, unless the enrollee, or the~~
6 ~~enrollee's authorized representative, requests an expedited appeal, the oral appeal must be~~
7 ~~followed by a written, signed appeal."~~

8 **SECTION 2.1.(g)** G.S. 108D-15(d) reads as rewritten:

9 "(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file
10 a request for an appeal by ~~sending~~ filing an appeal request form that meets the requirements of
11 subsection ~~(e)~~ (f) of this section to ~~with~~ OAH and the affected managed care entity by no later
12 than 120 days after the mailing date of the notice of resolution. ~~A request for appeal is deemed~~
13 ~~filed when a completed and signed appeal request form has been both submitted into the care and~~
14 ~~eustody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. The form~~
15 may be filed by either (i) sending the form by mail or fax to the address or fax number listed on
16 the form or (ii) calling the telephone number on the form and providing the information requested
17 on the form. Upon receipt of a timely filed appeal request form, information contained in the
18 notice of resolution is no longer confidential, and the managed care entity shall immediately
19 forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these
20 records after one year."

21 **SECTION 2.1.(h)** G.S. 108D-15(f)(1) reads as rewritten:

22 "(1) A statement ~~that that~~, in order to request an appeal, the enrollee must file the
23 form ~~in accordance with OAH rules, by mail or fax to the address or fax~~
24 ~~number listed on the form~~, no later than 120 days after the mailing date of the
25 notice of ~~resolution~~ resolution, and the form may be filed by either (i) sending
26 the form by mail or fax to the address or fax number listed on the form or (ii)
27 calling the telephone number on the form and providing the information
28 requested on the form."

29 **SECTION 2.1.(i)** This section is effective when it becomes law and applies to (i)
30 appeal request forms under G.S. 108A-70.9A(e), 108D-5.7(a), and 108D-15(f) issued on or after
31 that date and (ii) appeals requested on or after that date.

32 **EXPEDITED PROCESS FOR MEDICAID BENEFICIARY APPEALS**

33 **SECTION 2.2.(a)** G.S. 108A-70.9A(e) is amended by adding a new subdivision to
34 read:

35 "(3a) The option for the recipient to request an expedited appeal."

36 **SECTION 2.2.(b)** G.S. 108A-70.9A is amended by adding a new subsection to read:

37 "(e1) Expedited Appeal Request. – In accordance with 42 C.F.R. § 431.224, a recipient may
38 request that an appeal under subsection (d) of this section be expedited if the time otherwise
39 permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain,
40 or regain maximum function. With regard to a request for an expedited appeal, all of the
41 following apply:

42 (1) The recipient shall submit any additional documentation from a licensed
43 health care professional with relevant excerpts from the recipient's medical
44 record that was not already provided with regard to the adverse determination
45 to demonstrate the need for an expedited appeal.

46 (2) The Department shall determine if the recipient's request meets the criteria for
47 an expedited appeal.

48 (3) If the Department determines that the recipient's request does not meet the
49 criteria for an expedited appeal, then (i) the Department shall make reasonable
50 efforts to give the recipient, or the recipient's parent, guardian, or legal
51

1 representative, oral notice of the denial as expeditiously as possible and shall
2 follow up with a written notice of denial and (ii) the recipient's appeal shall
3 not be subject to the expedited time frame in subdivision (4) of this subsection.
4 The denial is not appealable.

5 (4) If the Department determines that the recipient's request meets the criteria for
6 an expedited appeal, then (i) the mediation procedure under
7 G.S. 108A-70.9B(c) shall not apply to the appeal request and (ii) the decision
8 required under G.S. 108A-70.9B(g) shall be made as expeditiously as
9 possible."

10 **SECTION 2.2.(c)** G.S. 108A-79(c) is amended by adding a new subdivision to read:

11 "(4a) With regard to the Medicaid and NC Health Choice programs only, the option
12 to request an expedited appeal in accordance with subsection (j1) of this
13 section."

14 **SECTION 2.2.(d)** G.S. 108A-79 is amended by adding a new subsection to read:

15 "(j1) In accordance with 42 C.F.R. § 431.224, a Medicaid or NC Health Choice applicant
16 or recipient may request that an appeal from the local appeal hearing decision under subsection
17 (g) of this section or an appeal of a case involving disability be expedited if the time otherwise
18 permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain,
19 or regain maximum function. With regard to a request for an expedited appeal, all of the
20 following apply:

21 (1) The appellant shall submit any documentation that was not previously
22 submitted to demonstrate the need for an expedited appeal. For cases not
23 involving disability, this documentation shall include documentation from a
24 licensed health care professional. For cases involving disability, this
25 documentation shall include relevant excerpts from the appellant's medical
26 record, including physical examinations, signs, symptoms, and laboratory
27 findings.

28 (2) The Department shall determine if the appellant's request meets the criteria
29 for an expedited appeal.

30 (3) If the Department determines that the appellant's request does not meet the
31 criteria for an expedited appeal, then (i) the Department shall make reasonable
32 efforts to give the appellant, or the appellant's authorized representative, oral
33 notice of the denial as expeditiously as possible and shall follow up with a
34 written notice of denial and (ii) the appeal shall not be subject to the expedited
35 time frame in subdivision (4) of this subsection. The denial is not appealable.

36 (4) If the Department determines that the appellant's request meets the criteria for
37 an expedited appeal, both the proposal for decision and the final decision
38 required under subsection (j) of this section shall be made as expeditiously as
39 possible.

40 (5) This subsection does not grant an appellant any greater assistance than the
41 appellant is otherwise entitled to under this section while the appellant's
42 appeal is pending."

43 **SECTION 2.2.(e)** G.S. 108D-5.7(b)(1) reads as rewritten:

44 "(1) No later than three calendar days after receiving the enrollee's request for
45 disenrollment, make reasonable efforts to give the enrollee and all other
46 affected parties oral notice of the denial and follow up with a written notice of
47 the ~~determination by mail~~ denial. The denial is not appealable."

48 **SECTION 2.2.(f)** G.S. 108D-14(a) reads as rewritten:

49 "(a) Request for Expedited Appeal. – When the time limits for completing a standard
50 managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's
51 life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the

1 enrollee's authorized representative, has the right to file a request for an expedited appeal of an
2 adverse benefit determination no later than 60 days after the mailing date of the notice of adverse
3 benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the
4 managed care entity shall presume an expedited appeal is necessary when the expedited appeal
5 is made by a network provider as an enrollee's authorized representative or when a network
6 provider has otherwise indicated to the managed care entity that an expedited appeal is
7 necessary."

8 **SECTION 2.2.(g)** G.S. 108D-14(b) reads as rewritten:

9 "(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request
10 for an expedited managed care entity level appeal, then (i) the managed care entity shall make
11 reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and
12 follow up with a written notice of denial by mail no later than 72 hours after receiving the request
13 for an expedited appeal. ~~In addition, appeal and~~ (ii) the managed care entity shall resolve the
14 appeal within the time limits established for standard managed care entity level appeals in
15 G.S. 108D-13. The denial is not appealable."

16 **SECTION 2.2.(h)** G.S. 108D-15(f) is amended by adding a new subdivision to read:

17 "(3a) The option for the enrollee to request an expedited appeal."

18 **SECTION 2.2.(i)** Article 2 of Chapter 108D of the General Statutes is amended by
19 adding a new section to read:

20 "**§ 108D-15.1. Expedited contested case hearings on disputed adverse benefit**
21 **determinations.**

22 In accordance with 42 C.F.R. § 431.224, an enrollee, or an enrollee's authorized
23 representative, may request that an appeal under G.S. 108D-15(d) be expedited if the time
24 otherwise permitted for a hearing could jeopardize the enrollee's life, health, or ability to attain,
25 maintain, or regain maximum function. With regard to a request for an expedited appeal, all of
26 the following apply:

27 (1) The enrollee shall submit any additional documentation from a licensed health
28 care professional with relevant excerpts from the enrollee's medical record
29 that was not already provided with regard to the adverse benefit determination
30 to demonstrate the need for an expedited appeal.

31 (2) The Department shall determine if the enrollee's request meets the criteria for
32 an expedited appeal.

33 (3) If the Department determines that the enrollee's request does not meet the
34 criteria for an expedited appeal, then (i) the Department shall make reasonable
35 efforts to give the enrollee, or the enrollee's authorized representative, oral
36 notice of the denial as expeditiously as possible and shall follow up with a
37 written notice of denial and (ii) the enrollee's appeal shall not be subject to the
38 expedited time frame in subdivision (4) of this subsection. The denial is not
39 appealable.

40 (4) If the Department determines that the enrollee's request meets the criteria for
41 an expedited appeal, then (i) the mediation procedure under G.S. 108D-15(i)
42 shall not apply to the appeal request and (ii) the decision required under
43 G.S. 108D-16 shall be made as expeditiously as possible."

44 **SECTION 2.2.(j)** This section is effective when it becomes law and applies to (i)
45 notices of action under G.S. 108A-79(c) and appeal request forms under G.S. 108A-70.9A(e) and
46 G.S. 108D-15(f) issued on or after that date and (ii) requests to expedite an appeal made on or
47 after that date.

49 **PART III. MISCELLANEOUS CHANGES RELATED TO THE MEDICAID PROGRAM**

1 **INCREASE ALLOWABLE AMOUNT OF MEDICAID-COVERED THERAPEUTIC**
 2 **LEAVE**

3 **SECTION 3.1.(a)** G.S. 108A-62 reads as rewritten:

4 "**§ 108A-62. Therapeutic leave for medical assistance patients.**

5 (a) Patients—A medical assistance beneficiary at an intermediate care facility or skilled
 6 nursing facility may take ~~up to 60 days of~~ therapeutic leave ~~in any one calendar year in~~
 7 accordance with this section without the facility losing reimbursement under the medical
 8 assistance program, ~~provided, however, no more than 15 consecutive days may be taken without~~
 9 ~~approval of the Department of Health and Human Services, Division of Health Benefits. Under~~
 10 ~~no circumstances shall the number of Medicaid-covered therapeutic leave days exceed 60 days~~
 11 ~~per patient per calendar year program.~~

12 (b) The maximum amount of therapeutic leave days that may be taken in a calendar year
 13 by a medical assistance beneficiary are as follows:

14 (1) Ninety days for a beneficiary in an intermediate care facility.

15 (2) Sixty days for a beneficiary in a skilled nursing facility.

16 (c) No more than 15 consecutive days of therapeutic leave may be taken by a medical
 17 assistance beneficiary without the approval of one of the following:

18 (1) The Division of Health Benefits of the Department.

19 (2) The local management entity/managed care organization with which the
 20 beneficiary is enrolled under Chapter 122C of the General Statutes.

21 (3) The prepaid health plan with which the beneficiary is enrolled under Chapter
 22 108D of the General Statutes."

23 **SECTION 3.1.(b)** This section is effective when it becomes law, and individuals
 24 who had exhausted the amount of therapeutic leave prior to that date shall be entitled to any
 25 additional leave for the calendar year allowed under G.S. 108A-62, as amended by this section.
 26

27 **CLARIFY CODIFICATION OF BEHAVIORAL HEALTH SERVICES COVERED BY**
 28 **STANDARD BENEFIT PLANS**

29 **SECTION 3.2.** G.S. 108D-35(1) reads as rewritten:

30 "(1) Medicaid services covered by the local management entities/managed care
 31 organizations (LME/MCOs) under the combined 1915(b) and (c) waivers
 32 shall not be covered under a standard benefit plan, except that all capitated
 33 PHP contracts shall cover the following services: ~~inpatient~~

34 a. Inpatient behavioral health services, outpatient services.

35 b. Outpatient behavioral health emergency room services, outpatient
 36 services.

37 c. Outpatient behavioral health services provided by direct-enrolled
 38 providers, mobile providers.

39 d. Mobile crisis management services, facility-based services.

40 e. Facility-based crisis services for children and adolescents,
 41 professional adolescents.

42 f. Professional treatment services in a facility-based crisis program,
 43 outpatient program.

44 g. Outpatient opioid treatment services, ambulatory services.

45 h. Ambulatory detoxification services, nonhospital services.

46 i. Nonhospital medical detoxification services, partial hospitalization,
 47 medically services.

48 j. Partial hospitalization.

49 k. Medically supervised or alcohol and drug abuse treatment center
 50 detoxification crisis stabilization, research-based stabilization.

- 1 l. Research-based intensive behavioral health treatment, diagnostic
 2 treatment.
 3 m. Diagnostic assessment services, and services.
 4 n. Early and Periodic Screening, Diagnosis, and Treatment services.
 5 In accordance with this subdivision, 1915(b)(3) services shall not be covered
 6 under a standard benefit plan."
 7

8 **BEHAVIORAL HEALTH SERVICES FOR POPULATIONS NOT COVERED BY**
 9 **PREPAID HEALTH PLAN CONTRACTS**

10 **SECTION 3.4A.(a)** G.S. 108D-60 reads as rewritten:

11 **"§ 108D-60. BH IDD tailored plans.**

12 (a) BH IDD tailored plans shall be defined as capitated PHP contracts that meet all
 13 requirements in this Article pertaining to capitated PHP contracts, except as specifically provided
 14 in this section. With regard to BH IDD tailored plans, the following shall occur:

15 ...

16 (b) The Department may contract with entities operating BH IDD tailored plans under a
 17 capitated or other arrangement for the management of behavioral health, intellectual and
 18 developmental disability, and traumatic brain injury services for any recipients excluded from
 19 PHP coverage under G.S. 108D-40(a)(4), (5), (7), (10), (11), (12), and (13)."

20 **SECTION 3.4A.(b)** G.S. 122C-115 is amended by adding a new subsection to read:

21 "(f) Entities operating the BH IDD tailored plans under G.S. 108D-60 may continue to
 22 manage the behavioral health, intellectual and developmental disability, and traumatic brain
 23 injury services for any Medicaid recipients described in G.S. 108D-40(a)(4), (5), (7), (10), (11),
 24 (12), and (13) under any contract with the Department in accordance with G.S. 108D-60(b)."
 25

26 **TRANSFER OF AREA AUTHORITY FUND BALANCES/AREA AUTHORITY**
 27 **DISSOLUTION**

28 **SECTION 3.5.(a)** G.S. 122C-115.3 is amended by adding a new subsection to read:

29 "(b1) The Secretary shall, prior to the date that BH IDD tailored plans begin operating,
 30 direct the dissolution of any area authority that does not receive an initial contract to operate a
 31 BH IDD tailored plan. The Secretary shall deliver a notice of dissolution to the board of county
 32 commissioners of each of the counties in the dissolved LME/MCO."

33 **SECTION 3.5.(b)** G.S. 122C-115.3(e) reads as rewritten:

34 "(e) Any fund balance or risk reserve available to an area authority at the time of its
 35 dissolution that is not utilized to pay liabilities shall be transferred to ~~the area authority~~ one or
 36 more area authorities contracted to operate the 1915(b)/(c) Medicaid Waiver or a BH IDD
 37 tailored plan in all or a portion of the catchment area of the dissolved area authority. If the fund
 38 balance transferred from the dissolved area authority is insufficient to constitute fifteen percent
 39 (15%) of the anticipated operational expenses arising from assumption of responsibilities from
 40 the dissolved area authority, the Secretary shall guarantee the operational reserves for the area
 41 authority assuming the responsibilities under the 1915(b)/(c) Medicaid Waiver until the assuming
 42 area authority has reestablished fifteen percent (15%) operational reserves. ~~authority, as directed~~
 43 by the Department."

44 **SECTION 3.5.(c)** G.S. 122C-115.3 is amended by adding a new subsection to read:

45 "(e1) Effective until the date that BH IDD tailored plans begin operating, if the fund balance
 46 transferred from the dissolved area authority under subsection (e) of this section is insufficient
 47 to constitute fifteen percent (15%) of the anticipated operational expenses arising from
 48 assumption of responsibilities from the dissolved area authority, the Secretary shall guarantee the
 49 operational reserves for the area authority assuming the responsibilities under the 1915(b)/(c)
 50 Medicaid Waiver until the assuming area authority has reestablished fifteen percent (15%)
 51 operational reserves."

1
2 **TRANSFER OF AREA AUTHORITY FUND BALANCES/COUNTY**
3 **DISENGAGEMENT**

4 **SECTION 3.5A.(a)** When a county disengages from one area authority and realigns
5 with another area authority under G.S. 122C-115, a portion of the risk reserve and other funds of
6 the area authority from which the county is disengaging shall be transferred to the area authority
7 with which the county is realigning. The amount of risk reserve and other funds to be transferred
8 shall be determined by the Department of Health and Human Services (DHHS) in accordance
9 with a formula or formulas developed in accordance with this section.

10 **SECTION 3.5A.(b)** Any formula developed by DHHS under this section shall
11 consider the stability of both the area authority from which the county is disengaging and the
12 area authority with which the county is realigning. The formula shall support the ability for each
13 area authority to carry out its responsibilities under State law and shall support the successful
14 operation of BH IDD tailored plans under G.S. 108D-60. The formula shall assure that the area
15 authority from which the county is disengaging retains sufficient funds to pay any outstanding
16 liabilities to health care providers, staff-related expenses, and other liabilities.

17 **SECTION 3.5A.(c)** Upon the Secretary's approval of a disengagement under
18 G.S. 122C-115(a3), the area authority from which the county is disengaging and the area
19 authority with which the county is realigning shall provide DHHS with all financial information
20 requested by DHHS that is necessary to determine the amount of funds to be transferred using
21 the formula or formulas developed under this section.

22 **SECTION 3.5A.(d)** DHHS shall post on its website any formula developed under
23 this section and provide notice of the formula to all area authorities, the Joint Legislative
24 Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee
25 on Medicaid and NC Health Choice, and the Fiscal Research Division. DHHS shall accept public
26 comment on the proposed formula.

27 **SECTION 3.5A.(e)** No later than October 15, 2021, DHHS shall report to the Joint
28 Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight
29 Committee on Medicaid and NC Health Choice, and the Fiscal Research Division on any
30 formulas developed under this section and any funds transferred during the previous quarter.
31 Beginning January 15, 2022, and quarterly thereafter through April 15, 2026, DHHS shall report
32 to the Joint Legislative Oversight Committee on Health and Human Services, the Joint
33 Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research
34 Division on any funds transferred as a result of disengagements during the previous quarter. A
35 final quarterly report shall be due June 30, 2026, for the quarter ending on that date.

36 **SECTION 3.5A.(f)** Notwithstanding any provision of law to the contrary, the
37 development and application of the formula or formulas under this section shall be exempt from
38 the rulemaking requirements under Article 2A of Chapter 150B of the General Statutes and the
39 contested case provisions of Chapter 150B of the General Statutes.

40 **SECTION 3.5A.(g)** This section is effective when it becomes law and applies to
41 disengagements approved by DHHS with an effective date on or after September 1, 2021.

42 **SECTION 3.5A.(h)** This section shall expire on June 30, 2026.

43
44 **REMOVE RATE FLOOR FOR DME**

45 **SECTION 3.6.(a)** Section 11 of S.L. 2020-88 reads as rewritten:

46 **"DURABLE MEDICAL EQUIPMENT RATE FLOOR**

47 **"SECTION 11.** For the first ~~three~~five years of the initial standard benefit plan prepaid health
48 plan capitated contracts required under Article 4 of Chapter 108D of the General Statutes, the
49 ~~rate floor reimbursement~~ for durable medical equipment and supplies, orthotics, and prosthetics
50 under managed care shall be set at one hundred percent (100%) of the lesser of the supplier's

1 usual and customary rate or the maximum allowable Medicaid fee-for-service rates for durable
2 medical equipment, equipment and supplies, orthotics, and prosthetics."

3 **SECTION 3.6.(b)** This section becomes effective July 1, 2021.
4

5 **PART IV. TECHNICAL CORRECTIONS**

6 **SECTION 4.1.** The Revisor of Statutes shall replace the phrase "the mentally
7 retarded" with the phrase "individuals with intellectual disabilities" in the following statutes:
8 G.S. 108A-58.2, 108A-61.1, and 108A-70.5.

9 **SECTION 4.2.(a)** G.S. 90-21.50(1) reads as rewritten:

10 "(1) "Health benefit plan" means an accident and health insurance policy or
11 certificate; a nonprofit hospital or medical service corporation contract; a
12 health maintenance organization subscriber contract; a self-insured indemnity
13 program or prepaid hospital and medical benefits plan offered under the State
14 Health Plan for Teachers and State Employees and subject to the requirements
15 of Article 3 of Chapter 135 of the General Statutes, a plan provided by a
16 multiple employer welfare arrangement; or a plan provided by another benefit
17 arrangement, to the extent permitted by the Employee Retirement Income
18 Security Act of 1974, as amended, or by any waiver of or other exception to
19 that act provided under federal law or regulation. ~~Except for the Health~~
20 ~~Insurance Program for Children established under Part 8 of Article 2 of~~
21 ~~Chapter 108A of the General Statutes,~~ "Health benefit plan" does not mean
22 any plan implemented or administered by the North Carolina or United States
23 Department of Health and Human Services, or any successor agency, or its
24 representatives. "Health benefit plan" does not mean any of the following
25 kinds of insurance:

26 "...."

27 **SECTION 4.2.(b)** G.S. 90-21.50(7) reads as rewritten:

28 "(7) "Managed care entity" means an insurer that:

29 ...

30 Except for the State Health Plan for Teachers and State ~~Employees and the~~
31 ~~Health Insurance Program for Children, Employees,~~ "managed care entity"
32 does not include: (i) an employer purchasing coverage or acting on behalf of
33 its employees or the employees of one or more subsidiaries or affiliated
34 corporations of the employer, or (ii) a health care provider."

35 **SECTION 4.3.** G.S. 108A-54.3A(5) reads as rewritten:

36 "(5) Children under the age of ~~19-21~~ who are receiving foster care or adoption
37 assistance under Title IV-E of the Social Security Act, without regard to
38 income."

39 **SECTION 4.4.** G.S. 108A-68.2 reads as rewritten:

40 **§ 108A-68.2. Beneficiary lock-in program for certain controlled substances.**

41 (a) ~~As used in this section, "covered substances" means any~~ The following definitions
42 apply in this section:

43 (1) Covered substances. – Any controlled substance identified as an opioid or
44 benzodiazepine, excluding benzodiazepine sedative-hypnotics, contained in
45 Article 5 of Chapter 90 of the General Statutes, unless one of the following
46 conditions are met:

47 (1)a. If the Department of Health and Human Services specifically identifies
48 the opioid or benzodiazepine as a substance excluded from coverage
49 by the Medicaid Beneficiary Management Lock-In Program described
50 in its Outpatient Pharmacy Clinical Coverage Policy adopted in

1 accordance with G.S. 108A-54.2, then the opioid or benzodiazepine is
2 not a covered substance under this section.

3 ~~(2)~~b. If the Department of Health and Human Services specifically identifies
4 a controlled substance contained in Article 5 of Chapter 90 of the
5 General Statutes other than an opioid or benzodiazepine as a controlled
6 substance covered by the Medicaid Beneficiary Management Lock-In
7 Program described in its Outpatient Pharmacy Clinical Coverage
8 Policy adopted in accordance with G.S. 108A-54.2, then the controlled
9 substance is a covered substance under this section.

10 (2) Lock-in program. – A requirement that a Medicaid or NC Health Choice
11 beneficiary select a single prescriber and a single pharmacy for obtaining
12 covered substances.

13 (3) Prepaid health plan or PHP. – As defined in G.S. 108D-1.

14 (b) ~~As used in this section, "lock-in program" means a requirement that a Medicaid or~~
15 ~~NC Health Choice beneficiary select a single prescriber and a single pharmacy for obtaining~~
16 ~~covered substances.~~

17 (c) ~~As used in this section, "Prepaid Health Plan" or "PHP" means an entity holding a~~
18 ~~PHP license under Article 93 of Chapter 58 of the General Statutes.~~

19"

20 **SECTION 4.5.** G.S. 108C-2.1 reads as rewritten:

21 "**§ 108C-2.1. Provider application and ~~recredentialing~~ revalidation fee.**

22 (a) Each provider that submits an application to enroll in the Medicaid program shall
23 submit an application fee. The application fee shall be the sum of the amount federally required
24 and one hundred dollars (\$100.00).

25 (b) The fee required under subsection (a) of this section shall be charged to all providers
26 at ~~recredentialing~~ revalidation every five years."

27 **SECTION 4.6.** G.S. 108D-1 is amended by adding a new subdivision to read:

28 "(6a) CMS. – The Centers for Medicare and Medicaid Services."

29 **SECTION 4.7.(a)** G.S. 108D-1(6) reads as rewritten:

30 "(6) Closed network. – The network of providers that have contracted with (i) a
31 local management entity/managed care organization operating the combined
32 1915(b) and (c) waivers or (ii) an entity operating a BH IDD tailored plan to
33 furnish mental health, intellectual or developmental disabilities, and substance
34 abuse services to enrollees."

35 **SECTION 4.7.(b)** G.S. 108D-23 reads as rewritten:

36 "**§ 108D-23. BH IDD tailored plan networks.**

37 Entities operating BH IDD tailored plans shall develop and maintain a closed provider
38 ~~networks~~ network of providers only for the provision of behavioral health, intellectual and
39 developmental disability, and traumatic brain injury services."

40 **SECTION 4.8.(a)** G.S. 108D-5.3(b)(1) reads as rewritten:

41 "(1) ~~Members of federally recognized tribes.~~ Beneficiaries who meet the definition
42 of Indian under 42 C.F.R. § 438.14(a)."

43 **SECTION 4.8.(b)** G.S. 108D-40(a)(5) reads as rewritten:

44 "(5) ~~Members of federally recognized tribes.~~ Members of federally recognized
45 tribes Recipients who meet the definition of Indian under 42 C.F.R. §
46 438.14(a) shall have the option to enroll voluntarily in PHPs."

47 **SECTION 4.8.(c)** G.S. 108D-40(a)(5a) is repealed.

48 **SECTION 4.8.(d)** G.S. 122C-115(e) reads as rewritten:

49 "(e) Beginning on the date that capitated contracts under Article 4 of Chapter 108D of the
50 General Statutes begin, LME/MCOs shall cease managing Medicaid services for all Medicaid

1 recipients other than recipients described in G.S. 108D-40(a)(1), (4), (5), ~~(5a)~~, (6), (7), (10), (11),
2 (12), and (13). Until BH IDD tailored plans become operational, all of the following shall occur:
3 (1) LME/MCOs shall continue to manage the Medicaid services that are covered
4 by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid
5 recipients described in G.S. 108D-40(a)(1), (4), (5), ~~(5a)~~, (6), (7), (10), (11),
6 (12), and (13).

7"

8 **SECTION 4.8.(e)** This section becomes effective July 1, 2021.

9 **SECTION 4.9.(a)** G.S. 108D-35(5) reads as rewritten:

10 "(5) Services documented in an individualized family service plan under the
11 Individuals with Disabilities Education Act, 20 U.S.C. § 1436, that are
12 provided and billed by a Children's Developmental Services Agency ~~(CDSA)~~
13 ~~that are included on the child's Individualized Family Service Plan or by a~~
14 provider contracted with a Children's Developmental Services Agency to
15 provide those services."

16 **SECTION 4.9.(b)** This section becomes effective July 1, 2021.

17 **SECTION 4.10.** Article 17 of Chapter 131E of the General Statutes is repealed.

18 **PART V. EFFECTIVE DATE**

19 **SECTION 5.** Except as otherwise provided, this act is effective when it becomes
20 law.
21