

# Summary of Your Rights Under North Carolina Managed Care

A quick list and explanation of the most important rights that  
Medicaid beneficiaries have in the Managed Care System

Compiled By



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Kate B. Reynolds  
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The following training resource is meant to assist in the building and maintaining of strong and effective Member Advisory Committees, as required in the laws governing Medicaid Managed Care. The training resources are for the Managed Care Organizations (Plans) as well as Medicaid beneficiaries and other stakeholders (Members) and consist of the topics listed below in the Table of Contents.

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# Summary of Your Rights Under NC Managed Care

When health care is delivered through a Medicaid managed care plan or “Plan,” the health plan must provide certain rights to members.

- The Plan can usually limit who you can use as a provider to those with which it has an agreement. The group of providers that have agreements is called the plan’s “network.”
- The Plan must have agreements with a large enough network that members can find a provider without having to travel an unreasonable distance to get health care.
- The Plan must also have agreements with enough medical providers so that members do not have an unreasonable wait time to get an appointment.
- The Plan must keep an updated list of the medical providers in its network. This list is called a directory.

If a member cannot find the type of provider needed within a reasonable travel time and distance in the Plan’s network, the member can get a referral to go to a medical provider that is not in the Plan. There are some situations when a member would not need a Plan referral to see a provider that is not in the network such as:

- When a member needs emergency or urgent care that’s not available from their Plan.
- When a member needs family planning services not available from their Plan.
- When a member needs care while traveling out of state.

Members have the right to access the same types of services in a Plan that they would receive through Medicaid if they were not in a Plan. Members in a Plan should:

- Pay the same amounts for cost-sharing, including for prescriptions and copays at appointments as those not in the Plan;
  - Be able to get the same medication as those not in the Plan;
  - Be able to get transportation to medical visits and other Medicaid-covered services; and
- Be able to access certain mental or behavioral health services.

## Disenrollment Rights

When a Member is approved for Medicaid or their Medicaid certification is renewed, they can choose a Plan or choose to leave one Plan and become a member of a different one. For 90 days after choosing a Plan, Members can leave that Plan and choose a different one for any reason. After the 90 days have passed, Members will need to have a special reason to get out of a Plan. Some special reasons might include:

- You moved out of your Plan's service area.
- You have a family member in a different Plan.
- A different Plan may be better for your complex medical conditions.
- Your Long-Term Services and Supports (LTSS) provider is not in your Plan.
- Your Plan does not cover a service you need for moral or religious reasons.
- Other reasons (such as poor quality of care, lack of access to covered services, lack of access to providers in dealing with your health care needs).



# The Right to Disagree with a Plan - Grievances and Appeals

## Grievance Process

Members have the right to use the Grievance or Appeal Process if they disagree with the Plan about decisions the Plan made.

## **WHEN** should Members Use the Grievance Process?

If you think a Plan employee or Plan provider has treated you unfairly by:

- Speaking to you disrespectfully.
- Not giving you quality of care.
- If you feel that you are being discriminated against because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender identity or expression, or sexual orientation.

## **HOW** can Members file a Grievance?

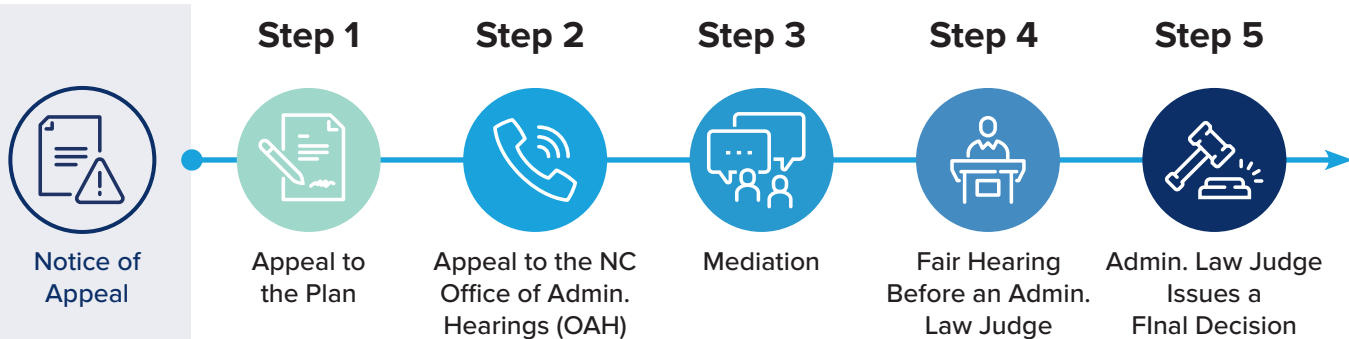
- The Plan must provide you with forms to file a grievance and member services will help you to complete the forms using the Plan grievance system, or
- The NC Medicaid Ombudsman provides **FREE**, confidential assistance.

## **WHAT** happens after a Grievance is filed?

- Within **5** days the Plan should tell you that your grievance has been received.
- Within **30** days, the Plan should tell you the outcome of the grievance.

## Appeals Process

You can file an Appeal by calling the Plan or by writing to let the Plan know that you disagree with the decision in the letter that you received.



## WHEN should Members Use the Appeals Process?

- If your doctor requests medication, a procedure, or services for you and the Plan denies that request.
- If the Plan ends or reduces services that you have been receiving.
- If the Plan delays providing the services that have been requested.
- If the Plan fails to handle the grievance within the required timelines.

## HOW can Members file an Appeal?

- When the Plan sends a letter that denies or terminates or reduces your services, it must include a description of your appeal rights. To file an Appeal, you must follow the steps on filing the Appeal within **60** days from the date of the letter.
- If you file an Appeal within **10** days of receiving the Plan letter, you can request to keep your services just as they have been while your Appeal is decided.

## STEPS for an Appeal

1. Reconsideration or Internal Review by the Plan
2. Appeal to NC Office of Administrative Hearings (OAH)
3. Mediation
4. Fair Hearing of Appeal before the Administrative Law Judge (ALJ) at OAH
5. The ALJ Issues a Written Decision