Article 2.

Enrollee Grievances and Appeals.

**§ 108D-11. Managed care entity grievance and appeal procedures, generally.**

(a) Each managed care entity 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 their authorized representatives constitutional rights to due process and a fair hearing.

(b) An enrollee, or the enrollee's authorized representative, may file grievances and managed care entity level appeals orally or in writing.

(c) A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for a managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent a managed care entity 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) A managed care entity 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 a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for a managed care entity level appeal.

(3) Requesting an expedited managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for a managed care entity 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.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries. (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, s. 2.1(f).)

**§ 108D-12. Managed care entity grievances.**

(a) Filing of Grievance. – An enrollee, or the enrollee's authorized representative, has the right to file a grievance with a managed care entity at any time to express dissatisfaction about any matter other than an adverse benefit determination. Upon receipt of a grievance, a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by mail.

(b) Notice of Grievance Disposition. – The managed care entity shall resolve the grievance and cause a notice of grievance resolution to be sent by mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than 30 days after receipt of the grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum. (2013-397, s. 1; 2019-81, s. 1(a).)

**§ 108D-13. Standard managed care entity level appeals.**

(a) Notice of Adverse Benefit Determination. – A managed care entity shall provide an enrollee with a written notice of an adverse benefit determination by mail as required under 42 C.F.R. § 438.404. The notice will employ a standardized form included as a provision in the contract between the managed care entity and the Department.

(b) Request for Appeal. – An enrollee, or the enrollee's authorized representative, has the right to file a request for a managed care entity level appeal of a notice of adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. Upon receipt of a request for a managed care entity level appeal, a managed care entity shall acknowledge receipt of the request for appeal in writing by mail.

(c) **(Effective until contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of a managed care entity level appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(c) **(Effective once contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of a managed care entity level appeal to the same extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – The managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than 30 days after receiving the request for appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by mail within this 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in this section or G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f). (2013-397, s. 1; 2019-81, s. 1(a); 2022-74, s. 9D.15(t).)

**§ 108D-14. Expedited managed care entity level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard managed care entity level appeal under G.S. 108D-13 could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or the enrollee's authorized representative, has the right to file a request for an expedited appeal of an adverse benefit determination no later than 60 days after the mailing date of the notice of adverse benefit determination. In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the managed care entity denies a request for an expedited managed care entity level appeal, then (i) the managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by mail no later than 72 hours after receiving the request for an expedited appeal and (ii) the managed care entity shall resolve the appeal within the time

limits established for standard managed care entity level appeals in G.S. 108D-13. The denial is not appealable.

(c) **(Effective until contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an expedited managed care entity level appeal to the extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(c) **(Effective once contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an expedited managed care entity level appeal to the extent required under 42 C.F.R. § 438.420.

(d) Notice of Resolution. – If the managed care entity grants a request for an expedited managed care entity level appeal, the managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than 72 hours after receiving the request for an expedited appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by mail within this 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

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

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f). (2013-397, s. 1; 2019-81, s. 1(a); 2021-62, s. 2.2(f), (g); 2022-74, s. 9D.15(u).)

**§ 108D-15. Contested case hearings on disputed adverse benefit determinations.**

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

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

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the enrollee, or the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or G.S. 108D-14 or (ii) the

enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or the enrollee's authorized representative, may file a request for an appeal by filing an appeal request form that meets the requirements of subsection (f) of this section with OAH by no later than 120 days after the mailing date of the notice of resolution. The form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The managed care entity shall be the respondent for purposes of this appeal. The managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

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

(1) A statement that, in order to request an appeal, the enrollee must file the form with OAH no later than 120 days after the mailing date of the notice of resolution, and the form may be filed by either (i) sending the form by mail or fax to the address or fax number listed on the form or (ii) calling the telephone number on the form and providing the information requested on the form.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse benefit determination identified in the notice of resolution.

(3a) The option for the enrollee to request an expedited appeal.

(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.

(g) **(Effective until contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(g) **(Effective once contingency met – see note)** Continuation of Benefits. – A managed care entity shall continue the benefits of a Medicaid enrollee 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 a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) 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 under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under 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 the county that contains the headquarters of the managed care entity 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) 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 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.

(5) 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 managed care entity 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 managed care entity'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.

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under 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.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the managed care entity's adverse benefit determination and regardless of whether the managed care entity had an opportunity to consider the evidence in resolving the managed care entity level appeal. Upon the receipt of new evidence and at the request of the managed care entity, 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 managed care entity to review the evidence. Upon reviewing the evidence, if the managed care entity decides to reverse the adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each adverse benefit determination, the administrative law judge shall determine whether the managed care entity substantially prejudiced the rights of the enrollee and whether the managed care entity, based upon evidence at the hearing, did any of the following:

(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.

(m) To the extent that anything in this Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under 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, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with rights that are no less than those provided under federal law. (2013-397, s. 1; 2014-100, s. 12H.27(c); 2019-81, s. 1(a); 2021-62, ss. 2.1(g), (h), 2.2(h); 2022-74, s. 9D.15(v).)

**§ 108D-15.1. Expedited contested case hearings on disputed adverse benefit determinations.**

In accordance with 42 C.F.R. § 431.224, an enrollee, or an enrollee's authorized representative, may request that an appeal under G.S. 108D-15(d) be expedited if the time otherwise permitted for a hearing could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. With regard to a request for an expedited appeal, all of the following apply:

(1) The enrollee shall submit any additional documentation from a licensed health care professional with relevant excerpts from the enrollee's medical record that was not already provided with regard to the adverse benefit determination to demonstrate the need for an expedited appeal.

(2) The Department shall determine if the enrollee's request meets the criteria for an expedited appeal.

(3) If the Department determines that the enrollee's request does not meet the criteria for an expedited appeal, then (i) the Department shall make reasonable efforts to give the enrollee, or the enrollee's authorized representative, oral notice of the denial as expeditiously as possible and shall follow up with a written notice of denial and (ii) the enrollee's appeal shall not be subject to the expedited time frame in subdivision (4) of this subsection. The denial is not appealable.

(4) If the Department determines that the enrollee's request meets the criteria for an expedited appeal, then (i) the mediation procedure under G.S. 108D-15(i) shall not apply to the appeal request and (ii) the decision required under G.S. 108D-16 shall be made as expeditiously as possible. (2021-62, s. 2.2(i).)

**§ 108D-16. Notice of final decision and right to seek judicial review.**

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 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 managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes. (2013-397, s. 1; 2019-81, s. 1(a).)

**§ 108D-17.** Reserved for future codification purposes.

**§ 108D-18.** Reserved for future codification purposes.

**§ 108D-19.** Reserved for future codification purposes.

**§ 108D-20.** Reserved for future codification purposes.