NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

Minutes of Rulemaking Public Hearings
January 25, 2019, 1pm-3pm

Staff Present

Sandra Terrell, DHB Director of Clinical and Operations
Ryan Eppenberger, DHB Interim Rulemaking Coordinator
Andrea Phillips, DHB Regulatory Affairs
Badia Henderson, Medicaid Communications
Laura Whitaker, DHB Clinical and Operations
Misty Piekaar-McWilliams, DHB Hearing Office
Katherine Vilas, DHB Hearing Office
Sharlene Mallette, Medicaid Transformation
Jill Dixon, Sign Language Interpreter
Brian Tipton, Sign Language Interpreter

Others Present

Jeff Horton, North Carolina Senior Living Association
Julie Kokocha, Trillium Health Resources
Matthew Cochran, Ott Cone & Redpath PA
Tracy Colvard, Association for Home and Hospice Care
Matt Wolfe, Parker Poe
Mike Vicario, NC Healthcare Association

1. Purpose of Hearings

A. Readoption of 10A NCAC Chapters 23 and 25

The purpose of this public hearing was to solicit verbal and/or written comments from the public on the North Carolina Department of Health and Human Services, Division of Health Benefits' proposed readoption, amendment, or repeal of 47 rules in 10A Chapters 23 and 25 published in the North Carolina Register on January 2, 2019.

B. Readoption of 10A NCAC 22F .0301

The purpose of this public hearing was to solicit verbal and/or written comments from the public on the North Carolina Department of Health and Human Services, Division of Health Benefits' proposed readoption of 10A NCAC 22F .0301 published on the website of the North Carolina Office of Administrative Hearings on January 7, 2019.

2. Hearing Summary and Transcript of Comments

The public hearing was opened by Sandra Terrell and Ryan Eppenberger at 1:00 p.m. There were 6 members of the public present for the hearings. Three oral comments (from one speaker) were recorded for the readoption of rules in 10A NCAC Chapters 23 and 25. Six oral comments (from four speakers) were recorded for the readoption of 10A NCAC 22F .0301. The following is a transcript of these public comments:

A. Readoption of rules in 10A NCAC Chapters 23 and 25

(1) Matthew Cochran, Ott Cone & Redpath PA

Matthew Cochran with Ott Cone and Redpath. I'll be brief here as I have to revisit some of these in more detail a bit later. But with respect to the rule republication that came out regarding 23 -- Chapters 23 and 25 Title 10A, there are number of categories of issues. But I would like to focus mostly on issues that impact the representatives of Medicaid applicants or recipients and the way in which the agency and the representative and the recipient or beneficiary or applicant interact.

The other sort of broad category of issues involves the extent to which rules line up with what I'll call generally due process considerations. Is there an opportunity, for example, in some rules to insert a provision that makes it more clear for the local -- the county DSS offices in the certain set of facts they need to issue a notice explaining the ordinary appeal rights, et cetera?

And then there are a number of just what I'll admit are fairly minor but potentially problematic ambiguities in a number of rules regarding the actual eligibility piece, for example, with respect to resources. A couple of just tweaks that have been made that at least in my estimation cause some potential for confusion or misinterpretation. There's perhaps one typographical error. And then there's an issue of DSS offices being held accountable for taking corrective action.

That rule is a bit more involved. But I will mention briefly the issues that I'm concerned are about are pieces of language in the proposed revised rule that could be used as -- or I guess I should say they might serve as a means for having DSS drag its feet, to be honest, in far too many instances.

And since I have a bit more time it appears, I will mention a few of the particulars of that rule. It is discussing when counties must correct their Medicaid eligibility determinations and decisions and processes after, for example, a decision comes back down from an appeal. Where an individual might appeal the denial of the eligibility benefits and then a state Hearing Officer might issue a decision saying, no, you must process it in accordance with X regulation, et cetera.

The rule is designed and properly so to prompt DSS to go ahead and take appropriate action once that type of thing happens. However, there is a good cause provision, and I love good cause, don't get me wrong. I like for it to be extended to me. But there's a good cause provision in Paragraph B of that rule that is -- has been problematic. And this is not so much a problem with how it's been modified in the published document that came out earlier this month but rather that it's been worded for a long time. Basically, the county is given an opportunity to slow the process down if for example, it claims it's unable to locate the applicant.

There are many situations in which DSS should have no reason to locate an applicant after a hearing decision comes down. Because all of the factual questions have been resolved. For example, a Hearing Officer might say, no, this is the appropriate analysis of the resources. This is the appropriate analysis of income. Yes, in fact, there was a child in the home. And that's that. And now process and approve this person on Medicaid. The DSS office has in some instances looked at Subparagraph 2 of Paragraph B and said, well, we're unable to locate the applicant, which may, in fact, be true. They might have moved away or just disappeared. Many folks are transients or homeless and they can't be located conveniently or easily. And things like this need to be addressed I would say in looking at this rule again so that the intent of making the agency at the local level move the ball forward is actually effectuated and not frustrated perhaps unintentionally so hopefully we can address more of those items in more detail. Thank you.

(2) Matthew Cochran, Ott Cone & Redpath PA

Going back to Chapters 23 and 25, as I mentioned earlier, the categories of issues that I'm concerned about have to do with the authorized representatives of Medicaid applicants particularly and appellants. A subcategory there has to do with access to records. As you know, there is a state statute that describes the circumstances under which individuals can be given access to records. There are also provisions in the state's Medicaid manuals, which are not rule or statute. But they are certainly guiding documents for the way that local agencies operate. Certainly, the DSS offices rely helpful upon the manuals. And there are quite a few versions even of the same manuals. And many of them, though, are pretty consistent about the way that they deal with access to the records.

A couple of -- I'm going to point out a couple of nuances that this just comes from my experience of representing many applicants and Medicaid appellants with respect to eligibility. Authorized representative under Federal regulation can be designated quite easily. One can simply write on a napkin, I want Matt Wolfe to be my authorized representative for purposes of my Medicaid application. Hand that in to the DSS worker. Their case worker. And then the agency is supposed to at least do the best they can to figure out who is Matt Wolfe, how do I contact this person, et cetera.

In fact, if there's no napkin handy, the applicant can call the DSS office and say basically the same thing orally, including leaving a voicemail to that effect. And again, the agency's -- or the DSS personnel are supposed to take that information in and then document it properly and take action on it. And for the most part this is done quite well by DSS workers, income maintenance case workers, and those who are tasked with dealing with Medicaid applicants in general.

With respect to access to records, however, the rules -- I'm going to list off a couple -- a handful of items out of 23H that are part of this discussion. 23H .0109. I should go in order. 23H .0107; 23H .0108, .0109 and .0110. In my view, these all sort of in varying ways have to do with the applicant's right to see records pertaining to their case.

What's peculiar, of course, is that there is language in these rules that allows the clients, it uses the term client, so I'll try to use that when I can remember to, the client has the right to view its file.

It also allows the individual to request that their representative or their attorney be allowed to have access effectively just as they would. And that rule is the 23H .0109. And one of the concerns that I have is that the rule seems to make it a requirement that the client make a direct manifestation to the DSS office of that -- of their desire to have the representative access the records.

In many cases, unfortunately, the applicant is a disabled individual or someone who is -- who has not yet been deemed disabled by Medicaid or even perhaps by the Social Security Administration but hasn't the capacity or ability to make any type of manifestation, certainly not with any -- in a timely manner. In many situations it might be necessary for the individual to be able to rely upon a previous written designation of an authorized representative in hopes that that representative would then be able to avail themselves of their status as such, show up at DSS, and say, I need to take a look at what you have documented for that person's -- let's say we need to compare what you have on file for the food stamps case and compare that to what you are seeing for their Medicaid. Because we believe there's a discrepancy and we want to understand why we're hearing different things from different sides of the house. That's just an example.

So, the language of 23H .0109 Paragraph C, just the initial clause of that paragraph, says that upon written request from the client. That language, to the extent that it is being interpreted by DSS offices as requiring that one-on-one sort of in-person direct manifestation separate from a designation of a representative is a problem.

So, for example, if the representative has already received a signed document saying, yes, I'm -- yes, I would like you to represent me in my Medicaid case, should that not be sufficient as a written quote-unquote request that the person be allowed to look at their records?

I know that the language here allows for quite a bit discussion and interpretation. I don't purport to have necessarily the answer. But I wanted to bring that up as an issue. There are many situations in which the person at the outset of their application process -- the outset of their application process will have designated an authorized representative. They then however might become very ill as the application process goes on. Especially if they are seeking to be deemed disabled by DSS, it might be six, eight, nine months. By that time, they have become very ill. They might not be able to pick up a pencil. They may at that point even be to a certain extent incapacitated and might not be able to make a separate writing. So, it's important at least from my perspective working for folks who are assisting applicants that an existing designation of a representative serve as a basis for that representative to take the action to look at records.

In connection with what I just pointed out about .0109 I would just mention that the general right of access rules, which I think are 107 and 108, my only recommendation there would be the word client be -- in addition to client say perhaps client or their representative to acknowledge the possibility of a representative being able to have the ability to look at records pursuant to .0109.

Finally, with respect to the idea of release of information, there is a rule that talks about the consent for release document. It's 23H 0110.

Again, as I mentioned earlier, the Federal rules that describe when someone -- how someone can be designated as an authorized representative also include rules that describe how the agency is to interact with that representative. And essentially that representative is given the right to notice.

The Federal rules intent is that the representative be able to act in all respects as the Medicaid applicant or recipient.

The consent for release rule here potentially goes beyond what the Federal rule requires in terms of the ingredients for a valid consent. And in some ways, I understand there's quite a bit of need to reconcile the language of the state statute regarding release of information and the Federal regulations pertaining to what information should be given to the representative, so I understand the conflict there.

I hope that that can be something that -- the issues here can be dealt with perhaps through further discussion. There will be some written comments going into more detail. But I will point out at the outset that Paragraph D of the proposed rule, which, again, this is not new information. This is language that's largely intact from the prior and the existing rule, I think that provision has caused confusion for DSS workers. That provision says, the client may alter the form to contain other information -- the existing language says which may include but need not be limited to. And it lists a number of things.

The revision says contain other information comma including colon. Which in my mind potentially could be read by DSS workers as saying, no, your designation form goes beyond the items that have been listed in that Paragraph D. So therefore, you have modified the consent documentation more than this rule allows and we're not going to recognize it. So, there's some problems there. And again, the details can be dealt with later. But I think that by and large, the agency does a good job of recognizing representatives. Particularly at the state hearing level I think there's never really been any hang-up at all. At the DSS level, however, that's where more of these issues crop up. And how am I doing on time?

>> You've got a minute and a half.

>> Okay. Good. Thank you.

So again, the first broad category of issues being representatives and how they interact. I did also want to mention 23E .0105. This is a rule regarding disability. Paragraph C of that rule says that a social history must be completed. It says completed by the case worker. In formal language. Income maintenance case worker.

In numerous cases, there's going to be a problem for -- presented by rather -- a problem is going to be presented if the Medicaid applicant is required to drive down the mountain or to get transportation to sit and have that form filled out. Now the form is generally the 5009-social history form. I'm sure many of you have seen that. And what we find is that most DSS staff are willing to work with the representatives and the applicants to allow the representative to do their best to complete the 5009. Some counties, however, refuse to accept 5009 that they did not themselves fill out.

This has been problematic. We have achieved good results with the hearings office on that issue. But DSS could benefit from language that makes it clear that the bottom line is that this form needs to be completed for a disability determination to happen. I think some clarity there could benefit folks both at the applicant side and DSS.

Again, there will be more written comments. But I'm hopeful that we can address these issues. They are -- in my world they are big. But for most they are very minor. But I'm optimistic. Thanks.

(3) Matthew Cochran, Ott Cone & Redpath PA

Okay. One of the things that I mentioned earlier that I would like to address, which I failed to do in my earlier allotted time, pertains to the due process considerations. One of the items put up for review this time around is 10A NCAC 23G .0304 and the caption is change in situation.

And I'm going to summarize briefly that the way that I perceive this to work in practice, having been involved from the perspective of the Medicaid applicant and the representative.

An individual may -- let's say they have minor children. They have Medicaid for years. Let's say the mother has Medicaid for a long time. Has minor children. Her children then age out. Her children then turn 18 years old and they are no longer in the home, whatever the case may be.

The next time the mother goes to renew her Medicaid, she actually -- they find that, well, sorry, you're no longer a caretaker relative of a minor child. So that category is not open to you. However, you are eligible for family planning.

Okay. Which is of course very restrictive coverage. It is not something that's going to pay for acute hospital services, for example.

So, time goes on. This person remains enrolled in family planning. They then have a serious health crisis of some sort and they come into the hospital. Then they realize, well, all I've really got is a family plan.

And it looks like I'm going to be needing chemotherapy for the next 16 months. I'm not going to be able to do a whole lot other than coming in for infusions or radiations I think I need to apply for MAD or Medicaid Aid to the Disabled.

So, they begin to ask the agency for Medicaid. And they send a letter to DSS with an application saying, please give me Medicaid, I think that I'm disabled, et cetera.

Depending on the DSS office, this may or may not be looked at as a quote change in situation. Keep in mind, to many DSS workers, that applicant is already a recipient in a quote-unquote ongoing family planning case. So, as you can see in Paragraph D of that rule it talks about for an ongoing Medicaid case once the DSS learns there's been a change in the household, et cetera, so many DSS workers process that type of situation. Or even if it's not a disability case but let's say the person despite having had their children age out adopts a child. Yet and again becomes a parent or caretaker relative to a minor and they reply for Medicaid. DSS workers will process this as a change in circumstances. A change in situation. Not an actual application.

And provide that the processing actually happens, an individual provides documentation properly and demonstrates financial eligibility, et cetera, that's not -- that's sort of the distinction without a difference. The problem, however, is when there is a -- when there's a breakdown that leads to, for example, the applicant not being able to provide proof of wages in a timely fashion. Or not being able to provide a copy of their bank statements in a timely fashion. The DSS worker then says, well, I've got to close your change of situation case, I've got to close this matter. Because

I asked for the verifications. I have not received them. And you're still going to be a family planning recipient. So, I'm not going to deny you.

So, what you see is to the DSS worker, the person has not been denied MAF benefits in that case. They see it as nothing has changed. The status quo is the same. Therefore, I don't have to send out any notice related to denial, et cetera. At most, the representative might receive a DMA-5020 saying the person has family planning. We already know they have family planning.

So, I'm trying to paint the scenario here, you know, depict it, so that you can understand, DSS workers believe that no due process is required when an individual requests Medicaid -- I say Medicaid, I mean full Medicaid, MAF, when someone is requesting that and they do not get that, that's a denial. I think that most of us in this room agree that when you don't get what you've asked for, rightly or wrongly, you've been denied what you've asked for.

State statute already says that when there is a decision, any decision, by the local DSS office, approving, denying, et cetera, modifying benefits, there has to be a notice explaining appeal rights, et cetera. I think it's 108A-79 Subparagraph A. And some DSS workers have been educated of that. And they have begun to send notices when someone has been -- when they are not being approved for MAF. That's my hypothetical. And notice comes out. And that's appropriate. Because it then triggers a deadline for that applicant to say, well, if I'm going to appeal, I need to -- let's get this show on the road, I've got to meet a deadline. I've got to scramble to get this documentation together. It starts a process that -- well, it starts a due process.

And that's an appropriate thing. However, that is not something that's being done consistently by DSS workers. That is when an individual is not approved for what they have requested but is instead merely kept on family planning, the DSS worker is saying, well, I do not need to provide notice, I just stop working on this, and I go about my business.

That I think does a disservice to the Medicaid program and certainly to that applicant because it denies them the opportunity to proceed with the ordinary appeals process with respect to the local hearings, state hearings, if necessary, and state de novo hearing in particular. As you know when clarifications are in question, if that individual can obtain the documentation by the time of the de novo hearing, they can be approved. When DSS is not even issuing a denial notice and refuses to honor an appeal request because there was no denial notice, that person is shut off from the due process that the State Legislature has intended exists.

Of course, that legislation also comports with Federal due process requirements.

So, when it comes to 23G .0304, my request is that some consideration be given to modifying some of the language to make it more clear to DSS workers that when action or -- when processing of a perceived change in situation happens, that it be accompanied by a disposition notice of some kind. That then triggers the appropriate obligations for appeal by the applicant or quote-unquote recipient in that situation. And otherwise moves the due process ball down the field.

That is the primary item that I wanted to address. I think it's fairly substantive. And it does impact a lot of people. I mean, I deal with I'll say -- well, too many to count really. But cases in which folks are coming from a family planning context. They are not getting notices. We are trying to hold ourselves as representatives to what we think would generally be an appeal deadline. When we get wind of the fact that the agency has not processed approval, we think, uh-oh, maybe someone didn't provide the documentation they need to provide. So, we start -- we may even try to proactively appeal. Saying, listen, our understanding is that something didn't go quite right, we think that that amounts to a denial. So, we're going to appeal.

Well, then DSS is rejecting that appeal request, that's when real problems arise.

So anyway, I've not done a great job of it but hopefully now you see a little bit of a fact pattern that pops up when it comes to changes in the situation. And how that really could use some additional guidance from DHB. And I think it would help a lot of people.

I will mention this, and I pointed it out before, with respect to the definition of resources that are countable under 23E .0202, the only thing that really bothers me in that, that entire revised rule, is Paragraph L, Subparagraph 3. It says the balance of checking accounts less the current monthly income and then it includes a little line that says at this time.

And in my view, the language that results from that is unclear. I don't know what this time means. And I think that even reading it sort of with -- in a light most favorable to the drafter, it's hard for me to see that DSS will be able to take a look at this and understand really how to interpret it. Especially in light of the fact that the language elsewhere in these rules that talks about what we used to call the First Amendment Rule has kind of been flipped around to now refer to the balance in a bank account at 11:59 p.m. on the last day of the previous month. So, there are a number of syntax things that have popped up in the way that the rule has been tinkered with that are not substantive, but they could result in some misinterpretation. So, with that I just leave the rest of this for some written comments. Hopefully now you see a few items that were maybe not quite as evident earlier on. So, thank you.

B. Readoption of 10A NCAC 22F .0301

(1) Jeff Horton, North Carolina Senior Living Association

My name is Jeff Horton. I represent the North Carolina Senior Living Association. We have about 300 members that are assisted living providers in North Carolina. Running anywhere from two to six-bed group homes to larger seven-bed and up assisted living communities.

Many of our providers are Medicaid -- provide Medicaid services, specifically Medicaid personal care services.

I'm speaking today about the 10A NCAC 22F .0301.

Having worked for the state for a number of years including Medicaid Program Integrity, we appreciate the rationale and the reason for Program Integrity in the state. The Federal Government requires it. The state has to do it to make sure that services are provided appropriately and are not duplicative and hopefully save the program money.

However, these rules, as they are trying to define 42 CFR 455 go way too much. We think they overreach. They create regulatory uncertainty. They are unnecessary. Will have unintended consequences that threaten North Carolina's Medicaid program.

Examples of the overreach. The first one under No. 4, provide and maintain a quality of care is subjective. Our comment is, what is defined by quality of care? It's defined broadly across many types of service types and healthcare delivery systems. This rule just says broadly quality of care. For example, quality of care of assisted living is -- may be defined by false pretension whereas in acute care it may be different according to the disease process being treated.

Is the state ready to define what is considered quality of care across all healthcare settings that provide and bill more Medicaid services? These provisions are unclear and unambiguous and unnecessarily carry out existing Federal law.

The other issue we would like to talk about is No. 9. The -- where it incorporates medical clinical coverage policies. In addition to Medicaid regulation for billing, there's literally thousands of Medicaid regulations required for certifications for Medicaid providers, which must comply. These regulations are enforced by DHSR and also for Centers for Medicare and Medicaid Services.

The -- in terms of the quality of care and the regulations that providers must comply with, will these providers now be classified as committing program abuse if they are out of compliance with DHSR or Federal regulations?

No. 13 goes beyond the 60-day overpayment rule and the Affordable Care Act and also creates another undefined term discovery. The rule basically requires providers to repay overpayments in 30 days.

No. 17, failure to notify provision is overreaching.

Nineteen does not include any reasonableness requirement division's request to access provider facilities.

And No. 20 Federal laws incorporated all have separate enforcement processes. Program Integrity should not take on the role of enforcing these requirements.

Our position is that 42 CFR 455 is sufficient in and of itself to carry out -- to define what program abuse is. What the state has done by incorporating the provider agreement terms in the program of use, there's so many things in the provider agreement, if you're short on one of these, the state can say, well, now, you committed program abuse.

Some folks would say, well, just trust the state. That won't say you're guilty of program abuse if you just don't respond within a certain amount of time to get your records to the state or something like that. However, that's not in the rule. We're giving the state a huge amount of latitude. It's unnecessary. And overreaching. And that's why we object to the rule. Thank you.

(2) Matthew Cochran, Ott Cone & Redpath

My name is Matt Cochran. I'm with the Law Firm of Ott Cone & Redpath. My firm represents providers, dedicated recipients, applicants, appellants, and the occasional traffic offender. Mostly that's just me representing myself.

[CHUCKLES].

As a point of order, I would like to ask, Ryan, is it possible to do such thing as yielding one's time in the interest of another's comment?

>> Explain.

>> If I have X minutes left and I were to yield that to the next person in line, would they be able to benefit from that time?

>> No, I think we have to give everyone the same amount of time.

>> Okay. So, I'll comment briefly then. I have been objecting to this rule in various forms since the early part of last year when the changes were first broadcast by Virginia and others to the Department. I will reiterate that fundamentally this is a problem of overbreadth. And when we're dealing with a -- a regime that has to function properly to protect both the Medicaid funding and the Medicaid patients from disruption, clearly this is an important regulation.

I think it can do exactly what it needs to do without being so dramatically overbroad. As has already been mentioned quite eloquently.

There is -- let's see. I'm not going to count them. But there are quite a few terms that need to be defined more clearly. There are quite a few provisions that are going to be difficult for the agency to enforce if it's going to enforce them consistently. For example, I would like to point out that there is a provision in here that makes it an instance of provider or program abuse rather if there's an inaccurate claim. Some of my clients are hospitals and they submit many, many thousands of claims. Tens of thousands, if not millions of claims statewide.

I have a feeling it's going to be difficult for the agency to enforce this particular provision and to find it to be program abuse. And if that's the case, if the agency is not going to haul everyone into a PI proceeding with every errant claim or inaccurate claim or perhaps there's a paper claim that gets picked up in the system as having some type of a glitch when it's scanned in and it does text recognition and that is dinged as an inaccurate claim, if the agency can't and won't enforce every single offense when it comes to an inaccurate claim, why does it want that provision in this rule? I would suggest, perhaps, that is something that need not be in this rule.

There are other things like that, other provisions that are similar that, in my view, extend the agency to account for phenomena that are truly not abusive. And that, again, issues that are impossible to police against effectively. And that really do not impact expenditures of the Medicaid program.

The failure to notify the Division in writing of any change in information contained in Medicaid provider enrollment application. So, if the provider's email address changes because they get bought out by a different company and their email address changes from @ABCcompany.com to @ABCDEFGcompany.com, that is program abuse, as this rule is written. That is ludicrous. And this provision could be stricken as with many others.

There are a number of issues here that have been plucked from the provider participation agreement and injected into the language of the rule. I understand why, knowing the history of the interaction between the agency and the rules of the new

Commission and everything else. However, the fact that those items existed in the provider participation agreement does not mean that they are useful for purposes of defining program abuse. I would ask the agency to look very carefully at those items in particular to identify whether or not the phenomena described in the subparagraphs that are, again, plucked from those PPAs, whether those events would really constitute abuse and whether the agency could, in fact, police for those issues is and whether it's equipped to enforce those definitions consistently.

I would suggest that quite a bit attention is needed with this rule and look forward to seeing what the agency will do with it. Thanks.

(3) Matt Wolfe, Parker Poe

Good afternoon. Matt Wolfe. I'm an attorney with Parker, Poe, Adams & Bernstein and like Mr. Cochran have the good fortune of representing providers along the continuum of care that focus on Medicaid beneficiaries along with other patients, that includes hospitals, health systems, nursing facilities, adult care homes like some of Mr. Horton's members, home health agencies, hospices, home care agencies, adult care homes, pharmacy, and if I excluded anyone, it was unintentional.

And the benefit of that experience is that I'm able to see how these rule changes impact providers of all different types. And ultimately and most importantly how they impact Medicaid beneficiaries.

I want to begin -- I know I have a brief time -- but echoing Sandy's compliments of Mr. Eppenberger, he had to sort of parachute in at the 11th hour with the Rules Review Commission and did a very able and eloquent job before the Rules Review Commission in getting their approval of it and addressing one of the objections that they raised to this particular rule. And then also requiring this process to occur.

Now, Mr. Eppenberger suggested that I was a little late to the party at the Rules Review Commission, so I did make sure I showed up plenty early this time for this particular public hearing.

I think that before I sort of go into the substance of the rule and our concerns, I think it's important to set the table for why this rule is necessary. Why we need to define program abuse. And, why the definition of abuse, and some of the concerns that have already been raised, why those things matter.

Everyone in this room, again, regardless of who you represent, who you work for, would agree that we need to ensure we have a Medicaid program that is run with integrity. We need to make clear to providers who are acceptable behaviors and what are unacceptable behaviors. We also need to make clear to providers what the consequences for impermissible behaviors are.

And we need to have standards for the Medicaid program to be able to enforce those consequences and for there to be a robust appeals process which I know Mr. Eppenberger is familiar with when providers are notified of potential consequences.

I am not arguing that there should not be a standard for providers. Or that that bar should somehow be lower. What I think we all need to -- all of the stakeholders involved in this need to ensure that the bar, the expectations for providers, are clear. They are clear so that they can ensure that they are met and so the agency can have clarity on what they are supposed to enforce so then when we go forward with the process there's clarity on what the consequences are when those standards are not met.

There is a very long and sordid history of this rule. And this is a readoption of a rule that in its current form has problems. So, I think on behalf of providers, I share in the eagerness to improve the rule and to provide some clarity to it.

But we are far away from doing that. And so what I would ask in this public hearing, because we have a lot of folks here who have an interest in this rule and ensuring that our Medicaid program is run with integrity is that we use this opportunity, not just in this public hearing and the written comments, which we'll be submitting, but we use the fact that this rule at its earliest will not go into effect into the 31st legislative day of the next legislative session which will be some time in 2020. We use this opportunity to have an engaged stakeholder process to actually start with a blank slate and not to try to -- and continue to add to a rule that already has some problems.

We have the Federal definition, which I think is a helpful starting point. But we I think can work together and we can identify specific practices or behaviors for providers that are abusive and that should be stopped, as my time suggests I should. And that we also make clear to providers what kinds of behaviors are permissible. So that they can focus on providing excellent quality care to Medicaid beneficiaries. And hopefully I'll have a chance to talk a little bit more about some detailed concerns about it.

But I did want to make sure in sort of my opening statement to make that request. Thank you.

(4) Mike Vicario, NC Healthcare Association

Good afternoon. My name is Mike Vicario, Vice President of regulatory affairs at the North Carolina Healthcare Association, a.k.a., the Hospital Association for some of you unfamiliar with the name change.

We previously submitted comments on Rule 22F .0301 definition program abuse by providers. I would like to briefly restate some of those concerns. And ask that they be thoughtfully considered by the state agency.

No. 1, rules are outside of agency's delegated authority. The proposed rules conflict with the APA and state agencies not authorized to develop rules to further define Federal laws and regulations. The provisions of the rules will expose providers to civil liability for unintentional errors without authority around the North Carolina statutes.

No. 2 the rules are unclear and ambiguous. The rules include numerous subjective statements that leave interpretation to the state division. Resulting in the potential for inconsistent enforcement.

No. 3, the rules are not reasonably necessary to implement or interpret state law or Federal law or regulation. It's already been referred to that Federal regulation is already defined as provider practices that are inconsistent with sound fiscal, business or medical practices and resulting in unnecessary cost to the Medicaid program or in a reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. That's from the

Federal definition. There's no need for authority to duplicate Federal requirements through state regulations. And doing so may result in duplicative and inconsistent enforcement.

No. 4 and finally, the rules were not adopted in accordance with the APA. New types of abuse have been included in the existing rule. Many of which are based on potentially minor occurrences. One example includes -- is included in .0301. No. 15 includes as program abuse the billing for inaccurate or merely incomplete claims. It's difficult to imagine a healthcare provider in 100% compliance with this requirement and of concern that the state agency wants to define an incomplete claim as program abuse.

Thank you for your consideration.

(5) Matthew Cochran, Ott Cone & Redpath

Again, Matthew Cochran with Ott Cone and Redpath. I'll be brief here as I have to revisit some of these in more detail a bit later. But with respect to the rule republication that came out regarding 23 -- Chapters 23 and 25 Title 10A, there are number of categories of issues. But I would like to focus mostly on issues that impact the representatives of Medicaid applicants or recipients and the way in which the agency and the representative and the recipient or beneficiary or applicant interact.

The other sort of broad category of issues involves the extent to which rules line up with what I'll call generally due process considerations. Is there an opportunity, for example, in some rules to insert a provision that makes it more clear for the local -- the county DSS offices in the certain set of facts they need to issue a notice explaining the ordinary appeal rights, et cetera?

And then there are a number of just what I'll admit are fairly minor but potentially problematic ambiguities in a number of rules regarding the actual eligibility piece, for example, with respect to resources. A couple of just tweaks that have been made that at least in my estimation cause some potential for confusion or misinterpretation. There's perhaps one typographical error. And then there's an issue of DSS offices being held accountable for taking corrective action.

That rule is a bit more involved. But I will mention briefly the issues that I'm concerned are about are pieces of language in the proposed revised rule that could be used as -- or I guess I should say they might serve as a means for having DSS drag its feet, to be honest, in far too many instances.

And since I have a bit more time it appears, I will mention a few of the particulars of that rule. It is discussing when counties must correct their Medicaid eligibility determinations and decisions and processes after, for example, a decision comes back down from an appeal. Where an individual might appeal the denial of the eligibility benefits and then a state Hearing Officer might issue a decision saying, no, you must process it in accordance with X regulation, et cetera.

The rule is designed and properly so to prompt DSS to go ahead and take appropriate action once that type of thing happens. However, there is a good cause provision, and I love good cause, don't get me wrong. I like for it to be extended to me. But there's a good cause provision in Paragraph B of that rule that is -- has been problematic. And this is not so much a problem with how it's been modified in the published document that came out earlier this month but rather that it's been worded for a long time. Basically, the county is given an opportunity to slow the process down if for example, it claims it's unable to locate the applicant.

There are many situations in which DSS should have no reason to locate an applicant after a hearing decision comes down. Because all of the factual questions have been resolved. For example, a Hearing Officer might say, no, this is the appropriate analysis of the resources. This is the appropriate analysis of income. Yes, in fact, there was a child in the home. And that's that. And now process and approve this person on Medicaid. The DSS office has in some instances looked at Subparagraph 2 of Paragraph B and said, well, we're unable to locate the applicant, which may, in fact, be true. They might have moved away or just disappeared. Many folks are transients or homeless and they can't be located conveniently or easily. And things like this need to be addressed I would say in looking at this rule again so that the intent of making the agency at the local level move the ball forward is actually effectuated and not frustrated perhaps unintentionally so hopefully we can address more of those items in more detail. Thank you.

(6) Matt Wolfe, Parker Poe

This public hearing process is allowing me to live out my fantasy of being an Olympic gymnast by competing in multiple events. I feel like the first chat was my vault. And now this is my floor routine because I have a full ten minutes to perform.

>> Do you want some music?

[CHUCKLES].

>> Yes. Only if you sing, Sandy. Only if you sing.

[CHUCKLES].

>> I want to begin with sort of an observation here, which is that obviously everyone that has spoken on this rule is in opposition to the rule and has some concerns with it. Now, of course, this is not a democratic process in that there's not votes taken. And it's entirely possible that there are folks or interests that are supportive of this rule. But they are not here today. And they have not spoken out in favor of it.

And it strikes me as good public policy not only that we try to form consensus but also that we have a better understanding of why a rule, such as the definition of abuse 22F .0301 may be defended or may be supported. And I am not the person to do that today. And I'm not going to attempt to defend the rule. But I am going to try to sort of go behind the curtain a little bit and understand what -- what the rule is set out to accomplish.

And it is, as I said before, designed to try to make clear to providers and to the Medicaid program and its Federal partner the Centers for Medicare & Medicaid services and other folks who come down from the Federal Government to visit us, like the Office of Inspector General, what it is that providers are required today and what it is that providers are not permitted to do.

And I don't think we're going to find a provider in the state or certainly not a provider I represent that dismisses the idea that there being certain things that cannot be done or there should not be any consequences when lines are crossed. But a good rule, a rule that meets the requirements of the APA and a rule that's effective is one that creates clear standards.

Now, I'm an attorney that spends a tremendous amount of time in the Medicaid space. I spend a significant amount of time in the Program Integrity space. And I've spent a lot of time with this rule and all of its iterations and every time I visit it, I identify another issue, another area of ambiguity, another issue where I am concerned that there's going to be a difference of opinions between folks like Mr. Cochran and myself and folks at the Attorney General's Office representing the agency. Or hearing officers like you all. Or the Administrative Law Judge. And it's all well and good for us to have those discussions and those debates. But that doesn't help the beneficiary. It certainly doesn't help the Medicaid program. And so, I would strongly prefer a rule that is clearer so that way we can have -- we'll still have those debates, we'll still have those arguments. But we'll have less of those.

Because the rule will be clear about what is permissible and not permissible.

Now, I talked a little bit about the Program Integrity and what it's important to Medicaid and to all of the stakeholders. But I think it's also important to emphasize what the consequences are when a provider is alleged to have engaged in program abuse. A lot of the focus is on the fact that program abuse can be a basis for seeking recoupment of funds or improper payments by the Office of Compliance and Program Integrity or one of its contractors.

But program abuse can also be the basis of a provider's participation in Medicaid being suspended. In fact, program abuse can be the basis for providers' participation in the Medicaid program being terminated. Involuntarily. Meaning that they can no longer serve Medicaid beneficiaries.

And that is not something to be taken lightly. Now, I often hear, and appreciate the fact, that our current members of the Office of Compliance and Program Integrity would never intend to do that for a simple claim denial or for a situation where they may not have updated an email correctly. But the fact remains that we would give -- in this current definition of abuse, we would give not just the Division of Health Benefits Office of compliance and Program Integrity that discretion, but we also would give their contractors and agents that kind of discretion.

And we don't just give it to the folks who are currently there who I know well and work with and think very highly of. But we give it to all future employees and contractors and agents of the Division of Health Benefits.

And that kind of discretion cannot serve any type of public policy. What it can do and will do is lead to lots of arguments among lawyers and other -- others involved in the appeal process. And it will lead to a lot of regulatory uncertainty.

Which for providers who are focused on and trying to deliver quality of care cost effective care to Medicaid beneficiaries is not just hand wringing, it's costs. It's additional costs.

And just as an example of one of those costs, under the Affordable Care Act there's something that's known as the 60-day rule. Which requires that providers that receive any type of Federal healthcare payments, so primarily Medicare or Medicaid, that they have an obligation to report and return any overpayments within 60 days of identification. And there have been a tremendous amount of rulemaking at the Federal level for this.

There's been some litigation, not on the Medicaid Part B side but on some of the other parts of

Medicaid, which are not germane to this discussion. But I raise that because it is an incredibly important and very complex consideration. When you create this affirmative obligation to providers to report and return overpayments within 60 days of identification.

This particular rule doesn't mirror that. It actually has the time that you have to return an overpayment. And then it creates a new term that Mr. Horton referenced which is no longer identification which would dovetail to the Federal standard but instead talks about discovery. Which is not a defined term. And again, creates all sorts of uncertainty.

What that means then for a hospital or a nursing home or anybody else is that they would have to comply with -- not just a higher standard. But a different standard for Medicaid payments than they would for any of the other types of payments that they may receive, including Medicare.

The consequences of a provider being told that they have committed program abuse don't just end with what Medicaid or what the Division of Health Benefits can do to a provider. Those almost always invariably also create other collateral consequences to the provider. So, if a provider is involuntarily terminated from Medicaid, that always requires reporting obligations and often can have a domino effect to others. But even if it's something short of termination, which is the most serious consequence from a Program Integrity perspective, even if it is just a recoupment or a warning letter, as 22F permits, oftentimes those actions also require reporting. And failure to report to the various entities involved, whether that be managed care plans, whether that be Medicaid or Medicaid advantage plans, can have consequences in and of itself.

So again, that goes back to the concern that this doesn't just create uncertainty. It also creates a regulatory burden that providers have to pay for. And providers already have a tremendous amount on their plate to -- in order to allow them to serve Medicaid beneficiaries. And as we move forward with Medicaid transformation, they are going to have significant additional considerations and additional costs to ensure that they comply with the standard plans and the tailored plans, and all of the MCOs in between. And creating not only more uncertainty but more burden just increases those costs to them.

The following consequence, though, to the current definition of abuse is one that isn't necessarily going to be felt by providers or is directly felt by providers. It is a consequence that's going to be felt by the Medicaid program itself. Which means that it will be felt by providers and beneficiaries.

Our Medicaid program as I think everybody in this room knows is primarily paid for by Federal funds. The Federal Government then has an obligation and takes very seriously its obligation to monitor the state's use of those Federal funds in its operation of the Medicaid program. And it does this through a variety of different processes.

The one way in which they do it is through the Office of Inspector General, which sits at the U.S. Department of Health and Human Services. This is not a theoretical concern. This is an issue that the state of North Carolina has faced in the past. And many of its sister states faced as recently as this month. Is that the Office of Inspector General comes down to the state and they expect that the state will meet what it says what it's going to do. Not just in the state plan. But also, in the state Medicaid regulations.

And so, by creating this unclear and broader definition of abuse, my biggest concern is not just that it hurts providers. My biggest concern is that it has the state biting off more than it can chew. Which means that the state exposes itself to significant risk with the Federal Government. And this is a significant risk that I don't want us to have -- to be talking about several years from now. And it's a risk at minimum that should require fiscal analysis. And should require a serious look at whether the Division of Health Benefits Office of Compliance and Program Integrity has the resources to actually carry out these additional responsibilities that they would be responsible for if 22F .0301 became regulation. Thank you.

3. Adjournment

The hearing was recessed at 2:05 p.m. to allow additional members of the public to attend. The hearing was resumed and recessed at 2:32 p.m. The public hearing was resumed a final time and adjourned at 3:00 p.m. The North Carolina Department of Health and Human Services, Division of Health Benefits will take all comments received into consideration.