GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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SENATE BILL 553
Health Care Committee Substitute Adopted 5/2/13

Short Title: LME/MCO Enrollee Grievances & Appeals. (Public)

Sponsors:

Referred to:

April 1, 2013

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME/MCO) MEDICAID ENROLLEES.

The General Assembly of North Carolina enacts:

SECTION 1. The General Statutes are amended by adding a new Chapter to read:

"**Chapter 108D.**

"**LME/MCO Enrollee Grievances and Appeals.**

"Article 1.

"General Provisions.

"**§ 108D-1. Definitions.**

The following definitions apply in this Chapter, unless the context clearly requires otherwise:

(1) Applicant. – A provider of MH/IDD/SA services who is seeking to participate in the closed network of one or more LME/MCOs.

(2) Closed network. – A network of providers that have contracted with an LME/MCO to furnish MH/IDD/SA services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at OAH pursuant to G.S. 108D-8 to resolve a dispute between an enrollee and an LME/MCO about a managed care action.

(4) Department. – The North Carolina Department of Health and Human Services.

(5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

(6) Emergency services. – As defined in 42 C.F.R. § 438.114.

(7) Enrollee. – A Medicaid beneficiary who is currently enrolled with an LME/MCO.

(8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).

(9) Local Management Entity/Managed Care Organization or LME/MCO. – An LME that has contracted with the Department to operate an MCO or PIHP in accordance with 42 C.F.R. § 438.

(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).

(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.

(12) MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department and an LME to operate an MCO or PIHP under the

1915(b)/(c) Medicaid Waivers approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of MH/IDD/SA services who has entered into a contract for participation in the closed network of one or more LME/MCOs. The term also includes a provider of emergency services.

(14) Notice of managed care action. – The notice required by 42 C.F.R. § 438.404.

(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).

(16) OAH. – The North Carolina Office of Administrative Hearings.

(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.

(18) Provider. – As defined in G.S. 108C-2(10).

(19) Provider of emergency services. – A provider who is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every LME/MCO and to every applicant, enrollee, provider of emergency services, and network provider of an LME/MCO.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. Part 438, federal law prevails to the extent of the conflict.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for behavioral health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"**§ 108D-4. LME/MCO enrollee grievance and appeal procedures, generally.**

(a) Each LME/MCO shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford enrollees, and network providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or network providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. An oral filing must be followed by a written, signed grievance or appeal unless the enrollee or network provider requests an expedited appeal.

(c) An LME/MCO shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an LME/MCO level appeal, or a request for a contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or network providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) An LME/MCO shall not take punitive action against a network provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting an LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level appeal.
(3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or supporting an enrollee's request for an LME/MCO level expedited appeal.
(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

"**§ 108D-5. LME/MCO enrollee grievances.**

(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express dissatisfaction about any matter other than a managed care action. Upon receipt of a grievance, an LME/MCO shall acknowledge receipt of the grievance in writing by United States mail.

(b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance as expeditiously as the enrollee's health condition requires, but no later than 90 days after receipt of the grievance. The LME/MCO shall provide the enrollee and all other affected parties with written notice of the grievance disposition by United States mail within this 90-day period.

(c) No Appeal of a Grievance Disposition. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, receiving a grievance disposition has no right to the administrative appeal procedures described in G.S. 108D-6, 108D-7, and 108D-8.

"**§ 108D-6. Standard LME/MCO enrollee level appeals.**

(a) Notice of Managed Care Action. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of a managed care action, an LME/MCO shall provide an enrollee with written notice of a managed care action and of the enrollee's right to appeal the managed care action. The LME/MCO shall not be required to notify an enrollee's parent, guardian, or legal representative unless the enrollee's parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the enrollee whose services are being affected by the managed care action, including the enrollee's full name and Medicaid identification number.
(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.
(3) The specific regulation, statute, or medical policy that supports or requires the managed care action.
(4) The effective date of the managed care action.
(5) An explanation of the recipient's right to appeal the LME/MCO's managed care action in an evidentiary hearing before an administrative law judge.
(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.
(7) A statement regarding the enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.
(8) The name and telephone number of a contact person at the LME/MCO to respond in a timely fashion to the enrollee's questions.
(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.
(10) The appeal request form that the enrollee may use to request a hearing.

(b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a

notice of managed care action no later than 30 days after the mailing date of the notice of managed care action. Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge receipt of the request for appeal in writing by United States mail.

(c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than 45 days after receiving the request for appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this 45-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing pursuant to G.S. 108D-8 as long as the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-8(e).

"**§ 108D-7. Expedited LME/MCO enrollee level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care action no later than 30 days after the mailing date of the notice of managed care action. For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the LME/MCO denies a request for an expedited LME/MCO level appeal, the LME/MCO shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with written notice of denial by United States mail by no later than two calendar days after receiving the request for an expedited appeal. In addition, the LME/MCO shall resolve the appeal within the time limits established for standard LME/MCO level appeals in G.S. 108D-6.

(c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an expedited LME/MCO level appeal to the extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee's health condition requires and no later than three working days after receiving the request for an expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written notice of resolution by United States mail within this three-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing pursuant to G.S. 108D-8 as long as the enrollee, or network provider, has exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-8(e).

"**§ 108D-8. Contested case hearings on disputed managed care actions.**

(a) Jurisdiction of OAH. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning a grievance. The Office of Administrative Hearings does

not have jurisdiction over a dispute involving a managed care action, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution issued by an LME/MCO. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting a managed care action.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution issued by an LME/MCO is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, has the right to file a request for appeal to contest a notice of resolution as long as the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-6 or G.S. 108D-7, if applicable.

(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may appeal a notice of resolution by filing an appeal request form that meets the requirements of subsection (f) of this section at OAH and sending a copy of the filing to the affected LME/MCO by no later than 30 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The LME/MCO shall be the respondent for purposes of this appeal. Either the LME/MCO or enrollee may move for the permissive joinder of the Department pursuant to Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party pursuant to Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form by mail or fax at the address or fax number listed on the form by no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal a specific managed care action identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order an LME/MCO to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures conducted pursuant to this section in order to complete the case as quickly as possible.

(1) To the extent possible, OAH shall schedule and hear contested Medicaid cases within 55 days of submission of a request for appeal.

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the North Carolina headquarters of the LME/MCO; however, for good cause shown, the in-person hearing may be conducted in the county of residence of the enrollee or a nearby county. Good cause shall include, but is not limited to, the enrollee's impairments limiting travel or the unavailability of the enrollee's treating professional witnesses. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, and how to request a hearing in the enrollee's county of residence.

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving an enrollee who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

(4) The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances. Continuances shall only be granted in accordance with rules adopted by OAH and shall not be granted on the day of the hearing, except for good cause shown. If a petitioner fails to make an appearance at a hearing that has been properly noticed via certified mail by OAH, OAH shall immediately dismiss the contested case, unless the recipient moves to show good cause within three business days of the date of dismissal.

(5) The notice of hearing provided by OAH to the enrollee shall include the following information:

a. The enrollee's right to examine at a reasonable time before the hearing and during the hearing the contents of the enrollee's case file and documents to be used by the LME/MCO in the hearing before the administrative law judge.

b. The recipient's right to an interpreter during the appeals process.

c. Circumstances in which a medical assessment may be obtained at agency expense and be made part of the record. Qualifying circumstances include those in which (i) a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision; and (ii) the administrative law judge considers it necessary to have a medical assessment other than that performed by the individual involved in making the original decision.

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-8(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the LME/MCO within 24 hours of the

resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of a managed care action until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. Nothing in this subsection shall restrict the right to a contested case hearing.

(j) Burden of Proof. – The enrollee has the burden of proof to show entitlement to a requested benefit or the propriety of requested action when the LME/MCO has denied the benefit or refused to take the particular action. The agency has the burden of proof when the appeal is from a managed care action to impose a penalty or to reduce, terminate, or suspend a previously granted benefit. The party with the burden of proof on any issue has the burden of going forward, and the administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the LME/MCO's managed care action and regardless of whether the LME/MCO had an opportunity to consider the evidence in resolving the LME/MCO level appeal. Upon the receipt of new evidence and at the request of the LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(l) Issue for Hearing. – For each managed care action, the administrative law judge shall determine whether the LME/MCO substantially prejudiced the rights of the enrollee and whether the LME/MCO, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this Part, Chapter 150B of the General Statutes, or any rules or policies adopted pursuant to these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Subpart F, Part 438, federal law prevails and applies to the extent of the conflict. All rules, rights, and procedures for contested case hearings concerning managed care actions shall be construed so as to be consistent with federal law and shall provide the enrollee with no lesser and no greater rights than those provided under federal law.

"**§ 108D-9. Notice of final decision and right to seek judicial review.**

The administrative law judge assigned to conduct a contested case hearing pursuant to G.S. 108D-8 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the LME/MCO to seek judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes."

SECTION 2. G.S. 122C-3 is amended by adding a new subdivision to read:

"(20c) "Local management entity/managed care organization" or "LME/MCO" means an LME that has been approved by the Department to operate the 1915(b)/(c) Medicaid Waiver."

SECTION 3. G.S. 122C-151.3 reads as rewritten:

"**§ 122C-151.3. Dispute with area authorities or county programs.**

(a) An area authority or county program shall establish written procedures for resolving disputes over decisions of an area authority or county program that may be appealed to the

State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and shall provide an opportunity for those who dispute the decision to present their position.

(b) This section does not apply to enrollee grievances or appeals subject to Chapter 108D of the General Statutes."

SECTION 4. G.S. 122C-151.4(g) reads as rewritten:

"(g) This section does not apply to ~~providers of community support services who appeal directly to the Department of Health and Human Services under the Department's community support provider appeal process.~~enrollee grievances or appeals subject to Chapter 108D of the General Statutes."

SECTION 5. G.S. 150B-23 is amended by adding a new subsection to read:

"(a3) A Medicaid enrollee, or network provider authorized in writing to act on behalf of the enrollee, who appeals a notice of resolution issued by an LME/MCO pursuant to Chapter 108D may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article. For purposes of contested cases commenced under this subsection, an LME/MCO is an agency."

SECTION 6. On or before December 1, 2013, the Department of Health and Human Services shall submit to the Centers for Medicare and Medicaid Services, a Medicaid State Plan Amendment necessary to implement this act.

SECTION 7. This act becomes effective June 1, 2014, upon approval by the Centers for Medicare and Medicaid Services of the Medicaid State Plan Amendment required in Section 6 of this act. The Department of Health and Human Services shall report to the Revisor of Statutes when approval is obtained and the date of the approval.