DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

DAVE RICHARD
DEPUTY SECRETARY FOR MEDICAL ASSISTANCE

Minutes of Rulemaking Public Hearing
January 24, 2018, 1pm-3pm

Staff Present
Dave Richard, Deputy Secretary for DMA
Sandra Terrell, DMA Director of Clinical and Operations
Virginia Niehaus, DMA Rulemaking Coordinator
Patrick Piggott, DMA Office of Compliance and Program Integrity
Pamela Beatty, DMA Policy and Regulatory Affairs
Ben Popkin, DMA Policy and Regulatory Affairs
Lymari Rentas-Gonzalez, DMA Provider Audit
Lavette Young, DMA Hearing Office
Tabitha Bryant, DHB Rulemaking Coordinator
Lynette Harris, Medicaid Communications
Badia Henderson, Medicaid Communications
Connie Hutchinson, Sign Language Interpreter
Sarah Ferguson, Sign Language Interpreter

Members of the Public Present
Pam Perry, Carolina Complete Health
Brandon Leebrick, Ott Cone & Redpath PA
Elizabeth Runyon, Wyrick Robbins
Mike Vicario, NC Healthcare Association
Shawn Parker, Smith Anderson
Kristen Spaduzzi, NC Medical Society

1. Purpose of Hearing

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 Medical Assistance's proposed readoption, amendment, or repeal of 90 rules in 10A Chapters 21 and 22 published in the North Carolina Register on January 2, 2018 as well as the fiscal notes for these rules.

2. Hearing Summary and Transcript of Comments

The public hearing was opened by Dave Richard and Virginia Niehaus at 1:00 p.m. There were 6 members of the public present for the hearing. Two oral comments were recorded. Each speaker was limited to six minutes. The following is a transcript of these two public comments:

(a) Brandon Leebrick, Ott Cone & Redpath

Brandon Leebrick with Ott Cone & Redpath out of Greensboro. Here on behalf of a number of hospitals and health systems throughout the State, including Vidant Health, Duke University Health Systems, WakeMed, Cone Health, Carolina's Healthcare System, Mission Health, Wake Forest Baptist Health, and others who serve a disproportionate share of indigent patients who are applying or seeking Medicaid benefits. Also, who provide Medicaid services that are subject to some of these rules.

First, I appreciate the scope that was involved in this rulemaking process and review process. There certainly are a lot of rules. With, and with so many rules being impacted or impacting the clients, and the patients my clients serve, I just want to give some general comments. Some of which may be more questions as well, but I wanted to make some comments. If you don't mind, I may ask for six minutes, if that is ok, and hopefully I won't need that amount of time.

The first comment regarding the proposed rules and the changes is a more procedural one, general in nature. Looking at the preamble, for example, there are a number of rules noted as readopted with substantive changes that within the text don't have that notation. There is some language early in the preamble indicating that, if the text is not included, that it is indication that it is repealed. One example is 10A NCAC 21B .0311, Register page 1259. There are a few others that have a similar procedural nature. Just some clarity there I think would be helpful just to make sure of what the intention is by DHHS there.

The next area I want to comment on, maybe in a little more detail because there were some substantive changes proposed, is 10A NCAC 21A .0303, Medicaid appeals. As mentioned, the hospitals I work with they represent and assist many applicants for Medicaid and oftentimes our law firm is involved with some of those cases. The proposed changes with regards to that rule, we think raise a few legal concerns, but also a number of practical considerations. First, the legal issue really stems from subsection (f). The statute this rule is based off is 108A-79. In subsection (j), it indicates that written and oral arguments can be made on appeal. Looking at the proposed changes, it suggests that only written or oral arguments can now be made. I think some clarity there would be helpful to make sure it is consistent with that state statute. With the timing, 10 days, which has been there previously, there are some changes that appear with regards to the process. From a practical standpoint, for a number of the patients that the hospitals serve, it is unworkable to be expected that a written argument, for example, be submitted within 10 days. As currently written the request could be made within 10 days for that chief hearing officer review. If it's required that a written argument be made within the 10 days, we think a number of indigent individuals throughout the state would have difficulty timely requesting and submitting relevant argument. Many individuals don't receive notice of the state hearing officer decision within 10 days, if they're in a rural location, and it can be difficult for them to obtain counsel or assistance, if they desire to have assistance. With regards to the timing, we would ask the agency to consider making some changes there, and again we will submit written comments with some further details there. Additionally, some other language there with the extension process with "good cause" appears to be undefined, and so we would ask for clarity with regards to "good cause" for appeal beyond the 10-day timeframe under that rule.

The next significant area that I wanted to just point out, and we think there are several, but just we have some examples, we believe there are some existing regulations that are not being proposed to be amended or modified that we think should be brought in line with state statute or federal law regulation. Two that come to mind and that we wanted to point out here, 10A NCAC 22F .0601, the recoupment provision.

The state statute allows up to 24 months for recoupment to be made, whereas the proposed or the current state regulation is one year. Another example is 10A NCAC 22C .0102, Medically Needy, there are some additional references to the Social Security Act that we think should be incorporated. We would ask that the agency look closely at some of the provisions and will be providing some comments to argue those.

And the last general comment I wanted to point out, we have some concerns with at least 2 instances of incorporation by reference, one is in 10A NCAC 22F .0202, references "policy" and we believe that reference doesn't really fit within the APA standards. And the last is regarding 10A NCAC 22K .0102, incorporates policy manual. Policy and the policy manual both are not subject to the rulemaking provisions and, therefore, don't have traditional public comment, so we ask that those be modified.

That's all, thank you.

(b) Elizabeth Runyon, Wyrick Robbins

I am Elizabeth Runyon. I am with Wyrick Robbins Law firm here in Raleigh. I wanted to offer my comments on the proposed amendment to 10A NCAC 22L .0201, which is the program definition under prepaid plans.

There is a proposed amendment to change the text to read that the division may contract with federally qualified health maintenance organizations, HMOs, and state licensed and certified HMOs to provide and coordinate medical services for Medicaid eligibles. It goes on to say that prior to the division awarding a contract to an HMO, the HMO shall demonstrate ability to meet qualifications set forth in the Medicaid provider administrative participation agreement. Really, two comments I wanted to offer. The first is that, while this rule appears to authorize Medicaid to contract with the HMOs, I think there might an inconsistency here or potentially a conflict with the insurance statute regarding HMOs, that is chapter 58-67-10. According to the HMO statute, the HMO articles do not apply to any prepaid health service or capitation arrangement implemented. I think this raises a big question of the potential conflict between the statute authorizing HMOs and the proposed rule, which appears to expressly authorize DMA to contract with HMOs for capitated services. I wanted to bring that to your attention and ask that be carefully considered as to that conflict. And then as to the second portion of the proposed rule, that an HMO demonstrate compliance with the Medicaid provider administrative participation agreement. The provider participation agreement is very specific to providers. It obviously has a lot of provisions that I think certainly apply to providers, talking about the submission of claims, billing, things that are specific to providers, that probably would not make sense for an HMO to be expressly agreeing to. Whether it is an adjustment that the substance needs to be the same, or just some recognition that an HMO would not be necessarily agreeing to all the same substantive provisions that a provider, a direct provider of the services would be.

Those are all my comments, thank you very much.

3. Adjournment

The hearing was recessed at 1:19 p.m. to allow additional members of the public to attend and comment. The hearing was resumed and recessed 3 additional times at 1:45 p.m., 2:07 p.m., and 2:30 p.m., but no additional members of the public wished to speak. 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 Medical Assistance will take all comments received into consideration.