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SENATE BILL DRS45119-MR-4 (11/08)

Short Title:	Conforming Changes LME/MCO Grievances/Appeals.	(Public)
Sponsors:	Senators Hise, Pate, and Krawiec (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE NORTH CAROLINA LME/MCO ENROLLEE GRIEVANCES AND APPEALS STATUTES TO CONFORM WITH RECENT CHANGES TO THE FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108D-1 reads as rewritten:

"**§ 108D-1. Definitions.**

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

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b).

~~(1)~~(1a) Applicant. – A provider of mental health, intellectual or developmental disabilities, and substance abuse services who is seeking to participate in the closed network of one or more local management entity/managed care organizations.

(2) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

(3) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about ~~a managed care action.~~an adverse benefit determination.

(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 a local management entity/managed care organization.

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

(9) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in G.S. 122C-3(20c).

~~(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) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered under a contract in effect between the Department of Health and Human Services and a local management entity to operate a managed care organization or prepaid

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inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).

(13) Network provider. – An appropriately credentialed provider of mental health, intellectual or developmental disabilities, and substance abuse services that has entered into a contract for participation in the closed network of one or more local management entity/managed care organizations.

(14) Notice of ~~managed care action.~~adverse benefit determination. – 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 of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition."

SECTION 2. G.S. 108D-12(a) reads as rewritten:

"(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.~~an adverse benefit determination. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment of receipt of the grievance to be sent by United States mail."

SECTION 3. G.S. 108D-13 reads as rewritten:

"**§ 108D-13. Standard LME/MCO level appeals.**

(a) Notice of ~~Managed Care Action.~~Adverse Benefit Determination. – An LME/MCO shall provide an enrollee with a written notice of ~~a managed care action~~ adverse benefit determination by United States mail as required under 42 C.F.R. § 438.404. The notice of action will employ a standardized form included as a provision in the contracts between the LME/MCOs and the Department of Health and Human Services.

(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~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~adverse benefit determination. 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~~ 30 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~~ 30-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 under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

(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-15(f)."

SECTION 4. G.S. 108D-14 reads as rewritten:

"**§ 108D-14. Expedited LME/MCO 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~~ an adverse benefit determination no later than 30 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. 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.

...

(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~~ 72 hours 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~~ 72-hour 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 under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~section or (ii) the enrollee has been deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

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SECTION 5. G.S. 108D-15 reads as rewritten:

"**§ 108D-15. Contested case hearings on disputed managed care actions.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, 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.~~an adverse benefit determination.

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(d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no later than ~~30~~ 120 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.

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(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 in accordance with OAH rules, by mail or fax to 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~~ adverse benefit determination 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.

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(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 enrollee 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~~ an adverse benefit determination 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. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

...

(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~~ adverse benefit determination 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~~ adverse benefit determination taken against the enrollee, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, 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.

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SECTION 6. This act is effective when it becomes law and applies to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.