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

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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.

Commented [MJC1]: We submitted extensive comments to DMA concerning the restrictive provisions proposed for this rule. ***See 2/26/2018 Comment Letter § II***, which discusses how the proposed language fails to satisfy the statutory requirement of an "opportunity" for additional agency review.

Commented [MJC2]: ***See 2/26/2018 Comment Letter § II.*** – The 10-day window is too small. The decisions issued by hearing officers do not reveal when they were actually "signed." Moreover, they are not necessarily *mailed* on the date shown in the decision. N.C.G.S. § 108A-79(j) is nowhere near this restrictive.

Commented [MJC3]: Problematic deletion as a matter of due process. If this change is retained, there needs to be language elsewhere that requires the "tentative decision" of subparagraph (a) to notify the appellant of "the opportunity to present oral and written arguments in opposition to or in support of [that] decision to the designated official of the Department who is to make the final decision," per N.C.G.S. § 108A-79(j).

Matthew Jordan Cochran
mjc@ocrlaw.com

(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

20

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;

Commented [MJC3]: For our full comment on this proposed language, please ***see 2/26/2018 Comment Letter § III***.

Commented [MJC4]: This needs to be "shall." The Division does not have authority to pick and choose, or to deny a provider's claim on timeliness grounds where the claim could not have been billed sooner due to the agency's own error (e.g., an erroneous denial of the recipient's Medicaid application that requires months or years of appeal efforts to resolve).

Commented [MJC5]: This 180-day timeframe should not commence until DMA or the local DSS office has actually *notified* the individual that, despite the agency's original "error in determining eligibility," his or her eligibility has now been approved. Without such notice, the approved individual may not know to inform relevant medical providers that he or she is now Medicaid eligible. ***See 2/26/2018 Comment Letter § III*** for proposed language to replace this final clause.

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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

26

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) ~~[~~m~~edicaid~~]Medicaid payment constitutes payment in full;~~full.~~

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

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

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

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

(6) theThe 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

Commented [MJC6]: This is not permissible under N.C.G.S. § 150B-21.6. ***See 2/26/2018 Comment Letter § VI.***

Matthew Jordan Cochran
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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

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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, ~~[~~ove~~r~~utilization,] 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.

Commented [MJC7]: We agree that the reference to "policy" is incorrect per N.C.G.S. § 150B-21.6. ***See 2/26/2018 Comment Letter § VII.***

Matthew Jordan Cochran
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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

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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) sepa~~r~~rateSepa~~rate~~ 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) ~~f~~ailureFail~~ure~~ 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~~h~~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.

Commented [MJC8]: This is undefined. By whom are the "standards" to have been "accepted" for this provision to apply? ***See 2/26/2018 Comment Letter § VIII.***

Commented [MJC9]: NCDMA cannot incorporate these sorts of unpromulgated materials into its rules by reference. N.C.G.S. § 150B-21.6. Moreover, the *agreements themselves* can and should govern the consequences of their breach.

Commented [MJC10]: Not defined. Subparagraph (5) should be stricken entirely. ***See 2/26/2018 Comment Letter § VIII.***

Matthew Jordan Cochran
mjc@ocrlaw.com

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.

Matthew Jordan Cochran
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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.

Commented [MJC11]: We disagree with this recommendation. It is appropriate as a matter of due process for such decisions to set forth the appropriate appeal options.

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

46

Matthew Jordan Cochran
mjc@ocrlaw.com

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 ~~[~~Dep~~artment~~'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.~~

Commented [MJC12]: We strongly recommend ***retaining*** this requirement.

Matthew Jordan Cochran
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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.

Matthew Jordan Cochran
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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 ~~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.

Commented [MJC13]: ***See 2/26/2018 Comment Letter § IX*** – The proposed one-year period is more restrictive than the governing statute, which provides that "[t]he payment plan can include a term of up to 24 months." N.C.G.S. § 108C-5(g). The rule should reflect the 24-month maximum.

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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

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Matthew Jordan Cochran
mjc@ocrlaw.com

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.

Commented [MJC14]: For our complete comments on the language of the rule as it has existed in its actual published form, ***see 2/26/2018 Comment Letter § X***.

Commented [MJC15]: This subparagraph does not comply with statutory requirements. Per the controlling statute, "a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested . . . ." N.C.G.S. § 108C-5(b). Suspension of payments itself cannot begin until "the thirty-first day after the suspension or termination [from participation in the Medicaid program] becomes final." N.C.G.S. § 108C-5(d).

Commented [MJC16]: This subparagraph lacks needed clarity as to the necessary quantum of proof. Page 9 of our 2/26/2018 Comment Letter proposes a potential formula.

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"

Commented [MJC17]: No, it is not. ***See 2/26/2018 Comment Letter § XI.***

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

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

10A NCAC 22F .0604 SUSPENDINGWITHHOLDING 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.

Commented [MJC18]: We agree with the change to include reference to N.C.G.S. § 108C provisions.

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

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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.

Commented [MJC19]: ***See 2/26/2018 Comment Letter § XIII*** – State law provides that a final overpayment is "[t]he amount the provider owes *after appeal rights have been exhausted*, which shall not include any agency decision that is being contested." N.C.G.S. § 108C-2(5) (emphasis added). Because this rule is totally incompatible with the controlling statute, it should simply be repealed.

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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

Commented [MJC20]: Much of this rule is without any authority in state or federal law. Recent expansions of "Family Planning" (FP) coverage have resulted in the agency enrolling virtually everyone in that program. FP only covers a very narrow selection of services. It is "Medicaid" in name only. Nevertheless, the agency issues a "Medicaid card" to FP recipients, which is then presented to providers. Thanks to the language of this rule, that renders the patient–provider transaction "acceptance of a patient as a Medicaid patient" even though the "Medicaid" does not and cannot cover the services provided.

Commented [MJC21]: There is no state or federal authority for this restriction. The provider should be able to bill the patient regardless of when it discovers there is no actual Medicaid coverage for the services performed.

Commented [MJC22]: This subparagraph should be revised to say, "the patient, when receiving the services and when billed by the provider, is not eligible for Medicaid benefits that cover the services provided."

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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.

Commented [MJC23]: This federal regulation does not provide the authority needed by DMA for this rule, as it only says the State Plan must limit participation to providers "who accept, as payment in full, the amounts ***paid by*** the [Medicaid] agency . . . ." (emphasis added). If a patient is enrolled in a restrictive Medicaid eligibility category that clearly does not cover the providers services, nothing will be "paid by" the agency.

Commented [MJC24]: This regulation does not authorize the offending restrictions, either. It merely governs cost-sharing maximums and related details.

Commented [MJC25]: Ditto; this regulation governs the state's payment of Medicaid claims in context of third-party liability.

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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

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Matthew Jordan Cochran
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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.

Commented [MJC26]: We strongly agree with removal of the reference to the Manual provisions. ***See 2/26/2018 Comment Letter § XIV***.

Ott Cone & Redpath, P.A.
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February 26, 2018

VIA E-MAIL (MedicaidRulesComments@dhhs.nc.gov)
COPY VIA FIRST CLASS MAIL

Ms. Virginia Niehaus
DMA Rulemaking Coordinator
NCDHHS, Division of Medical Assistance
2501 Mail Service Center
Raleigh, N.C. 27699-2501

RE: Comments on Proposed Changes to Medical Assistance Regulations

Dear Ms. Niehaus:

For several decades, our firm and its professionals have served as advocates in connection with the pursuit of Medicaid benefits for thousands of individuals each year. We also represent numerous Medicaid providers ranging from individual practitioners to large academic medical centers and other hospitals. We write to provide the following comments on the proposed readoption and revision of rules published on January 2, 2018 by the Division of Medical Assistance ("DMA").

I. General Concerns

Through the pages of the North Carolina Register containing the proposed republication of rules, DMA has inserted a number of chapter, subchapter, and section headings in bold type that are not accompanied by any regulatory text. *See* 32 N.C. Reg. 1258, 1262 (Jan. 2, 2018) (setting forth only the heading for section 22F.0605 and a citation to its supporting authorities). Other section headings, meanwhile, feature a parenthetical indicating the rule is "readopt[ed] without substantive changes." *E.g.*, *id.* at 1265 (referencing section 22H.0203). Although the publication's introductory language indicates that the only sections being repealed are 22F.0401, 22N.0201, and 22N.0301, we wish to confirm whether DMA intends to repeal any other provisions. We would also appreciate clarification as to why certain headings do not include any mention of "readoption without substantive changes."

II. 10A N.C. Admin. Code 21A.0303 – Appeal Decision

This rule has long described procedures for appealing the Medicaid eligibility decision of a state hearing officer ("SHO") for further review by DMA's Chief Hearing Officer ("CHO"). This process is an efficient mechanism for resolution of errors committed across various levels of the Medicaid agency including improper denials issued by county departments of social services ("DSS"). Meaningful argument and deliberation through CHO review allows DMA to exercise more direct oversight over the decision-making of its many hearing officers. This process also provides an opportunity for DMA to

address and correct the agency's violations of law and regulation rather than be forced to defend those violations in court, where statutes expose the agency to liability for the appellant's attorneys' fees. *See* N.C. Gen. Stat. § 6-19.1(a).

As explained below, even if the proposed revisions to this rule are not adopted, the regulation stands in need of correction to address important due process issues. In addition, the proposed changes to this rule would run counter to governing state law. They would also significantly truncate existing procedures for review of Medicaid eligibility determinations in ways that would expose both DMA and appellants to tremendous and avoidable litigation costs.

This regulatory provision exists because of the following statutory text:

> After the administrative hearing [held pursuant to subsection 108A-79(i)], the [SHO] shall prepare a proposal for decision, citing pertinent law, regulations, and evidence, which shall be served upon the appellant and the county department of social services *or their personal representatives*. The appellant and the county department of social services shall have the opportunity to present oral *and* written arguments in opposition to or in support of the proposal for decision to the [CHO] who is to make the final decision.

N.C. Gen. Stat. § 108A-79(j) (emphasis added). This language, along with other provisions of section 108A-79, informs our comments on the regulation at issue.

A. Concerns Regarding Existing Regulatory Language

Setting aside for the moment DMA's proposed changes to this regulation, the rule has long been problematic in that the deadline for requesting CHO review is triggered by "the date the notice of the tentative decision *is signed*." 10A N.C. Admin. Code 21A.0303(c) (emphasis added). The "tentative decision" referenced is that of the SHO who presided over the state administrative hearing conducted pursuant to N.C. Gen. Stat. § 108A-79(i). These decisions, however, do not reveal when they were actually "signed." Instead, they feature a printed date that usually appears on the last page of the decision near the name of the SHO who authored it. Unfortunately, regardless of what that printed date might suggest to the contrary, these decisions are not necessarily *mailed* on that date. Our experience in assisting thousands of Medicaid applicants and their authorized representatives has taught us that, quite often, the SHO decision is not actually delivered to anyone until many days after the date printed on the decision. Because the window of time for requesting CHO review is only 10 days from that date—as opposed to the certified mail delivery date or the date on which the decision postmarked—in many instances Medicaid applicants and their representatives are left with only a few days to review and analyze the SHO decision to determine whether further appeal is required. This phenomenon frequently results in either **(i)** the expiration of the CHO appeal opportunity altogether due to timeliness or **(ii)** the submission of appeals that, although sometimes imprudent or unwarranted in hindsight, are requested solely to gain additional time for review of the SHO decision.

The timing problems described above are not helped by DMA's practice of bypassing certified mail requirements when notifying authorized representatives. Although the rule has long required that "[SHO decisions] affirming the county department's actions . . . be sent by *certified mail* to the appellant," 10A N.C. Admin. Code 21A.0303(a) (emphasis added), DMA's hearing officers have not followed this provision when it comes to serving the appellant's authorized representative. While the Medicaid

applicant/appellant himself receives the SHO decision via certified mail, his or her authorized representative does not. State law, however, provides that the SHO decision "shall be served upon the appellant . . . *or their personal representatives*." N.C. Gen. Stat. § 108A-79(j) (emphasis added). This statute recognizes the legal significance of principal–agent relationships and requires DMA to do likewise when it comes to issuing notices of SHO decisions. Requiring certified mailings to an appellant's representative is consistent with federal regulations requiring that such representatives "[r]eceive copies of the applicant or beneficiary's notices and other communications from the agency." 42 C.F.R. § 435.923(b)(3).

Proper notice to representatives is also vital in light of the fact that notice to the appellants themselves is often of limited practical consequence due to their medical conditions and socioeconomic circumstances. For example, many Medicaid applicants are unable to receive mail reliably at all, as is frequently the case with homeless indigent persons. Even if they do receive their mail, a significant number of applicants (such as those suffering from neurological injuries or psychological impairments) may be unable to appreciate the meaning or significance of things like SHO decisions. Even for individuals who do understand the importance of notifying their representative when they receive a SHO decision, practical obstacles prevent timely forwarding of the decision to the representative for review and analysis. For instance, they usually do not have access to things like fax machines or document scanners (for e-mail purposes). In such situations, the only *meaningful* notice provided by DMA's hearing officers is the one issued to the appellant's personal representative.

If certified mail were required for service of SHO decisions on all adversely affected parties *including* their personal representatives, questions regarding the date on which the decision was "signed" versus when it was actually mailed could be rendered irrelevant. Certified service on representatives would definitively establish the decision's actual delivery date, providing a clear procedural history for purposes of determining the timeliness of requests for CHO review.

Therefore, regardless of whether DMA gives favorable consideration to any of our other comments on this rule, we ask that DMA revise the rule in paragraph (a) to replace the word "appellant" with "appellant and their representative." We also request that a similar change be made to what is currently paragraph (f), which in DMA's proposed revised version of the rule is paragraph (g). Finally, *throughout* the rule, we would urge DMA to revise the phrase "the date the notice of the tentative decision is signed" as follows: "the date the notice of the tentative decision is ~~signed~~ delivered to the appellant and their representative." In our view, these changes would bring the regulation into closer conformity with the requirements articulated in N.C. Gen. Stat. § 108A-79(j).

B. Concerns Regarding Proposed Revisions

Under the current version of 10A N.C. Admin. Code 21A.0303, appellants are provided 10 days to initiate further appeal proceedings by "contacting" the CHO. In light of the timing and notice issues discussed above whose practical effect is to reduce the 10-day window significantly, this relatively streamlined process for protecting one's CHO review opportunity is critical. However, paragraphs (d) and (f) of the revised rule appear to require appellants not only to "contact" the CHO, but also to present *the arguments themselves* to the CHO within 10 days if such arguments are to be presented at all. Revised paragraph (f) indicates that arguments—whether oral or written—will only be "considered" if they are actually *presented* to the CHO "within the timeframes established in [paragraphs] (c) and (d)."

For a number of reasons, the procedure envisioned by these proposed revisions is unworkable and, in important respects, at odds with N.C. Gen. Stat. § 108A-79(j). First, the unstated assumption of revised paragraph (f) is that it is, in fact, possible for written and oral arguments to be presented to the CHO within 10 days of the SHO decision's signature date. But that is *not* possible. As explained above, the SHO decision itself does not actually reach an appellant until several days after it is *mailed*, and the decision is not necessarily *mailed* on the same day that it is "signed" (i.e., the date typed above the SHO's signature). In addition, even if an appellant receives a SHO decision on the very day it was issued, scheduling and conducting oral arguments requires a certain amount of time as well as coordination between the CHO and the appellant. Consider the following illustration, which is a timeline based on actual cases with which we have been involved:

Date	Event
1/1/2018	Working after business hours, the SHO finishes drafting a Medicaid decision that is unfavorable to the appellant. She types a date of 1/1/2018 above her signature line, then prints out the notice and places it in her office outbox.
1/2/2018	The SHO decision is carried to the post office or mail center where it is stamped and sent out for delivery to the appellant via first-class U.S. mail.
1/5/2018	The SHO decision is delivered to the appellant, who only actually receives it after returning home from work. By this time it is Friday evening after business hours.
1/8/2018	Monday morning, the appellant drives to the office of his personal representative to show her the SHO decision, as he needs help understanding it and does not know what to do next.

In this illustration, the appellant and his representative could have as little as *48 hours* to review the SHO decision, analyze its findings and conclusions, conduct needed legal research, prepare a coherent written argument, and submit that argument to the CHO. Moreover, they must endeavor to identify some period of time during the next two business days during which they can be available to present their oral argument to the CHO. If the CHO requires the oral argument to be presented in person in DMA's Raleigh offices, the appellant may also need to obtain an approved absence from his employer, secure transportation to Raleigh, and make arrangements for child care—again, all on very short notice. In addition, the CHO herself would have a maximum of two days to schedule and conduct an oral argument—and even that assumes the appellant or his representative immediately notified the CHO that they were appealing the SHO decision. The proposed revisions thus replace an orderly and manageable process with one that eviscerates the appellant's "opportunity" for presenting arguments and while throwing both the CHO and the parties into relative chaos. Even ignoring the hardship that would be imposed on Medicaid appellants by the proposed revisions, we struggle to see how DMA stands to benefit from these changes.

Second, the proposed procedure is remarkable in that it is unlike any appeal framework in Medicaid law or North Carolina's general courts of justice. In the context of court proceedings, for example, an individual need only file a timely notice of appeal to preserve their appeal rights. The appellant is not required to submit a brief explaining their contentions until a later date. The proposed changes to 21A.0303 are the Medicaid equivalent of requiring litigants to file *briefs* to initiate appeal proceedings rather than notices of appeal.

Finally, the insertion of a revised paragraph (d) in DMA's proposed rule replaces the flexible scheduling approach currently used by the CHO with a needlessly demanding and administratively burdensome standard that would grant extensions only "for good cause or in the interests of justice." Moreover, this proposed provision does not mitigate the problems described above, because virtually *all* cases will require an extension for submission of arguments for the reasons we have already provided. If the

proposed changes are adopted, all applicants and representatives with whose Medicaid appeals we are involved will be advised to request good cause extensions as a matter of course. In contrast, the current regulatory configuration imposes a 10-day deadline for *initiation* of the CHO appeal but allows the parties to establish a reasonable timeframe for submission of written arguments and scheduling of oral arguments. This is a much more efficient and reasonable practice than the process contemplated in the proposed revised rule.

The net effect of the proposed changes, unfortunately, is to *erode* an appellant's opportunity for presenting oral and written arguments to the CHO—an opportunity expressly mandated by N.C. Gen. Stat. § 108A-79(j). The proposed revisions will also make any review that does occur less meaningful, as the extraordinarily short "presentation" deadline will prevent appellants from being able to submit clear, comprehensive arguments to the CHO. Accordingly, we ask that DMA not adopt any proposed changes to the rule that would require oral or written arguments to be "presented" to the CHO within the 10-day timeframe in order to be considered. Specifically, to address the problems we have described here as well as the concerns discussed above in Section II.A of our comments, DMA should revise its proposed paragraph (c) as follows:

> (c) If ~~a written argument or a request for oral argument~~ an appeal from the tentative decision is not received by the Chief Hearing Officer within 10 calendar days of the date the notice of the tentative decision is ~~signed~~ delivered to the appellant and their representative, the tentative decision shall become final.

In addition, proposed paragraph (f) should be revised to *remove* the phrase "within the timeframes established in Paragraphs (c) and (d) of this Rule." Finally, to the extent that a change should be made to the 10-day appeal timeframe itself, it should be broadened to track N.C. Gen Stat. § 108A-79(k). That subsection provides 30 days from a final agency decision to petition for judicial review. In addition, it permits the filing of untimely petitions when there is good cause, recognizing the importance of flexibility given the many difficulties faced by sick, indigent Medicaid applicants.

III. 10A N.C. ADMIN. CODE 22B.0104 – TIME LIMITATION [PAYMENT OF CLAIMS]

Although DMA has proposed to readopt this rule without modifying it, paragraph (c) should be revised as follows:

> (c) The time limitation specified in Paragraph (a) of this Rule ~~may~~ shall 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 latest date by which the county department of social services both approves the eligibility and provides written notice of the approval to the approved individual and their authorized representatives.

First, replacing the rule's permissive language with mandatory wording is necessary because DMA does not have the authority to deny a provider's claim on timeliness grounds where the claim could not have been billed sooner due to the agency's own error (e.g., an erroneous denial of the recipient's Medicaid application that requires months or years of appeal efforts to resolve). Second, the 180-day timeframe in paragraph (c) should not commence until DMA or the local DSS office has actually *notified* the individual that, despite the agency's original "error in determining eligibility," his or her eligibility

has now been approved. Without such notice, the approved individual may not know to inform relevant medical providers that he or she is now Medicaid eligible. If the 180-day clock can be started without proper notice of the corrected eligibility determination, and if providers remain unaware that Medicaid coverage is now authorized for the dates in question, the corrective action by DMA will have been rendered inconsequential. We therefore recommend modifying the rule as shown above to provide that the 180-day period for filing of claims in this scenario is not triggered until the agency has both entered the approval and provided notice thereof to the approved person and his or her authorized representatives.

IV. 10A N.C. Admin. Code 22C.0101 – Cost Sharing

Although DMA has proposed to readopt this rule without modification, it refers to "SSA 1902(a)(ar)." Assuming this reference is intended to refer to § 1902 of the Social Security Act, the referenced subsection (a)(ar) does not exist. Thus, we recommend that the phrase "SSA 1902(a)(ar) and" simply be deleted from this rule.

V. 10A N.C. Admin. Code 22C.0102 – Medically Needy

Although DMA has proposed to readopt this rule without modifying it, the federal statute to which it refers has been updated significantly in the four decades since the rule was last readopted. Subsection 1905(a) of the Social Security Act lists not five, but 29 types of care and services. Similarly, 42 C.F.R. § 440.220 was modified in 1993. Accordingly, we would recommend revising paragraph (a) of this rule as follows: "Each item of care and service listed in Section 1905(a)(1) to ~~(5)~~(29) of the Social Security Act shall be provided for persons classified medically needy."

VI. 10A N.C. Admin. Code 22F.0104 – Prevention

Although DMA has proposed to readopt this rule without modifying it, it should be revised to eliminate certain provisions for which there is no legal authority.

First, paragraph (a) states that DMA "may at its discretion . . . conduct on-site educational visits to assist a provider in complying with requirements of the Medicaid Program." However, DMA is without statutory or federal regulatory authority to enter a provider's premises at its "discretion" in the interest of provider education. Accordingly, paragraph (a) of this rule should be revised to remove the offending language, as follows: "The Division 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."

Second, paragraph (e) of this rule, which is entitled "Claims Forms," contains a rather out-of-place subparagraph (6) declaring that DMA "may suspend or terminate a provider for violations of Medicaid laws, regulations, *policies, or guidelines*." 10A N.C. Admin. Code 22F.0104(e)(6) (emphasis added). DMA is without authority to take adverse action against a provider based on mere "policies" or "guidelines." Such action can only be predicated on violations of enacted legislation or promulgated regulations.

The language of subparagraph (e)(6) represents an indirect attempt to incorporate unpromulgated materials into the rule by reference in a manner that does not conform with the requirements of N.C.

Gen. Stat. § 150B-21.6. This law permits administrative agencies to engage in the practice of "incorporation by reference" only with respect to the following two categories of materials:

> (1) Another rule or part of a rule *adopted* by the agency.
> (2) All or part of a code, standard, or regulation *adopted* by *another* agency, the federal government, or a generally recognized organization or association.

N.C. Gen. Stat. § 150B-21.6 (emphasis added). In both of these categories, the referentially incorporated material is required to have been "adopted." *Id.* The Administrative Procedure Act defines the term "adopt" as meaning "to take final action to create, amend, or repeal a *rule*." *Id.* § 150B-2(1b) (emphasis added). In other words, section 150B-21.6 only permits DMA to incorporate materials by reference in its rules if those materials are themselves enacted legislation or formally promulgated administrative rules. Because DMA clearly intends the phrase "policy[] or guidelines" to refer to something other than laws or regulations, subparagraph (e)(6) of this rule violates section 150B-21.6 of the General Statutes.

In short, if DMA were to suspend or terminate a provider based solely on perceived violations of "policy" or "guidelines" as opposed to violations of laws or regulations, DMA's action would be "[i]n excess of the statutory authority or jurisdiction of the agency" and "[m]ade upon unlawful procedure." N.C. Gen. Stat. § 150B-51(b) (listing grounds for reversal of agency actions upon judicial review). We therefore urge DMA to strike subparagraph (e)(6) from this rule in its entirety.

VII. 10A N.C. Admin. Code 22F.0202 – Investigation

This rule, as DMA proposes to revise it, indicates that a preliminary investigation will occur in response to complaints concerning (among other things) "practices not conforming to regulations *or policy*." 10A N.C. Admin. Code 22F.0202(a) (emphasis added). Inclusion of the undefined phrase "or policy" is problematic for several reasons. First, to the extent "policy" means promulgated administrative rules, it is redundant because the proposed phrase already includes the term "regulations."

Second, if by "policy" DMA means something other than law or regulations, the proposed language represents an indirect attempt to incorporate unpromulgated materials into the rule by reference in a manner that does not conform with the requirements of N.C. Gen. Stat. § 150B-21.6. For the same reasons discussed above in Section VI of our comments, if by "policy" DMA does *not* mean regulation, the proposed revision of subparagraph (a) of this rule violates section 150B-21.6.

In addition, because "policy" is undefined in revised subsection (a), the proposed language invites disputes regarding whether an investigation of a Medicaid provider was properly initiated. If an investigation were to be commenced based solely on perceived nonconformity with "policy" as opposed to nonconformity with regulations, that investigation and any resulting agency action would be subject to reversal upon judicial review. *See* N.C. Gen. Stat. § 150B-51(b). For all of the foregoing concerns, we urge DMA to strike the phrase "or policy" from revised paragraph (a).

VIII. 10A N.C. Admin. Code 22F.0301 – Definition of Provider Abuse

Although DMA has proposed to readopt this rule without modifying it, it should nevertheless be revised. According to the opening paragraph of this regulation, "Provider abuse 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 . . . ."

10A N.C. Admin. Code 22F.0301 (emphasis added). The concept of "accepted practices" is patently overbroad, as the rule neither elucidates these "practices" nor explains what constitutes "acceptance" of them. The rule does not explain *who* must have "accepted" these practices. It is therefore impossible for a provider to determine in advance whether DMA will characterize the provider's conduct or dealings as "inconsistent" with such "practices."

Similarly, the rule's attempt to define provider abuse as including *any* services or practices that are "not reasonable" or "not necessary" is overbroad in the extreme. Commercial activities may be unreasonable in certain instances without being "abusive." The notion that everything a provider says and does must be "necessary" is even more absurd. In addition, the concept of "financial loss" in the existing language of the rule is not defined. Moreover, it is unnecessary because the regulation's ensuing subparagraphs already list abusive practices that are characterized by adverse financial impacts on the program (such as duplicative billing). For all of these reasons, we recommend that the opening paragraph of this rule be revised to eliminate its overbroad and undefined components and to refocus the meaning of abuse through reference to the specific behaviors enumerated in the subparagraphs. Specifically, we request that DMA change the rule's initial paragraph as follows:

> Provider abuse includes ~~incidents, services, or practices inconsistent with accepted fiscal or medical practices which are not reasonable or which are not necessary including, for example,~~ the following:

Finally, among the examples of provider abuse listed in the rule is "[b]reach of the terms and conditions of participation agreements, or a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form." 10A N.C. Admin. Code 22K.0102(5). This language is an overreach and attempts to redefine the concept of "abuse"—a volitional act—as encompassing potentially unintentional phenomena. Breaches of contract provisions, for instance, are not necessarily intentional, let alone abusive. Moreover, this language is in effect an attempt to impart to such agreements the force of regulation—regardless of the parties to those agreements or the infinite possible variations in their actual terms. As we have explained in several instances above, DMA cannot incorporate these sorts of unpromulgated documents into its rules by reference. N.C. Gen. Stat. § 150B-21.6. The terms in this sentence are also impermissibly vague. For example, "requirements of certification" is not defined. We request that DMA strike subparagraph (5) from this rule entirely.

IX. 10A N.C. Admin. Code 22F.0601 – Recoupment

DMA has proposed to readopt this regulation without modifying it. However, the rule needs to be revised to bring it into conformity with state law. The rule provides that, when DMA is authorized to recoup funds from a provider, "[r]ecovery may be by lump sum payment, by a negotiated payment schedule *not to exceed one year*[,] or by withholding from the provider's pending claims the total or a portion of the recoupment amount." 10A N.C. Admin. Code 22F.0601(a) (emphasis added). The rule's limitation of repayment plans to terms of one year is more restrictive than the governing statute, which provides that "[t]he payment plan can include a term of up to 24 months." N.C. Gen. Stat. § 108C-5(g). We therefore recommend that DMA revise paragraph (a) of this rule to replace the words "one year" with the words "24 months."

X. 10A N.C. ADMIN. CODE 22F.0603 – PROVIDER LOCK-OUT

Although DMA proposes to readopt this rule without modification, the rule in its current form deviates from the procedures contemplated in 42 C.F.R. § 455.23 and does not comport with governing state law found in Chapter 108C of the General Statutes. For example, subparagraph (a)(1) says that, "[b]efore imposing any restrictions [on the provider's participation in the Medicaid program], the Division will give the provider notice and opportunity for review in accordance with procedures established by the Division." Although perhaps the due process contemplated by this prerequisite is not completely valueless, it does not measure up with Chapter 108C's requirements. That chapter provides that "a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested . . . ." N.C. Gen. Stat. § 108C-5(b). The actual suspension of payments by DMA cannot begin until "the thirty-first day after the suspension or termination [from participation in the Medicaid program] becomes final." *Id.* § 108C-5(d). For these reasons, paragraph (a) and subparagraph (a)(1) of this rule should be revised as follows:

> (a) The Division may restrict the provider, through suspension or otherwise, from participating in the Medicaid program as provided under section 108C-5 of the General Statutes, provided that:
>
> (1) Before imposing any restrictions, the Division will give the provider notice and opportunity for review in accordance with procedures established by the Division, and thirty full days must elapse after the suspension of the provider from participation in the Medicaid program has become "final" as described in section 108C-5 of the General Statutes.

The rule is also problematic because subparagraph (a)(2) contains a vague provision incapable of fixed meaning or consistent application. This subparagraph, taken together with its subparts, indicates that, "before . . . restricting a provider," DMA must demonstrate that certain errors by the provider exist "in a *significant* number of proportion of cases." 10A N.C. Admin. Code 22F.0603(a)(2) (emphasis added). Of course, this phrase ("number of proportion of") appears to involve a clerical/proofing error. More concerning is the undefined qualifying term "significant." The rule offers no guidance for determining what quantum of cases DMA will consider "significant" in a given dispute. A more appropriate and interpretable threshold would establish the rate of such errors among similarly situated Medicaid providers and then evaluate the extent to which the suspect provider's error rate is greater than the mean. By way of example, we would recommend that subparagraph (a)(2) of this rule be updated as follows:

> (2) The Division shows, before so restricting a provider, that in a ~~significant number of proportion of cases~~ percentage of its claims for services that is greater than one standard deviation from the average percentage of such claims involving other providers of the same services that have not been placed under restriction, the provider has:

XI. 10A N.C. ADMIN. CODE 22F.0604 – WITHHOLDING OF MEDICAID PAYMENTS

Like section 22F.0603, this regulation fails to acknowledge the role of Chapter 108C of the General Statutes pertaining to payment suspensions. Although the rule incorporates 42 C.F.R. § 455.23 by reference, it should be revised to reference Chapter 108C as well. In addition, paragraph (b) of this rule is redundant in light of the provisions of 10A N.C. Admin. Code 22F.0601.

Our recommendation is that, at a minimum, paragraph (b) be stricken from this rule. Alternatively, because the rule does little other than to declare the applicability of federal regulations that are already binding on providers, it is redundant as a whole and may easily be repealed in its entirety without any substantive impact.

XII. 10A N.C. Admin. Code 22F.0606 – Technique for Projecting Medicaid Overpayments

DMA proposes to readopt this rule without modification. However, we recommend that paragraph (a) of this regulation be stricken in its entirety because it is redundant in light of section 22F.0601. In addition, paragraph (d) unlawfully purports to limit the provider to challenging only the "validity of the findings in the SAMPLE itself." This restriction is without authority and does not comport with N.C. Gen. Stat. § 108C-5(n), which permits providers to challenge *any* aspect of an audit or an extrapolation. We therefore recommend revising paragraph (d) as follows: "The provider may challenge ~~the validity of the findings in the SAMPLE itself in accordance with the provisions found at 10A NCAC 22F .0402~~the extrapolation or its findings as provided in section 108C-5 of the General Statutes."

XIII. 10A N.C. Admin. Code 22J.0105 – Payment Status

Although DMA proposes to readopt this rule without modification, the rule does not align with Chapter 108C of the General Statutes. The regulation's text says that, "[o]nce a final overpayment or final erroneous payment is determined by DMA to exist," DMA will take action to recover the overpayment regardless of whether the provider has appealed DMA's determination. 10A N.C. Admin. Code 22J.0105. In contrast, state law provides that a final overpayment is "[t]he amount the provider owes *after appeal rights have been exhausted*, which shall not include any agency decision that is being contested." N.C. Gen. Stat. § 108C-2(5) (emphasis added). Because this rule is totally incompatible with the controlling statute, it should simply be repealed.

XIV. 10A N.C. Admin. Code 22K.0102 – Agreement [Presumptive Eligibility]

This proposed rule revision states that DMA will terminate a provider's authority to make presumptive eligibility determinations if (among other things) the provider "fails to follow procedures set forth in Section MA3245 of [DHHS]'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." 10A N.C. Admin. Code 22K.0102(b).

Here DMA has expressly incorporated unpromulgated materials into its rule by reference. Although this proposed provision comports with the requirement in N.C. Gen. Stat. § 150B-21.6 stating that "the agency must designate in the rule whether or not the incorporation includes subsequent amendments and editions of the referenced material," it nevertheless violates the statute. This is because, as discussed above in Section VI of our comments, all materials incorporated by reference must themselves be "a *rule* adopted by the agency." N.C. Gen. Stat. § 150B-21.6(1) (emphasis added). The Family and Children's Medicaid Manual, however, is created, updated, and published on the Internet without any public notice or comment and without regard for any of the other rulemaking requirements imposed by the Administrative Procedure Act. Clearly it is not promulgated in accordance with that Act. Because of this, its provisions are not valid rules. *See Dillingham v. Dep't of Human Res.*, 132 N.C. App.

704, 710, 712, 513 S.E.2d 823, 827, 828 (1999) (stating that "[a]n administrative rule is not valid unless adopted in accordance with the provisions of Article 2A of the Administrative Procedure Act" and holding that the agency committed reversible error by requiring a Medicaid applicant to satisfy an unpromulgated standard of proof set forth in a Medicaid Manual).

Because the rule as revised by DMA would violate state law, paragraph (b) should be changed to remove the attempted incorporation of the Family and Children's Medical Manual by reference.

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Thank you in advance for your careful consideration of these comments. We would be glad to discuss these items with you in more detail if you have any questions or concerns. Please do not hesitate to reach out to us if we can be of assistance in this process.

Sincerely,

OTT CONE & REDPATH, P.A.

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