MEDICAID APPEALS PROCESSES
SUMMARY

A. Two different processes:

1. Applicants/recipients
   a. Expedited Hearing at OAH
   b. Services continue at current level pending final decision by DHHS
   c. Notice requirements
   d. Option to Mediate
      1. If mediation accepted and settlement reached appeal is dropped;
      2. If mediation declined or does not achieve settlement, hearing by ALJ
   e. ALJ makes decision, returns record to DHHS
   f. DHHS makes final decision
   g. Petitioner may appeal DHHS decision to Superior Ct.

2. Providers of Community Supports (CS)
   a. DHHS develops and implements a process to hear appeals by CS Providers:
      1. Aggrieved by a DHHS decision to reduce, deny, recoup, or recover reimbursement for CS services, or to deny, suspend, or revoke a provider agreement;
      2. Whose endorsement has been withdrawn or whose application for endorsement has been denied by an LME.
   b. Hearing held by DHHS w/in 30 days; DHHS appoints hearing officer
   c. Notice requirements
   d. Hearing: discovery; evidence; representation; cross-examination; recording
   e. DHHS hearing officer decides based on preponderance of evidence; prepares a proposal for the decision. Proposal sent to both parties for review and comment to final DHHS Official who will make the final decision. Parties have 15 days to respond to proposal. If no response proposal for decision is final. If comments made, final decision must be rendered w/in 90 days.
   f. DHHS may suspend endorsement pending a final agency decision.

B. Both processes expire July 1, 2010. DHHS and OAH must present first report on March 1, 2009.

MEDICAID APPLICANT/RECIPIENT APPEALS

S.L. 2008-118, Sec. 3.13 (HB 2438)

[*Note: following is the language enacted by the 2007 General Assembly on newly established appeals processes for Medicaid applicants appealing certain decisions regarding MH/DD/SA services. Certain phrases or sentences are italicized for the reader's convenience to summarize the purpose of the section.]*

SECTION 3.13.(a) Subsection 10.15A(h1) of S.L. 2008-107 is rewritten to read:

"SECTION 10.15A.(h1)

(1) **General Rule.** – Notwithstanding any provision of State law or rules to the contrary, this subsection shall govern ***the process used by a Medicaid applicant or recipient to appeal a determination made by the Department of Health and Human Services to deny, terminate, suspend, or reduce Medicaid covered services.*** For purposes of this subsection, the phrase "adverse determination" means a determination by the Department to deny, terminate, suspend, or reduce Medicaid covered services. For purposes of this subsection, all references to an applicant or recipient include the applicant or recipient's parent, guardian, or legal representative; however, notice need only be given to a parent, guardian, or legal representative who has requested in writing to receive the notice.

(2) **Notice.** – Except as otherwise provided by federal law or regulation, ***at least 30 days before the effective date of an adverse determination, the Department shall notify the applicant or recipient, and the provider, if applicable, in writing of the determination and of the applicant's or recipient's right to appeal the determination.*** The notice shall be mailed on the date indicated on the notice as the date of the determination. ***The notice shall include:***

a. An ***identification of the applicant or recipient*** whose services are being affected by the adverse determination, including full name and Medicaid identification number.

b. An ***explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.***

c. The ***specific regulation, statute, or medical policy*** that supports or requires the adverse determination.

d. The ***effective date of the adverse determination.***

e. An ***explanation of the applicant's or recipient's right to appeal*** the Department's adverse determination in an evidentiary hearing before an administrative law judge.

f. An ***explanation of how the applicant or recipient can request a hearing*** and a statement that the applicant or recipient may represent himself or use legal counsel, a relative, or other spokesperson.

g. A ***statement that the applicant or recipient will continue to receive Medicaid services*** at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the applicant or recipient, whichever is less, if the applicant or recipient requests a hearing before the effective date of the adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

h. The ***name and telephone number of a contact person at the Department*** to respond in a timely fashion to the applicant's or recipient's questions.

i. The ***telephone number by which the applicant or recipient may contact a Legal Aid/***Legal Services office.

j. The appeal request form described in subdivision (4) of this subsection that the applicant or recipient may use to request a hearing.

(3) **Appeals.** – Except as provided by this subsection and subsection 10.15A(h2) of this act, ***a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of***

Article 3 of Chapter 150B of the General Statutes. ***The applicant or recipient must request a hearing within 30 days of the mailing*** of the notice required by subdivision (2) of this subsection by sending an appeal request form to the Office of Administrative Hearings and the Department. The Department shall immediately forward a copy of the notice to the Office of Administrative Hearings electronically. The information contained in the notice is confidential unless the recipient appeals. The Office of Administrative Hearings may dispose of the records after one year. ***The Department may not influence, limit, or interfere with the applicant's or recipient's decision to request a hearing.***

(4) **Appeal Request Form.** – Along with the notice required by subdivision (2) of this subsection, ***the Department shall also provide the applicant or recipient with an appeal request form which shall be no more than one side of one page.*** The form shall include the following:

a. A statement that in order to request an appeal, the applicant or recipient must send the form by mail or fax to the address or fax number listed on the form within 30 days of mailing of the notice.
b. The applicant's or recipient's name, address, telephone number, and Medicaid identification number.
c. A preprinted statement that indicates that the applicant or recipient would like to appeal the specific adverse determination of which the applicant or recipient was notified in the notice.
d. A statement informing the applicant or recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.
e. A space for the applicant's or recipient's signature and date.

(5) **Final Decision.** – After a hearing before an administrative law judge, the judge shall return the decision and record to the Department in accordance with subsection 10.15A(h2) of this act. ***The Department shall make a final decision in the case within 20 days of receipt of the decision and record from the administrative law judge and promptly notify the applicant or recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes.***

SECTION 3.13.(b) Section 10.15A of S.L. 2008-107 is amended by adding five new subsections to read:

"**SECTION 10.15A.(h2)**

(1) **Application.** – This subsection applies only to contested Medicaid cases commenced by Medicaid applicants or recipients under subsection 10.15A(h1) of this act. Except as otherwise provided by subsection 10.15A(h1) and this subsection governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid applicant or recipient is subject to the provisions of Article 3 of Chapter 150B. To the extent any provision in this subsection or subsection 10.15A(h1) of this act conflicts with another provision in Article 3 of Chapter 150B, this subsection and subsection 10.15A(h1) controls.

(2) **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 that apply to a contested Medicaid case involving a Medicaid applicant or recipient in order to complete the case as quickly as possible.*** To the extent possible, the Hearings Division shall schedule and hear contested Medicaid cases ***within 45 days of submission of a request for appeal.*** 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 a Medicaid applicant or recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing. 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.

(3) **Mediation. –** Upon receipt of an appeal request form as provided by subdivision 10.15A(h1)(4) of this act or other clear request for a hearing by a Medicaid applicant or recipient, ***the chief administrative law judge shall immediately notify the Mediation Network of North Carolina which shall within five days contact the petitioner 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. If mediation is successful, the mediator shall inform the Hearings Division, which shall confirm with the agency that a settlement has been achieved, and the case shall be dismissed. If the petitioner rejects the offer of mediation or the mediation is unsuccessful, the mediator shall notify the Hearings Division that the case will proceed to hearing. Nothing in this subdivision shall restrict the right to a contested case hearing.

(4) **Burden of Proof.** – The petitioner has the burden of proof to show entitlement to a requested benefit or the propriety of requested agency action when the agency has denied the benefit or refused to take the particular action. ***The agency has the burden of proof when the appeal is from an agency determination to impose a penalty or reduce, terminate, or suspend a benefit previously granted.*** 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.

(5) **Decision.** – The ***administrative law judge*** assigned to a contested Medicaid case ***shall hear and decide the case*** without unnecessary delay. The Hearings Division shall send a copy of the audiotape or diskette of the hearing to the agency within five days of completion of the hearing. ***The judge shall prepare a written decision and send it to the parties. The decision must be sent together with the record to the agency within 20 days of the conclusion of the hearing.***

"**SECTION 10.15A.(h3)** From funds available to the Department of Health and Human Services for the 2008-2009 fiscal year, the sum of two million dollars ($2,000,000) shall be transferred by the Department of Health and Human Services to the Office of Administrative Hearings. These funds shall be allocated by the Office of Administrative Hearings for mediation services provided for Medicaid applicant and recipient appeals and to contract for other services necessary to conduct the appeals process.

"**SECTION 10.15A.(h4)** ***Effective October 1, 2008, the Department of Health and Human Services shall discontinue its current informal appeals process for Medicaid applicants and recipients appealing a determination made by the Department to deny, terminate, suspend, or reduce Medicaid covered services.*** All such informal appeals by Medicaid applicants or recipients under the current system which are pending on that date and for which a hearing has not been held shall be discontinued and the applicant or recipient offered an opportunity to appeal to the Office of Administrative Hearings in accordance with the provisions of subsection 10.15A(h1) of this act. The Department shall make every effort to resolve or settle all of the backlogged cases prior to the effective date of this act.

"**SECTION 10.15A.(h5)** Nothing in this act shall prevent the Department of Health and Human Services from engaging in an informal review of the case with the applicant or recipient prior to issuing a notice of adverse determination as provided by subsection 10.15A(h1) of this act.

"**SECTION 10.15A.(h6)** ***The appeals process for Medicaid applicants and recipients established under this section shall expire July 1, 2010.*** The Department of Health and Human Services and the Office of Administrative Hearings shall each report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on March 1, 2009, October 1, 2009, and March 1, 2010, on the costs, effectiveness, and efficiency of the appeals process for Medicaid applicants and recipients and make recommendations regarding the continuation of the process."

COMMUNITY SUPPORT PROVIDER APPEALS

S.L. 2008-107, Sec. 10.15A (HB 2436)

[*Note: following is the language enacted by the 2007 General Assembly on newly established appeals processes providers of community support services appealing certain decisions regarding these services or provider endorsement. Certain phrases or sentences are italicized for the reader's convenience to summarize the purpose of the section.]*

SECTION 10.15A.(e1) For the purpose of expediting the resolution of community support provider appeals and thereby saving State and federal funds that are paid for services that are found to be unnecessary or otherwise ineligible for payment, ***the Department shall implement on a temporary basis a community support provider appeals process. The process shall be a substitute for informal provider appeals at the Department level and formal provider appeals by the Office of Administrative Hearings.*** The community support provider appeals process shall apply to a community support services provider:

(1) Who is aggrieved by a decision of the Department to reduce, deny, recoup, or recover reimbursement for community support services, or to deny, suspend, or revoke a provider agreement to provide community support services.

(2) Whose endorsement has been withdrawn or whose application for endorsement has been denied by a local management entity.

SECTION 10.15A.(e2) The community support provider appeals process shall be developed and implemented as follows:

(1) A hearing under this section shall be commenced by filing a ***petition with the chief hearings clerk of the Department within 30 days of the mailing of the notice by the Department of the action giving rise to the contested case.*** The petition shall identify the petitioner, be signed by the party or representative of the party, and shall describe the agency action giving rise to the contested case. As used in this section, "file or filing" means to place the paper or item to be filed into the care and custody of the chief hearings clerk of the Department and acceptance thereof by the chief hearings clerk, except that the hearing officer may permit the papers to be filed with the hearing officer, in which event the hearing officer shall note thereon the filing date. The Department shall supply forms for use in these contested cases.

(2) If there is a timely request for an appeal, ***the Department shall promptly designate a hearing officer who shall hold an evidentiary hearing.*** The hearing officer shall conduct the hearing according to applicable federal law and regulations and shall ensure that:

a. ***Notice of the hearing is given not less than 15 days before the hearing.*** The notice shall state the date, hour, and place of the hearing and shall be deemed to have been given on the date that a copy of the notice is mailed, via certified mail, to the address provided by the petitioner in the petition for hearing.

b. ***The hearing is held in Wake County, except*** that the hearing officer may, after consideration of the numbers, locations, and convenience of witnesses and in order to promote the ends of justice, hold the hearing by telephone or other electronic means or hold the hearing in a county in which the petitioner resides.

c. ***Discovery is no more extensive or formal than that required by federal law and regulations applicable to the hearings.*** Prior to and during the hearing, a provider representative shall have adequate opportunity to examine the provider's own case file. No later than five days before the date of the hearing, each party to a contested case shall provide to each other party a copy of any documentary evidence that the party intends to introduce at the hearing and shall identify each witness that the party intends to call.

(3) The hearing officer shall have the power to administer oaths and affirmations, subpoena the attendance of witnesses, rule on prehearing motions, and regulate the conduct of the hearing. The following shall apply to hearings held pursuant to this section:

a. At the hearing, ***the parties may present such sworn evidence, law, and regulations as are relevant to the issues in the case.***

b. The petitioner and the respondent agency each have ***a right to be represented by a person of his choice,*** including an attorney obtained at the party's own expense.

c. The petitioner and the respondent agency shall each have the ***right to cross-examine witnesses*** as well as make a closing argument summarizing his view of the case and the law.

d. ***The appeal hearing shall be recorded.*** If a petition for judicial review is filed pursuant to subsection (f) of this section, a transcript will be prepared and made part of the official report and shall be prepared at no cost to the appellant. In the absence of the filing of a petition for a judicial review, no transcript will be prepared unless requested by a party, in which case each party shall bear the cost of the transcript or part thereof or copy of the transcript or part thereof requested by the party. The recording of the appeal hearing may be erased or otherwise destroyed 180 days after the final decision is mailed as provided in G.S. 108A-79(i)(5).

(4) ***The hearing officer shall decide the case based upon a preponderance of the evidence, giving deference to the demonstrated knowledge and expertise of the agency as provided in G.S. 150B-34(a).*** The hearing officer shall prepare a proposal for the decision, citing relevant law, regulations, and evidence, which shall be served upon the petitioner or the petitioner's representative by certified mail, with a copy furnished to the respondent agency.

(5) ***The petitioner and the respondent agency shall have 15 days from the date of the mailing of the proposal for decision to present written arguments in opposition to or in support of the proposal for decision to the designated official of the Department who will make the final decision.*** If neither written arguments are presented, nor extension of time granted by the final agency decision maker for good cause, within 15 days of the date of the mailing of the proposal for decision, the proposal for decision becomes final. If written arguments are presented, such arguments shall be considered and the final decision shall be rendered. ***The final decision shall be rendered not more than 90 days from the date of the filing of the petition.*** This time limit may be extended by agreement of the parties or by final agency decision maker, for good cause shown, for an additional period of up to 30 days. The final decision shall be served upon the petitioner or the petitioner's representative by certified mail, with a copy furnished to the respondent agency. In the absence of a petition for judicial review filed pursuant to subsection (f) of this section, the final decision shall be binding upon the petitioner and the Department.

(6) ***A petitioner who is dissatisfied with the final decision of the Department may file, within 30 days of the service of the decision, a petition for judicial review in the Superior Court of Wake County or of the county from which the case arose.*** The judicial review shall be conducted according to Article 4 of Chapter 150B of the General Statutes.

(7) In the event of a conflict between federal law or regulations and State law or regulations, federal law or regulations shall control. This section applies to all petitions that are filed by a Medicaid community support services provider on or after July 1, 2008, and for all Medicaid community support services provider petitions that have been filed at the Office of Administrative Hearings previous to July 1, 2008, but for which a hearing on the merits has not been commenced prior to that date. The requirement that the agency decision must be rendered not more than 90 days from the date of the filing of the petition for hearing shall not apply to (i) community support services provider petitions that were filed at the

Office of Administrative Hearings or (ii) requests for a hearing under the Department's informal settlement process prior to the effective date of this act. The Office of Administrative Hearings shall transfer all cases affected by this section to the Department of Health and Human Services within 30 days of the effective date of this section. This act preempts the existing informal appeal process and reconsideration review process at the Department of Health and Human Services and the existing appeal process at the Office of Administrative Hearings with regard to all appeals filed by Medicaid community support services providers under the Medical Assistance program.

SECTION 10.15A.(e3) Notwithstanding any other provision of law to the contrary, ***the Department of Health and Human Services may, pursuant to its statutory authority or federal Medicaid requirements, suspend the endorsement or Medicaid participation of a provider of community support services pending a final agency decision based on a fair hearing of the provider's appeal filed with the Department under its community support provider appeal process.*** A provider of community support services whose endorsement, Medicaid participation, or services have been suspended is ***not entitled to payment during the period the appeal is pending, and the Department shall make no such payment to the provider during that period. If the final agency decision is in favor of the provider, the Department shall remove the suspension, commence payment for provider services, and reimburse the provider for payments withheld during the period of appeal.*** Contracts between the Department or a local management entity and the provider shall contain a provision indicating the circumstances under which a provider may appeal an agency decision and giving notice of the suspension of payments to the provider while the appeal is pending. This subsection applies to community support provider appeals pending in the Department of Health and Human Services or the Office of Administrative Hearings, as applicable, on and after July 1, 2008.

SECTION 10.15A.(e4) ***The Department's community support provider appeals process established under this section shall expire July 1, 2010.*** The Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on March 1, 2009, October 1, 2009, and March 1, 2010, on the effectiveness and efficiency of the community support provider appeals process.

SECTION 10.15A.(f) G.S. 150B-1(e) is amended by adding the following new subdivision to read:

"(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

…

(16) The Department of Health and Human Services with respect to contested cases commenced by (i) Medicaid providers appealing a denial or reduction in reimbursement for community support services, and (ii) community support services providers appealing decisions by the LME to deny or withdraw the provider's endorsement."

[***note: the following amends current law to provide a process whereby a provider is adversely affected by the decision of the LME with respect to the provider's endorsement or application for endorsement. This section does not apply to appeals by community support providers covered under the DHHS appeals process for these providers.]***

SECTION 10.15A.(g) The Department of Health and Human Services shall adopt guidelines for LME periodic review and rules for endorsement and reendorsement of providers to ensure that only qualified providers are endorsed and that LMEs hold those providers accountable for the Medicaid and State-funded services they provide.

SECTION 10.15A.(h) G.S. 122C-151.4 reads as rewritten:

"**§ 122C-151.4. Appeal to State MH/DD/SA Appeals Panel.**

(a) Definitions. – The following definitions apply in this section:

(1) "Appeals Panel" means the State MH/DD/SA Appeals Panel established under this section.

(1a) "Client" means an individual who is admitted to or receiving public services from an area facility. "Client" includes the client's personal representative or designee.

(1b) "Contract" means a contract with an area authority or county program to provide services, other than personal services, to clients and other recipients of services.

(2) "Contractor" means a person who has a contract or who had a contract during the current fiscal ~~year.~~ year, or whose application for endorsement has been denied by an area authority or county program.

(3) "Former contractor" means a person who had a contract during the previous fiscal year.

(b) Appeals Panel. – The State MH/DD/SA Appeals Panel is established. The Panel shall consist of three members appointed by the Secretary. The Secretary shall determine the qualifications of the Panel members. Panel members serve at the pleasure of the Secretary.

(c) Who Can Appeal. – The following persons may appeal to the State MH/DD/SA Appeals Panel after having exhausted the appeals process at the appropriate area authority or county program:

(1) A contractor or a former contractor who claims that an area authority or county program is not acting or has not acted within applicable State law or rules in denying the contractor's application for endorsement or in imposing a particular requirement on the contractor on fulfillment of the contract;

(2) A contractor or a former contractor who claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract;

(3) A contractor or former contractor who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided by the contractor or former contractor;

(4) A client or a person who was a client in the previous fiscal year, who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided to the client directly by the area authority or county program; and

(5) A person who claims that an area authority or county program did not comply with a State law or a rule adopted by the Secretary or the Commission in developing the plans and budgets of the area authority or county program and that the failure to comply has adversely affected the ability of the person to participate in the development of the plans and budgets.

(d) Hearing. – All members of the State MH/DD/SA Appeals Panel shall hear an appeal to the Panel. An appeal shall be filed with the Panel within the time required by the Secretary and shall be heard by the Panel within the time required by the Secretary. A hearing shall be conducted at the place determined in accordance with the rules adopted by the Secretary. A hearing before the Panel shall be informal; no sworn testimony shall be taken and the rules of evidence do not apply. The person who appeals to the Panel has the burden of proof. The Panel shall not stay a decision of an area authority during an appeal to the Panel.

(e) Decision. – The State MH/DD/SA Appeals Panel shall make a written decision on each appeal to the Panel within the time set by the Secretary. A decision may direct a contractor, an area authority, or a county program to take an action or to refrain from taking an action, but it shall not require a party to the appeal to pay any amount except payment due under the contract. In making a decision, the Panel shall determine the course of action that best protects or benefits the clients of the area authority or county program. If a party to an appeal fails to comply with a decision of the Panel and the Secretary determines that the failure deprives clients of the area authority or county program of a type of needed service, the Secretary may use funds previously allocated to the area authority or county program to provide the service.

(f) Chapter 150B Appeal. – A person who is dissatisfied with a decision of the Panel may commence a contested case under Article 3 of Chapter 150B of the General Statutes. Notwithstanding G.S. 150B-2(1a), an area authority or county program is considered an agency for purposes of the limited appeal authorized by this section. If the need to first appeal to the State

MH/DD/SA Appeals Panel is waived by the Secretary, a contractor may appeal directly to the Office of Administrative Hearings after having exhausted the appeals process at the appropriate area authority or county program. The Secretary shall make a final decision in the contested case.

(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."

SECTION 10.15A.(h1) The Department of Health and Human Services and the Office of Administrative Hearings shall work together to streamline the process for hearing Medicaid recipient appeals. The process shall be designed to significantly reduce the backlog of Medicaid recipient appeals pending as of July 1, 2008, and shall ensure that Medicaid recipients continue to receive benefits at current levels pending the outcome of the appeal. The Department shall further ensure that Medicaid applicants who have been determined to be eligible for Medicaid shall be eligible to receive community support services if the services are determined to be medically necessary.