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Section 1135 Medicaid Waiver Authority – North Carolina

Background
When the President of the United States declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the HHS Secretary is authorized to use Section 1135 of the Social Security Act to modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements in order to allow states to respond to the emergency.

On March 23, 2020, the Centers for Medicare & Medicaid Services (CMS) approved North Carolina's Section 1135 waiver, accessible here.

On August 28, 2020, CMS approved North Carolina' 2nd Section 1135 waiver, accessible here.

This one-pager is meant to be a general guide and is not an exhaustive description of the waiver.

What does North Carolina's Section 1135 waiver look like?
This waiver makes several changes to North Carolina's Medicaid program, as outlined below:

Provider Enrollment
CMS authorized North Carolina to expedite the enrollment of out of state providers who are not currently enrolled in the state's Medicaid program. North Carolina may continue to use existing procedures to enroll out of state providers who are already in the state's Medicaid program (with one small exception, CMS is waiving the limit on claims within a 180 day period).

CMS has also authorized providers not currently enrolled in Medicare or another state's Medicaid agency to temporarily enroll in North Carolina's programs. To make this possible, North Carolina will be allowed to waive application fee requirements, criminal background checks, site visits, and state licensure requirements. However, the program provider must maintain an out of state license. To these temporarily authorized providers, North Carolina must cease payment within six months of the emergency declaration being lifted, unless the providers submit an application for full participation in the program and are approved.

CMS has also authorized the state's request to temporarily cease revalidation of providers who are located in North Carolina or otherwise impacted by the emergency.

Pre-Approval Requirements
North Carolina is also authorized to temporarily waive or modify pre-approval requirements for Medicaid procedures through its fee for service program. This applies to services provided on or after March 1, 2020, through the termination of the emergency.

Extend pre-existing authorizations for which a beneficiary has previously received prior authorization through the end of the public health emergency
North Carolina is approved to allow services approved to be provided on or after March 1, 2020 to continue to be provided without a requirement for a new or renewed prior authorization.

Pre-Admission Screening and Annual Resident Review
Level 1 and 2 assessments can be waived for 30 days and all new admissions may be treated like exempt hospital discharges. While CMS is not setting a time frame for the completion of Resident Reviews, reviews should be completed on new admissions having a mental illness or intellectual disability diagnosis as soon as resources are available.

Allowing services in alternative settings
Pursuant to the waiver, North Carolina may allow services to be provided in unlicensed settings, as a temporary shelters, when a provider's facility is not available. The state has to make a reasonable assessment that the facility meets minimum standards to ensure the health, safety, and comfort of beneficiaries and staff. The placing facility is responsible for determining reimbursements for the temporary setting.

Conflict of Interest Requirements under HCBS State Plan and Waiver Authorities
North Carolina may temporarily authorize reimbursement for Home and Community Based Services provided by an entity that also provides case management services and/or is responsible for the development of the person-centered plan in circumstances beyond what is currently allowed under existing regulations.

1915(c) HCBS Waiver Level of Care Determination and Redetermination Timeline
North Carolina may modify the deadline for conducting initial evaluations of eligibility and initial assessments of need to establish a care plan. These activities no longer have to be completed before the start of care. Services will continue until the assessment can occur.

1905(a)(7) Home Health State Plan Services Face-to-Face Timeframes
North Carolina may modify the deadline for the face-to-face encounter required for Home Health services. The face-to-face encounter does not need to be completed before the start of services and may occur at the earliest time, not to exceed 12 months from the start of service.

Clinic Facility Requirement
North Carolina has received a waiver to the requirement in 42 C.F.R. § 440.90 that services provided under that regulation be provided "by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients." This waiver is provided only to the extent necessary to permit the state and clinic to temporarily designate a clinic practitioner's location as part of the clinic facility so that clinic services may be provided via telehealth when neither the patient nor practitioner is physically onsite at the clinic. The waiver permits services provided via telehealth in clinic practitioners' homes (or another location) to be considered to be provided at the clinic for purposes of 42 C.F.R. § 440.90(a).

State fair hearing requests and appeal deadlines
North Carolina is approved to modify the timeline under which managed care enrollees can request an appeal of a denial of services. Enrollees may request a state fair hearing immediately, bypassing the requirement to exhaust all appeals with their managed care organization. Further, North Carolina is authorized to waive the 120 day deadline for enrollees to file an appeal with the state, provided the 120 day deadline would have occurred between March 1, 2020 and June 29, 2020. Managed care recipients in that situation will receive an additional 120 days to file their appeal for a state fair hearing.

North Carolina also has the flexibility to allow recipients to have up to 120 days to request a state fair hearing for eligibility or fee for service issues.

<u>How does this affect Tribes?</u>
If a state seeks a Section 1135 waiver, Tribes are impacted by its provisions. North Carolina has one federally recognized Tribe, the Eastern Band of Cherokee Indians.

Emergency Section 1115 Medicaid Waiver Authority – North Carolina

Background

Section 1115 of the Social Security Act delegates to the Secretary of Health and Human Services the authority to approve "experimental, pilot, and demonstration projects" for the Medicaid program. Medicaid is a partnership between states and the federal government and is designed to be a health insurance program for low-income and other vulnerable populations. In their implementation of Medicaid, states have some flexibility in how they design their State Plans. However, there are some restrictions. If states wish to deliver their Medicaid program in a way that requires waiving some of these restrictions, they can design a project and submit a Section 1115 waiver to the Centers for Medicare & Medicaid Services (CMS), the agency responsible for evaluating and approving these waivers.

On June 25, 2020, the Centers for Medicare & Medicaid Services (CMS) approved North Carolina's Section 1115 waiver, accessible here. This one-pager is meant to be a general guide and is not an exhaustive description of the waiver.

All approvals are until 60 days after the end of the Public Health Emergency, unless otherwise stated.

Expedited Eligibility for Long-Term Care Services and Supports

The state is allowed to allow for self-attestation or alternative verification if individuals eligibility and level of care to qualify for 1905(a) and 1915(b)(3) LTSS services. The person may be eligible until the state verifies that their income and/or assets are above what is allowable under the state plan. Under this waiver, the state may delay income and asset verification and level of care assessment for up to one year.

LTSS

The state is authorized to reimburse for 1905(a) or 1915(b)(3) LTSS services for individuals even if services are not timely updated in the plan of care, or are delivered in allowable alternative settings for the period of the PHE. The state defines alternative settings as those which would have been otherwise-approvable via 1915(c), Appendix K (e.g. hotels, shelters, schools and churches).

Home and Community Based Services (HCBS) rates

The state is allowed to pay higher rates to 1915(k) HCBS providers in order to maintain the level of providers that will be needed to address issues during the emergency. The state is currently authorized to increase rates by up to 50 percent over current rates. However, in "extraordinary circumstances," they may request the authority to increase rates even further.

Retainer Payment

The state is allowed to make retainer payments to providers of personal care and rehabilitation services in order to maintain capacity during the emergency. The providers will be authorized to bill for services as if they're being provided in the beneficiaries provided. This payments are limited to the lesser of 30 consecutive days or the number or days for which the state authorizes a payment of "bed hold" in a nursing facility. These payments may only be paid to providers who had a relationship with the beneficiary prior to the emergency. These payments also may not exceed the approved rates or average expenditure amounts paid during the previous quarter for services that may have been provided.

Modified Eligibility

The state can expand the federal poverty level for individuals who self-attest to eligibility for LTSS services but are later found ineligible. Beneficiaries can also self-attest to disability and level of care in order to receive LTSS for the duration of the emergency.

Functional Assessments

The state is authorized to delay the need for a functional assessments to determine the Level of Care and Person-Centered Care Plans for beneficiaries. They are authorized to delay assessments for a year.

Medicaid Disaster State Plan Amendment – North Carolina

Background
The Medicaid State Plan is the foundational document for a state's Medicaid program; it sets the rules for eligibility, benefits, and payments. Before a state can participate in the Medicaid program, it must file a state plan with the Centers for Medicare & Medicaid Services (CMS). There are certain requirements that a state plan must adhere to and if a state wishes to deviate from these statutory requirements, they must seek a waiver (such as a Section 1115 or Section 1915 waiver) of the usual Medicaid rules. When a state wants to amendment their State Plan, they have to file what is called a "State Plan Amendment" (SPA).

On May 18, 2020, North Carolina was approved for an Emergency State Plan Amendment in order to respond to COVID-19. You can find it here.

On August 18, 2020, North Carolina was approved for a 2nd Emergency SPA. You can find it here.

On August 20, 2020, North Carolina was approved for a 3rd Emergency SPA. You can find it here.

On September 4, 2020, North Carolina was approved for a 4th Emergency SPA. You can find it here.

On January 5, 2021, North Carolina was approved for a 5th Emergency SPA. You can find it here.

All approvals are for the duration of the federally declared COVID-19 emergency, unless stated otherwise.

COVID-19 Testing
North Carolina is amending their State Plan in order to allow for coverage for COVID-19 testing for uninsured populations.

Premiums and Cost Shares
North Carolina is amending their State Plan to allow for the suspension of premiums and cost-shares for COVID-19 testing and treatment.

The state will also premiums and cost shares for the Health Care for Workers with Disabilities (HCWD) program.

Rate Increase
North Carolina is amending their State Plan to allow for a rate increase of 5% for the following groups: Skilled Nursing facilities, Adult Care Homes, CDSAs, Local Health Departments, Home Health Providers, Veteran

Home Nursing Facilities, Tribal Skilled Nursing Facility, Outpatient Specialized Therapy Programs (Physical, Occupational, Respiratory, Speech Therapy and Audiology).

The state is also making temporary modifications to benefit and payment provisions during the emergency declaration period, including the following temporary rate increases: 1) a 10% rate increase for certain providers facing a disproportionate impact during the pandemic, 2) a 5% general increase to all providers that have not yet received one as required by the State's General Assembly, and 3) authority to provide payments to pharmacy providers for mail-prescriptions to reduce direct contact for beneficiaries and providers.

Telehealth

North Carolina is amending their State Plan to allow telephonic visits to be reimbursed at 80% the rate of comparable face to face visits. The state will also reimburse other telehealth visits at the same rate as face to face visits.

Payment Adjustment

North Carolina is amending their State Plan in order to calculate a monthly deficit payment adjustment to ensure NC hospitals are paid up to their full Medicaid costs as projected in the FFY2020 North Carolina supplemental payment "MRI/GAP Plan" after accounting for substantially lower-than expected actual FFY2020 claims revenue.

They also providing for rate increases and an enhanced rate for NEMT providers during the PHE and providing authority to make quarterly payments to MRI/DSH/GAP payments to hospital providers.

Questions?

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