HOUSE BILL 320
Committee Substitute Favorable 5/14/13

Short Title: Medicaid Managed Care/Behavioral Health Svcs. (Public)

Sponsors:

Referred to:

March 18, 2013

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH STANDARDS FOR MEDICAID MANAGED CARE FOR BEHAVIORAL HEALTH SERVICES UNDER THE 1915(B)/(C) MEDICAID WAIVER, INCLUDING THE ESTABLISHMENT OF GRIEVANCE AND APPEAL PROCEDURES FOR ENROLLEES.

The General Assembly of North Carolina enacts:

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

"**Chapter 108D.**

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

"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 who is seeking to participate in the closed network of one or more LME/MCOs.

(2) Closed network. – The network of providers who 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-29 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 in an MCO or PIHP operated by 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 been approved by the Department to operate an MCO or PIHP in accordance with 42 C.F.R. Part 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. – 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 of emergency services. – A provider that 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.

"Article 2.

"Rights and Responsibilities of LME/MCOs, Providers, and Applicants.

"**§ 108D-10. Right to operate a closed network.**

Each LME/MCO has the right to operate a closed network of appropriate providers sufficient to provide adequate access to all MH/IDD/SA services covered under the contract in effect between the LME/MCO and the Department, in accordance with 42 C.F.R. § 438.206(b)(1) and 42 C.F.R. § 438.214. The relationship between an LME/MCO and a provider is contractual, and the provider does not have the right to join the closed network of any LME/MCO.

"**§ 108D-11. Provider selection and screening.**

Each LME/MCO shall select, credential, and re-credential its providers in accordance with 42 C.F.R. § 438.214. In addition, each LME/MCO shall comply with the provider screening and designation requirements of G.S. 108C-3 and any other applicable State law.

"**§ 108D-12. Criminal history record checks of applicants and providers.**

Each LME/MCO shall conduct a criminal history record check of each applicant, each provider, each person with an ownership or control interest in the applicant or provider, and each managing employee of the applicant or provider, in accordance with federal law and regulation. In addition, the LME/MCO shall deny or terminate enrollment to an applicant or provider in accordance with G.S. 108C-4. For the purpose of this section, "person with an ownership or control interest" and "managing employee" are as defined in 42 C.F.R. § 455.101.

"**§ 108D-13. Investigations and audits.**

(a) An LME/MCO is authorized to conduct, and providers shall cooperate with, all announced and unannounced site visits, audits, investigations, post-payment reviews,

monitoring, or any other program integrity activities permitted under federal law or under the terms and conditions of the contract in effect between the LME/MCO and the Department.

(b) The LME/MCO shall avoid interfering with the clinical activities of the provider while conducting the activities authorized by this subsection on the provider's premises.

"**§ 108D-14. Threshold recovery of overpayments.**

An LME/MCO shall not pursue recovery of any overpayments owed to the LME/MCO for any total amount less than one hundred fifty dollars ($150.00) unless directed to do so by the Centers for Medicare and Medicaid Services, or unless recovery would be cost-effective and in the best interest of the LME/MCO.

"**§ 108D-15. Suspension of payments to providers.**

(a) An LME/MCO is authorized to suspend payments to a provider in accordance with 42 C.F.R. § 455.23, and under any of the following circumstances:

(1) If a contract in effect between the LME/MCO and a provider has been suspended or terminated in order to recover an overpayment identified by the LME/MCO.

(2) If the suspension or termination of payments to the provider is in accordance with the terms and conditions of a contract in effect between the LME/MCO and the provider.

(b) When issuing payment suspensions authorized by this section, the LME/MCO may suspend payment to all providers that share the same IRS Employee Identification Number or corporate parent as the provider or provider site location which has had its contract suspended or terminated or which owes the identified overpayment. The LME/MCO shall give at least 30 days' advance written notice to all providers that share the same IRS Employee Identification Number or corporate parent as the provider or provider site location of the LME/MCO's intention to implement a payment suspension.

(c) In lieu of a payment suspension authorized by this section, an LME/MCO may, but is not required to, establish a payment plan for a provider to pay an identified overpayment, including interest and any penalty, unless payment suspension is otherwise required under 42 U.S.C. § 455.23.

(d) All payments suspended in accordance with this section shall be applied toward any amounts owed by the provider to the LME/MCO.

"**§ 108D-16. Prepayment claims review; no right to appeal.**

(a) In order to ensure that claims presented to an LME/MCO by a provider for payment meet the requirements of federal and State laws and medical necessity criteria, an LME/MCO may require the provider to undergo prepayment claims review by the LME/MCO or its vendor in accordance with G.S. 108C-7.

(b) A provider does not have the right to appeal a decision by an LME/MCO to place the provider on prepayment claims review, and OAH does not have jurisdiction over this decision.

"**§ 108D-17. Change of ownership.**

A provider shall notify each LME/MCO with which it contracts of any change in ownership at least 30 calendar days prior to the effective date of the change. For the purpose of this section, any of the following occurrences constitutes a change of ownership:

(1) In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by Chapter 59 of the General Statutes.

(2) In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC, or when a business entity converts or merges into the LLC pursuant to Chapter 57A of the General Statutes.

(3) In the case of an unincorporated sole proprietorship, the transfer of title and property of the provider to another party.

(4) A one hundred percent (100%) stock purchase, the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, which may or may not result in the creation of a new corporation.

(5) The lease of all or part of a provider's facility that will continue to be utilized for the provision of services, goods, supplies, or merchandise to an enrollee shall constitute a change of ownership of the leased portion.

"**§ 108D-18. Resolution of disputes between LME/MCOs and providers or applicants.**

(a) All disputes between an LME/MCO and a provider or applicant, including disputes about the terms and conditions of a contract in effect between the LME/MCO and a provider, are governed by 42 C.F.R. Part 438.

(b) G.S. 122C-151.3, G.S. 122C-151.4, and any rules or policies adopted pursuant to those sections do not apply to disputes concerning LME/MCOs.

(c) The venue for all legal actions concerning a dispute between an LME/MCO and a provider or applicant shall be in the superior court of the county in which the corporate office of the LME/MCO is located, unless the contract in effect between the LME/MCO and the provider or applicant specifies a different venue.

"Article 3.

"Enrollee Grievances and Appeals.

"**§ 108D-25. LME/MCO 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 providers authorized in writing to act on behalf of enrollees, constitutional rights to due process and a fair hearing.

(b) Enrollees, or providers authorized in writing to act on behalf of enrollees, may file requests for grievances and LME/MCO level appeals orally or in writing. However, unless the enrollee or provider requests an expedited appeal, the oral filing must be followed by a written, signed grievance or 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 contested case hearing. However, nothing in this Chapter shall be construed to prevent an LME/MCO from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or 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 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-26. LME/MCO grievances.**

(a) Filing of Grievance. – An enrollee, or a 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) Right to LME/MCO Level Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"**§ 108D-27. Standard LME/MCO level appeals.**

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

(b) Request for Appeal. – An enrollee, or a 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 grievance disposition or a notice of managed care action no later than 30 days after the mailing date of the grievance disposition or 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 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-29 as long as the enrollee or provider has exhausted the appeal procedures described in G.S. 108D-27 or G.S. 108D-28.

(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-29(e).

"**§ 108D-28. 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 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 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-27.

(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 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-29 as long as the enrollee or provider has exhausted the appeal procedures described in G.S. 108D-27 or G.S. 108D-28.

(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-29(e).

"**§ 108D-29. 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 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 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 provider has exhausted the appeal procedures described in G.S. 108D-27 or G.S. 108D-28.

(d) Filing Procedure. – An enrollee, or a 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 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) 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 send the form 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 grievance disposition or 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.

(f) 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.

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

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

(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 Wake County unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. 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, as well as written instructions on how to request a hearing in the enrollee's county of residence.

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

(4) Neither an enrollee nor an LME/MCO is required to be represented by an attorney at a contested case hearing. For cases in which the enrollee is not represented by an attorney, the administrative law judge assigned to hear the case shall make reasonable efforts to assure a fair hearing and to maintain a complete record of the hearing.

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

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

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any

documents to be used by the LME/MCO in the hearing before the administrative law judge.

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

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

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

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

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

(i) 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.

(j) 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.

(k) 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. Part 438, Subpart F, 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-30. 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-29 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. 108C-1 reads as rewritten:

"**§ 108C-1. Scope; applicability of this Chapter.**

This Chapter applies to providers enrolled in Medicaid or Health Choice. Except as expressly provided by law, this Chapter does not apply to LME/MCOs, enrollees, applicants,

providers of emergency services, or network providers subject to Chapter 108D of the General Statutes."

SECTION 3. 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 a managed care organization or prepaid inpatient health plan in accordance with 42 C.F.R. Part 438."

SECTION 4. 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 LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes."

SECTION 5. 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.~~LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes."

SECTION 6. This act becomes effective July 1, 2013.