REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 21A .0301

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *On line 7, what is meant by "mailed or delivered"? Do you mean delivered if sent in electronic format or delivered by hand?*
>
> *When will the modification of assistance become effective if it results in an increase? I think that it is immediately based upon the previous language, but since that has been deleted, it is now unclear when this will occur. If you choose to use "immediately", please give it some meaning.*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 21A .0301 is readopted as published in 32:13 NCR 1258–1268 as follows:

SECTION .0300 - APPEALS

10A NCAC 21A .0301 NOTICE

In cases involving termination or modification of assistance, no action shall become effective until ten business ~~work~~ days after the notice is mailed or delivered, except ~~that it may be effective immediately~~ when:

(1) modification ~~Modification~~ results in an increase in benefits ~~is beneficial~~ to the applicant or beneficiary; ~~client;~~ or

(2) permitted pursuant to ~~Federal regulations at~~ 42 C.F.R. 431.213, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~431.213 are adopted by reference pursuant to 150B-14(c).~~

History Note: *Authority G.S. 108A-54; 108A-54.1B; ~~108A-79~~ 108A-79(b); ~~150B-14(c);~~ 42 C.F.R. 431.211; 42 C.F.R. 431.213;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 21A .0302

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Overall, would it make sense to shorten this Rule to say something like "Local and State appeal hearings under G.S. 108A-79 shall be delayed for good cause. Good cause exists when…"

If the above does not work for your purposes, currently, I read (a) to say that the factors that will be considered in delaying a local appeals hearings are contained in G.S. 108A-79(e); however, I do not believe that is the intent as those factors are not contained in that statute, but are instead contained in Paragraph (c). As such, please delete "as provided in G.S. 108A-79(e) at the end of the sentence.

In (b), please change "may be delayed" to "shall be delayed" (assuming that is what you mean.)

(b) says that the hearing may be delayed "for as much as 30 calendar days", but how will it be determined how much time will be allowed? Is this at the request of the parties? Does it depend upon what kind of good cause is shown?

In (c), please add something like "For purposes of this Rule, good cause exists when…"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 21A .0302 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21A .0302 GOOD CAUSE FOR DELAYED HEARINGS

(a) A local appeal hearing under G.S. 108A-79 shall be delayed for good cause as provided in G.S. 108A-79(e).

(b) A State ~~state~~ appeal hearing under G.S. 108A-79 may be delayed for as much as 30 calendar days when there is good cause. ~~The postponement may not exceed 30 calendar days.~~

(c) Good cause exists when:

(1) there~~There~~ is a death in the appellant's family;

(2) the~~The~~ appellant or someone in his or her family is ill;

(3) the~~The~~ appellant is unable to obtain representation;

(4) the~~The~~ appellant's representative has a conflict with the scheduled date;

(5) the~~The~~ appellant receives a notice of action proposing a reduction or termination of assistance after the ten business ~~work~~ day notice expires;

(6) the~~The~~ appellant is unable to obtain transportation; or

(7) the~~The~~ hearing officer determines that the hearing should be delayed for some other reason in the interests of justice or to promote judicial economy. ~~other circumstances satisfactory to the hearing officer.~~

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-79;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 21A .0303

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *In (a), the hearing officer will make a tentative decision regarding what? Please keep in mind that because titles of rules can be changed without going through the rule-making process, we typically read rules without the titles.*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 21A .0303 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21A .0303 APPEAL DECISION

(a) The hearing officer shall make a tentative decision that ~~which~~ shall be served upon the county department, ~~department and~~ the ~~appellant~~ appellant, and representatives by mail. Decisions reversing ~~proposing to reverse~~ the county department's action shall be sent by certified mail to the county department. ~~department while decisions~~ Decisions affirming the county department's actions shall ~~will~~ be sent by certified mail to the appellant. Decisions shall be sent by regular mail to representatives.

(b) The county and the appellant may present oral and written argument, for and against the decision ~~decision.~~ by contacting the Chief Hearing Officer. ~~Written argument may be submitted to or contact made with the Chief Hearing officer to request a hearing for oral argument.~~

(c) If a written argument, a request for a time extension to submit a written argument, or a request for oral argument is not received by the Chief Hearing Officer ~~is not contacted~~ within 10 calendar days of the date the notice of the tentative decision is signed, the tentative decision shall become final.

(d) If a request for a time extension to submit [~~an~~] a written argument or a request for an oral argument is received by the Chief Hearing Officer [~~officer~~] within 10 calendar days of the date the notice of the tentative decision is signed, an extension [~~may~~] shall be granted and a letter shall be mailed stating the date the written argument is due or the date and time the oral argument shall be heard. [~~for good cause or in the interests of justice.~~]

(e)~~(d)~~ If the party that requested oral argument fails to appear ~~at the hearing~~ for the scheduled oral argument, the tentative decision shall become ~~becomes~~ final.

(f)~~(e)~~ If ~~oral~~ [~~or~~] ~~and~~ ~~written~~ arguments are ~~presented,~~ presented within the timeframes established in Paragraphs (c) and (d) of this Rule, then all such arguments shall be considered and a final decision shall be rendered.

(g)~~(f)~~ The final decision shall be served upon ~~mailed to~~ the appellant and ~~any~~ the county department by certified mail. Decisions shall be sent by regular mail to representatives.

(h)~~(g)~~ A decision upholding the appellant shall be put into effect within two weeks after the county department's receipt of the final decision ~~decision.~~ by certified mail.

(i)~~(h)~~ As provided for in 42 C.F.R. 431.245 ~~431.245,~~ and G.S. 108A-79(k), the decision shall contain the appellant's right to ~~request a State agency hearing and~~ seek judicial review. ~~review to the extent that either is available to him~~.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 108A-79; 42 C.F.R. 431.244; 42 C.F.R. 431.245; 42 C.F.R. 431.246;*
Eff. September 1, 1984;
Amended Eff. September 1, 1992; ~~1992.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 21B .0204

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Just so I'm clear, in (a)(2), a person will receive the full three months if they were eligible during that time and those were months of medical need?

I assume that eligibility for this coverage is set forth elsewhere in rule or statute?

In (b)(2), where can the state plan be found? Is your regulated public familiar?

In (c), what is meant by "the month in which notice of termination expires"? Does the notice of termination provide an expiration date of the notice or does it provide a termination date of coverage?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 21B .0204 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21B .0204 EFFECTIVE DATE OF ASSISTANCE

(a) The first month of Medicaid coverage shall be:

(1) the~~The~~ month of application, or for SSI recipients, the month of application for SSI; ~~or~~

(2) as~~As~~ much as three months prior to the month of application when the client received medical services covered by the program and was eligible during the month or months of medical need; or

(3) if~~If~~ the client applies prior to meeting a non-financial requirement, no earlier than the calendar month in which all non-financial requirements are met.

(b) Assistance shall be authorized beginning on the first day of the month except when:

(1) the~~The~~ client's income exceeds the income level and he or she must spenddown the excess income for medical care. The assistance shall be authorized on the day his or her incurred medical care costs equal the amount of the excess income; or ~~income.~~

(2) ~~For groups identified in Rule .0311, Sub-item (3)(a) of this Subchapter, the client shall be authorized on the day the reserves are reduced, or incurred medical care costs equal the amount of the excess income, whichever occurs later.~~ otherwise stated in the Medicaid State Plan.

(c) Medicaid coverage shall end on the last day of the last month of eligibility except for those individuals eligible for emergency conditions only as described in 10A NCAC 23E .0102. The last month of eligibility shall be the month in which notice of termination expires. ~~be:~~

~~(1) The month in which timely notice of termination expires; or~~

~~(2) The month in which adequate notice of termination expires.~~

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.915; ~~435.914; 42 C.F.R. 435.919; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;~~*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; October 1, 1991; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004; ~~2004.~~
Readopted Eff. July 1, 2018.

10A NCAC 21B .0311 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 21B .0311 TRANSFER OF RESOURCES

History Note: *Authority G.S. 108A-54; 108A-58; P.L. 100-360; P.L. 100-485; 42 U.S.C. 1396p(c); 42 C.F.R. 435.121; 42 C.F.R. 435.840; 42 C.F.R. 435.841; 42 C.F.R. 435.845; S.L. 2002-126;*
Eff. September 1, 1984;
Amended Eff. December 1, 1991; August 1, 1990;
Temporary Amendment Eff. April 21, 2003; March 1, 2003;
Amended Eff. August 1, 2004; ~~2004.~~
Repealed Eff. July 1, 2018.

10A NCAC 21D .0101 - .0103 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 21D - ESTATE RECOVERY

SECTION .0100 - RECIPIENTS SUBJECT TO ESTATE RECOVERY

10A NCAC 21D .0101 NOTICE OF ESTATE RECOVERY

10A NCAC 21D .0102 PERMANENTLY INSTITUTIONALIZED

10A NCAC 21D .0103 AGE 55 AND OVER

History Note: *Authority G.S. 108A-70.5; 42 U.S.C. 1396p.;*
Temporary Adoption Eff. May 6, 1996 to expire on July 1, 1996, or the last day of the 1996 session of the General Assembly, whichever is later;
Temporary Rule Expired on July 1, 1996;
Eff. July 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.

10A NCAC 21D .0201 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SECTION .0200 - RECONSIDERATION REVIEW

10A NCAC 21D .0201 RECONSIDERATION REVIEW

History Note: *Authority G.S. 108A-70.5; 42 U.S.C. 1396p.;*
Temporary Adoption Eff. May 6, 1996 to expire on July 1, 1996, or the last day of the 1996 session of the General Assembly, whichever is later;
Temporary Rule Expired on July 1, 1996;
Eff. July 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.

10A NCAC 21D .0301 - .0302 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 21D - ESTATE RECOVERY

SECTION .0300 - MEDICAID PAYMENTS SUBJECT TO RECOVERY

10A NCAC 21D .0301 PERMANENTLY INSTITUTIONALIZED

10A NCAC 21D .0302 AGE 55 AND OVER

History Note: *Authority G.S. 108A-70.5; 42 U.S.C. 1396p.;*
Temporary Adoption Eff. May 6, 1996 to expire on July 1, 1996, or the last day of the 1996 session of the General Assembly, whichever is later;
Temporary Rule Expired on July 1, 1996;
Eff. July 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.

10A NCAC 21D .0401 - .0402 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 21D - ESTATE RECOVERY

SECTION .0400 - FILING AND COLLECTION OF CLAIMS AGAINST ESTATE

10A NCAC 21D .0401 FILING CLAIM AGAINST ESTATE

10A NCAC 21D .0402 COLLECTION OF CLAIMS

History Note: *Authority G.S. 108A-70.5; 42 U.S.C. 1396p.;*
Temporary Adoption Eff. May 6, 1996 to expire on July 1, 1996, or the last day of the 1996 session of the General Assembly, whichever is later;
Temporary Rule Expired on July 1, 1996;
Eff. July 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.

10A NCAC 21D .0501 - .0503 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 21D - ESTATE RECOVERY

SECTION .0500 - WAIVER OF RECOVERY

10A NCAC 21D .0501 RECOVERY NOT COST EFFECTIVE

10A NCAC 21D .0502 UNDUE HARDSHIP

10A NCAC 21D .0503 DETERMINATION OF UNDUE HARDSHIP

History Note: *Authority G.S. 108A-70.5; 42 U.S.C. 1396p.;*
Temporary Adoption Eff. May 6, 1996 to expire on July 1, 1996, or the last day of the 1996 session of the General Assembly, whichever is later;
Temporary Rule Expired on July 1, 1996;
Eff. July 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.

10A NCAC 22B .0101 is readopted as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22B – PROVIDER ISSUES

SECTION .0100 - GENERAL

10A NCAC 22B .0101 INSTITUTIONAL HEALTH SERVICES

No provider shall ~~may~~ be enrolled in the Medicaid Program to provide any new institutional health service for which a Certificate of Need is required under G.S. 131E, Article 9 without first obtaining a Certificate of Need and meeting the conditions imposed by it.

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. March 1, 1993;
Recodified from 10 NCAC 26B .0124 Eff. October 1, 1993;
Recodified from 10 NCAC 26B .0125 Eff. April 1, 1994;
Recodified from 10 NCAC 26B .0126 Eff. January 1, 1998; ~~1998.~~
Readopted Eff. July 1, 2018.

10A NCAC 22B .0102 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22B .0102 COORDINATION WITH TITLE XVIII

The entire range of benefits under Part B of Title XVIII of the Social Security Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/, to Medicare-eligible ~~Medicare – eligible~~ persons shall be provided through a buy-in agreement with the Secretary of Health and Human Services. This agreement shall cover all persons eligible under the Medicaid State Plan. ~~state's approved Title XIX plan.~~

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. June 1, 1998; ~~1988.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22B .0103

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *What is the overall intent of this Rule? Specifically, what is meant by "these standards are specified by North Carolina state licensing law and by federal statutes and regulations"? Is this just saying that institutions have to abide by the law? If so, is there a simpler way of saying this?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22B .0103 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22B .0103 INSTITUTIONAL STANDARDS

Institutions shall ~~must~~ meet standards prescribed for participation in Titles XVIII, XIX, and XXI of the Social Security Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/. ~~and XIX.~~ These standards are specified by North Carolina ~~state~~ licensing law and by federal statutes and regulations, and are kept on file in the Department of Health and Human Services, Division of Health Services Regulation ~~state agency~~ and available on request.

History Note: *Authority G.S. 108A-25(b); 108A-54; 131-E; 42 C.F.R. 440.10; 42 C.F.R. Part 442; 42 C.F.R. 457.990; ~~442, Subparts (D)(E);~~*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977; ~~1977.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22B .0104

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a)(1), please add a comma in between "home health" and "or nursing home services"

Please add a comma after "services" and before "not to exceed"

In (a)(3), please consider saying: within ~~Within~~ 180 days of the Medicare or other third party ~~payment, or within 180 days of~~ payment or final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs" *if that's what you mean.*

In (a)(3)(B), what is meant by "there was a possibility of receiving payment…" Does this just mean that a claim was filed, but a denial was not issued nor payment received?

In a)(3)(C), what is meant by "good faith"? How is this determined? Is this set forth elsewhere?

In (c), by "may be waived", do you mean "shall be waived" given that you've set forth parameters in (c)? Also,

In (c), you have changed "Division of Medical Assistance" to "Division" elsewhere in your Rules. Was it the intention to do that here as well?

Overall, (c) appears to be missing some words. Please clarify and consider breaking this down into a list. I think that the following is the intent of the Paragraph (but please verify):

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

(c) The time limitation specified in Paragraph (a) of this Rule ~~may~~ shall be waived by the Division of Medical Assistance under the following circumstances: when a

(1) ~~correction of~~ an administrative error in determining eligibility has occurred by the Division; or ~~eligibility,~~

(2) ~~application of~~ a court order or hearing decision grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

In (d), I don't understand what is meant by "The Director of DMA shall be the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing…" These sentences appear contradictory. I think that you mean the decision of the Director shall be final. The final decision of the Director may be appealed by filing a contested case in accordance with G.S. 150B-23.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22B .0104 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims shall ~~must~~ be filed either:

(1) within ~~Within~~ 365 days of the date of service for services other than inpatient hospital, home health or nursing home services; ~~or~~

(2) within ~~Within~~ 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services not to exceed the limitations as specified in 42 C.F.R. 447.45, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~447.45;~~ or

(3) within ~~Within~~ 180 days of the Medicare or other third party payment, or within 180 days of final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Paragraph, ~~Rule,~~ if it is [~~may~~] ~~can~~ ~~be~~ shown that:

(A) a ~~A~~ claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Paragraph; ~~Rule; and~~

(B) there ~~There~~ was a possibility of receiving payment from the third party payor with whom the claim was filed; and

(C) good faith ~~Bona fide and timely~~ efforts were pursued to achieve either payment or final denial of the third-party claim.

(b) Providers shall ~~must~~ file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule may be waived by the Division of Medical Assistance when a correction of an administrative error in determining eligibility, application of court order or hearing decision grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows good cause for the failure to do so, ~~so was beyond his control, he~~ the provider may request a reconsideration review by the Director of the Division of Medical Assistance. "Good cause" is an action uncontrollable by the provider. The Director of the Division of Medical Assistance shall be ~~is~~ the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 447.45;*
Eff. February 1, 1976;
Amended Eff. October 1, 1977;
Readopted Eff. October 31, 1977;

Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985; ~~1985.~~

Readopted Eff. July 1, 2018.

10A NCAC 22B .0105 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22B .0105 OVERUTILIZER IDENTIFICATION

History Note: *Authority G.S. 108A-25(b);*
Eff. January 1, 1978;
Amended Eff. May 1, 1990; October 4, 1979; ~~1979.~~
Repealed Eff. July 1, 2018.

10A NCAC 22C .0101 - .0103 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22C – AMOUNT: DURATION: AND SCOPE OF ASSISTANCE

10A NCAC 22C .0101 COST SHARING

10A NCAC 22C .0102 MEDICALLY NEEDY

10A NCAC 22C .0103 CATEGORICALLY NEEDY

History Note: *Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; 34 C.F.R. 447.50; 42 C.F.R. 440.220; 42 C.F.R. 440.240; 42 C.F.R. 440.210;*
Eff. February 1, 1976;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; ~~1990.~~
Repealed Eff. July 1, 2018.

10A NCAC 22D .0101 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22D – RECIPIENT ISSUES

10A NCAC 22D .0101 CO-PAYMENT

History Note: *Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86; 42 C.F.R. 440.230(d); Tax Equity and Fiscal Responsibility Act of 1982, Subtitle B; Section 95 of Chapter 689, 1991 Session Laws; Eff. January 1, 1984; Temporary Amendment Eff. August 15, 1991 For a Period of 180 Days to Expire on February 15, 1992; Amended Eff. February 1, 1992; Temporary Amendment Eff. September 15, 1992 For a Period of 180 Days or Until the Permanent Rule Becomes Effective, Whichever is Sooner; Amended Eff. February 1, 1993; Temporary Amendment Eff. January 1, 2002; Amended Eff. April 1, 2003; ~~2003.~~ Repealed Eff. July 1, 2018.*

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0104

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Is the intent of (a) that if a provider asks, then the Division will conduct an on-site educational visit? If so, please say "Upon the request of a provider, the Division shall conduct an on-site…"

In (d), is the process for "prior approval" set forth elsewhere in rule, statute, cfr, or the Plan?

In (e), line 20, please delete "shall be binding on the Division and the providers:" as unnecessary.

For purposes of consistency with the remainder with the other sub-paragraphs, please change "constitutes" to "shall constitute" in (e)(1).

In (e)(6), are the factors that will go into deciding whether the Division will suspend or terminate a provider set forth elsewhere?

In (g), what is a lock-in system? Is this already in place? Is this specific to each individual provider or is it a provider wide system? I'm a bit confused by "the Division shall establish…" as this language appears to have been in this Rule since 1984 – is it still accurate?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0104 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0104 PREVENTION

(a) Provider Education. The Division may, ~~may at its discretion, or shall~~ upon the request of a provider, conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program.

(b) Provider Manuals. The Division shall ~~will~~ prepare and make available ~~furnish each provider with~~ a provider manual containing at least the following information:

(1) amount, duration, and scope of assistance;

(2) participation standards;

(3) penalties;

(4) reimbursement rules; and

(5) claims filing instructions.

(c) Prepayment Claims Review. The Division shall ~~will~~ check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation. ~~other appropriate methods of review.~~

(d) Prior Approval. The Division shall require prior approval for certain specified covered services as set forth in the Medicaid State Plan.

(e) Claim Forms. The following terms and conditions shall apply to the submission of claims [~~Claim~~] forms and [~~shall contain~~] ~~The Division's provider claim forms shall include the following requirements~~ [~~that~~] ~~for provider participation and payment. These requirements~~ shall be binding on ~~upon~~ the Division and the providers:

(1) [~~medicaid~~]Medicaid payment constitutes payment in full;~~full.~~

(2) charges~~Charges~~ to Medicaid recipients for the same items and services shall not be higher than for private paying patients;~~patients.~~

(3) the~~The~~ provider shall keep all records as necessary to support the services claimed for reimbursement;~~reimbursement.~~

(4) the~~The~~ provider shall ~~fully~~ disclose the contents of his Medicaid financial and medical records to the Division and its agents;~~agents.~~

(5) [~~medicaid~~]Medicaid reimbursement shall only be made for medically necessary care and services as defined in 10A NCAC 25A .0201; and ~~services.~~

(6) the~~The~~ Division may suspend or terminate a provider for violations of Medicaid laws, federal regulations, the rules of this Subchapter, the provider administrative participation agreement, the Medicaid State Plan, and Medicaid Clinical Coverage policies. ~~policies, or guidelines.~~

(f) ~~Pharmacy and Institutional~~ Provider Administrative Participation Agreements. All ~~institutional and pharmacy~~ providers shall ~~be required to~~ execute a written participation agreement as a condition for participating in the N.C. State Medicaid ~~Medical Assistance~~ Program.

(g) The Recipient Management LOCK-IN System. The ~~Department of Health and Human Services,~~ Division ~~of Medical Assistance, will~~ shall establish a lock-in system to control recipient overutilization of provider services. A

lock-in system restricts an overutilizing recipient to the use of one physician and one pharmacy, of the recipient's choice, provided the recipient's physician is able to ~~can~~ refer the recipient to other physicians as medically necessary, as defined in 10A NCAC 25A .0201. ~~necessary.~~

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. Part 455; 42 CFR 455.23;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0105

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Given .0202, is this Rule necessary? It appears to be duplicative of .0202.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0105 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0105 DETECTION

~~(a)~~ The Division shall ~~will~~ accept, investigate, ~~investigate~~ and ~~where good reason to do so exists,~~ refer for prosecution ~~prosecution,~~ allegations or complaints of provider or recipient fraud, waste, abuse, ~~overutilization,~~ error, ~~error~~ or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan. ~~aberrant practices.~~

~~(b) The Division will conduct post payment reviews and audits of a statistically significant sampling of provider claims.~~

~~(c) The Division will compare provider and recipient practices to establish statistical models of normal provider or recipient practices.~~

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0106

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Elsewhere in these Rules, you have changed "Division of Medical Assistance" to "the Division." Was the intent to do that here as well?

Is there a specific law that you could cite for "State or Federal law or regulation"? Is your regulated public familiar?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0106 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0106 CONFIDENTIALITY

All investigations by the North Carolina Division of Medical Assistance concerning allegations of provider fraud, abuse, over-utilization, or inadequate quality of care shall be confidential, and the information contained in the files of such investigations shall be confidential, except as permitted by State or Federal law or regulation.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108A-64; 132-1.3; 42 C.F.R. Part 455; 42 C.F.R. 455.21;*
Eff. May 1, 1984;
Amended Eff. May 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0107 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0107 RECORD RETENTION

All Title XIX and Title XXI providers shall keep and maintain all Medicaid and NC Health Choice financial, medical, or other records necessary to ~~fully~~ disclose the nature and extent of services furnished to Medicaid and NC Health Choice recipients and claimed for reimbursement. These records shall be retained for a period of not less than five full years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, ~~regulations~~ or data retention agreements. Upon notification of an audit or upon receipt of a request for records, all records related to the audit or records request shall be retained until notification that the investigation has been concluded. [~~concluded or five full years from the initial notification, whichever is longer.~~]

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-63; 108A-64; 42 C.F.R. Part 455; 42 C.F.R. 455.12–23; 42 C.F.R. 431.107;*
Eff. April 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0201

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Overall, is this Rule necessary? It appears to simply recite 108A-63.

If this Rule is necessary, please remove the incorporation language for G.S. 108A-63.

Please also add a comma in between "representative" and "or agent"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0201 is readopted as published in 32:13 NCR 1258–1268 as follows:

SECTION .0200 - PROVIDER FRAUD AND PHYSICAL ABUSE OF RECIPIENTS

10A NCAC 22F .0201 DEFINITION OF PROVIDER FRAUD

(a) The parameters of provider ~~Provider~~ fraud are set out in ~~is defined as provided by~~ ~~N.C.G.S.~~ G.S. 108A-63, which is adopted and incorporated by reference with subsequent changes or amendments pursuant to G.S. 150B-21.6. ~~N.C.G.S. 150B-14(a)(2)(c).~~

(b) "Provider" shall include any person who provides ~~furnishes~~ goods or services under this Rule and any other person acting as an employee, representative or agent of such person.

History Note: *Authority G.S. 108A-25(b); 108A-63; ~~143B-10;~~ 150B-21.6; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1990; May 1, 1984; ~~1984~~.
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0202

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Who is to be conducting this investigation? The Division?

Are both .0105 and .0202 necessary? They seem to be duplicative, with .0202 providing some additional information?

In (a), line 6, do you mean "complaints received ~~or~~ of fraud…"?

In (a)(1), please consider providing a cross-reference to Paragraph (b) of this Rule to show what a full investigation may consist of.

In (a)(2), are there cross-references available for the civil and criminal fraud references? I assume that this would provide some additional information that would indicate when this may be warranted?

In (b)(2), is there a cross-reference for "program abuse"? Do you mean provider abuse as set forth in 22F .0301?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0202 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0202 INVESTIGATION

~~(a) The Division will publish methods and procedures for the control of provider fraud, abuse, error, and overutilization.~~

(a)~~(b)~~ There shall be a preliminary investigation of all complaints received or fraud, waste, abuse, [~~overutilization,~~] error, or practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan [~~regulations or policy~~] ~~aberrant practices~~ detected, until it is determined:

(1) whether there are sufficient findings to warrant a full investigation;

(2) whether there is sufficient evidence to warrant referring the case for civil fraud investigation, [~~and~~] ~~and/or~~ criminal fraud investigation, or both; ~~action;~~ or

(3) whether there is insufficient evidence to support the allegation(s) and the case may be closed.

(b)~~(c)~~ There shall be a full investigation if the preliminary findings support the conclusion of possible fraud until:

(1) the case is referred to the appropriate law enforcement agency;

(2) the case is found to be one of program abuse subject to administrative action;

(3) the case is closed for insufficient evidence of fraud or abuse; or

(4) the provider is found not to have abused or defrauded the program.

History Note: *Authority G.S. 108A-25(b); 108A-63; 42 U.S.C. 1396(b) et seq.; 42 C.F.R. Part 455, Subpart A; ~~455;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0203

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

We read rules without titles, but it caught my eye – did you mean "law enforcement agency" when the body of the Rule says "State Medicaid Fraud Control Unit"?

On line 4, how is it determined whether something is "credible"? Is this based upon the investigation in .0202?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0203 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0203 REFERRAL TO LAW ENFORCEMENT AGENCY

The Division shall refer credible allegations of ~~all cases of reasonably suspected~~ provider fraud, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, ~~fraud~~ or suspected physical abuse of recipients to the State Medicaid Fraud Control Unit.

History Note: *Authority G.S. 108A-25(b); 108A-63; P.L. 95-142; 42 C.F.R. 455.14; 42 C.F.R. 455.15; 42 C.F.R. 455.2;*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0301

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

I realize that you all deleted "provider abuse" because that is not what is defined by 42 CFR 455.2, but please make it clear within the body of the text of the rule that this is referring to provider abuse.

It looks like in your investigations rules, you have removed "overutilization"; however, you have kept it in (1). Was this intentional?

In (1), what is considered "overutilization"? I assume that this is set forth elsewhere in rule, statute, or the Plan?

Please change the comma at the end of (2)(a) to a semi-colon.

In (3), who is an "unauthorized" person? Is this set forth in the contract between the provider?

(4) appears to be missing a lead in to the sub-items. Should there be an "including" or something of the like at the end?

Please end (4)(a) and (b) with semi-colons, rather than commas.

In (4)(a), please delete or define "proper"

In (4)(b), please delete or define "appropriate"

In (4)(c), please delete or define "medically necessary"

In (5), what are the requirements of certification? Are these set forth elsewhere?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0301 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

SECTION .0300 - PROVIDER ABUSE

10A NCAC 22F .0301 DEFINITION OF PROVIDER ABUSE

~~Provider abuse~~ Abuse, defined as provided by 42 C.F.R. 455.2, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, ~~includes any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary including~~, includes ~~for example,~~ the following:

(1) overutilization~~Overutilization~~ of ~~medical and~~ health care ~~and~~ services; ~~services.~~

(2) separate~~Separate~~ billing for care and services that are:

(a) part of an all-inclusive procedure, or

(b) included in the daily per-diem rate; ~~rate.~~

(3) billing~~Billing~~ for care and services that are provided by an unauthorized or unlicensed person; ~~person.~~

(4) failure~~Failure~~ to provide and maintain within accepted medical standards for the community, as set out in 10A NCAC 25A .0201: ~~community:~~

(a) proper quality of care,

(b) appropriate care and services, or

(c) medically necessary care and services; or ~~services.~~

(5) breach~~Breach~~ of the terms and conditions of the Provider Administrative Participation Agreement, ~~participation agreements, or~~ a failure to comply with requirements of certification, or failure to comply with the terms and conditions for the submission of claims set out in Rule .0104(e) of this Subchapter. ~~provisions of the claim form.~~

~~The foregoing examples do not restrict the meaning of the general definition.~~

History Note: *Authority G.S. 108A-25(b); 108A-54.2; 108A-63; 42 C.F.R. Part 455; ~~455, Subpart C;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0302

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

What are clinical coverage policies? Are these agreements entered into with the providers?

What is the "investigative unit"? Is this not the Division?

In looking at Rule .0202 of this Subchapter, I assume that this Rule will come into play only if "the case is found to be one of program abuse subject to administrative action"?

In (c), would it be appropriate to add something like "upon a determination by the Division based upon their investigation that program abuse has occurred, the Division shall seek restitution in accordance with 10A NCAC 22F .0601 and may also take one of more of the following administrative actions:" Please see my notes for 22F .0602.

In (c), how will the Division determine whether to take additional action? Are these set forth elsewhere in rule or statute?

In (c)(1) – who has final decision making power to suspend or terminate? To whom is the recommendation being made? It appears to me that the Department has the authority to take this action so is "recommendation" accurate? Please clarify.

In (e), please capitalize "state"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0302 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0302 INVESTIGATION

(a) ~~Abusive practices~~ Fraud, waste, abuse, [~~overutilization,~~] error, or practices not conforming to state and federal Medicaid laws and regulations, [~~regulations or~~] clinical coverage policies, [~~policy~~] or the Medicaid State Plan shall be investigated according to the provisions of Rule .0202 of this Subchapter.

(b) A Provider Summary Report shall be prepared by the investigative unit furnishing the full investigative findings of fact, conclusions, and recommendations.

(c) The Division shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of the case. ~~case~~ The Division shall seek full restitution of any improper provider payments as required by 10A NCAC 22F .0601. In addition, the Division may also take one or more of ~~from among~~ the following administrative actions:

(1) to recommend suspension or termination; ~~To place provider on probation with terms and conditions for continued participation in the program.~~

(2) to place the provider on probation with terms and conditions for continued participation in the program; [~~program including, placing~~]

(3) to place the provider on prepayment claims review pursuant to G.S. 108C-7; ~~To recover in full any improper provider payments.~~

~~(3)~~(4) to ~~To~~ negotiate a financial settlement with the provider; ~~provider.~~

~~(4)~~(5) to ~~To~~ impose remedial measures to include a monitoring program of the provider's Medicaid practice terminating with a "follow-up" review to ensure corrective measures have been introduced; or ~~introduced.~~

~~(5)~~(6) to ~~To~~ issue a warning letter notifying the provider that he or she must not continue his or her ~~aberrant~~ practices not conforming to state and federal Medicaid laws and regulations, clinical coverage policies, or the Medicaid State Plan or he or she will be subject to further division actions.

~~(6) To recommend suspension or termination.~~

(d) The tentative decision shall be subject to the review procedures described in Section .0400 of this Subchapter.

(e) If the investigative findings show that the provider is not licensed or certified as required by federal and state law, then the provider shall not ~~cannot~~ participate in the North Carolina State Medical Assistance Program (Medicaid). The Division is required to verify provider licensure pursuant to 42 C.F.R. 455.12, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

History Note: *Authority G.S. 108A-25(b); 108A-63; 108C-7; 42 C.F.R. 455, Subpart A; 455 C.F.R. 412; ~~455.14; 42 C.F.R. 455.15;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1988; May 1, 1984; ~~1984.~~

Readopted Eff. July 1, 2018.

10A NCAC 22F .0401 is repealed as published in 32:13 NCR 1258–1268 as follows:

SECTION .0400 – AGENCY RECONSIDERATION REVIEW

10A NCAC 22F .0401 PURPOSE

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 456;*
Eff. December 1, 1982;
Transferred and Recodified from 10 NCAC 26I .0201 Eff. July 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015; ~~2015.~~
Repealed Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0402

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *In (b), rather than "the provider shall be instructed to submit to the Division in writing a request…" please consider saying "if the provider wishes to submit a request for reconsideration, he or she shall submit the request in writing within 30 business days from the date of the receipt of the notice."*
>
> *If (f), rather than "the decision shall state that the provider may request", please consider saying "~~the decision shall state that~~ the provider may request…" Please also consider making this a separate paragraph.*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0402 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0402 RECONSIDERATION REVIEW FOR PROGRAM ABUSE

(a) The Division shall notify the provider in writing by certified mail of the tentative decision made pursuant to Rule .0302 of this subchapter and the opportunity for a reconsideration of the tentative decision. ~~Upon notification of a tentative decision the provider will be offered, in writing, by certified mail, the opportunity for a reconsideration of the tentative decision and the reasons therefor.~~

(b) The provider shall ~~will~~ be instructed to submit to the Division in writing a ~~his~~ request for a Reconsideration Review within 30 business ~~fifteen working~~ days from the date of receipt of the notice. Failure to request a Reconsideration Review in the specified time shall result in the implementation of the tentative decision as the [~~Department's~~] Division's final decision.

(c) ~~If requested, the~~ The Notice of Reconsideration Review shall be sent to the provider ~~scheduled~~ within 30 business ~~twenty calendar~~ days from receipt of the request. The provider shall ~~will~~ be notified in writing to appear at a specified day, time, ~~time~~ and place. The provider may be accompanied by legal counsel if the provider ~~he~~ so desires.

(d) The provider shall provide a written statement to the Hearing Unit prior to the Reconsideration Review identifying any claims that the provider wishes to dispute and setting forth the provider's specific reasons for disputing the determination on those claims.

(e)~~(d)~~ The purpose of the Reconsideration Review includes:

(1) clarification~~Clarification,~~ formulation, and simplification of issues;

(2) exchange~~Exchange~~ and full disclosure of information and materials;

(3) review~~Review~~ of the investigative findings;

(4) resolution~~Resolution~~ of matters in controversy;

(5) consideration~~Consideration~~ of mitigating and extenuating circumstances;

(6) reconsideration~~Reconsideration~~ of the administrative measures to be imposed; and

(7) reconsideration~~Reconsideration~~ of the restitution of overpayments.

(f)~~(e)~~ The Reconsideration Review decision shall ~~will~~ be sent to the provider, ~~provider~~ in writing by certified mail, ~~mail~~ within 30 business ~~five working~~ days following the date the review record is closed. The review record is closed when all arguments and documents for review have been received by the Hearing Unit. ~~of review. It will state the schedule for implementing the administrative measures and/or recoupment plan, if applicable, and it will~~ The decision shall state that ~~if the Reconsideration Review decision is not acceptable to the provider,~~ the provider ~~he~~ may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103. ~~the provisions found at 10A NCAC 01.~~ Pursuant to G.S. 150B-23(f), the provider shall have 60 days from receipt of the Reconsideration Review decision to request a contested case hearing in the Office of Administrative Hearings. ~~hearing.~~ Unless the request is received within the time provided, the Reconsideration Review decision shall become the Division's final decision and no further appeal shall be permitted. ~~decision. In processing the contested case request, the Director of the Division of Medical Assistance shall serve as the secretary's designee and shall be responsible for making the final agency decision.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 150B, Article 3; S.L. 2011-375, s. 2; ~~150B-22;~~ 42 C.F.R. Part 455.512; ~~455;~~*
Eff. April 15, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection October 22, 1987;
Amended Eff. November 1, 1988; March 1, 1988; May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0601 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

SECTION .0600 – ADMINISTRATIVE SANCTIONS AND RECOUPMENT

10A NCAC 22F .0601 RECOUPMENT

(a) The Division ~~Medicaid Agency~~ shall ~~will~~ seek full restitution of ~~any and all~~ improper ~~payments~~ payments, as defined by 42 C.F.R. 431.958, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, made to providers by the Medicaid Program. Recovery may be by lump sum payment, by a negotiated payment schedule, ~~schedule not to exceed one [year,] year~~ or by withholding from the provider's pending claims the total or a portion of the recoupment amount.

(b) A provider may seek reconsideration review of a recoupment imposed by the division under Rule .0402 of this Subchapter. ~~may argue all or a part of a recoupment imposed by the Medicaid Agency by requesting a Reconsideration Review of the investigative findings and, thereafter, an Executive Decision.~~

History Note: *Authority G.S. 108A-25(b); 108C-5(g); 42 C.F.R. Part 431, Subpart Q; ~~431;~~ 42 C.F.R. Part 455, Subpart F; ~~455;~~ 42 C.F.R. Part 456;*
Eff. February 1, 1982;
Amended Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0602

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

What are these? (b) references "administrative sanctions", (a) references "sanctions or remedial measures." Please be consistent. (Also, keep in mind that .0302 references "administrative actions."

I'm a bit confused as to what the difference is between the actions contained in 10A NCAC 22F .0302(c) and this Rule. Is .0302 applicable for provider abuse and .0602 is applicable to program abuse by providers? I don't read them as being different (though if they are the same, please make them consistent)? Please note that .0301 current just defines "abuse" without the title, which just adds to the confusion here.

In (a), please consider deleting "which do not have to be imposed in any particular order" or other move it to the end.

Please change the period to a semi-colon at the end of (a)(4) and add an "and" or an "or", whichever is applicable. Please also make the "R" in "Remedial" lower case in (a)(5).

In (b)(7), what is a peer review committee? It's possible that this is already set forth elsewhere in your rules, but all I've seen is the investigation by the division.

Please make page 2, line 6 beginning "when a provider…" its own Paragraph. Also, please delete or define "appropriate" in "appropriate county department"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0602 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0602 ADMINISTRATIVE SANCTIONS AND REMEDIAL MEASURES

(a) The following types of sanctions or remedial measures may be imposed ~~imposed, singly or in combination,~~ by the Division ~~Medicaid Agency~~ in instances of program abuse by providers, ~~providers:~~which do not have to be imposed in any particular order:

(1) warning ~~Warning~~ letters for ~~those~~ instances of abuse that can be ~~satisfactorily~~ settled by issuing a warning to cease the specific abuse. The letter shall ~~will~~ state that any further violations shall ~~will~~ result in administrative or legal action initiated by the Division; ~~Medicaid Agency.~~

(2) suspension ~~Suspension~~ of a provider from further participation in the Medicaid Program for a specified period of time, provided that ~~the appropriate~~ findings have been made by the Divison ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable service of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/; ~~quality.~~

(3) termination ~~Termination~~ of a provider from further participation in the Medicaid Program, provided that ~~the appropriate~~ findings have been made by the Division ~~and provided~~ that this action shall ~~does~~ not deprive recipients of access to reasonable services of adequate quality as set out in 42 C.F.R. 440.230, 440.260, and 455.23, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov; ~~quality.~~

(4) probation ~~Probation~~ whereby a provider's participation is ~~closely~~ monitored for a specified period of time not to exceed one year. At the termination of the probation period the Division ~~Medicaid Agency~~ shall ~~will~~ conduct a follow-up review of the provider's Medicaid practice to ensure compliance with all applicable laws, regulations, and conditions of participation in Medicaid. ~~the Medicaid rules. Notwithstanding his probation, a probationary provider's participation, like that of all providers, is terminable at will.~~

(5) Remedial Measures may include, but are not limited to: ~~to include:~~

(A) placing the provider on prepayment review in accordance with G.S. 108C-7; ~~"flag" status whereby his claims are remanded for manual review;~~ or

[~~(6)~~] (B) establishing a monitoring program not to exceed one year whereby the provider shall ~~must~~ comply with pre-established conditions of participation to allow review and evaluation of the provider's Medicaid claims. ~~his Medicaid practice, i.e., quality of care.~~

(b) The following factors are illustrative of those to be considered in determining the kind and extent of administrative sanctions to be imposed:

(1) seriousness of the offense;

(2) extent of violations found;

(3) history of ~~or~~ prior violations;

(4) prior imposition of sanctions;

(5) ~~period~~ length of time provider practiced violations;

(6) provider willingness to obey program rules;

(7) recommendations by the investigative staff or Peer Review Committees; and

(8) effect on health care delivery in the area.

When a provider has been administratively sanctioned, the Division shall notify the licensing board or other certifying group governing the sanctioned provider, ~~appropriate professional society, board of licensure, State Attorney General's Office,~~ federal and state agencies, and appropriate county departments of social services of the findings made and the sanctions imposed.

History Note: *Authority G.S. 108A-25(b); 108C-5; 108C-7; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. 455.23;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; May 1, 1990; ~~1990.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0603

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

By "the division may restrict the provider through suspension" do you mean "the Division may suspend the provider"?

How will the decision be made whether to suspend the provider? Based upon those factors contained in .0602(b)?

Please end (a)(1), (2), and (a)(3) with semi-colons, and add an "and" at the end of (a)(3). Please also begin (a)(1) through (a)(4) with lower case letters for purposes of consistency.

In (a)(2), what is meant by "relevant and factual"? Please delete or define.

In (a)(4), how does the Division give notice to the public? Is this set forth elsewhere in rule, statute, or CFR?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0603 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0603 PROVIDER LOCK-OUT

(a) The Division may restrict the provider through suspension ~~provider, through suspension or otherwise,~~ from participating in the Medicaid program, provided that:

(1) Before imposing any restrictions, the Division shall ~~will~~ give the provider notice and opportunity for review. ~~review in accordance with procedures established by the Division.~~

(2) The Division shall demonstrate a relevant and factual basis for imposing the restriction. ~~shows, before so restricting a provider, that in a significant number of proportion of cases, the provider has:~~

~~(A) provided care, services, and items at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the Division; or~~

~~(B) provided care, service, and items of a quality that does not meet professionally recognized standards of health care.~~

(3) The Division shall ~~will~~ assure that recipients do not lose reasonable access to services of adequate ~~quality~~ quality, as set out in 42 C.F.R. 440.230, 440.260, and 431.54, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, as a result of such restrictions.

(4) The Division shall ~~will~~ give general notice to the public of the restriction, its basis, and its duration.

(b) Suspension or termination from participation of any provider shall preclude the ~~such~~ provider from submitting claims for payment to the Division. ~~state agency.~~ No claims may be submitted by or through any clinic, group, corporation, or other association for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination effective date.

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R.431.54; 42 C.F.R. Part 455;*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0604

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *Is (b) necessary? GS 108C-5 and 42 CFR 455.23 appear to set forth exactly when this may occur and how. If (b) is necessary, what is your authority to suspend payment to "implement the penalty provision of the Patient's Bill of Rights"? I see that you have the authority to suspend payment for fraud under 42 CFR 455.23 and for overpayment pursuant to 108C-5, but I'm not sure where the penalty provision comes in under the cited authority. Also, I'm not exactly sure what "penalty provision" is referring to.*
>
> *Please remove the comma after "overpayments"*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0604 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0604 SUSPENDING~~WITHHOLDING~~ OF MEDICAID PAYMENTS

(a) The Division ~~Medicaid Agency~~ shall suspend ~~withhold~~ Medicaid payments in accordance with the provisions of G.S. 108C-5 and 42 CFR 455.23, ~~455.23~~ which is ~~hereby~~ incorporated by reference with ~~including~~ subsequent changes or amendments, and available free of charge at https://www.ecfr.gov/. ~~amendments and editions. A copy of 42 CFR 455.23 is available for inspection and may be obtained from the Division of Medical Assistance at a cost of twenty cents ($.20) a page.~~

(b) The Division ~~Medicaid Agency~~ shall suspend ~~withhold~~ Medicaid payments in whole or in part to ensure recovery of overpayments, or to implement the penalty provision of the Patient's Bill of Rights described at 10A NCAC 13B .3302. ~~Rights.~~

History Note: *Authority G.S. 108A-25(b); 108C-5; 150B-21.6; 42 C.F.R. Part 431; 42 C.F.R. ~~Part~~ 455.23; ~~455;~~*
Eff. May 1, 1984;
Amended Eff. December 1, 1995; ~~1995.~~
Readopted Eff. July 1, 2018.

10A NCAC 22F .0605 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0605 TERMINATION

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. Part 431; 42 C.F.R. Part 455;*
Eff. May 1, 1984; ~~1984.~~
Repealed Eff. July 1, 2018.

10A NCAC 22F .0606 proposed for readoption without substantive changes as published in 32:13 NCR 1258–1268 is repealed through readoption as follows:

10A NCAC 22F .0606 TECHNIQUE FOR PROJECTING MEDICAID OVERPAYMENTS

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-63; 42 C.F.R. Part 455, Subpart F; ~~455;~~*
Eff. October 1, 1987;
Temporary Amendment Eff. November 8, 1996;
Amended Eff. August 1, 1998; ~~1998.~~
Repealed Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0704

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

What are the "methods and procedures"? Are these set forth in the Plan? Is there a different cross-reference available?

In (b)(1), how is a recipients utilization determined to be "inappropriate"?

In (b)(4), you have changed "Division of Medical Assistance" to just "Division" elsewhere. Was the intent to also do that here?

In (c), please delete or define "periodically", unless it is already set forth elsewhere.

In (d), please add "the" before "division"

In (d)(2), please provide the same cross-reference for the assurance of reasonable access as you have elsewhere in your Rules.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0704 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0704 RECIPIENT MANAGEMENT LOCK-IN SYSTEM

(a) The Division shall have methods and procedures for the control of recipient overutilization of Medicaid benefits. These methods and procedures shall include Lock-In of a recipient, shown to be an overutilizer, to specified providers of health care and services, as set out in 42 C.F.R. 440.230, 440.260, and 431.54(e), which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~services.~~

(b) Prior to implementing Lock-In, ~~Lock-In~~ the following steps shall be taken:

(1) Recipient's utilization pattern shall ~~will~~ be documented as inappropriate;

(2) Recipient shall ~~will~~ be notified that the State is imposing a Lock-In procedure;

(3) Recipient shall ~~will~~ be offered the opportunity to select a provider;

(4) In the event the recipient fails to select a provider, a provider shall ~~will~~ be selected for him or her by the Division of Medical Assistance; and

(5) Recipient shall ~~will~~ receive an eligibility card indicating the selected providers.

(c) Recipient utilization patterns shall ~~will~~ be reviewed periodically to determine if changes have occurred. If the utilization pattern has been corrected, the Lock-In status shall end; ~~will be ended;~~ if the utilization pattern remains inappropriate ~~aberrant,~~ Lock-In status shall continue. ~~will be continued.~~

(d) Division may Lock-In a recipient provided:

(1) the~~The~~ recipient is given notice and an opportunity for a hearing before imposing restriction, pursuant to ~~state statutes governing appeals by public assistance~~ G.S. 150B-23; and ~~recipients.~~

(2) the~~The~~ Division assures that the recipient has reasonable access to Medicaid care and services of adequate quality.

History Note: *Authority G.S. 108A-25(b); 108A-64; 108A-79; 42 C.F.R. 440.230; 42 C.F.R. 440.260; 42 C.F.R. Part 431; 42 C.F.R. 431.54; 42 C.F.R. Part 455; 42 C.F.R. Part 456;*
Eff. May 1, 1984; ~~1984.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22F .0706

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *What is meant by "the Division shall Direct"? It appears to me that Items (1) through (7) are requirements in and of themselves. As an example, Is the intent of this Rule really that the Division must only tell counties to recover recipient responsible overpayments? Or is the intent that "Counties shall recover recipient responsible overpayments as a debt to the participating governments"? It's possible that this Rule just needs to be reorganized a bit.*
>
> *In Item (1), what is meant by "as a debt to the participating governments"? What is the overall intent of (1)?*
>
> *In Item (4), please change "are forwarded" to "shall be forwarded"*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22F .0706 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22F .0706 RECOUPMENT OF OVERPAYMENTS

The Division shall direct [~~oversee~~] ~~will ensure~~ that:

(1) counties recover ~~any and all~~ recipient responsible overpayments as a debt to the participating governments;

(2) counties accept payments from each recipient and give the recipient a receipt for each transaction;

(3) counties keep a separate accounting for Medicaid repayments on each recipient;

(4) repayments are forwarded to the Division of Medical Assistance utilizing the DMA 7050 form. This shall ~~must~~ be done ~~at least~~ on a monthly basis;

(5) the recoupment monies that are apportioned to the repayment of ~~usual adjustments to~~ federal, State, ~~state,~~ and county funds shall be ~~are~~ made by the State; ~~state;~~

(6) Medical Assistance overpayments shall not be ~~are not~~ recouped through check reduction; and

(7) the Division receives its prorated share of recoupments of recipient overpayments involving multiple programs. ~~payments received from recipients with overpayments involving more than one program will be prorated so that the Medicaid program will receive its fair share of each payment.~~

History Note: *Authority G.S. 108A-25(b); 108A-64; 42 C.F.R. Part 431; 42 C.F.R. Part 455; 42 C.F.R. Part 456; Eff. May 1, 1984; ~~1984.~~*
Readopted Eff. July 1, 2018.

10A NCAC 22G .0108 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0108 REIMBURSEMENT METHODS FOR STATE-OPERATED FACILITIES

~~(a) A NC Division of Health Service Regulation certified State-operated nursing facility shall be reimbursed for the reasonable costs that are necessary to efficiently meet the needs of its patients and to comply with federal and state laws and regulations. The costs shall be determined in accordance with Rules .0103 and .0104 of this Section, except that annual cost reports shall be required for the fiscal year beginning on July 1 and ending on the following June 30 and must be submitted to the Division of Medical Assistance within 150 days after their fiscal year end. Payments shall be suspended if reports are not filed. The Division of Medical Assistance shall extend the deadline for filing the report if the Division determines good cause. "Good cause" is an action uncontrollable by the provider. The Medicare principles for the reimbursement of skilled nursing facilities shall be utilized for the cost principles that are not specifically addressed in this Section.~~

~~(b) A per diem rate based on the providers estimated annual cost divided by patient days shall be used to make interim payments. A desk audit and a tentative settlement shall be performed on each annual cost report to determine the amount of Medicaid reasonable cost and the amount of interim payments received by the provider.~~

~~(c)~~ The Division's reimbursement methodology is set forth in the Medicaid State Plan. Any payments in excess of costs shall be refunded to the Division. Any costs in excess of payments shall be paid to the provider. ~~An annual field audit shall be performed by a qualified independent auditor to determine the final settlement amounts.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. 447, Subpart C;*
Eff. January 1, 1992;
Temporary Amendment Eff. August 3, 2004;
Amended Eff. January 1, 2005; ~~2005.~~
Readopted Eff. July 1, 2018.

10A NCAC 22G .0109 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0109 NURSING HOME PROVIDER ASSESSMENT

(a) In accordance with 42 USC 1396b(w) and 42 CFR, Part 433, Subpart B, which are adopted and incorporated by reference with subsequent changes or amendments; ~~B;~~ and consistent with the CMS Federal Waiver approved April 5, 2004 with an effective date of October 1, 2003, which is adopted and incorporated by reference with~~2003 including~~ subsequent changes or amendments, ~~amendments and revisions,~~ a monthly nursing facility assessment based on all occupied nursing facility bed days of service shall be ~~is~~ imposed on all nursing bed days in licensed nursing facilities, except:

(1) any~~Any~~ nursing facility bed day of service provided by a Continuing Care Retirement Community (CCRC), as defined by G.S. ~~GS~~ 58-64 and licensed by the North Carolina Department of Insurance; or

(2) any~~Any~~ nursing facility bed day of service paid for under the Medicare program established under Title XVIII of the Social Security Act.

A copy of the CMS Federal Waiver may be obtained by contacting the Division of Medical Assistance, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501, (919) 855-4000. ~~857-4016.~~ Copies of 42 USC 1396b(w) and 42 CFR, Part 433, Subpart B are available free of charge at http://uscode.house.gov/ and https://www.ecfr.gov/, respectively.

(b) ~~Effective October 1, 2003, the~~ The assessment is payable monthly and due to the Department of Health and Human Services or designee of the Department within 15 days of the last day of the reporting month. Facilities shall submit payment and an account of all actual patient days during the month. Failure to provide accurate ~~and timely~~ reporting of days, ~~days~~ and payment of assessment within 15 days of the last day of the reporting month shall result in a 10% reduction in facility rates for Medicaid participating facilities and recoupment. ~~recoupment per the Department Cash Management Plan.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 2003-284, Sec. 10.28; CMS Waiver approved April 5, 2004; 42 CFR Part 433, Subpart B; 42 USC 1396b(w);*
Temporary Adoption Eff. August 3, 2004;
Eff. January 1, 2005; ~~2005.~~
Readopted Eff. July 1, 2018.

10A NCAC 22G .0208 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0208 ADMINISTRATIVE RECONSIDERATION REVIEWS

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-55; 42 C.F.R. 447, Subpart C;*
Eff. February 1, 1995; ~~1995.~~
Repealed Eff. July 1, 2018.

10A NCAC 22G .0502 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0502 MENTAL HEALTH CLINIC SERVICES

History Note: *Authority G.S. 108A-25(b); S.L. 1985, c. 479, s. 86;*
Eff. February 1, 1984; ~~1984.~~
Repealed Eff. July 1, 2018.

10A NCAC 22G .0504 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0504 HEALTH MAINTENANCE ORGANIZATIONS AND PREPAID HEALTH PLANS

Reimbursement to Health Maintenance Organizations and Prepaid Health Plans for services rendered shall ~~will~~ be paid as a monthly capitation fee developed by the Division and set out in contract with the Health Maintenance Organization or Prepaid Health Plan. ~~of Medical Assistance.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-55; S.L. 1985, c. 479, s. 86; 42 C.F.R. Part 434; 42 C.F.R. Part 438.6;*
Eff. August 1, 1984;
Amended Eff. February 1, 1985; ~~1985.~~
Readopted Eff. July 1, 2018.

10A NCAC 22G .0509 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22G .0509 REIMBURSEMENT PRINCIPLES, HEARING AIDS/ACCESSORIES/BATTERIES

History Note: *Authority G.S. 108A-25(b); 108A-54;*
Eff. January 4, 1993;
Recodified from 10 NCAC 26H .0509 Eff. January 1, 1994; ~~1994.~~
Repealed Eff. July 1, 2018.

10A NCAC 22H .0101 is readopted as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22H - APPEALS PROCEDURES

SECTION .0100 - BENEFICIARY APPEALS ~~RECIPIENT/APPLICANT APPEAL REVIEW PROCEDURES~~ FOR DENIAL, TERMINATION, SUSPENSION, OR REDUCTION OF A MEDICAID SERVICE OR AN AUTHORIZATION FOR A MEDICAID SERVICE ~~PRIOR APPROVAL REQUESTS FOR MEDICAID COVERED MEDICAL SERVICES OR FOR OTHER MEDICAID COVERED MEDICAL SERVICES~~

10A NCAC 22H .0101 APPEALS BY MEDICAID BENEFICIARIES ~~PURPOSE AND SCOPE~~

Appeals by Medicaid beneficiaries of determinations by the Division to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service are governed by G.S. 108A-70.9A and 108A-70.9B.

~~(a) The purpose of the rules in this Section is to specify the policies and procedures to provide for recipient/applicant or his/her representative requests for an informal appeal of decisions changing a Medicaid recipient/applicant's level of care, denial, termination, suspension, or reduction of prior approval requests for Medicaid covered medical services or for other Medicaid covered medical services. These policies and procedures do not apply to provider requests for Reconsideration Review of DMA provider post payment review decisions set out in 10A NCAC 22F.~~

~~(b) The rules in this Section apply to decisions made by the Division of Medical Assistance "(DMA)", a Medical Review Independent Professional Review Team "(MR/IPR)", a Prior Approval Unit "(PAU)", other Agencies, or other entities acting as agents of this State agency.~~

~~(c) The decision making body as set out in Paragraph (b) of this Rule shall, within two working days, notify the recipient/applicant in writing of the decision and the following:~~

- ~~(1) the effective date of the decision denying, terminating, reducing, or suspending a service;~~
- ~~(2) the reasons for the agency decision;~~
- ~~(3) the specific regulations that support, or the change in Federal or State law that requires the decision;~~
- ~~(4) the date Medicaid payment will cease, if applicable; at least 11 days after the date of the notification letter;~~
- ~~(5) the opportunity for informal and formal appeal of this decision and procedures for requesting such an appeal; and~~
- ~~(6) the fact that, if appealed, payment for the currently certified level of care or approved service will continue for an eligible Medicaid recipient pending appeal.~~

~~Editor's Note: Thomas R. West, Administrative Law Judge with the Office of Administrative Hearings, declared Rule 10 NCAC 26I .0101(codified as 10A NCAC 22H .0101 effective July 1, 2003) void as applied in Linda Allred, Petitioner v. North Carolina Department of Human Resources, Division of Medical Assistance, Respondent (90 DHR 0940).~~

History Note: *Authority G.S. 108A-25(b); 108A-70.9A; 108A-70.9B; 42 C.F.R. 431; 42 C.F.R. 456;*
Eff. April 13, 1979;
Amended Eff. May 1, 1990; November 1, 1983; October 4, 1979;
RRC objection due to lack of Authority and ambiguity Eff. October 18, 1995;
Amended Eff. December 11, 1995; ~~1995.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0102 - .0103 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0102 REQUESTS FOR FORMAL AND INFORMAL APPEALS

10A NCAC 22H .0103 TIME LIMITS ON REQUESTS FOR RECIPIENT/APPLICANT INFORMAL APPEALS

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. 431; 42 C.F.R. 456;*
Eff. April 13, 1979;
Amended Eff. December 1, 1995; May 1, 1990; November 1, 1983; October 4, 1979;
Amended Eff. May 1, 1990; October 4, 1979;
RRC objection to Rule .0103 due to lack of Authority and ambiguity Eff. October 18, 1995;
Amended Eff. December 11, 1995; ~~1995.~~
Repealed Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0104

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

How will it be determined whether "recovery procedures" will be instituted against the beneficiary? What is meant by "recovery procedures"? This appears to be a recitation of 42 CFR 431.230 without providing any additional information.

Please remove 150B-21.6 from your History Note as this does not provide you authority for these Rules.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0104 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0104 PAYMENT PENDING APPEALS

~~(a) If no informal appeal is requested, payment shall continue for the existing level of care or approved service(s) rendered until the required change (action) date stated in the notification or until the recipient moves from that level of care or discontinues approved service(s), whichever comes first.~~

~~(b) If an informal appeal is requested in accordance with Rule .0103 of this Section, Medicaid payment for that level of care or approved service(s) shall continue until the informal appeal process is completed.~~

~~(c) If a formal appeal is requested in accordance with Rule .0102(b) of this Section, Medicaid payment for that level of care or approved service(s) shall continue until the formal appeal process is completed.~~

~~(d)~~ If a final decision rendered in accordance with G.S. 108A-70.9B(g) upholds the adverse determination, as defined in G.S. 108A-70.9A(a), the Division ~~If the formal appeal decision upholds the original decision by DMA, MR/IPR, PAU, other State Agency or entity, DMA~~ may institute recovery procedures against the beneficiary ~~applicant or recipient~~ to recoup the cost of any services furnished resulting from the ~~formal~~ appeal process.

History Note: *Authority G.S. 108A-25(b); 108A-70.9A; 108A-70.9B; 42 C.F.R. 431.230(b); ~~431;~~*
Eff. April 13, 1979;
Amended Eff. December 1, 1995; October 4, 1979; ~~1979.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0105 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0105 DISMISSAL OF APPEAL

History Note: *Authority G.S. 108A-25(b); 42 C.F.R. Part 431;*
Eff. April 13, 1979;
Amended Eff. December 1, 1995; May 1, 1990; ~~1990.~~
Repealed Eff. July 1, 2018

10A NCAC 22H .0201 is amended with changes as published in 32:13 NCR 1258–1268 as follows:

SECTION .0200 - HEARINGS: TRANSFER AND DISCHARGES FROM NURSING FACILITIES

10A NCAC 22H .0201 DEFINITIONS

The following definitions shall apply throughout this Section: ~~Subchapter:~~

(1) "Division" means the North Carolina Division of Medical Assistance, ~~Assistance of the~~ Department of Health and Human Services.

(2) "Hearing Officer" means the person designated by the Chief Hearing Officer of the Division's Hearing Unit to preside over hearings between a resident and a nursing facility provider regarding transfers and discharges.

(3) "Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Medical Assistance, Department of Health and Human Services.

(4) "Notice of Transfer or~~and~~ Discharge form" means the form developed by the Division containing the elements described at 42 C.F.R. 483.15(c)(5), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~Division.~~

(5) "Request for Hearing" means a written request ~~clear expression, in writing~~ by the resident, ~~resident or~~ family member, ~~member~~ or legal representative of the resident ~~resident,~~ that the resident wants to appeal the facility's decision to transfer or discharge.

(6) The ~~"Request~~ "Nursing Home Hearing Request Form ~~for Hearing form~~" means the form developed by the Division containing: ~~Division.~~

(a) the resident's name;

(b) the facility's name;

(c) the date of the Notice of Transfer or Discharge form;

(d) the date of the scheduled transfer or discharge;

(e) the requestor's preference for a telephone hearing or in-person hearing in Raleigh, North Carolina;

(f) the requestor's name, address, telephone number, and signature; and

(g) the telephone number, fax number, mailing address, and email address of the Division's Hearing Unit.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483; ~~42 C.F.R. 483.5; 42 C.F.R. 483.12; 42 C.F.R. 483.202; 42 C.F.R. 483.206;~~*
Eff. April 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015; ~~2015.~~

Amended Eff. July 1, 2018.

10A NCAC 22H .0202 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0202 TRANSFER AND DISCHARGE REQUIREMENTS

(a) To transfer or discharge a resident, a facility shall comply with all of the requirements of 42 C.F.R. 483.15, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/.

(b)~~(a)~~ In addition to the requirements in Paragraph (a) of this Rule, a ~~A~~ resident and, if contact information is available, ~~known,~~ a family member or legal representative of the resident, shall be notified in writing of a facility's decision to transfer or discharge the resident. The Notice of Transfer or Discharge form shall be used by a facility when giving notice of a transfer or discharge.

(c)~~(b)~~ Failure to complete the Notice of Transfer or Discharge form shall result in the notice of the transfer or discharge being invalid. ~~ineffective.~~

(d)~~(c)~~ The resident shall be handed the Notice of Transfer or Discharge form on the same day that it is dated.

(e)~~(d)~~ A copy of the notice of Transfer or Discharge form shall be mailed to the family member or legal representative, if contact information is available, ~~representative~~ on the same day that it is dated.

(f)~~(e)~~ The facility shall provide a Nursing Home Hearing Request ~~for Hearing~~ Form to the resident and to the family member or legal representative, if contact information is available, ~~representative simultaneously with~~ at the same time as providing the Notice of Transfer or Discharge form.

History Note: *Authority G.S. 108A-25(b); 150B-21.6; 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. 483; ~~42 C.F.R. 483.5; 42 C.F.R. 483.12; 42 C.F.R. 483.202; 42 C.F.R. 483.206;~~*
Eff. April 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0203

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Please add commas after “Sunday on line 7 and 8.

In (b), line 9, please delete “or” in between “mail,” and “facsimile”

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0203 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0203 INITIATING A HEARING

(a) In order to initiate an appeal of a facility's intent to transfer or discharge, a resident, ~~resident or~~ family member, ~~member~~ or legal representative shall submit a written request for a hearing to the Hearing Unit. The request for hearing shall ~~must~~ be received by the Hearing Unit within 11 calendar days from the date of the facility's notice of transfer or discharge. If the eleventh day falls on a Saturday, Sunday or legal holiday, then the period during which an appeal may be requested shall run until the end of the next business day which is not a Saturday, Sunday or legal holiday.

(b) The request for hearing shall be submitted to the Hearing Unit by mail, or facsimile, or hand delivery.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff. April 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0204

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Please make it clear within the body of the text of the rule that these hearings are regarding facility's determinations to discharge or terminate services.

In (d), how is "good cause" determined?

In (e), do you mean that the hearing officer shall (rather than may) dismiss the request for hearing unless good cause is shown? If you mean may, please provide the factors that will be used in making this determination.

In (g), if Division hearings are not "contested case hearings within the meaning of G.S. 150B", what are they? Are they otherwise appealable?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0204 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0204 HEARING PROCEDURES

(a) Upon timely receipt of a request for a hearing, as set out in Rule .0203 of this Section, the Hearing Unit shall ~~promptly~~ notify the parties ~~facility~~ of the request.

(b) The parties shall be notified by certified mail of the date, time, ~~time~~ and place of the hearing. Hearings shall be conducted by telephone, unless an in-person hearing is requested. If the hearing is to be conducted in person, it shall be held in Raleigh, North Carolina.

(c) ~~At least five working days prior to the hearing, the~~ The facility ~~administrator~~ shall make available to the resident all documents and records to be used at the hearing, to be received at least five business days prior to the hearing. ~~hearing.~~ The facility administrator shall forward identical information to the Hearing Unit, to be received at least five business ~~working~~ days prior to the hearing.

(d) The hearing officer may grant continuances for good cause. ~~continuances.~~

(e) The hearing officer may dismiss a request for hearing if the resident or family member or legal representative of the resident fails to appear at a scheduled hearing.

(f) The hearing officer shall ~~may~~ proceed to conduct a scheduled hearing if a facility representative fails to appear at a scheduled hearing.

(g) The Rules of Civil Procedures as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes shall not apply in any hearings held by a Division Hearing Officer. ~~Officer unless another specific statute or rule provides otherwise.~~ Division hearings are not contested case hearings within the meaning of G.S. 150B and shall not be governed by the provisions of that Chapter unless otherwise stated in these Rules. Parties may be represented by counsel or other representative at the hearing.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff April 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0205

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *In (a), please consider saying "uphold or reverse the facility's decision regarding the transfer or discharge of a patient" to make it clear what is going on within this particular final decision rule.*
>
> *On lines 8-9, what is your authority to say how service is to be made in a Superior Court proceeding? What if the Rules of Civil Procedure change?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0205 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0205 HEARING OFFICER'S FINAL DECISION

(a) The Hearing Officer's final decision shall uphold or reverse the facility's decision. Copies of the final decision shall be mailed via certified mail to the parties.

(b) A party may appeal the Hearing Officer's final decision by filing a petition for judicial review in Wake County Superior Court or in the superior court of the county where the petitioner resides within 30 days of the date of the decision letter. Service is made by the placing of the decision in an official depository of the United States Postal Service and addressed to the person or entity at the last address provided. The Department as the decision maker in the appeal to the Hearing Unit shall not be a party of record.

History Note: *Authority G.S. 108A-25(b); 42 USCS 1396r(e)(3), (f)(3); 42 C.F.R. Part 483, Subpart E; ~~483.12;~~*
Eff. April 1,1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22H .0301 is amended with changes as published in 32:13 NCR 1258–1268 as follows:

SECTION .0300 - PASRR ~~PASARR~~ HEARINGS

10A NCAC 22H .0301 DEFINITIONS

The following definitions shall apply throughout this Section:

(1)~~(a)~~ "Division" means the North Carolina Division of Medical Assistance, ~~Assistance of the~~ Department of Health and Human Services.

(2)~~(b)~~ "Hearing Officer" means the person designated by the Chief Hearing Officer of the Division's Hearing Unit to preside over hearings regarding Preadmission Screening and ~~Annual~~ Resident Review (PASRR) ~~(PASARR)~~ determinations.

(3)~~(c)~~ "Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Medical Assistance, Department of Health and Human Services.

(4)~~(d)~~ "Preadmission Screening and ~~Annual~~ Resident Review (PASRR) ~~(PASARR)~~ Notice of Determination" means the form developed by the Division, containing the elements described at 42 C.F.R. 483.130(k), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~Division.~~

(5)~~(e)~~ "Request for Hearing" means a written request on a Hearing Request Form ~~clear expression, in writing,~~ by the evaluated individual or family member or legal representative of the evaluated individual, that the evaluated individual wants to appeal the (PASRR) ~~PASARR~~ determination.

(6)~~(f)~~ The "Hearing Request Form" ~~"Request for Hearing"~~ ~~form~~ means the form developed by the Division containing: ~~Division.~~

(a) the individual's name;

(b) the facility name, if the individual is residing in a facility;

(c) the requestor's preference for a telephone hearing or in-person hearing in Raleigh, North Carolina; and

(d) the requestor's name, address, telephone number, and signature.

(7)~~(g)~~ The "North Carolina PASRR ~~PASARR~~ II Screening Form" [~~form"~~] means both the North Carolina PASRR-MI Psychiatric Screening form and the North Carolina Dual Psychiatric and Intellectual Developmental Disabilities/Related Conditions PASRR II Screening Data form developed by the Division, containing the elements described at 42 C.F.R. 483.128(i)–(j), which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~Psychiatric/Mental Retardation/Dual Psychiatric and MR/RC Evaluation" forms means the forms developed by the Division.~~

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i-3(e)(3), (f)(3); 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 483.5; 42 C.F.R. Part 483, Subparts C and E; 42 C.F.R. 483.128; 42 C.F.R. 483.130; ~~42 C.F.R. 483.12; 42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015; ~~2015.~~
Amended Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0302

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Rather than incorporating the same CFR twice, please consider changing 42 CFR 483.130(k) to just 483.130 in (a) and deleting cross-reference and incorporation language in (b)?

Please remove 150B-21.6 from your History Note as this does not provide you authority for these Rules.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0302 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0302 PASRR ~~PASARR~~ REQUIREMENTS

(a) The evaluated individual and family member or legal representative shall be notified in writing of the Division of MH/DD/SAS' PASRR ~~PASARR~~ determination under the provisions of 42 CFR 483.130(k) which is incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~amendments. A copy of 42 CFR 483.130(k) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

(b) The PASRR ~~PASARR~~ Notice of Determination form shall be used by Division of MH/DD/SAS when giving notice of a PASRR ~~PASARR~~ determination under the provisions of 42 CFR 483.130(l)(1-4) which is incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~amendments. A copy of 42 CFR 483.130(l)(1-4) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

(c) The Division of MH/DD/SAS shall provide a Hearing Request ~~Request for Hearing~~ form, ~~pertinent~~ PASRR II Screening ~~Evaluation~~ form, and PASRR ~~PASARR~~ Notice of Determination form to the evaluated individual and legal representative under the provisions of 42 CFR 483.128(1) which is incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~amendments. A copy of 42 CFR 483.128(1) can be obtained from the Division of Medical Assistance at a cost of twenty cents ($0.20) per copy.~~

History Note: *Authority G.S. 108A-25(b); 150B-21.6; 42 U.S.C.S. 1395i-3(e)(3), (f)(3); 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 483.5; 42 C.F.R. Part 483, Subparts C and E; ~~42 C.F.R. 483.12; 42 C.F.R. 483.128; 42 C.F.R. 483.130; 42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted July 1, 2018.

10A NCAC 22H .0303 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0303 INITIATING A HEARING

(a) In order to initiate an appeal of a PASRR ~~PASARR~~ determination, the evaluated individual, ~~individual or~~ family member, ~~member~~ or legal representative shall submit a Hearing Request Form ~~written request for a hearing~~ to the Hearing Unit. The form ~~request for hearing~~ shall ~~must~~ be received by the Hearing Unit within 11 calendar days from the date of the PASRR ~~PASARR~~ Notice of Determination. If the 11th day falls on a Saturday, Sunday, or legal holiday, then the period during which an appeal may be requested shall run until the end of the next business day which is not a Saturday, Sunday, or legal holiday.

(b) The Hearing Request Form ~~request for hearing~~ shall be submitted to the Hearing Unit by mail, facsimile, or hand delivery.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i - 3(e)(3) and - (f)(3); 1396r(e)(3), (e)(7)(F), and (f)(3); 42 C.F.R. 431.200; 42 C.F.R. 483.5; 42 C.F.R. Part 483, Subpart E; ~~42 C.F.R. 483.12; 42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0304

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Please make it clear within the body of the text of the Rule that these hearings are related to PASRR determinations.

In (d), how is "good cause" determined?

In (e), do you mean that the hearing officer shall (rather than may) dismiss the request for hearing unless good cause is shown? If you mean may, please provide the factors that will be used in making this determination.

In (g), if Division hearings are not "contested case hearings within the meaning of G.S. 150B", what are they? Are they otherwise appealable?
When "may' the hearing officer use the Rule of Evidence for these hearings? I note that this language was not in Rule .0204.

42 USCR 1396r does not appear to be applicable here.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0304 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0304 HEARING PROCEDURES

(a) Upon ~~timely~~ receipt of a Hearing Request Form, ~~request for a hearing,~~ the Hearing Unit shall notify the Division of MH/DD/SAS of the request.

(b) The parties shall be notified by certified mail of the date, time, ~~time~~ and place of the hearing. Hearings shall be conducted by telephone, unless an in-person hearing is requested. If the hearing is to be conducted in person, it shall be held in Raleigh, North Carolina.

(c) The Division of MH/DD/SAS shall mail all documents and records to be used at the hearing to the person requesting the hearing by certified mail and forward identical information to the Hearing Unit, to be received by both the requestor and the Hearing Unit at least five business ~~working~~ days prior to the hearing.

(d) The hearing officer may grant continuances for good cause. ~~continuances.~~

(e) The hearing officer may dismiss a request for a hearing if the evaluated individual or legal representative fails to appear at a scheduled hearing.

(f) The hearing officer shall ~~may~~ proceed to conduct a scheduled hearing if the Division of MH/DD/SAS fails to appear at a scheduled hearing.

(g) The Rules of Civil Procedure as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes shall not apply in any hearings held by the Division Hearing Officer. ~~Officer unless another specific statute or other rule provides otherwise.~~ Division hearings are not contested case hearings within the meaning of G.S. 150B and shall not be governed by the provisions of that chapter unless otherwise stated in these Rules. The hearing officer may use the North Carolina Rules of Evidence for guidance in conducting hearings. Parties may be represented by counsel or other representative at the hearing.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i-3(e)(3), ~~(e)(7)(F),~~ (f)(3); 42 U.S.C.S. 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 431.200; 42 C.F.R. Part 483, Subpart E; ~~42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22H .0305

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), please consider saying "uphold or reverse the Division of MH/DD/SAS' PASRR decision…"

On lines 8-9, what is your authority to say how service is to be made in a Superior Court proceeding? What if the Rules of Civil Procedure change?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22H .0305 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22H .0305 HEARING OFFICER'S FINAL DECISION

(a) The Hearing Officer's final decision shall uphold or reverse the Division of MH/DD/SAS' decision. Copies of the final decision shall be mailed via certified mail to the parties.

(b) A party may appeal the Hearing Officer's final decision by filing a petition for judicial review in Wake County Superior Court or in the superior court of the county where the petitioner resides within 30 days of the date of the decision letter. Service is made by the placing of the decision in an official depository of the United States Postal Service and addressed to the person or entity at the last address provided. The Department as the decision maker in the appeal to the Hearing Unit shall not be a party of record.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C.S. 1395i-3(e)(3), ~~(e)(7)(F),~~ (f)(3); 42 U.S.C.S. 1396r(e)(3), (e)(7)(F), (f)(3); 42 C.F.R. 431.200; 42 C.F.R. Part 483, Subpart E; ~~42 C.F.R. 483.200; 42 C.F.R. 483.204; 42 C.F.R. 483.206;~~*
Eff. October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

10A NCAC 22I .0102 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22I .0102 EXIT CONFERENCE

At the conclusion of the audit, the provider may request an exit conference to discuss the audit findings with the provider ~~which~~ that shall be held by personnel of the unit conducting the audit. ~~audit, to discuss the audit findings with the provider.~~

History Note: *Authority G.S. 108A-25(b);*
Eff. September 24, 1980; ~~*1980.*~~
Readopted Eff. July 1, 2018.

10A NCAC 22I .0104 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22I .0104 RECONSIDERATION REVIEW

History Note: *Authority G.S. 108A-25(b);*
Eff. September 24, 1980;
Amended Eff. January 1, 1988; ~~1988.~~
Repealed Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22J .0102

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), line 8, please delete or define "correctly."

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22J .0102 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0102 PETITION FOR RECONSIDERATION REVIEW

(a) A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement, ~~reimbursement~~ and adjustments. ~~adjustments and~~ A provider may request a reconsideration review within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances and payment adjustment means that all administrative actions necessary to have a claim paid correctly have been taken by the provider and the Division ~~DMA~~ or the fiscal agent has issued a final adjudication. If no request is received within the respective 30 or 60 day periods, the Division's ~~state agency's~~ action shall become final.

(b) A request for reconsideration review shall ~~must~~ be in writing and signed by the provider and contain the provider's name, address, ~~address~~ and telephone number. It shall ~~must~~ state the specific dissatisfaction with the Division's ~~DMA's~~ action and should be mailed to: Appeals, Division of Medical Assistance, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501. ~~Assistance at the Division's current address.~~

(c) The provider may appoint another individual to represent him. A written statement setting forth the name, address, ~~address~~ and telephone number of the representative so designated shall be sent to the address listed in paragraph (b) of this Rule. ~~above address.~~ The representative may exercise any ~~and all~~ rights given the provider in the review process. Notice of meeting dates, requests for information, or hearing decisions ~~decisions, etc. will~~ shall be sent to the authorized representative. Copies of such documents shall ~~will~~ be sent to the petitioner only if a written request is made.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22J .0103

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), what is "good cause"? Is this the same as "good cause" in 10A NCAC 21A .0302? Please say what will constitute "good cause"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22J .0103 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0103 RECONSIDERATION REVIEW PROCESS

(a) Upon receipt of a ~~timely~~ request for a reconsideration review that is submitted timely pursuant to Rule .0102 of this Subchapter, ~~review,~~ the Deputy Director shall appoint a reviewer or panel to conduct the review. The Division shall ~~DMA will~~ arrange with the provider a time and date of the hearing. The provider shall ~~must~~ reduce his arguments to writing and submit them to the Division ~~DMA~~ no later than 14 calendar days prior to the review. Failure to submit written arguments within this time frame shall be grounds for dismissal of the reconsideration, unless the Division within the 14 calendar day period agrees to a delay for good cause. ~~delay.~~

(b) The provider shall ~~will~~ be entitled to an in-person ~~a personal~~ review meeting unless the provider agrees to a review of documents only or a discussion by telephone.

(c) Following the review, the Division ~~DMA~~ shall, within 30 calendar days or such additional time thereafter as specified in writing during the 30 day period, render a decision in writing and send it by certified mail to the provider or his representative.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988;
Pursuant to G.S. 150B-33(b)(9), Administrative Law Judge Augustus B. Elkins, II declared this rule void as applied in Psychiatric Solutions, Inc., d/b/a/ Holly Hill Hospital v. Division of Medical Assistance, North Carolina Department of Health and Human Services (02 DHR 1499); ~~1499).~~
Readopted Eff. July 1, 2018.

10A NCAC 22J .0104 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0104 PETITION FOR A CONTESTED CASE HEARING

If the provider disagrees with the reconsideration review decision, ~~decision~~ the provider ~~he~~ may request a contested case hearing in accordance with G.S. 150B, Article 3 and 26 NCAC 03 .0103. ~~10A NCAC 01.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b; 42 C.F.R. 455.512;*
Eff. January 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22J .0105

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *How will the Division recover the overpayment? I assume that this is set forth elsewhere in rule, statute, or CFR? Is there a cross-reference available?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22J .0105 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0105 PAYMENT STATUS

Once a final overpayment or final erroneous payment is determined by the Division ~~DMA~~ to exist, the Division shall act ~~action will be taken immediately~~ to recover such overpayment or erroneous payment from the provider. ~~payment.~~ If the provider's appeal is successful, repayment shall ~~will~~ be made to the provider.

History Note: *Authority G.S. 108A-25(b); 108A-54; ~~150B-11;~~ 42 U.S.C. 1396b(d)(2);*
Eff. January 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22J .0106 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22J .0106 PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS

(a) A provider may refuse to accept a patient as a Medicaid patient and bill the patient as a private pay patient only if the provider informs the patient that the provider will not bill Medicaid for any services but will charge the patient for all services provided.

(b) Acceptance of a patient as a Medicaid patient by a provider includes, but is not limited to, entering the patient's Medicaid number or card into any sort of patient record or general record-keeping system, obtaining other proof of Medicaid eligibility, or filing a Medicaid claim for services provided to a patient. A patient, or a patient's representative, must request acceptance as a Medicaid patient by:

(1) presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing; ~~or~~

(2) stating either orally or in writing that the patient has Medicaid coverage; or

(3) requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

(c) Providers may bill a patient accepted as a Medicaid patient only in the following situations:

(1) for allowable deductibles, co-insurance, or co-payments as specified in the Medicaid State Plan; ~~10A NCAC 22C .0102; or~~

(2) before the service is provided the provider has informed the patient that the patient may be billed for a service that is not one covered by Medicaid regardless of the type of provider or is beyond the limits on Medicaid services as specified in the Medicaid State Plan or applicable clinical coverage policy promulgated pursuant to G.S. 108A-54.2(b); ~~under 10A NCAC 22B, 10A NCAC 22C, and 10A NCAC 22D; or~~

(3) the patient is 65 years of age or older and is enrolled in the Medicare program at the time services are received but has failed to supply a Medicare number as proof of coverage; or

(4) the patient is no longer eligible for Medicaid as defined in the Medicaid State Plan. ~~10A NCAC 21B.~~

(d) When a provider files a Medicaid claim for services provided to a Medicaid patient, the provider shall not bill the Medicaid patient for Medicaid services for which it receives no reimbursement from Medicaid when:

(1) the provider failed to follow program regulations; ~~or~~

(2) the Division ~~agency~~ denied the claim on the basis of a lack of medical necessity; or

(3) the provider is attempting to bill the Medicaid patient beyond the situations stated in Paragraph (c) of this Rule.

(e) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment, ~~payment~~ plus any authorized deductible, co-insurance, co-payment, ~~co-payment~~ and third party payment as payment in full for all Medicaid covered services provided, except that a provider shall ~~may~~ not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance, ~~co-insurance~~ or co-payment amount as specified

in the Medicaid State Plan. ~~10A NCAC 22C .0102.~~ An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. Notwithstanding anything contained in this Paragraph, a provider may ~~actively~~ pursue recovery of third party funds that are primary to Medicaid.

(f) When a provider accepts a private patient, bills the private patient personally for Medicaid services covered under Medicaid for Medicaid recipients, and the patient is later found to be retroactively eligible for Medicaid, the provider may file for reimbursement with Medicaid. Upon receipt of Medicaid reimbursement, the provider shall refund to the patient all money paid by the patient for the services covered by Medicaid with the exception of any third party payments or cost sharing amounts as described in the Medicaid State Plan. ~~10A NCAC 22C .0102.~~

History Note: *Authority G.S. 108A-25(b); 108A-54; 108A-54.2; ~~150B-11;~~ 42 C.F.R. 447.15; 42 C.F.R. 447.52(e); 42 C.F.R. 433.139;*
Eff. January 1, 1988;
Amended Eff. February 1, 1996; October 1, 1994; ~~1994.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22K .0101

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *Who are providers "qualified to make presumptive determinations of Medicaid eligibility"?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22K .0101 is readopted as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22K - QUALIFIED PROVIDERS

10A NCAC 22K .0101 DEFINITION

A provider qualified to make presumptive determinations of Medicaid eligibility for pregnant women shall ~~must~~ meet the conditions required by Section 1920 of the Social Security ~~Act~~ Act, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at http://uscode.house.gov/. ~~as amended by P.L. 99-509~~ and sign a written agreement with the Division of Medical Assistance (Division). ~~(DMA).~~

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. § 1396r–1; 42 C.F.R. 435.1103; ~~1987 Session Laws, c. 738; P.L. 99-509;~~*
Eff. June 1, 1998; ~~1988.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22K .0102

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *Is the intent that the provider participate in the training or simply that they agree to participate (without actually doing so)? Is this Rule going to what will be in the contract (agreement) with the provider? If so, would it help to make that more clear within the body of the rule? Please keep in mind that since titles can be changed without going through the rule-making process, rules are read without the titles.*
>
> *In (b), what are the "required referrals"? Are these set forth in 42 CFR 435.1103?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22K .0102 is readopted with changes as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22K .0102 AGREEMENT

(a) The provider ~~must~~ shall agree to participate in training offered by the Division ~~of Medical Assistance (DMA)~~ or its agents and to make presumptive eligibility determinations pursuant to 42 C.F.R. 435.1103, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/, and the Medicaid State Plan.~~based on the procedures and guidelines issued by the DMA.~~

(b) The Division ~~DMA may~~ shall terminate the provider's Medicaid Participation agreement and authority to make presumptive determinations if the provider fails to make required referrals within five business days or fails to follow procedures set forth in the Medicaid State Plan, ~~[Section MA3245 of the Department of Health and Human Service's Family and Children's Medical Manual, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www2.ncdhhs.gov/info/olm/manuals/dma/fcm/man/ma3245-01.htm,]~~~~procedures and guidelines~~ resulting in eligibility denials for a majority of the provider's referrals.

(c) Termination of the agreement ~~will~~ shall occur 30 calendar days following notification when termination is initiated by the Division. ~~DMA.~~

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. 1396r–1; 42 C.F.R. 435.1103; ~~1987 Session Laws, c. 738; P.L. 99-509;~~*
Eff. June 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22K .0103 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22K .0103 PRESUMPTIVE DETERMINATIONS

(a) Presumptive determinations of eligibility shall apply only to pregnant women whose family income does not exceed the federal poverty guidelines issued in the Federal Register by the US Department of Health and Human Services and ~~as~~ revised ~~annually~~ annually, which are adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://aspe.hhs.gov/poverty-guidelines.

(b) Only one presumptive determination of eligibility during a single pregnancy ~~may~~ shall be made by the same qualified provider.

(c) A presumptive determination of eligibility may be made by a different qualified provider if the provider has no knowledge of a prior determination.

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. § 1396r–1; 42 CFR § 435.1103; ~~1987 Session Laws, c. 738; P.L. 99-509;~~*
Eff. June 1, 1988; ~~1988.~~
Readopted Eff. July 1, 2018.

10A NCAC 22L .0101 is amended as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22L - MANAGED CARE AND PREPAID PLANS

SECTION .0100 - MANAGED CARE

10A NCAC 22L .0101 PROGRAM DEFINITION

~~Carolina ACCESS~~ The Division's primary care case management contractor ~~will~~ shall contract with primary care physicians in participating counties to deliver and coordinate the health care of certain categories of Medicaid ~~recipients.~~ beneficiaries listed in 10A NCAC 22L .0104.

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Amended Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22L .0102

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

By "has the authority to", do you mean "shall" or "may"?

If you mean "may", how will it be determined whether it will be paid? Is this set forth elsewhere in rule, statute, or cfr?

What is the "monthly fee"? How much will this fee be? Is this set forth elsewhere in rule, statute, or CFR?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22L .0102 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22L .0102 COORDINATION FEE

In addition to normal Medicaid payments, the Division ~~of Medical Assistance~~ has the authority to pay participating physicians a monthly fee to provide case management ~~coordination fee~~ for providing or coordinating the health care services of enrollees who have selected them as their primary care physician.

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992. ~~1992.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22L .0103

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *What services are beneficiaries eligible for? I assume this is set forth elsewhere in a CFR?*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22L .0103 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22L .0103 ACCESS TO CARE

~~Carolina ACCESS~~ The Division's primary care case management enrollees ~~are~~ shall be eligible to receive ~~all~~ health care services that ~~all~~ Medicaid ~~recipients~~ beneficiaries are eligible for. ~~They~~ Beneficiaries receive ~~their~~ services through their primary care physician who either provides or coordinates ~~their~~ health care. ~~The Division of Medical Assistance has the authority to deny payment for covered services that are not authorized by the primary care physician.~~

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992; ~~1992.~~
Readopted July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22L .0104

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

> *Please consider breaking this Rule into two paragraphs. With (a) beginning with All Medicaid beneficiaries… domiciliary care" and (b) The following beneficiaries…" Please also consider breaking those eligible persons into a list. It would look like this:*

(b) The following beneficiaries have the option to enroll in primary care case management:

(1) Medicaid for Pregnant ~~Women,~~ women;

(2) benefit diversion ~~beneficiaries,~~ beneficiaries

(3) beneficiaries with end stage renal ~~disease,~~ disease; and

(4) Native Americans/Alaska Natives.

~~Medicaid recipients who are Medicaid Pregnant Women, foster children or who are also on Medicare, have the option to enroll in Carolina ACCESS.~~

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22L .0104 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22L .0104 ENROLLMENT

All Medicaid beneficiaries ~~recipients~~ in participating counties who are eligible for ~~Carolina ACCESS~~primary care case management shall enroll. ~~enroll in Carolina ACCESS.~~ Eligible Medicaid beneficiaries ~~recipients eligible for Carolina ACCESS~~ include ~~AFDC,~~ AFDC-related, MIC, Aged, Blind and Disabled categories, unless exempt due to institutional placement. Institutional placement includes nursing home, mental institutions, ~~institutions~~ and domiciliary care. The following beneficiaries have the option to enroll in primary care case management: Medicaid for Pregnant Women, benefit diversion beneficiaries, beneficiaries with end stage renal disease, and Native Americans/Alaska Natives. ~~Medicaid recipients who are Medicaid Pregnant Women, foster children or who are also on Medicare, have the option to enroll in Carolina ACCESS.~~

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992; ~~1992.~~
Readopted July 1, 2018.

10A NCAC 22L .0201 proposed for amendment as published in 32:13 NCR 1258–1268 is repealed as follows:

SECTION .0200 - PREPAID PLANS

10A NCAC 22L .0201 PROGRAM DEFINITION

History Note: *Authority G.S. 108A-25(b);*
Eff. August 3, 1992;
Amended Eff. April 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Repealed Eff. July 1, 2018.

10A NCAC 22L .0203 proposed for readoption without substantive changes as published in 32:13 NCR 1258–1268 is repealed through readoption as follows:

10A NCAC 22L .0203 ACCESS TO CARE

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. 1396u-2(b)(2)(B),(C);*
Eff. August 3, 1992;
Amended Eff. April 1, 1999; ~~1999~~.
Repealed Eff. July 1, 2018.

10A NCAC 22N .0101 is amended as published in 32:13 NCR 1258–1268 as follows:

SUBCHAPTER 22N – PROVIDER ENROLLMENT

SECTION .0100 – GENERAL

10A NCAC 22N .0101 DEFINITIONS

(a) For the purpose of this Subchapter, a "provider" is defined as in G.S. 108C-2(10). ~~any individual, facility or entity that applies to furnish services to authorized Medicaid recipients and bill Medicaid directly for reimbursement. The term "provider" also includes suppliers of medical equipment and supplies.~~

(b) For the purpose of this Subchapter, an “owner” is defined as in G.S. 108C-2(9).

History Note: *Authority G.S. 108A-54; 108C-2(9),(10); 143B-139.1; 42 C.F.R. 400.203; 42 C.F.R. 455.101;*
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Amended Eff. July 1, 2018.

10A NCAC 22N .0102 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22N .0102 SIGNED AGREEMENTS

Each provider shall sign a Provider Administrative Participation Agreement ~~participation contract agreement~~ with the Department ~~Division of Medical Assistance~~ and shall not be reimbursed for services rendered prior to the effective date of the participation agreement.

History Note: *Authority G.S. 108A-54; 143B-139.1; 42 C.F.R. Part 455, Subpart E;*
Eff. July 1, 2004; ~~2004~~.
Readopted Eff. July 1, 2018.

10A NCAC 22N .0201 is repealed as published in 32:13 NCR 1258–1268 as follows:

SECTION .0200 - ENTITIES LICENSED UNDER NCGS 122C OR NCGS 131D

10A NCAC 22N .0201 DEFINITIONS

History Note: *Authority G.S. 108A-54; 143B-139.1;*
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Repealed Eff. July 1, 2018.

10A NCAC 22N .0202 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22N .0202 DISCLOSURE OF OWNERSHIP

Providers who undergo a change in ownership as defined in G.S. 108C-10 ~~licensed under North Carolina G.S. 122C or G.S. 131D~~ shall comply with the following disclosure conditions:

(1) when~~When~~ applying to participate in the North Carolina Medicaid program, the provider shall supply the legal name and social security number of each individual who is an owner; ~~owner.~~

(2) an~~An~~ enrolled provider shall notify the Division ~~of Medical Assistance~~ in writing of a change in the legal name of any owner. The notification ~~must~~ shall be received within 30 calendar days of the effective date of any change; ~~within 30 business days following the change.~~

(3) an~~An~~ enrolled provider shall notify the Division ~~of Medical Assistance~~ in writing if a new owner joins the provider. The notification shall include the new owner's legal name and social security number. The notification ~~must~~ shall be received within 30 calendar days of the effective date of any change; ~~no later than 30 business days following the change.~~ and

(4) an~~An~~ enrolled provider shall notify the Division ~~of Medical Assistance~~ in writing if an owner withdraws his ownership interest in the provider. The notification shall include the name of the departing owner and ~~must~~ shall be received within 30 calendar days of the effective date of any ~~no later than 30 business days following the~~ change.

History Note: *Authority G.S. 108A-54; 108C-10; 143B-139.1; 42 C.F.R. 455.104; 42 C.F.R. 455.106;*
Eff. July 1,2004; ~~2004.~~
Readopted Eff. July 1, 2018.

REQUEST FOR TECHNICAL CHANGE

AGENCY: DHHS – Division of Medical Assistance

RULE CITATION: 10A NCAC 22N .0203

DEADLINE FOR RECEIPT: Friday, June 8, 2018

***PLEASE NOTE:** This request may extend to several pages. Please be sure you have reached the end of the document.*

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (b)(3), line 16, please change "which" to "that"

In (d), what "action" is being referenced? The denial of enrollment?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amber May
Commission Counsel
Date submitted to agency: May 29, 2018

10A NCAC 22N .0203 is readopted as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22N .0203 ENROLLMENT RESTRICTIONS

(a) The Department shall deny enrollment, including enrollment for new or additional services in accordance with G.S. 122C-23(e1) and G.S. 131D-10.3(h). ~~They may be accessed online at http://www.ncleg.net/statutes/generalstatutes/html/bysection/chapter_122c/gs_122c-23.html and http://www.ncleg.net/statutes/generalstatutes/html/bysection/chapter_131d/gs_131d-10.3.html.~~

(b) The Department may deny enrollment when an applicant meets any of the following conditions:

(1) if the Department has initiated revocation or summary suspension proceedings against any facility licensed pursuant to G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, or G.S. 110, Article 7 ~~which~~ that was previously held by the applicant and the applicant voluntarily relinquished the license;

(2) there is a pending appeal of a denial, revocation, ~~revocation~~ or summary suspension of any facility licensed pursuant to G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, or G.S. 110, Article 7 ~~which~~ that is owned by the applicant;

(3) the applicant had an individual as part of their governing body or management who previously held a license which was revoked or summarily suspended under G.S. 122C, Article 2, G.S. 131D, Articles 1 or 1A, and G.S. 110, Article 7 and the rules adopted under these laws; or

(4) the applicant is an individual who has a finding or pending investigation by the Health Care Personnel Registry in accordance with G.S. 131E -256.

(c) When an application for enrollment of a new service is denied:

(1) pursuant ~~Pursuant~~ to G.S. 150B-22, the applicant shall be given an opportunity to provide reasons why the enrollment should be granted or the matter otherwise settled;

(2) the Division ~~DMA~~ shall give the applicant written notice of the denial, the reasons for the denial and advise the applicant of the right to request a contested case hearing pursuant to G.S. 150B; and

(3) the ~~The~~ provider shall not provide the new service until a decision is made to enroll the provider, despite an appeal action.

(d) If the action is reversed on appeal, the ~~owner~~ provider may re-apply for enrollment in accordance with 42 C.F.R. 455, Subpart E, which is adopted and incorporated by reference with subsequent changes or amendments and available free of charge at https://www.ecfr.gov/. ~~and may be approved back to the date of the denied application if all qualifications are met.~~

History Note: *Authority G.S. 108A-54; 143B-139.1;122C-23(e1),(e3); 131E-256; 110, Article 7; 42 C.F.R. 455.422; 42 C.F.R. 1002.213;*
Eff. July 1, 2004; ~~2004.~~
Readopted Eff. July 1, 2018.

10A NCAC 22N .0301 is repealed as published in 32:13 NCR 1258–1268 as follows:

SECTION .0300 – ENTITIES PROVIDING SPECIFIED HABILITATIVE AND REHABILITATIVE SERVICES

10A NCAC 22N .0301 DEFINITIONS

History Note: *Authority G.S. 108A-54; 143B-139.1;*
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Repealed Eff. July 1, 2018.

10A NCAC 22N .0302 - .0303 are repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22N .0302 DISCLOSURE OF OWNERSHIP

10A NCAC 22N .0303 ENROLLMENT RESTRICTIONS

History Note: *Authority G.S. 108A-54; 143B-139.1;*
Eff. July 1, 2004; ~~2004~~.
Repealed Eff. July 1, 2018.

10A NCAC 22O .0112 is repealed through readoption as published in 32:13 NCR 1258–1268 as follows:

10A NCAC 22O .0112 PSYCHIATRIC ADMISSION CRITERIA/MEDICAID BENEFICIARIES UNDER AGE 21

History Note: *Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 441, Subpart D; 42 C.F.R. 441.151;*
Eff. October 1, 1993;
Amended Eff. February 1, 1996; ~~1996.~~
Repealed Eff. July 1, 2018.