

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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SENATE BILL 553
Health Care Committee Substitute Adopted 5/2/13
PROPOSED HOUSE COMMITTEE SUBSTITUTE S553-PCS85255-TJ-55

Short Title: LME/MCO Enrollee Grievances & Appeals.

(Public)

Sponsors:

Referred to:

April 1, 2013

1 A BILL TO BE ENTITLED
2 AN ACT TO ESTABLISH GRIEVANCE AND APPEAL PROCEDURES FOR LOCAL
3 MANAGEMENT ENTITY/MANAGED CARE ORGANIZATION (LME/MCO)
4 MEDICAID ENROLLEES.

5 The General Assembly of North Carolina enacts:

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

7 **"Chapter 108D.**

8 **"Medicaid Managed Care for Behavioral Health Services.**

9 **"Article 1.**

10 **"General Provisions.**

11 **"§ 108D-1. Definitions.**

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

- 14 (1) Applicant. – A provider of mental health, intellectual or developmental
15 disabilities, and substance abuse services who is seeking to participate in the
16 closed network of one or more local management entity/managed care
17 organizations.
- 18 (2) Closed network. – The network of providers that have contracted with a
19 local management entity/managed care organization to furnish mental
20 health, intellectual or developmental disabilities, and substance abuse
21 services to enrollees.
- 22 (3) Contested case hearing. – The hearing or hearings conducted at the Office of
23 Administrative Hearings under G.S. 108D-8 to resolve a dispute between an
24 enrollee and a local management entity/managed care organization about a
25 managed care action.
- 26 (4) Department. – The North Carolina Department of Health and Human
27 Services.
- 28 (5) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.
- 29 (6) Emergency services. – As defined in 42 C.F.R. § 438.114.
- 30 (7) Enrollee. – A Medicaid beneficiary who is currently enrolled with a local
31 management entity/managed care organization.
- 32 (8) Local Management Entity or LME. – As defined in G.S. 122C-3(20b).
- 33 (9) Local Management Entity/Managed Care Organization or LME/MCO. – As
34 defined in G.S. 122C-3(20c).
- 35 (10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).



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- 1 (11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.
 2 (12) Mental health, intellectual or developmental disabilities, and substance abuse
 3 services or MH/IDD/SA services. – Those mental health, intellectual or
 4 developmental disabilities, and substance abuse services covered under a
 5 contract in effect between the Department of Health and Human Services
 6 and a local management entity to operate a managed care organization or
 7 prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver
 8 approved by the federal Centers for Medicare and Medicaid Services (CMS).
 9 (13) Network provider. – An appropriately credentialed provider of mental
 10 health, intellectual or developmental disabilities, and substance abuse
 11 services that has entered into a contract for participation in the closed
 12 network of one or more local management entity/managed care
 13 organizations.
 14 (14) Notice of managed care action. – The notice required by 42 C.F.R. §
 15 438.404.
 16 (15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).
 17 (16) OAH. – The North Carolina Office of Administrative Hearings.
 18 (17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.
 19 (18) Provider of emergency services. – A provider that is qualified to furnish
 20 emergency services to evaluate or stabilize an enrollee's emergency medical
 21 condition.

22 **§ 108D-2. Scope; applicability of this Chapter.**

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

25 **§ 108D-3. Conflicts; severability.**

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

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

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

35 "Article 2.

36 "Enrollee Grievances and Appeals.

37 **§ 108D-4. LME/MCO grievance and appeal procedures, generally.**

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

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

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

- 50 (1) Offering an enrollee alternative services.
 51 (2) Engaging in clinical or educational discussions with enrollees or providers.

- 1 (3) Engaging in informal attempts to resolve enrollee concerns prior to the
2 issuance of a notice of grievance disposition or notice of resolution.
3 (d) An LME/MCO shall not take punitive action against a provider for any of the
4 following:
5 (1) Filing a grievance on behalf of an enrollee or supporting an enrollee's
6 grievance.
7 (2) Requesting an LME/MCO level appeal on behalf of an enrollee or
8 supporting an enrollee's request for an LME/MCO level appeal.
9 (3) Requesting an expedited LME/MCO level appeal on behalf of an enrollee or
10 supporting an enrollee's request for an LME/MCO level expedited appeal.
11 (4) Requesting a contested case hearing on behalf of an enrollee or supporting
12 an enrollee's request for a contested case hearing.

13 **"§ 108D-5. LME/MCO grievances.**

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

19 (b) Notice of Grievance Disposition. – The LME/MCO shall resolve the grievance and
20 cause a notice of grievance disposition to be sent by United States mail to the enrollee and all
21 other affected parties as expeditiously as the enrollee's health condition requires, but no later
22 than 90 days after receipt of the grievance.

23 (c) Right to LME/MCO Level Appeal. – There is no right to appeal the resolution of a
24 grievance to OAH or any other forum.

25 **"§ 108D-6. Standard LME/MCO level appeals.**

26 (a) Notice of Managed Care Action. – An LME/MCO shall provide an enrollee with
27 written notice of a managed care action by United States mail as required under 42 C.F.R. Part
28 438, Subpart F.

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

35 (c) Continuation of Benefits. – An LME/MCO shall continue the enrollee's benefits
36 during the pendency of an LME/MCO level appeal to the same extent required under 42 C.F.R.
37 § 438.420.

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

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

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-8(f).

49 **"§ 108D-7. Expedited LME/MCO level appeals.**

50 (a) Request for Expedited Appeal. – When the time limits for completing a standard
51 appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or

1 regain maximum function, an enrollee, or a network provider authorized in writing to act on
2 behalf of an enrollee, has the right to file a request for an expedited appeal of a managed care
3 action no later than 30 days after the mailing date of the notice of managed care action. For
4 expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee
5 qualifies for an expedited appeal. For expedited appeal requests made by network providers on
6 behalf of enrollees, the LME/MCO shall presume an expedited appeal is necessary.

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

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

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

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

26 (f) Reasonable Assistance. – An LME/MCO shall provide the enrollee with reasonable
27 assistance in completing forms and taking other procedural steps necessary to file an appeal,
28 including providing interpreter services and toll-free numbers that have adequate
29 teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

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

33 **"§ 108D-8. Contested case hearings on disputed managed care actions.**

34 (a) Jurisdiction of the Office of Administrative Hearings. – The Office of
35 Administrative Hearings does not have jurisdiction over a dispute concerning a managed care
36 action, except as expressly set forth in this Chapter.

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

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

47 (d) Filing Procedure. – An enrollee, or a network provider authorized in writing to act
48 on behalf of an enrollee, may file a request for an appeal by sending an appeal request form that
49 meets the requirements of subsection (e) of this section to OAH and the affected LME/MCO by
50 no later than 30 days after the mailing date of the notice of resolution. A request for appeal is
51 deemed filed when a completed and signed appeal request form has been both submitted into

1 the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings
2 clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of
3 resolution is no longer confidential, and the LME/MCO shall immediately forward a copy of
4 the notice of resolution to OAH electronically. OAH may dispose of these records after one
5 year.

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

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

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

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

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

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

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

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

31 (h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
32 150B of the General Statutes, the chief administrative law judge of OAH may limit and
33 simplify the administrative hearing procedures that apply to contested case hearings conducted
34 under this section in order to complete these cases as expeditiously as possible. Any simplified
35 hearing procedures approved by the chief administrative law judge under this subsection must
36 comply with all of the following requirements:

37 (1) OAH shall schedule and hear cases by no later than 55 days after receipt of a
38 request for a contested case hearing.

39 (2) OAH shall conduct all contested case hearings telephonically or by video
40 technology with all parties, unless the enrollee requests that the hearing be
41 conducted in person before the administrative law judge. An in-person
42 hearing shall be conducted in the county that contains the headquarters of the
43 LME/MCO unless the enrollee's impairments limit travel. For enrollees with
44 impairments that limit travel, an in-person hearing shall be conducted in the
45 enrollee's county of residence. OAH shall provide written notice to the
46 enrollee of the use of telephonic hearings, hearings by video conference, and
47 in-person hearings before the administrative law judge, as well as written
48 instructions on how to request a hearing in the enrollee's county of residence.

49 (3) The administrative law judge assigned to hear the case shall consider and
50 rule on all prehearing motions prior to the scheduled date for a hearing on
51 the merits.

1 (4) The administrative law judge may allow brief extensions of the time limits
2 imposed in this section only for good cause shown and to ensure that the
3 record is complete. The administrative law judge shall only grant a
4 continuance of a hearing in accordance with rules adopted by OAH for good
5 cause shown and shall not grant a continuance on the day of a hearing,
6 except for good cause shown. If an enrollee fails to make an appearance at a
7 hearing that has been properly noticed by OAH by United States mail, OAH
8 shall immediately dismiss the case, unless the enrollee moves to show good
9 cause by no later than three business days after the date of dismissal. As
10 used in this section, "good cause shown" includes delays resulting from
11 untimely receipt of documentation needed to render a decision and other
12 unavoidable and unforeseen circumstances.

13 (5) OAH shall include information on at least all of the following in its notice of
14 hearing to an enrollee:

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

19 b. The enrollee's right to an interpreter during the hearing process.

20 c. The circumstances in which a medical assessment may be obtained at
21 the Department's expense and made part of the record, including all
22 of the following:

23 1. A hearing involving medical issues, such as a diagnosis, an
24 examining physician's report, or a decision by a medical
25 review team.

26 2. A hearing in which the administrative law judge considers it
27 necessary to have a medical assessment other than the
28 medical assessment performed by an individual involved in
29 any previous level of review or decision making.

30 (i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-8(f)
31 or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation
32 Network of North Carolina, which shall contact the enrollee within five days to offer mediation
33 in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed
34 within 25 days of submission of the request for appeal. Upon completion of the mediation, the
35 mediator shall inform OAH and the LME/MCO within 24 hours of the resolution by facsimile
36 or electronic messaging. If the parties have resolved matters in the mediation, OAH shall
37 dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of
38 a managed care action until it has received notice from the mediator assigned that either (i) the
39 mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the
40 petitioner has failed to appear at a scheduled mediation. Nothing in this subsection shall restrict
41 the right to a contested case hearing.

42 (j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to
43 OAH for a contested case hearing under this section and has the burden of going forward. The
44 administrative law judge shall not make any ruling on the preponderance of evidence until the
45 close of all evidence in the case.

46 (k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of
47 whether it was obtained before or after the LME/MCO's managed care action and regardless of
48 whether the LME/MCO had an opportunity to consider the evidence in resolving the
49 LME/MCO level appeal. Upon the receipt of new evidence and at the request of the
50 LME/MCO, the administrative law judge shall continue the hearing for a minimum of 15 days
51 and a maximum of 30 days in order to allow the LME/MCO to review the evidence. Upon

1 reviewing the evidence, if the LME/MCO decides to reverse the managed care action taken
2 against the enrollee, it shall immediately inform the administrative law judge of its decision.

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

6 (1) Exceeded its authority or jurisdiction.

7 (2) Acted erroneously.

8 (3) Failed to use proper procedure.

9 (4) Acted arbitrarily or capriciously.

10 (5) Failed to act as required by law or rule.

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

17 **"§ 108D-9. Notice of final decision and right to seek judicial review.**

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

24 **SECTION 2.** G.S. 122C-151.3 reads as rewritten:

25 **"§ 122C-151.3. Dispute with area authorities or county programs.**

26 (a) An area authority or county program shall establish written procedures for resolving
27 disputes over decisions of an area authority or county program that may be appealed to the
28 State MH/DD/SA Appeals Panel under G.S. 122C-151.4. The procedures shall be informal and
29 shall provide an opportunity for those who dispute the decision to present their position.

30 (b) This section does not apply to LME/MCOs, enrollees, applicants, providers of
31 emergency services, or network providers subject to Chapter 108D of the General Statutes."

32 **SECTION 3.** G.S. 122C-151.4(g) reads as rewritten:

33 (g) This section does not apply to ~~providers of community support services who appeal~~
34 ~~directly to the Department of Health and Human Services under the Department's community~~
35 ~~support provider appeal process.~~LME/MCOs, enrollees, applicants, providers of emergency
36 services, or network providers subject to Chapter 108D of the General Statutes."

37 **SECTION 4.** G.S. 150B-23 is amended by adding a new subsection to read:

38 (a3) A Medicaid enrollee, or network provider authorized in writing to act on behalf of
39 the enrollee, who appeals a notice of resolution issued by an LME/MCO under Chapter 108D
40 of the General Statutes may commence a contested case under this Article in the same manner
41 as any other petitioner. The case shall be conducted in the same manner as other contested
42 cases under this Article. Solely and only for the purposes of contested cases commenced as
43 Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes, an
44 LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not
45 be considered an agency for any other purpose."

46 **SECTION 5.** By September 30, 2013, the Department of Health and Human
47 Services shall take any action necessary to implement this act, including submitting to the
48 Centers for Medicare and Medicaid Services a Medicaid State Plan Amendment with a
49 retroactive effective date of July 1, 2013. On or before September 30, 2013, the Department of
50 Health and Human Services shall report to the Joint Legislative Oversight Committee on
51 Health and Human Services on the status of the implementation of this act.

1 **SECTION 6.** This act is effective when it becomes law and applies to grievances
2 and managed care actions filed on or after that date.