SENATE BILL 161: Conforming Changes LME/MCO Grievances/Appeals.

2017-2018 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 30, 2017
Introduced by:	Sens. Hise, Pate, Krawiec	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 161 amends the statutes that govern Medicaid enrollees' appeals and grievances related to actions taken by local management entities/managed care organizations (LME/MCOs) to make these statutes conform to changes in the Medicaid federal regulations that recently took effect.

CURRENT LAW: Chapter 108D of the General Statutes governs the process for Medicaid beneficiaries who are enrolled with an LME/MCO to appeal decisions made by LME/MCOs and to file grievances with LME/MCOs. Medicaid beneficiaries enroll with an LME/MCO in order to receive behavioral health services. The statutes in Chapter 108D allow enrollees to appeal certain LME/MCO actions through an LME/MCO level (first-level) appeal and to appeal the LME/MCO's resolution of the first-level appeal by requesting a contested case hearing with the Office of Administrative Hearings. The statutes also allow enrollees to file grievances with LME/MCOs related to matters that are not subject to appeal.

The State is required to establish procedures for Medicaid enrollee appeals and grievances in accordance with federal managed care regulations in Part 438 of Title 42 of the Code of Federal Regulations. Effective July 5, 2016, changes were made to these federal regulations that conflict with certain provisions in Chapter 108D.

BILL ANALYSIS: **Section 1** amends the definitions pertaining to LME/MCO grievances and appeals by replacing the term "managed care action" with the term "adverse benefit determination" in accordance with a change to that terminology in the federal regulations. Conforming changes are made in **Section 2** and throughout the bill.

Section 3 amends the statute governing standard LME/MCO level enrollee appeals to do the following:

- Allows enrollees 60 days instead of 30 days to request an LME/MCO level appeal after receiving a notice of adverse benefit determination.
- Requires LME/MCOs to resolve an LME/MCO level appeal and send a notice of resolution to the enrollee within 30 days instead of 45 days after receiving the request for appeal.
- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 4 amends the statute governing expedited LME/MCO level appeals to do the following:

- Requires LME/MCOs to resolve expedited LME/MCO level appeals within 72 hours instead of three working days after receiving the request for expedited appeal.

- Allows an enrollee to request a contested care hearing when the LME/MCO level appeal is deemed to have been exhausted in accordance with federal requirements.

Section 5 amends the statute governing enrollee contested case hearings to allow enrollees 120 days instead of 30 days after the mailing date of the notice of resolution to file a request for an appeal at the Office of Administrative Hearings.

EFFECTIVE DATE: The bill would be effective when it becomes law and would apply to notices of adverse benefit determination and notices of resolution mailed on or after that date and to requests for LME/MCO level appeals received by the LME/MCOs on or after that date.