

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

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

7 (14) Notice of ~~managed care action~~ adverse benefit determination. – The notice
8 required by 42 C.F.R. § 438.404.

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

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

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

12 (18) Provider of emergency services. – A provider that is qualified to furnish
13 emergency services to evaluate or stabilize an enrollee's emergency medical
14 condition."

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

16 "(a) Filing of Grievance. – An enrollee, or a network provider authorized in writing to act
17 on behalf of an enrollee, has the right to file a grievance with an LME/MCO at any time to express
18 dissatisfaction about any matter other than a ~~managed care action~~ an adverse benefit
19 determination. Upon receipt of a grievance, an LME/MCO shall cause a written acknowledgment
20 of receipt of the grievance to be sent by United States mail."

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

22 **"§ 108D-13. Standard LME/MCO level appeals.**

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

28 (b) Request for Appeal. – An enrollee, or a network provider authorized in writing to act
29 on behalf of the enrollee, has the right to file a request for an LME/MCO level appeal of a notice
30 of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing
31 date of the ~~grievance disposition or notice of managed care action~~ adverse benefit determination.
32 Upon receipt of a request for an LME/MCO level appeal, an LME/MCO shall acknowledge
33 receipt of the request for appeal in writing by United States mail.

34 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits during
35 the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R. §
36 438.420.

37 (d) Notice of Resolution. – The LME/MCO shall resolve the appeal as expeditiously as the
38 enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for
39 appeal. The LME/MCO shall provide the enrollee and all other affected parties with a written
40 notice of resolution by United States mail within this ~~45-day~~ 30-day period.

41 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
42 authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing
43 under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal
44 procedures described in this section or ~~G.S. 108D-14~~ G.S. 108D-14 or (ii) the enrollee has been
45 deemed to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

46 (f) Request Form for Contested Case Hearing. – In the same mailing as the notice of
47 resolution, the LME/MCO shall also provide the enrollee with an appeal request form for a
48 contested case hearing that meets the requirements of G.S. 108D-15(f)."

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

50 **"§ 108D-14. Expedited LME/MCO level appeals.**

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

10 ...

11 (d) Notice of Resolution. – If the LME/MCO grants a request for an expedited LME/MCO
12 level appeal, the LME/MCO shall resolve the appeal as expeditiously as the enrollee's health
13 condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an
14 expedited appeal. The LME/MCO shall provide the enrollee and all other affected parties with a
15 written notice of resolution by United States mail within this ~~three day~~ 72-hour period.

16 (e) Right to Request Contested Case Hearing. – An enrollee, or a network provider
17 authorized in writing to act on behalf of an enrollee, may file a request for a contested case hearing
18 under G.S. 108D-15 as long as (i) the enrollee or network provider has exhausted the appeal
19 procedures described in G.S. 108D-13 or this ~~section~~ section or (ii) the enrollee has been deemed
20 to have exhausted the LME/MCO level appeals process under 42 C.F.R. § 438.408(c)(3).

21"

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

23 **"§ 108D-15. Contested case hearings on disputed managed care actions.**

24 (a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative
25 Hearings does not have jurisdiction over a dispute concerning ~~a managed care action~~, an adverse
26 benefit determination, except as expressly set forth in this Chapter.

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

31 ...

32 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act on
33 behalf of an enrollee, may file a request for an appeal by sending an appeal request form that
34 meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by no
35 later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is
36 deemed filed when a completed and signed appeal request form has been both submitted into the
37 care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk.
38 Upon receipt of a timely filed appeal request form, information contained in the notice of
39 resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of the
40 notice of resolution to OAH electronically. OAH may dispose of these records after one year.

41 ...

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

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

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

- 1 (3) A preprinted statement that indicates that the enrollee would like to appeal a
- 2 specific ~~managed-care action~~ adverse benefit determination identified in the
- 3 notice of resolution.
- 4 (4) A statement informing the enrollee of the right to be represented at the
- 5 contested case hearing by a lawyer, a relative, a friend, or other spokesperson.
- 6 (5) A space for the enrollee's signature and date.

7 ...

8 (i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or
 9 other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation
 10 Network of North Carolina, which shall contact the enrollee within five days to offer mediation in
 11 an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed
 12 within 25 days of submission of the request for appeal. Upon completion of the mediation, the
 13 mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile or
 14 electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the
 15 case. OAH shall not conduct a hearing of any contested case involving a dispute of a ~~managed~~
 16 ~~care action~~ an adverse benefit determination until it has received notice from the mediator
 17 assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of
 18 mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee
 19 accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall
 20 dismiss the contested case.

21 ...

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

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

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

39"

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