DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 355
Kansas City, Missouri 64106-2898

Medicaid and CHIP Operations Group

October 25, 2024

Jay Ludlam
Deputy Secretary of Medical Assistance
Division of Medical Assistance
2001 Mail Service Center
1985 Umstead Drive
Raleigh, NC 27699-20014

Re: Section 1135 Flexibilities Requested on October 22, 2024

Dear Secretary Jay Ludlam:

On September 25, 2024, the President of the United States issued a proclamation that 2024 Hurricane Helene constitutes an emergency by the authorities vested in the President by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (the Act). On September 28, 2024, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services (HHS) declared a public health emergency (PHE), invoking the authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act. During a PHE, the Centers for Medicare and Medicaid Services (CMS) may approve the use of section 1135 authority to help ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in CMS programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of September 28, 2024, with a retroactive effective date of September 25, 2024. The emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the PHE, including any extensions.

Your submission to CMS on October 22, 2024 detailed federal Medicaid requirements that pose issues or challenges for the health care delivery system in North Carolina. Below, please find a response to each of your requests for waivers or modifications, pursuant to section 1135 of the Act, to address the challenges posed by 2024 Hurricane Helene. To the extent the requirements the state requested to waive or modify apply to the Children's Health Insurance Program (CHIP), the state may apply the approved flexibilities to

CHIP.

We appreciate the efforts of you and your staff in responding to the needs of the residents and health care community in North Carolina. Please contact your state lead if you have any questions or need additional information.

Sincerely,

Courtney Miller
Director

cc: Courtney Miller
Anne Marie Costello
Daniel Tsai

NORTH CAROLINA
APPROVAL OF FEDERAL SECTION 1135 WAIVER REQUESTS

CMS Response: October 25, 2024

To the extent applicable, the following waivers and modifications also apply to CHIP.

Fee for Service and Eligibility Fair Hearings

Extend fair hearing request timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify requirements in 42 C.F.R. § 431.221(d) to allow applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals by permitting extensions of the timeline to file a fair hearing request (e.g. additional time more than 90 days). This waiver supplements the timeframe in 42 C.F.R. § 431.221(d), which requires states to choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service appeals.

Managed Care Appeals, Fair Hearings, and Continuation of Benefits

Modify state fair hearings timelines

Pursuant to section 1135(b)(5) of the Act, CMS is granting the authority to modify timeframes in 42 C.F.R. § 438.408(f)(2) for managed care enrollees to exercise their appeal rights. If the 120-day deadline to request an appeal occurred during the PHE, managed care enrollees will have more than 120 days from the date of the managed care plan's notice of resolution of an appeal to request a state fair hearing (e.g. additional 120 days).

Modify timelines to resolve appeals

The requirements of 42 C.F.R. §438.408(f)(1) establish that an enrollee may request a state fair hearing only after receiving a notice that the Managed Care Organization, Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan is upholding the adverse benefit determination but also permits, at 42 C.F.R. §438.408(c)(3) and (f)(l)(i) that an enrollee's appeal may be deemed denied and the appeal process of the managed care plan exhausted (such that the State fair hearing may be requested) if the managed care plan fails to meet the timing and notice requirements of 42 C.F.R. §438.408. Pursuant to section 1135(b)(5) of the Act, CMS is granting authority to modify requirements in 42 C.F.R. §438.408(f)(1) which authorizes the state to modify the timeline for managed care plans to resolve appeals to no less than one day. If the state uses this authority, it would mean that all appeals filed through the end of the public health emergency are deemed to satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) after one day (or more if that is the timeline elected by the state) and allow enrollees to file an appeal to the state fair hearing.