SENATE BILL 600
Health Care Committee Substitute Adopted 4/16/25

Short Title: Medicaid Agency Omnibus. (Public)

Sponsors:

Referred to:

March 26, 2025

A BILL TO BE ENTITLED

AN ACT MAKING TECHNICAL, CONFORMING, AND OTHER MODIFICATIONS TO LAWS PERTAINING TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH BENEFITS.

The General Assembly of North Carolina enacts:

TEMPORARILY EXTEND OPTION TO DECREASE MEDICAID ENROLLMENT BURDEN ON COUNTY DEPARTMENTS OF SOCIAL SERVICES

SECTION 1. Section 1.8(a) of S.L. 2023-7, as amended by Section 9(a) of S.L. 2024-34, reads as rewritten:

"**SECTION 1.8.(a)** Notwithstanding G.S. 108A-54(d) and in accordance with G.S. 143B-24(b), the Department of Health and Human Services (DHHS) is authorized, on a temporary basis to conclude by June 30, ~~2025,~~ 2028, to utilize the federally facilitated marketplace (Marketplace), also known as the federal health benefit exchange, to make Medicaid eligibility determinations. In accordance with ~~G.S. 108A-54(b),~~ G.S. 108A-54(f), these eligibility determinations shall be in compliance with all eligibility categories, resource limits, and income thresholds set by the General Assembly."

CLARIFY ENROLLMENT IN MEDICAID MANAGED CARE AFTER RELEASE FROM INCARCERATION

SECTION 2.(a) G.S. 108D-40 reads as rewritten:

"**§ 108D-40. Populations covered by PHPs.**

(a) Capitated PHP contracts shall cover all Medicaid program aid categories except for the following categories:

…

(9) Recipients who are inmates of prisons. Upon the recipient's release from prison, the exception under this subdivision shall continue to apply ~~for a period that is the shorter of the following:~~until the first day of the month following the twelfth month after the recipient's release.

~~a. The recipient's initial Medicaid eligibility certification period post release.~~

~~b. Three hundred sixty-five days.~~

(9a) Recipients residing in carceral settings other than prisons and whose Medicaid eligibility has been suspended. Upon the recipient's release from incarceration, the exception under this subdivision shall continue to apply ~~for~~

~~a period that is the shorter of the following:~~until the first day of the month following the twelfth month after the recipient's release.

~~a. The recipient's initial Medicaid eligibility certification period post release.~~

~~b. Three hundred sixty-five days.~~

…."

SECTION 2.(b) This section is effective when it becomes law and applies to (i) inmates released on or after that date and (ii) inmates released on or after January 1, 2025, who are not enrolled with a PHP on the date this act becomes law.

CONFORM NORTH CAROLINA LAW TO FEDERAL REQUIREMENTS FOR MEDICAID CATEGORICAL RISK LEVELS FOR PROVIDER SCREENINGS

SECTION 3.(a) G.S. 108C-3 reads as rewritten:

"**§ 108C-3. Medicaid provider screening.**

(a) Provider Screening. – The Department shall conduct provider screening of Medicaid providers in accordance with applicable State or federal law or regulation.

(b) Enrollment Screening. – The Department must screen all initial provider applications for enrollment in Medicaid, including applications for a new practice location, and all revalidation requests based on ~~Department~~ the Department's assessment of risk and assignment of the provider to a categorical risk level of ~~"limited," "moderate," or "high."~~ limited, moderate, or high. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(c) Limited Categorical Risk Provider Types. – ~~The~~ All of the following provider types are ~~hereby~~ designated as ~~"limited"~~ limited categorical risk:

…

(4) Health programs operated by an Indian Health ~~Program (as~~ Program, as defined in section 4(12) of the Indian Health Care Improvement ~~Act)~~ Act, or an urban Indian ~~organization (as~~ organization, as defined in section 4(29) of the Indian Health Care Improvement ~~Act)~~ Act, that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.

…

(10) Nursing facilities, including Intermediate Care Facilities for Individuals with Intellectual ~~Disabilities.~~Disabilities, that are not skilled nursing facilities.

(10a) Skilled nursing facilities that are limited categorical risk under subsection (k) of this section.

…

(12) Physician or nonphysician ~~practitioners (including~~ practitioners, including nurse practitioners, CRNAs, physician assistants, physician extenders, occupational therapists, speech/language pathologists, chiropractors, and ~~audiologists), optometrists,~~ audiologists; optometrists; dentists and ~~orthodontists,~~ orthodontists; and medical groups or clinics.

…

(d) Limited Categorical Risk Screenings. – When the Department designates a provider as a ~~"limited"~~ limited categorical level of risk, the Department shall conduct ~~such~~ the applicable screening functions ~~as~~ required by federal law.

(e) Moderate Categorical Risk Provider Types. – ~~The~~ All of the following provider types are ~~hereby~~ designated as ~~"moderate"~~ moderate categorical risk:

…

(8) Pharmacy ~~Services.~~ services.

…

(11) Revalidating agencies providing durable medical equipment, ~~including, but not limited to,~~ including orthotics and prosthetics.

…

(15) Skilled nursing facilities that are moderate categorical risk under subsection (k) of this section.

(f) Moderate Categorical Risk Screenings. – When the Department designates a provider as a ~~"moderate"~~ moderate categorical level of risk, the Department shall conduct ~~such~~ the applicable screening functions ~~as~~ required by federal law and regulation.

(g) High Categorical Risk Provider Types. – ~~The~~ All of the following provider types are ~~hereby~~ designated as ~~"high"~~ high categorical risk:

(1) ~~Prospective (newly enrolling)~~ Prospective, or newly enrolling, adult care homes delivering Medicaid-reimbursed services.

…

(4) ~~Prospective (newly enrolling)~~ Prospective, or newly enrolling, agencies providing durable medical equipment, including, but not limited to, orthotics and prosthetics.

…

(6) ~~Prospective (newly enrolling)~~ Prospective, or newly enrolling, agencies providing nonbehavioral health home- or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under 42 U.S.C. § 1396n(c).

(7) ~~Prospective (newly enrolling)~~ Prospective, or newly enrolling, agencies providing personal care services or in-home care services.

(8) ~~Prospective (newly enrolling)~~ Prospective, or newly enrolling, agencies providing private duty nursing, home health, or home infusion.

(9) Providers against ~~whom~~ which the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 within the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the cessation of the payment suspension.

…

(11) Providers ~~who~~ that have incurred a Medicaid final overpayment, assessment, or fine to the Department in excess of twenty percent (20%) of the provider's payments received from Medicaid in the previous 12-month period. The Department shall return the provider to its original risk category not later than 12 months after the completion of the provider's repayment of the final overpayment, assessment, or fine.

…

(13) Skilled nursing facilities that are high categorical risk under subsection (k) of this section.

(h) High Categorical Risk Screenings. – When the Department designates a provider as a ~~"high"~~ high categorical level of risk, the Department shall conduct ~~such~~ the applicable screening functions ~~as~~ required by federal law and regulation.

(i) Dually-Enrolled Providers. – For providers dually enrolled in the federal Medicare program and Medicaid, the Department may rely on the results of the provider screening performed by Medicare contractors.

(j) Out-of-State Providers. – For out-of-state providers, the Department may rely on the results of the provider screening performed by the Medicaid agencies or Children's Health Insurance Program agencies of other states.

(k) Skilled Nursing Facilities. – The categorical risk level for provider screening of skilled nursing facilities is the categorical risk level required by federal law or regulation. If

federal law or regulation does not require a particular categorical risk level, skilled nursing facilities are limited categorical risk."

SECTION 3.(b) G.S. 108C-3, as amended by Section 3(a) of this act, reads as rewritten:

"**§ 108C-3. Medicaid provider screening.**

…

(c) Limited Categorical Risk Provider Types. – All of the following provider types are designated as limited categorical risk:

(1) Ambulatory surgical centers.

(1a) Behavioral health and intellectual and developmental disability provider agencies that are nationally accredited by an entity approved by the ~~Secretary.~~Secretary, unless they meet the description in subdivision (g)(15) of this section.

…

~~(16) Portable X-ray suppliers.~~

…

(e) Moderate Categorical Risk Provider Types. – All of the following provider types are designated as moderate categorical risk:

…

(5) ~~Hospice organizations.~~Revalidating hospice organizations, unless they meet the description in subdivisions (g)(14) and (g)(15) of this section.

…

(10) Revalidating adult care homes delivering Medicaid-reimbursed ~~services.~~services, unless they meet the description in subdivision (g)(15) of this section.

(11) Revalidating agencies providing durable medical equipment, including orthotics and ~~prosthetics.~~ prosthetics, unless they meet the description in subdivision (g)(15) of this section.

(12) Revalidating agencies providing nonbehavioral health home- or community-based services pursuant to waivers authorized by the federal Centers for Medicare and Medicaid Services under ~~42 U.S.C. § 1396n(c).~~42 U.S.C. § 1396n(c), unless they meet the description in subdivision (g)(15) of this section.

(13) Revalidating agencies providing private duty nursing, home health, personal care services or in-home care services, or home ~~infusion.~~infusion, unless they meet the description in subdivision (g)(15) of this section.

…

(16) Portable X-ray suppliers.

…

(g) High Categorical Risk Provider Types. – All of the following provider types are designated as high categorical risk:

…

(14) Prospective, or newly enrolling, hospice organizations and revalidating hospice organizations undergoing a change in ownership.

(15) The following revalidating providers (i) that are revalidating for the first time since newly enrolling and (ii) for which fingerprinting requirements, as a newly enrolling provider, were waived due to a national, state, or local emergency:

a. Opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Administration since October 23, 2018.

b. Agencies providing durable medical equipment, including orthotics and prosthetics.
c. Adult care homes delivering Medicaid-reimbursed services.
d. Agencies providing private duty nursing, home health, personal care services, or in-home care services, or home infusion.
e. Hospice organizations.

…."

SECTION 3.(c) Subsection (a) of this section is retroactively effective January 1, 2023. The remainder of this section is retroactively effective January 1, 2024.

CLARIFY MEDICAID SUBROGATION RIGHTS IN MANAGED CARE ENVIRONMENT

SECTION 4.(a) G.S. 108A-57 reads as rewritten:

"**§ 108A-57. Subrogation rights; withholding of information a misdemeanor.**

(a) As used in this section, the term "beneficiary" means (i) the beneficiary of medical assistance, including a minor beneficiary, (ii) the medical assistance beneficiary's parent, legal guardian, or personal representative, (iii) the medical assistance beneficiary's heirs, and (iv) the administrator or executor of the medical assistance beneficiary's estate.

Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State shall be subrogated to all rights of recovery, contractual or otherwise, of a beneficiary against any person. Any claim brought by a medical assistance beneficiary against a third party shall include a claim for all medical assistance payments for health care items or services furnished to the medical assistance beneficiary as a result of the injury or action, hereinafter referred to as the "Medicaid claim." Any claim brought by a medical assistance beneficiary against a third party that does not state the Medicaid claim shall be deemed to include the Medicaid claim. If the beneficiary has claims against more than one third party related to the same injury, then any amount received in payment of the Medicaid claim related to that injury shall reduce the total balance of the Medicaid claim applicable to subsequent recoveries related to that injury.

The Department may designate one or more PHPs to receive all or a portion of payments due under this section to the Department for the Medicaid claim by sending a notice of designation to (i) the beneficiary who has the claim against the third party and (ii) any PHP designated in the notice. As used in this section, the term "designated PHP" refers to a PHP designated in the notice of designation under this subsection.

(a1) If the amount of the Medicaid claim does not exceed one-third of the medical assistance beneficiary's gross recovery, it is presumed that the gross recovery includes compensation for the full amount of the Medicaid claim. If the amount of the Medicaid claim exceeds one-third of the medical assistance beneficiary's gross recovery, it is presumed that one-third of the gross recovery represents compensation for the Medicaid claim.

(a2) A medical assistance beneficiary may dispute the presumptions established in subsection (a1) of this section by applying to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State, for a determination of the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim. An application under this subsection shall be filed with the court and served on the Department pursuant to the Rules of Civil Procedure no later than 30 days after the date that the settlement agreement is executed by all parties and, if required, approved by the court, or in cases in which judgment has been entered, no later than 30 days after the date of entry of judgment. If a PHP made payments on behalf of a Medicaid beneficiary that are included in the Medicaid claim, then the application shall also be served on that PHP within the same time frame in which service is required on the Department.

The court shall hold an evidentiary hearing no sooner than 60 days after the date the action was filed. All of the following shall apply to the court's determination under this subsection:

(1) The medical assistance beneficiary has the burden of proving by clear and convincing evidence that the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim is less than the portion presumed under subsection (a1) of this section.

(2) The presumption arising under subsection (a1) of this section is not rebutted solely by the fact that the medical assistance beneficiary was not able to recover the full amount of all claims.

(3) If the beneficiary meets its burden of rebutting the presumption arising under subsection (a1) of this section, then the court shall determine the portion of the recovery that represents compensation for the Medicaid claim and shall order the beneficiary to pay the amount so determined to the ~~Department~~ Department, or designated PHP, in accordance with subsection (a5) of this section. In making this determination, the court may consider any factors that it deems just and reasonable.

(4) If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the court shall order the beneficiary to pay the amount presumed pursuant to subsection (a1) of this section to the ~~Department~~ Department, or designated PHP, in accordance with subsection (a5) of this section.

(a3) Notwithstanding the presumption arising pursuant to subsection (a1) of this section, the medical assistance beneficiary and the Department may reach an agreement on the portion of the recovery that represents compensation for the Medicaid claim. If such an agreement is reached after an application has been filed pursuant to subsection (a2) of this section, a stipulation of dismissal of the application signed by both parties shall be filed with the court.

(a4) Within 30 days of receipt of the proceeds of a settlement or judgment related to a claim described in subsection (a) of this section, the medical assistance beneficiary or any attorney retained by the beneficiary shall notify the ~~Department~~ Department, and any designated PHP, of the receipt of the proceeds.

(a5) The medical assistance beneficiary or any attorney retained by the beneficiary shall, out of the proceeds obtained by or on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the ~~Department~~ Department, or designated PHP, the amount due pursuant to this section as follows:

(1) If, upon the expiration of the time for filing an application pursuant subsection (a2) of this section, no application has been filed, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the ~~Department~~ Department, or designated PHP, within 30 days of the beneficiary's receipt of the proceeds, in the absence of an agreement pursuant to subsection (a3) of this section.

(2) If an application has been filed pursuant to subsection (a2) of this section and no agreement has been reached pursuant to subsection (a3) of this section, then the ~~Department~~ Department, or designated PHP, shall be paid as follows:

a. If the beneficiary rebuts the presumption arising under subsection (a1) of this section, then the amount determined by the court pursuant to subsection (a2) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the ~~Department~~ Department, or designated PHP, within 30 days of the entry of the court's order.

b. If the beneficiary fails to rebut the presumption arising under subsection (a1) of this section, then the amount presumed pursuant to subsection (a1) of this section, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the ~~Department~~ Department, or designated PHP, within 30 days of the entry of the court's order.

(3) If an agreement has been reached pursuant to subsection (a3) of this section, then the agreed amount, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, shall be paid to the ~~Department~~ Department, or designated PHP, within 30 days of the execution of the agreement by the medical assistance beneficiary and the Department.

(a6) The United States and the State of North Carolina shall be entitled to shares in each net recovery by the Department under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney and to the Department the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) **(For contingent repeal, see note)** This section applies to the administration of and claims payments under the NC Health Choice Program established under Part 8 of this Article.

(d) As required to ensure compliance with this section, the Department may apply to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction in this State for enforcement of this section."

SECTION 4.(b) This section is effective when it becomes law and applies to Medicaid claims brought by medical assistance beneficiaries against third parties on or after that date.

EFFECTIVE DATE

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