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MEMORANDUM

TO: Medicaid Providers

FROM: Curtis B. Venable

DATE: July 26, 2011

RE: Passage of Legislation Effecting Medicaid Providers, Implementing Requirements of Affordable Care Act and Limiting Medical Policy

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The General Assembly during the 2011 session passed a major piece of legislation (Senate Bill 496, Session Law 2011-399) which substantially changes the relationship between Medicaid providers and the N.C. Department of Health and Human Services. The legislation initially came about to address several of the Department's needs to codify existing authority for such items as payment suspension and pre-payment reviews, and to enact requirements of the federal Affordable Care Act. Late in 2010, the Department worked with a limited number of providers within the context of a work group convened by the North Carolina Institute of Medicine. In the Institute of Medicine discussions, the Department unveiled legislation that did a great deal more than simply implement the requirements of the Affordable Care Act. Many of the proposed provisions would have further limited the due process rights and remedies of North Carolina's Medicaid providers and would have granted even more general authority to the Department. These concepts were introduced into the legislative arena through the Governor's proposed budget in Senate Bill 500.

With the introduction of these provisions that were, on the whole, harmful to the interest of providers, a provider work group composed of the North Carolina Hospital Association, the North Carolina Medical Society, the North Carolina Providers Council, the North Carolina Health Care Facility Association and the Developmental Disabilities Facilities Association was assembled to attempt to craft and guide legislation that would, on one hand, afford the Department the authority it needed to appropriately manage the Medicaid budget and ensure the removal of fraud in Medicaid providers and, on the other, allow Medicaid providers to operate their businesses without undue and unnecessary burdens and to allow for reasonable due process.

The product of this effort was Senate Bill 496, introduced by Senator Louis Pate and co-

sponsored by House member Nelson Dollar. Senate Bill 496 (now noted as Session Law 2011-399) created a new chapter of the General Statutes (108C) and made modifications to the Department's authority with respect to rule making and the issuing of medical policy (in 108A-54.2).

The following is a review of sections of the new chapter 108C:

108C-1 Scope:

This section delineates that the chapter applies to Medicaid and Health Choice providers. Of importance is what it does not contain. The original proposed by the Department explicitly eliminated any liberty or property interest on behalf of providers. It also stated that the Department had sovereign immunity from claims by providers. Both such provisions were removed. The removal was to make clear that Medicaid providers do have rights and due process protections by the new chapter.

This section is effective upon enactment (July 25, 2011).

108C-2 Definitions:

The definition section contains comprehensive definitions used throughout the chapter. The definitions are key to ensuring that providers are accorded reasonable due process with respect to claims made by the Department.

In paragraph (3) "Department" is defined so as to encompass not only the actions of the Department, but also its various vendors and contractors such as CCME and PCG. Services and products delivered within Medicaid waivers are also included. As the Department moves toward more outsourcing and waivers, such language is critical.

In paragraph (5) defines "final agency overpayment, assessment or fine" so as to make clear that before the Department can move against a provider to recoup funds, the Department must prove the validity of its claims. The definition specifically references the conclusion of appeals. Thus, it is only after the Department has demonstrated that funds are owed, that funds can be withheld.

This section is effective upon enactment (July 25, 2011).

108C-3 Medicaid and Health Choice Providers Screening:

This section is one of three required by the Affordable Care Act. As a result, almost all of the language derived from federal rules. Federal law and regulation requires that states assign risk levels for various provider classes largely based upon the classifications laid out by Medicare. The state is given the option of assigning a provider class to a higher (and thus more burdensome) risk classification. For instance, hospitals and doctors are placed at the lowest or "limited" level of risk. Pharmacy services and dentists as well as critical access behavioral health agencies are placed in the mid-range or "moderate" risk level. Finally, various types of new providers, such as newly enrolling home health or critical access behavioral health service providers as well as providers who have had various sanctions applied against them are placed in the highest and most burdensome risk level of "high."

In the Department's version of legislation, the effects of the various risk levels were left open

for the Department later to define in rules. The legislation connects the screening requirements to those screening requirements listed in federal law.

This section is effective upon enactment (July 25, 2011).

108C-4 Criminal History Record Checks:

This is the second section required by the Affordable Care Act. Beyond the federal requirements in paragraph C, it makes clear that individuals convicted of a long list of various crimes can be denied enrollment in the Medicaid or Health Choice programs.

This section is effective upon enactment (July 25, 2011).

108C-5 Payment Suspension and Audits Using Extrapolation:

For many providers, this is the most important of all the provisions passed. Previous Departmental authority gave the Department authority to suspend Medicaid payments at the initial determination of any overpayment. While unwritten Departmental policy allowed for the payment to be collected after the Department's informal reconsideration review process, this put providers in the situation of being forced to pay disputed funds prior to any real due process being granted. The enactment of 108C-5 ensures that there are ample protections for providers relative to both payment suspensions and the audit processes used by the Department, particularly extrapolation audits.

108C-5 can be divided into two parts. Paragraphs (a) through (h) constitute the provisions addressing payments suspension. Paragraphs (i) through (s) concern audits, particularly extrapolation audits. The paragraphs addressing payment suspensions layout how the Department is to collect overpayments, assessments and fines. The Department is provided with the authority to act upon the demonstration of proof that the provider actually owes the sum in question. Of key importance is the implementation of due process to protect providers from unjustified claims on the part of the Department.

In paragraph (e), language was added at the request of the Department so as to allow for the possibility of an offset where a provider owes a debt to another state agency. But the language was carefully drafted so as to give the Department the authority to not put in place the offset if it would harm the provider. Paragraph (f) contains language added at the request of the Department to make clear the Department's authority to allow claims to be chased to affiliate companies that share the same employer identification number. The provision makes clear that prior to going to a common IRS Identification number, there needs to be notice to the affiliated corporation so as to avoid a surprising grab of a check write.

The sections concerning audits and extrapolation audits were the source of a great deal of negotiation and debate between the provider work group and the Department and the Attorney General's office. The key paragraph (i) makes clear that before the Department can subject a provider to an extrapolation audit, the Department must demonstrate that the provider "failed to substantially comply with the requirements of state or federal law or regulation…." Many parties expressed concern with the fuzzy/vague notion of "substantially comply." But the challenge was never met to come up with other language that would make clear the legislation intent to move away from the current policy of the Department which requires providers to show perfection to avoid the penalty of extrapolation.

During discussions with the Department, the Department proposed to utilize language from the Medicare Act to define the standard for when extrapolation would arise. This proposed language would have permitted extrapolation in cases of "high levels of payment error." This language was ultimately rejected as it failed to define how one determined "payment error." In short, it was simply the status quo, but with a different label. Thus, the language of "substantially comply" remained.

The other sections addressing extrapolation audits and audits generally tried to ensure that providers were made aware of just what was being examined in such extrapolation audits. Paragraph (k) requires the Department to inform the provider at the start of the extrapolation audit of just what was the subject of the audit. The legislation aims to ensure that there is clarity with respect to document requests so as to ensure that the provider provides the correct information as early as possible. This would hopefully ensure that the audit process was as short and economical as possible.

Another provision requires broader notice to all providers. Paragraph (r) requires that the Department shall, at least annually, inform all Medicaid providers of the targets of extrapolation audits. The requirement would put providers on notice as to the particular services and audit elements that were to be reviewed. Again, allowing providers some advance notice of what could be coming their way so as to allow the effected provider groups to make provisions for the upcoming audits.

There is a long section laying out how providers can challenge the proposed results of an extrapolation audit. The provisions in paragraph (n) allow the providers to produce a 100% file review or, alternatively, to request a second extrapolated random sample for review as well. In both instances, the Department is afforded some protection that the self-audits conducted by the provider are of sufficient quality by allowing the Department to reject them in certain circumstances.

Paragraph (m) allows providers to engage in routine self-audits so as to ensure that the provider's compliance programs are operating properly and also to give the Department a measure of confidence that providers are returning funds that should not be retained. Providers conducting these self-audits are accorded some level of protection by the provision.

This section is effective upon enactment (July 25, 2011) but applies to audits instituted on or after that date and to final overpayments, assessments, or fines due on or after that date

108C-6 Agents, Clearing Houses, and Alternative Payees; Registration Required:

This is the third section required by the Affordable Care Act. This was not a responsibility that the Department sought. There will eventually be put in place requirements for the registration of these alternative payees.

This section is effective January 1, 2012.

108C-7 Prepayment Reviews:

This section codifies existing authority for the Department to manage claims from error-prone providers. This section aids the Department in either educating providers as to clean billing or to remove such providers from the Medicaid program. The provisions of 108C-7 make clear how a provider can fall into prepayment reviews and provides the standard of how a provider will later leave

the prepayment reviews. Effectively, the provider has to have three consecutive months of a 70% clean claims admission.

The provision makes clear that if a provider is subjected to prepayment review, there is no appeal of this determination by the Department. The rationale behind this was that prepayment review was simply part of the claims adjudication process. It did not directly affect the provider's interest and, thus, no appeal rights were necessary.

This section is effective upon enactment (July 25, 2011).

108C-8 Threshold Recovery:

A simple section requested by the Department. Federal law and the Department's Controller's Office required DMA to chase all overpayments no matter how small. The agency wanted authority to ignore *de minimus* claims, defined as those less than $150.

This section is effective upon enactment (July 25, 2011).

108C-9 Enrollment Criteria:

Originally, the Department's versions of the statute put in place requirements upon all Medicaid providers new and re-enrolling. In the end, the focus was placed on newly-enrolling providers. The Department was granted authority to require new providers to demonstrate a minimal level of competency in terms of billing and business acumen. The section allows for the Department to put in place new provider training programs and to recover the cost of these training programs.

This section is effective upon enactment (July 25, 2011).

108C-10 Changes in Ownership and Successor Liability:

This section makes clear that the Medicaid provider must notify the Department prior to specifically defined acts that constitute a change in ownership. Of key importance, the simple merger of related corporations does not require notice. In instances where a purchasing provider wishes to take assignment of the selling provider's Medicaid number, the statute makes clear that the purchasing provider take subject to the seller's various Medicaid fines, assessments and overpayments. But it is important to note that there is no requirement to take assignment of such debts.

The Department's version of this legislation contained language that effectively mandated purchasers of Medicaid providers to also take the seller's Medicaid debt. The language in paragraph (d) makes clear that the Department cannot mandate the acceptance of the seller's debt as a condition of participation in the program.

This section is effective upon enactment (July 25, 2011).

108C-11 Cooperation with Investigations and Audits:

This section makes clear to all Medicaid providers of the obligation that exists in both law and the provider agreement that there must be cooperation with the Department. The language used tracks

existing federal language and the Medicaid provider agreement. Paragraph (b) assist providers by making it clear that documentation examinations should occur without interfering with clinical activities of the provider.

This is another instance where what was omitted is as important than what was included. The Department originally proposed a $500 fine for the failure to cooperate with investigations or audits. Due to the poorly-defined nature of the possible fine, the provision was not included in the final version of the statute.

This section is effective upon enactment (July 25, 2011).

108C-12 Provider Appeals:

One of the fundamental problems for all Medicaid providers is the lack of any defined appeal process. Federal courts and the federal Centers for Medicare and Medicaid Services make clear that there is no basic federal right for Medicaid providers (in contrast to recipients) to have due process. Thus, the inclusion of these provisions is of vital importance to providers. While one would hope that it would not be subject to challenge that Medicaid providers do have appeal rights under North Carolina's Administrative Procedures Act, the Department made proposals to move Medicaid provider appeals outside of the Office of Administrative Hearings and into their own captive hearings unit.

The provisions of 108C-12 offer a clear balance between the Department and providers. One provision ensures that provider appeals occur in a fairly expeditious 180 days (subject to delays if caused by the Department). On the other, the statute in paragraph (d) makes clear that as the Department generally is acting in an prosecutorial role towards providers, it should carry the burden of proof when acting against providers.

This section is effective upon enactment (July 25, 2011).

DMA Policymaking:

Sections 4 and 5 of Senate Bill 496, Session Law 2011-399 concern the rule making requirements for the Department with respect to Medicaid services. The most important change affects the Department's authority to issue medical policy, found in 108A-54.2.

As originally envisioned, 108A-54.2 would allow the Department authority to issue policies with respect to Medicaid services by a simplified process outside of the Administrative Procedures Act rule making requirements. The focus was to be on medical matters. The notion was that medical treatment procedures and technology move at such a quick pace today, the Department would be constantly hamstrung if it had to go through the rule making process.

The problems that arose after the codification of 108A-54.2 in 2006 were that the Department often times used this authority to issue policies well outside of clinical matters. The specific change to the statute lay out just what constitutes an appropriate "medical coverage policy." The items falling within the definition allow the Department to continue to be able to act quickly to address any number of medical matters. Further, the language allows the initiatives undertaken by the Community Care of North Carolina networks to move forward by clearly including clinical outcomes and clinical support treatment practices.

For the items that fall outside of the definition, the Department must engage in traditional rule making. This ensures that the non-medical policy items are subject to public notice, comment and, if necessary, legislative oversight. The importance of the requirement that the agency move non-medical policy through rule making is to ensure that there is some level of stability to agency policy. This will permit providers a level of confidence in the stability of policy in developing business models.

To aid the Department with this statutory change, it was permitted that the statute change is effective January 1, 2012 and then applies to any new medical policies or changes to existing policies. Thus, to the extent the Department wishes to allow existing policy to stand, no additional rule making requirements arise. But to the extent existing policy is changed, then the rule making requirements would apply.

CBV/ngh