

Rule Analysis

Fiscal Impacts of Proposed Amendments

10A NCAC, Chapter 45 – General Procedures for Public Health Programs, Subchapter 45A – Payment Programs and 10A NCAC 43H .0111 Medical Services Covered (Sickle Cell Syndrome program)

Commission for Public Health

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Impact Summary:

State government: Yes
Local government: No
Federal government: No
Private entities: Yes
Substantial: No

Authorizing Statutes: 130A-5(3); 130A-124; 130A-127; 130A-129, 130A-205; 150B-21.2(b);SL2007-323; Public Law 108-446; 34 CFR Part 303.520(a);.

I. Purpose of Programs:

Purchase of Medical Care Services System

The public health payment programs pay for healthcare services for selected conditions on a fee-for-service basis. These programs receive state appropriations each biennium to provide the services to North Carolina residents who meet specific financial eligibility requirements. The appropriations fill a funding gap for residents who do not qualify for Medicaid, for those who have reached Medicaid payment limitations, or who otherwise do not have private insurance. In addition to the state appropriations, some programs, such the Aids Drug Assistance Program (ADAP), also receive federal funding.

Reimbursements for services are authorized by the Purchase of Medical Care Services (POMCS) unit within the Division of Public Health (DPH). Currently, providers submit paper claims for the authorized services provided, and the claims are processed and paid by the DHHS Office of the Controller. Both authorizations and claims are processed manually using an internally developed legacy payment system, also called POMCS.

North Carolina Sickle Cell Syndrome Program

The North Carolina Sickle Cell Syndrome Program was established in 1973. The program offers comprehensive services for individuals affected by sickle cell disease – and their families – as well as education and genetic counseling for the general public.

North Carolina Sickle Cell Syndrome Program is committed to providing quality care and services through its system of Regional Sickle Cell Educator/Counselors, comprehensive medical centers and community-based organizations. The program works closely with the governor’s appointed Council on Sickle Cell Syndrome to address the changing needs and issues of the sickle cell community. The mission of the program is to promote the health and well-being of persons with sickle cell disease through the reduction of morbidity and mortality and the heightened awareness of the disease and its complications. As part of its mission, the program provides financial assistance from state appropriated funds that reimburse medical providers for defined services for eligible

Part C of IDEA

The Early Intervention Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, from birth through age 2 years, and their families. This program contracts with private providers to deliver authorized services to the program participants. The POMC system processes healthcare claims and remits payments to private providers for these services.

II. Reasons for Rule Changes:

In general, the DPH APA rules for POMCS payment programs were originally adopted in 1981 and need to be modified so that programs no longer in effect are removed. The payment programs no longer in effect have been proposed for repeal. References to these programs have been deleted in the proposed amendments to the rules for the payment programs.

The following are no longer included in the public health payments programs:

- ~~(a) Children's Special Health Services,~~
- ~~(b) Cancer Program,~~
- ~~(c) Kidney Program,~~
- ~~(d) Maternal and Child Health Program,~~
- ~~(e) Migrant Health Program,~~
- ~~(f) School Health Fund,~~
- ~~(i) Adult Cystic Fibrosis Program.~~

The payment functionality of the POMCS system will be automated early in the 3rd quarter of 2013, when the payment programs are incorporated into the new NC Medicaid Management Information System (MMIS), called NC Tracks, which includes multi-payer claims processing functions. The NC Tracks will process claims for Medicaid, mental health payment programs, the public health payment programs, and the Office of Rural Health and Community Care programs. This new system will provide claims processing functionality that was not available in the POMCS system

Since their adoption in 1982, the payment program rules have used Medicaid reimbursement rates as the basis for paying for services covered under the public health payment programs.

Administratively, the Medicaid business rules within the NC Tracks system can now be applied to the public health payment program, thus eliminating duplication of effort and maintenance of separate processing requirements for different types of healthcare claims. Currently, POMCS staff has access to Medicaid program rules and clinical policies, which they manually check to ensure

that requested services meet coverage policies. While current data does not exist regarding potential time savings to be realized by automating business rules, the potential exists to provide quicker authorizations for healthcare, more timely processing of claims, and improved services to all stakeholders, including healthcare providers and patients.

See Appendix A for a summary of the operational benefits and potential administrative cost avoidance benefits to be realized by incorporating the payment programs into the NC Tracks multi-payer system.

Any reduction in the opportunity costs of staff time (i.e., reduced time spent processing paper claims) is unlikely to translate into a reduction in direct staff costs because of an expected availability in staff time that can be applied to processing authorizations for other programs, such as the Aids Drug Assistance Program.

Further, since the payment programs do not include a large-enough pool of insured, nor do they have underwriters available to address the nuances and complexities of rate setting, the program has adopted Medicaid as the basis for reimbursement because Medicaid has set the standard for provider payments from public healthcare programs in North Carolina. NC Session Law 2007-323 established that “Providers of medical services under the various State programs, other than Medicaid, offering medical care to citizens of the State shall be reimbursed at rates no more than those under the North Carolina Medical Assistance Program.”

When NC Tracks is implemented and starts paying both Medicaid and DPH claims, the claims will be priced and paid consistently at the same rate of reimbursement. The following proposed rule amendments reflect the change to Medicaid pricing:

- 10A 45A.0401
- 10A 45A.403

Under the proposed rule changes, public health payment programs use will the Medicaid clinical pricing as the basis to set their reimbursement rates for the services for which the program pays. Basing reimbursement rates on Medicaid clinical pricing aligns with the public health payment rule that apply to many other types of covered services, which limit DPH payment program rates to no more than Medicaid reimbursement rates for the covered service (10A NCAC 45A .0403).

Healthcare providers will likely benefit from consistent payment rules and amounts based on Medicaid rates and policies, as the payments will align with the services provided to their Medicaid patients. This consistency may reduce providers’ administrative burden by eliminating duplicative accounting costs and potentially improving cash-flow projections.

Section III provides a summary of the impact of the proposed rules. Sections IV – VII explain in more detail the specific proposed rule amendments.

III. Impact Summary

The following table provides a summary of the quantifiable estimated annual economic impacts to the stakeholders affected by the proposed rule amendments:

Rule	State	Local	Private Sector	Clients
Pharmacy Claims	+\$38,000	0	+\$28,000 (pharmacies) -\$61,350 (insurers)	-\$4,650 (insurance co-pay)
Inpatient Reimbursement rate*	+\$23,000	0	-\$23,000 (hospitals)	0
Net Cost/Benefit	+\$61,000	0	-\$56,350	-\$4,650
Total Impact (Costs + Benefits)	\$61,000	0	\$112,350	\$4,650

* Note that the impact of changing the inpatient reimbursement to DRG pricing does not reflect any impact due to the change from a 7-day limit on reimbursable admissions to a two-admission limit.

Impact on State Government

Quantified Benefits: The ability to bill third-party payers for pharmacy claims (see proposed amendment to rule 10A NCAC 45A .0302) has the potential to reduce state government costs by approximately \$38,000 annually, which is based on the average dollar value the program paid for the past two fiscal years.

This figure does not include those clients covered by Medicaid since those claims are rejected by POMCS and referred back to the pharmacies to bill Medicaid directly. The rule change will not affect Medicaid pharmacy payments.

Unquantified Benefits: Reduced staff time to authorize services and consistent reimbursement rates and rules with providers who also service Medicaid clients. Due to inadequate data on processing times for authorizations under the current POMCS system, DPH cannot quantify the potential savings associated with the expected reduction in staff time spent authorizing services.

Impact on Local Governments:

There is no impact to local governments from this proposed rule amendment.

Impact on Private Entities

Costs: The proposed rule change requiring pharmacies to bill insurance before POMCS will have an impact on insurance companies providing coverage to residents receiving sickle cell services. The impact is estimated at approximately \$66,000, before considering client co-payments, annually across all private insurers based on the assumption that insurers would pay at 70% of the average amount billed in 2011/12 for the 19% of those claims that were reimbursed for NC residents where it was indicated that they had private insurance.¹

¹ The POMCS paid-claims file contains a field where staff indicate whether the client has third-party insurance other than Medicaid. The relevant field in the claims file is not subject to subsequent verification and, therefore, may include errors. However, this is the best data available upon which to base estimated impacts.

POMCS clients with private insurance may also be affected by the proposed rule change if clients' insurance plans have co-pay obligations for their prescription benefits. The co-pay impact for individual clients could range from a low of \$10 to \$20 per prescription for generic drugs to much higher co-pays for specialty drugs, depending on the type of benefits plan. Staff has estimated potential per client annual total impact of approximately \$174 based on a \$15 co-pay. For those clients with higher co-pay, the potential per client annual impact is estimated at \$580 based on a \$50 co-payment. These co-payment estimates are relevant to a total of eight clients with third-party insurance during 2011/12. The estimated total client cost (\$4,650) is based on a \$50 co-payment for eight clients with private insurance and for 19% of the averaged total claims (i.e. 19% of the 488.5 average annual claims [93 claims] for, on average, eight clients with private insurance).

IV. Inpatient Rate of Reimbursement

The current reimbursement rate for inpatient hospitalizations is set at a seven-day maximum stay per patient per year. This rate was based on a formula negotiated with Medicaid that priced inpatient claims at a percentage of the provider's ratio of cost to charges (RCC). The RCC-based formula was aligned with the Medicaid policy at the time of the negotiation of paying inpatient care at a per diem rate. Medicaid later changed the reimbursement rates for inpatient care based on the diagnosis-related group pricing (DRGs); however, because of its technical limitations, the POMCS system could not be modified to the new per diem payment methodology.

Background: In the past when Medicaid paid for inpatient care at a per diem rate, DPH did the same. When Medicaid changed to diagnosis-related group (DRG) pricing, the POMCS application was unable to accommodate the system changes in a timely manner and therefore was unable to follow suit. Since Medicaid was no longer providing inpatient per diem rates, DPH obtained an administrative rule change in 1999 and began paying inpatient claims at a percentage of the RCC rate as is done for outpatient hospital care.

Change Needed: Staff proposes to amend 10 NCAC 45A .0402, Reimbursement for Inpatient Hospitalization, to pay claims base on Medicaid rates at the date of service and proposes to amend the Sickie Cell (SC) program rule 10 NCAC 43H .0101, Medical Services Covered, to reflect the payment program rule change.

Justification for rule change: When NC Tracks is implemented and starts paying both Medicaid and DPH claims, claims will be priced and paid consistently at the same rate of reimbursement as the payment programs set reimbursement rates to those in effect for Medicaid. The proposed rule change provides a benefit to the regulated community (i.e. healthcare providers) by consistently pricing claims across public-benefit healthcare reimbursement programs. Providers will be able to submit claims electronically, thus eliminating the labor-intensive, manual paper-based process. They will receive their reimbursements with a quicker turnaround time, contributing to improved cash flow for their organizations.

Fiscal Impact: The Sickie Cell program is the only public health payment program that reimburses for inpatient hospital stays.

The figures in Appendix B² show the reimbursements made for inpatient hospitalization from state fiscal years 2009 through 2012. Each claim represents one hospital admission. During these fiscal years, there were only four instances where a hospital submitted claims where a client experienced more than two hospital admissions in a single year. The claims in excess of two per client per year represented less than five percent of hospital admissions. Given the need to shift to DRG-based pricing, program staff estimates that capping reimbursement to two annual admissions per patient aligns within current and expected appropriations. Further, a sampling of hospital claims below show that on average, the switch to DRG-based pricing may result in a slight cost savings to the program. (See Appendix C.) The sampling shows a savings of approximately \$23,330 per year for a cluster of 36 hospital payments. The cost savings to the State, however, will be offset by any additional costs absorbed by other payers and by hospitals.

Staff is unable to determine the overall net impact on patients and providers of replacing the 7-day treatment cap with the two-admission cap for Sickle Cell inpatient care. Patients who require more than two inpatient admissions per year will no longer have additional admissions covered, but some patients who would have hit the seven-day cap prior to the completion of two full inpatient stays, under the proposed rules, will have all admissions covered.

Program records indicate that four clients had more than two admissions per year over a four-year period from fiscal year (FY) 2009 to FY 2012. Based on a straight-line average cost per stay of approximately \$5,685 (derived from Appendix C DRG rates), the total impact to hospitals from un-reimbursed stays that exceed 2 visits would be approximately \$5,685 per year (i.e. one uncovered admission per year). This is the amount that the public health payment program would have paid without the proposed rule change. Presumably, hospitals would include this amount under their indigent care cost if they cannot receive payment from other third parties or from the patients. For those hospitals treating patients beyond the two admissions, the hospitals customarily classify those patients as “self-pay.” Hospitals will bill these patients directly; however, based on the financial situations of most patients, the hospitals unlikely will be unable to collect any fees beyond a marginal amount. Hospitals typically will include these unpaid services as part of their indigent care.

Two hospitals providing regular care to Sickle Cell patients that staff contacted affirmed that they do indeed provide these services as indigent care; however, they could not provide any specific figures that break out the unpaid and un-reimbursed services provided to Sickle Cell patients.

Fiscal Impact on State Appropriations: Funding for the public health payment programs, including sickle cell syndrome, is appropriated by the General Assembly each biennium. The amount of funding is set at a maximum fixed amount, and each public health payment program provides reimbursements within this fixed budget either until the funds are either depleted or until the budget is adjusted downward and funds are reduced.

This proposed rule amendment will not affect state appropriations. NC DHHS has set the Sickle Cell program at the same amount, adjusted for inflation, since 2001 in order to provide the most services to the most eligible SC patients as possible. In 2001, the SC program provided unlimited

² Figures provided by NC DHHS Division of Information Resources from claims data extracted from POMCS legacy data system.

services for pharmaceuticals, hospital admissions, and emergency room visits. The program exceeded its budget, and DHHS was forced to close the program. SC staff and DHHS budget analysts reviewed expenditures for the covered services and determined that limitations must be placed on them in order to avoid exceeding the program's annual budget.

The need for services is difficult to predict in any given year, as this need fluctuates each year based on the changing needs of the client population. The program has taken a conservative approach to ensure that it can continue to operate within its annual budget. Program staff looked at average numbers for the two years prior to 2001 to determine how they can continue to ensure services while not exceeding budget. The program moved to prescription drug formulary, capped emergency room visits based on program average for previous two years, and limited the number of inpatient hospitalizations to seven days per client, based on the average number of stays the past two years. Since the 2001 program adjustments, the program consistently has operated within its budget, even reverting funds in some years.

With the proposed rule changes to align with Medicaid pricing, program staff are confident that it can continue to provide needed services without changes to appropriations.

Impact on Local Governments: There is no impact to local governments from this proposed rule amendment.

V. Pricing Based on Date of Service

Background: Due to the POMCS application limitations, DPH was only able to maintain a limited number of pricing segments on the POMCS database. For that reason, DPH pays provider claims at the rate of reimbursement in effect on the date the claim is received by the POMCS unit rather than maintaining multiple pricing segments in order to pay claims based on the date of service.

Changes Needed: Staff proposes to amend 10 NCAC 45A .0401, General, and NCAC 45A .0403, Reimbursement for Professional, Outpatient, Other Services.

Justification for rule changes: The proposed amendment reflects the change to this industry-standard third-party-payer reimbursement practice of paying based on rates in effect on the date of service. This change will reduce burden on healthcare providers, who currently have to maintain different liabilities for receivables based on different reimbursement methodologies. It also reduces opportunity costs of staff time by streamlining the claims processing system for the State.

Fiscal Impact: The proposed rule amendment should result in only a minimal financial impact to private entities and the State. Standard industry practice for health plans is to reimburse for services based on based on rates in effect on the date the service is provided. Providers agree to accept these rates for reimbursement when they enroll as Medicaid participants. Staff is unable to estimate the direct impact of the proposed rule change as quantitative data is not available for comparative purposes between Medicaid rates in place for a claim processed based on date of receipt versus the date on which the service was provided. Estimating the impact on opportunity costs would require a prohibitively high amount of staff time and data-processing resources to run reports for a sample of selected services showing the amount paid based on a claim's date received versus what the provider would have been paid had the claim been paid based on the date of service.

Benefits: By incorporating the industry standard reimbursement methodology and automating the end-to-end claims adjudication process, providers should realize quicker claims turnaround time, more accurate claims calculations, and consistency across the payment programs. The State, as mentioned, can recoup unknown opportunity costs associated with the more streamlined claims processes.

VI. Requirement for Pharmacy Providers to Bill Insurance

Background: DPH currently requires all providers, except pharmacies, to bill other third-party insurance payers before billing the State for covered services. When this rule was originally adopted in 1981, pharmacies could not bill insurance directly because of technical limitations in electronic claims submission/processing systems. As a result of this exception, the State has been the direct payer for DPH-covered medications for insured recipients and the insurance companies have not been billed by the pharmacies.

Changes Needed: Staff proposes amending NCAC 45A .0302(6) by deleting the provision that exempted pharmacies from billing third-party payers except Medicaid. Pharmacies have implemented direct electronic billing systems since the rules were adopted and are now able to bill third-party payers at the point of sale when the medication are dispensed. This proposed rule change reflects the current standards of practice within the pharmacy POS systems.

Justification for rule change: The NC Tracks Pharmacy Point of Sale (POS) system will require pharmacies to provide third-party payer claims status before it will pay out of public health payment funds. This aligns with the regulatory³ requirement to be the payer of last resort for services funded by State appropriations, which fill a gap for services provided to uninsured patients. The proposed rule change has the potential to realize cost savings within the DPH payment programs that provide prescription coverage. Further, the proposed rule changes will benefit pharmacies and patients while conserving state public resources. The proposed rule change provides stewardship of state dollars while honoring the state’s obligation to provide needed services to its underserved citizens.

Fiscal Impact: Currently, the Sickle Cell program is the only POMCS program affected by the proposed change to pharmacy billing whose payments will be processed by the NC Tracks system.⁴

The following table shows the paid pharmacy claims for the past two fiscal years:

<u>FY</u>	<u>Program</u>	<u>Paid Claims</u>	<u>Clients</u>	<u>Amount Paid</u>	<u>Billed Amount</u>
2011	Sickle Cell	499	39	\$201,817	\$436,964
2012	Sickle Cell	478	43	\$199,861	\$552,015

The amount paid by the Sickle Cell program represents a potential savings to the State, as many of these claims would be paid by private insurance under the proposed rule changes. The proposed rule changes would result in additional costs to private insurers for some medications claims currently paid by the State.

³ 10A NCAC 45A .0303(b) – Payment Limitations

⁴ The Aids Drug Assistance Program (ADAP) pharmacy claims are not processed by POMCS. Currently, a third-party contract with *Walgreens* handles all pharmacy services for ADAP via a bulk mail order system with negotiated rates.

Census data compiled by StateHealthFacts.org show that in 2010/2011 approximately 19% of NC non-elderly residents with incomes at or below 139 percent of the federal poverty line had private insurance (employer or individual).⁵ Using the average amount billed above for 2011/12, the potential impact across all insurers, before accounting for client co-payments, could be approximately \$66,000 annually (2011/12 average billed paid at 70%⁶ times 19% total claims for clients who may have third party insurance benefits).

Pharmacies have the potential to receive additional revenue by billing private insurers, which typically reimburse at higher rates than Medicaid. Pharmacies should experience a reduced administrative burden, as they will be able to submit POMCS claims electronically to NC Tracks versus the current practice of submitting paper claims manually.

Within the healthcare industry, pharmacies have led the way in the adoption of electronic systems to improve their operations. Further, earlier regulations, such as HIPAA and Medicare rules of participation have mandated electronic claims processing. With their automated payment systems, pharmacies will be able to process claims without any additional burden. A 2009 white paper by the National Council for Prescription Drug Programs (NCPDP) noted that “99% of all pharmacy claims are submitted and processed with a response via real-time transactions – the entire electronic communications cycle taking less than five seconds.” Further, the paper states that “within seconds, pharmacies knew the status of the patient and drug eligibility for coverage and the patient’s copayments before the prescription was dispensed. Pharmacies knew instantly how much they would be paid for the claim.”⁷ Due to the near-universal adoption of automated payment systems among pharmacies, claims processing costs for sickle cell medications should be minimal (and much lower than the costs of the current paper-based claims process for POMCS clients).

POMCS clients with private insurance may also be affected by the proposed rule change if clients’ insurance plans have co-pay obligations for their prescription benefits. The co-payment impact for individual clients could range from a low of \$10 to \$20 per prescription for generic drugs to much higher co-pays for specialty drugs, depending on the type of benefits plan. Staff has estimated potential per client annual total impact of approximately \$174, assuming client co-payment of \$15. For those clients with higher co-pay, the potential per client annual impact is estimated to be \$580, assuming a co-payment of \$50. These figures could affect a total of eight clients with third-party insurance during 2011/12. The estimated total client cost (\$4,650) is based on a \$50 co-payment for eight clients with private insurance and for 19% of the averaged total claims (i.e. 19% of the 488.5 average annual claims [93 claims] for, on average, eight clients with private insurance).

Benefits: Some pharmacies have elected not to participate in the Sickle Cell program because of the burdensome paper-based claims process. Staff anticipates that with the automated point of sale claims processing, many more pharmacies would now elect to participate, thus reducing hardships

⁵ See 2010/2011 figures for North Carolina, based on the Census Bureau’s Current Population Survey, at <http://www.statehealthfacts.org/profileind.jsp?ind=849&cat=3&rgn=35&cmpgrn=1>

⁶ Estimates conducted by *Forbes* suggest that insurers receive rebates from pharmaceutical companies averaging 30% of a drug’s list price. For more information, see <http://www.forbes.com/sites/matthewherper/2012/05/10/why-astrazeneca-gives-insurers-60-discounts-on-nexiums-list-price/>

⁷ “Pharmacy – A Prescription for Improving the Healthcare System,” The National Council for Prescription Drug Programs, Inc. Scottsdale Arizona, 2009. http://www.ncdpd.org/pdf/NCPDP_white_paper.pdf

for patients who may have had difficulty finding conveniently located pharmacies that would fill their prescriptions.

Further, the NCPDP paper cited above illustrates a potentially significant health-outcome benefit associated with electronic prescription processing: “Real-time clinical alerts, such as potential allergies and interactions with other drugs, could be provided to pharmacists, who, in turn, could work with the prescribing physician prior to dispensing, thus improving patient safety.”⁸

VII. Incorporate IDEA Part C Federal Regulations into Payment Limitations Rule

Background: Part C of IDEA: The Early Intervention Program for Infants and Toddlers with Disabilities was established by Congress in 1986 in recognition of "an urgent and substantial need" to:

- Enhance the development of infants and toddlers with disabilities;
- Reduce educational costs by minimizing the need for special education through early intervention;
- Minimize the likelihood of institutionalization, and maximize independent living; and,
- Enhance the capacity of families to meet their child's needs”.⁹

The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, from birth through age 2 years, and their families.

On September 28, 2011, the IDEA 2004 Part C Final Regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities were published in the Federal Register. These regulations became effective on October 28, 2011.

Among the changes in the updated regulation is language that clarifies how states may use public benefits and private insurance to pay for services provided to infants and toddlers. The federal regulation promulgates the following:

Section 303.520(a) establishes three new requirements that are designed to provide important protections for parents of infants and toddlers with disabilities balanced against the need for States to have access to public benefits and public insurance to finance part C services while implementing the system of payments, coordination of funding sources, and payor of last resort requirements under part C of the Act. Under this section, a State must obtain a parent’s consent prior to requiring a parent to enroll in a public benefits or insurance program or if the use of funds from a public benefits or insurance program imposes certain costs on the parent. This section also requires a State to provide written notice to parents of applicable confidentiality and no-cost protections if the State lead

⁸ Ibid.

⁹ Findings of Congress as stated in Public Law 99-457 (1986). P.L 99-457 is the statute of the Education of the Handicapped Act Amendments of 1986, passed by Congress on October 8, 1986. As first authorized in 1986, the early intervention program was known as Part H of IDEA. It became Part C with the reauthorization of IDEA in 1997 and continues as Part C to the present day.

agency or EIS provider or program uses public benefits or insurance to pay for part C services.¹⁰

Change Needed: Staff proposes to amend 10A NCAC 45A .0303, Payment Limitation, to incorporate the federal regulations by reference into the rule.

Justification: The proposed rule change aligns the NC Early Intervention services with federal regulations and, by incorporating all subsequent editions and amendments, will allow the program to always be current with federal requirements.

Fiscal Impact: There is no fiscal impact to state or local government entities. Further, there is no impact to others who may be affected by the proposed rule change, including providers, insurance companies, or parents of children served by the program. The updated federal regulation provides clarity to the payer-of-last-resort requirements in previous editions of the regulation. There was ambiguity in the interpretation of how states could implement their system of payments, how to incorporate parental informed consent into accessing public benefits or private insurance, and how to inform parents of costs accruing to them.

The NC Infant Toddler Program (ITP), which implements Part C Early Intervention Services, has had policies in place that conform to the updated federal regulations. For example, ITP has always required parental informed consent where permission is required for the program to bill any third-party payer, including Medicaid. (See Appendix D: ITP Financial Consent Form) ITP implemented this policy to align with the Family Education Rights and Privacy Act (FERPA), which protects education records such as those of children enrolled in an IDEA program. FERPA prohibits the release of identifying information for all but a few uses without parental permission, and release to third-party payers is not one of the allowed releases.

Benefits: By incorporating the federal regulations into Rule, the program will be assured that they will always be in compliance with federal requirements. The program must submit an annual plan as part of its federal funding request, and the US Office of Special Education reviews and must approve all state policies.

¹⁰ 34 CFR part 303.520(a), Subpart F—Use of Funds and Payor of Last Resort, 60142 Federal Register / Vol. 76, No. 188 / Wednesday, September 28, 2011 / Rules and Regulations. <http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf>

Appendix A: NC Tracks Benefits

The following highlights overall anticipated benefits for stakeholders when the multi-payer replacement Medicaid Management Information System, called NC Tracks, is deployed after July 1, 2013:¹¹

The replacement MMIS will have numerous advanced features to maximize the administrative efficiency and ease of use for:

- NC taxpayers;
- Recipients;
- Agency staff; and
- Healthcare providers.

In the following summary, the public health payment program stakeholders particular benefits have been highlighted.

New Systems Benefits for Stakeholders:

➤ NC Taxpayer Benefits

Cost avoidance for the Division of Prevention, Access and Public Health Services through the elimination of the largely manual POMCS system as a result of the improved sequencing, processing and payment of claims.

➤ DHHS Benefits

Cost Savings

- Redirected State staffing costs through automated business functions and efficiencies gained through the consolidation of functions, resources and systems, as well as business process streamlining;
- Increased State purchasing cost-reduction opportunities through a single integrated multi-payer system for State-sponsored health programs;
- Reduced claims payment errors;
- Improved accuracy in dispensing services, equipment, and drugs to program recipients;
- Easier, more timely and cost-effective system changes;
- Reduced operating and drug costs;
- Enhanced cost avoidance; and
- Improved waste, fraud, and abuse detection across programs since administrators can analyze multiple healthcare programs' utilization, billing, and coding patterns.

➤ *Functionality*

- Automated business functions;
- Consolidated business functions, resources, systems, and processes;
- Increased ease of future system growth and alignment with:
 - Medicaid Information Technology Architecture (MITA),
 - National Provider Identification (NPI) taxonomy frameworks, and
 - Industry standard code sets;

¹¹ The information is adapted from the “MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM Quarterly Report to the North Carolina General Assembly - November 2012 – January 2013: APPENDIX D – REPLACEMENT MMIS BENEFITS SUMMARY”, State of North Carolina, Department of Health and Human Services, April 1, 2013.

- Improved information access and coordination of benefits across multiple agencies;
- Improved program administration, while improving services to providers; and
- Improved confidentiality protection, while providing information to those who need to know.

➤ **Health Care Provider Benefits**

- The Provider Web Portal will provide a secure and convenient mechanism to complete, electronically sign, and submit initial provider enrollment applications, retrieve, view, and update enrollment information, and check the status of a new application, re-credentialing application, or enrollment change request.
- Providers will be able to inquire about recipient eligibility for a single date or a span of dates, and can submit an online “mini-batch” to obtain eligibility information for up to 25 recipients in a single transaction.
- The new system will allow the electronic submission of all claim types, including pharmacy claims for the Sickle Cell Program in the Division of Public Health.
- Providers will receive electronic Remittance Advices.
- The automated pharmacy prior approval function will enable an immediate response to a prior approval request submitted via secure website or fax/paper.
- The new system will fully support Electronic Fund Transfers (EFT) of claims payments for the Division of Public Health.

Appendix B: Sick Cell Syndrome Hospital Inpatient Admissions

SICKLE CELL CLIENT COUNTS

FISCAL YEAR	PROV NUM	PROV NAME	PROV CITY	CASE #	SUM OF DAYS	# CLAIMS
2009	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6071887	5	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6079305	4	2
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6082592	5	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6099793	7	2
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6115946	2	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6116234	4	2
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6005065	6	2
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6079060	5	2
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6116698	4	2
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6034663	5	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6080005	5	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6087840	3	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6099182	4	2
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6103445	4	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	18703001	4	1
				*	67	22
2010	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6063968	6	2
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6066107	2	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6120756	7	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6079060	5	3
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6105145	2	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6122034	2	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	8803057	7	3
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6092906	1	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6096467	8	3
	34000610	UNIV OF NC HOSPITALS	CHAPEL HILL	6097031	2	1
	34000610	UNIV OF NC HOSPITALS	CHAPEL HILL	6112153	7	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6034663	7	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6054203	6	2
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6079481	2	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6099182	4	2
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	8703001	1	1
	34001300	UNION MEMORIAL HOSPITAL	MONROE	6112343	1	1
	34001430	CATAWBA MEMORIAL HOSPITAL	HICKORY	6120603	4	1
				*	74	27
2011	34000020	MEMORIAL MISSION HOSPITAL IN	ASHEVILLE	6047207	5	1
	34000280	CAPE FEAR VALLEY MEDICAL CTR	FAYETTEVILLE	6120756	3	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6079305	3	1
	34000300	DUKE UNIVERSITY MED CIR	DURHAM	6119591	1	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6063565	1	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6079060	1	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6117037	6	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6120959	4	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6124460	3	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6135753	5	4
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6136147	4	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6137871	3	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	18803057	5	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	19200556	3	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6034663	7	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6063430	3	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6096467	5	2
	34000500	SOUTHEASTERN GENERAL HOSP	LUMBERTON	6120407	4	1
	34000610	UNIV OF NC HOSPITALS	CHAPEL HILL	6066495	7	1
	34000610	UNIV OF NC HOSPITALS	CHAPEL HILL	6130261	6	2
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6026152	3	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6099182	6	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	18703001	6	2
	34000990	ROANOKE CHOWAN HOSP	AHOSKIE	6124460	2	1
	34001130	CAROLINAS MEDICAL CENTER	CHARLOTTE	6063036	6	1
	34001320	MARIA PARHAM HOSPITAL	HENDERSON	6119591	6	1

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					*	108 32
2012	34000280	CAPE FEAR VALLEY MEDICAL CTR	FAYETTEVILLE	6120756	5	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6124460	5	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6126009	1	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6129680	5	2
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6132443	4	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	6136147	2	1
	34000400	PITT COUNTY MEMORIAL HOSP	GREENVILLE	137871	3	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6034663	5	1
	34000470	NC BAPTIST HOSPITAL INC	WINSTON-SALEM	6109718	2	2
	34000610	UNIV OF NC HOSPITALS	CHAPEL HILL	6066495	2	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6063298	5	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6079481	1	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6119286	5	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6136943	7	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	6141210	7	1
	34000910	MOSES H CONE MEMORIAL HOSP	GREENSBORO	18703001	4	1
	34001070	HERITAGE HOSPITAL	TARBORO	19200556	4	1
	34001130	CAROLINAS MEDICAL CENTER	CHARLOTTE	6002771	4	1
	34001130	CAROLINAS MEDICAL CENTER	CHARLOTTE	6063036	7	1
	34001430	CATAWBA MEMORIAL HOSPITAL	HICKORY	6075389	5	1
					-----	-----
					*	83 22
					=====	=====
					332	103

Appendix C. Comparison of Current Inpatient Pricing versus DRG-based Pricing (FY 2011)

Provider Name	Number of Days	What DPH Paid	DRG Code	DRG would Pay
Pitt County Memorial Hospital	2	\$4,360.70	683	\$4,374.56
Pitt County Memorial Hospital	4	\$4,182.84	812	\$3,330.86
Pitt County Memorial Hospital	3	\$2,935.20	690	\$3,075.62
Pitt County Memorial Hospital	1	\$2,038.03	391	\$4,816.66
Pitt County Memorial Hospital	1	\$1,772.00	392	\$2,944.90
Pitt County Memorial Hospital	2	\$4,087.57	812	\$3,865.76
Pitt County Memorial Hospital	2	\$14,328.92	811	\$3,714.16
Pitt County Memorial Hospital	2	\$3,510.19	812	\$3,967.63
Pitt County Memorial Hospital	1	\$5,594.20	811	\$6,876.85
Pitt County Memorial Hospital	1	\$750.34	812	\$2,520.64
Pitt County Memorial Hospital	4	\$2,817.82	812	\$3,330.86
Carolinas Med Ctr	4	\$5,296.69	089	\$3,247.32
Duke University Hospital	2	\$2,339.50	812	\$3,748.75
Duke University Hospital	1	\$4,844.62	419	\$5,057.55
Cape Fear Valley Medical Ctr	5	\$4,074.52	812	\$2,497.95
Heritage Hospital	2	\$4,550.45	812	\$2,793.22
Roanoke Chowan Hospital	2	\$2,270.07	812	\$2,548.07
Moses Cone Health System	5	\$6,131.54	811	\$4,151.30
Moses Cone Health System	5	\$3,270.69	812	\$2,944.30
Moses Cone Health System	4	\$3,174.74	812	\$2,894.44
Moses Cone Health System	1	\$1,784.21	812	\$2,530.19
Moses Cone Health System	1	\$1,364.97	812	\$2,908.15
Moses Cone Health System	1	\$4,751.30	811	\$4,151.30
Moses Cone Health System	3	\$2,925.07	202	\$2,433.75
Mission Hospitals Inc	5	\$17,028.69	470	\$7,850.64
Southeastern Regional Med	4	\$6,262.90	149	\$2,124.55
NC Baptist Hospital	1	\$6,828.81	551	\$4,531.56
NC Baptist Hospital	5	\$15,334.09	871	\$8,832.82
NC Baptist Hospital	3	\$5,377.14	592	\$9,376.22
NC Baptist Hospital	3	\$3,635.13	812	\$3,967.63
NC Baptist Hospital	2	\$3,915.63	812	\$3,967.63
NC Baptist Hospital	1	\$2,219.99	812	\$3,398.57
UNC Hospitals	5	\$5,413.69	871	\$11,513.08
UNC Hospitals	3	\$25,450.95	253	\$15,715.05
UNC Hospitals	2	\$2,070.42	812	\$4,734.89
UNC Hospitals	1	\$1,636.48	812	\$4,203.86

Total

\$188,330.10

\$164,941.29

Appendix D. ITP Financial Consent Form

North Carolina Infant-Toddler Program Financial Consent Form

Child's Name: _____ Date of Birth: _____

I. ITP FEE AND BILLING POLICY: (BASED ON THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) AND THE NC INTERAGENCY AGREEMENT)

- Fees for child find, screening, evaluation, assessment, service coordination, and IFSP development may not be charged to parents of children under age five.
 - Medicaid will be billed if the child is eligible for Medicaid, and private insurance will be billed, with written parental consent.
- Families are responsible for payment for treatment services according to ITP Fee and Billing Policy.
 - Needed services, identified through the IFSP process, will not be denied to a family with an inability to pay as defined in ITP Policy.
 - The determined Sliding Fee Scale (SFS) percentage will be applied to all chargeable amounts after any insurance payment is received.
 - Written parental consent is required for the ITP to bill private insurance for services
 - If you decline to have your health insurance billed, you will be billed at the ITP rate (Medicaid rate) for any chargeable services.
 - The family has the right to refuse or decline any service.

II. PRIVACY POLICY NOTICE:

- The Family Education Rights and Privacy Act (FERPA) is a federal law that protects the privacy of children and parents who receive services from the North Carolina Infant-Toddler Program. Information concerning a child or family member is confidential and must not be exchanged among service providers without written authorization from the parent, except under special circumstances where this release is allowable by law such as a health or safety emergency, under court order, or as an allowable child find activity. An agency, however, may release confidential information to its own employees who have a legitimate need for access to the information.

III. AGREEMENT: [Please indicate your acceptance by initialing the spaces that apply and signing below]

- a. _____ I understand that, in order to determine the SFS percentage for chargeable ITP services, I must provide the requested family size and accurate financial information to the CDSA prior to signing the IFSP and annually when update is required. If I do not provide this information, I understand my SFS will be set at 100% until the time this information is provided.
- b. _____ The CDSA and enrolled ITP providers authorized to provide services for my child may file my insurance claim [including public benefits programs such as, Medicaid] for all authorized services provided. I authorize the release of medical or clinical information necessary to process the insurance claim.
I authorize my insurance company to make payment directly to the CDSA and enrolled ITP providers who have been authorized to provide
1. _____ services for my child.
I understand if the insurance payment is made directly to the insurance plan subscriber that I am responsible for submitting this payment to the
2. _____ CDSA or any enrolled ITP Provider who provided the authorized service.
I have been informed of and understand that there may be costs (including co-payments, premiums or deductibles) associated with billing
3. _____ private insurance for ITP services. I understand my option of paying directly for chargeable ITP service.
4. _____ I understand that final Medicaid payments are considered payment in full and as applicable, my insurance will be billed first.
- c. _____ My child is not covered by health insurance. I understand that I will be responsible for all authorized charges for early intervention services according to the ITP Fee and Billing Policy, and based on my SFS%, I will be billed directly for chargeable services using the ITP rate. (Medicaid rate)
- d. _____ I do not give permission for the CDSA or enrolled ITP providers to file my insurance claim. I understand that I will be responsible for all authorized charges for early intervention services according to the ITP Fee and Billing Policy, and based on my SFS%, I will be billed directly for chargeable services using the ITP rate. (Medicaid rate)
- e. _____ I understand that the health information used and disclosed may include information related to the HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing. I understand that I may request a restriction of the release of all or part of my family's health information.
1. _____ Send health information as is. 2. _____ Send health information with restrictions only (requires completion of *Request Restriction on Use and Disclosure of Health Information*, ITP form #7009)
- f. _____ As the parent/guardian of a child enrolled in the ITP, I understand that I am responsible for payment for treatment services according to ITP Fee and Billing Policy. I agree to pay per the CDSA determined Sliding Fee Scale percentage of [_____]%. The ITP Fee and Billing Policy have been explained to me and I understand how the Sliding Fee Scale will be applied to those chargeable early intervention services authorized on the IFSP.
 The required financial information was not provided to the CDSA in order to verify family ability to pay, therefore the SFS % was set at 100% per ITP Policy.
- g. _____ I understand my total monthly payments for ITP services should not exceed [**\$ _____/mo.**] based on ITP Policy. I will monitor this and report it to the CDSA business office if my monthly charged amount for IFSP services exceeds this determined amount.

IV. CDSA FEE COLLECTION POLICY:

All payments for services provided by the CDSA and authorized ITP providers are due within 30 days of the invoice date, and families are expected to pay within this time period. If payment is not made for three months from initial invoice without arrangements for a payment plan, the CDSA is obligated to initiate collection procedures. This includes 1) notifying the North Carolina Attorney General's Office of the past due account, and 2) the CDSA is obligated to file delinquent accounts with the North Carolina Department of Revenue, subject to Debt Setoff Collection Against Individual Income Tax Refunds Policy in accordance with G.S. 105A Setoff Debt Collection Act. This means that funds from individual tax returns may be withheld against any unpaid debt to the CDSA for services provided.

The ITP Fee and Billing Policy and the CDSA Fee Collection Policy have been explained to me, and I understand how they apply to my family. I agree to notify the CDSA within thirty [30] days of any changes in health insurance coverage or applicable Medicaid coverage. I certify the information I have provided is true to the best of my knowledge and belief. This consent to release information is in effect for all authorized services rendered by enrolled ITP Providers until all third party payers have been filed and payment received, or until this consent form is updated.

Parent/Guardian's Signature _____ Date _____ ITP Representative's Signature _____ Date _____

ID #:

Appendix E. Proposed Amendments

10A NCAC 45A .0101 is proposed for amendment as follows:

10A NCAC 45A .0101 GENERAL

(a) The purpose of this Subchapter is to establish uniform policies and procedures for the administration of all Department of Health and Human Services' payment programs. These rules are intended to facilitate efficient financial eligibility and payment mechanisms with a mutual goal of the Department and the providers to render appropriate services to eligible patients.

(b) In the event of conflict between the rules in this Subchapter and the rules adopted by the various payment programs, the rules of this Subchapter will control.

~~(c) The rules of this Subchapter shall not apply to the North Carolina Hemophilia Assistance Plan, 10A NCAC 43F-1100 or to the Home Health Program, 10A NCAC 39A .0200.~~

~~(c) Persons who wish to receive rule making notices concerning the rules in this Subchapter must submit a written request to Office of the Controller, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904. The request must specify the calendar year during which the person wishes to receive the notices. A check for ten dollars (\$10.00) made payable to the N.C. Department of Health and Human Services must be enclosed with each request to cover the cost of printing and mailing the notices for the year specified. The fee is non refundable if there are no notices during the year.~~

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129, 130A-205; 150B-21.2(b)

10A NCAC 45A .0102 is proposed for amendment as follows:

10A NCAC 45A .0102 DEFINITIONS

The following definitions shall apply throughout this Subchapter:

- (1) "Benefits" means the purchase of medical or dental care on a fee-for-service basis. "Benefits" also means the purchase of medical or dental appliances.
- (2) "Department" means the Department of Health and Human Services, or its contractor.
- (3) "Inpatient services" means medical or dental care administered to a person who has been admitted to a hospital.
- (4) "Outpatient services" means medical or dental care administered without admission to a hospital.
- (5) "Payment programs" refers to Department program activities involving the purchase of medical or dental care on a fee-for-service basis or the purchase of medical or dental appliances, either through direct payment or through contracts with local health departments, other agencies, or private institutions. ~~These activities are administered in the following:~~
 - ~~(a) — Children's Special Health Services,~~
 - ~~(b) — Cancer Program,~~
 - ~~(c) — Kidney Program,~~
 - ~~(d) — Maternal and Child Health Program,~~
 - ~~(e) — Migrant Health Program,~~
 - ~~(f) — School Health Fund,~~
 - ~~(g) — Sickle Cell Program,~~
 - ~~(h) — HIV Medications Program, and~~
 - ~~(i) — Adult Cystic Fibrosis Program.~~
- (6) "Provider" means a person or entity who administers medical or dental care or furnishes medical or dental appliances under any of the payment programs.
- (7) "Authorization" means agreement by a payment program to pay for a medical or dental service or appliance provided all requirements in 10A NCAC 45A are met.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; ~~130A-177~~; 130A-205

10A NCAC 45A .0202 is proposed for amendment as follows:

10A NCAC 45A .0202 DETERMINATION OF FINANCIAL ELIGIBILITY

(a) A patient must meet the financial eligibility requirements of this Subchapter to be eligible for benefits provided by the payment programs. Financial eligibility shall be determined through application of income scales. The definition of annual net income in Rule .0203 of this Subchapter and the definitions of family in Rule .0204 of this Subchapter shall be used in applying the income scales, except as provided in ~~Paragraph (c) Paragraphs (c), (e) and (f)~~ of this Rule.

(b) A person is financially eligible for services under the Sickle Cell Program if the net family income is at or below the federal poverty level in effect on July 1 of each fiscal year.

(c) A person is financially eligible for the HIV Medications Program if the gross family income is at or below 300 percent of the federal poverty level in effect on July 1 of each fiscal year, with the following exceptions:

- (1) If a waiting list develops, priority for enrollment into the Program shall be given to those whose net family income is at or below 125 percent of the federal poverty level, and second priority to those individuals with income above 125 percent and at or below 250 percent of federal poverty guidelines; and
- (2) At any time that the Program's financial eligibility level is changed, all clients enrolled in the Program during the most recent year or at the time the eligibility level is changed shall be eligible to continue to be enrolled in and served by the Program. This shall be true even if the clients' financial status at that time places them above the newly-established level. The eligibility of these clients shall remain in force until:
 - (A) they no longer qualify for the Program other than for financial reasons; or
 - (B) they no longer require the services of the Program; or
 - (C) their income increases such that they have an income that exceeds the level under which they originally qualified for and enrolled into the Program; or
 - (D) they fail to comply with the rules of the Program.

Changes related to the Program's financial eligibility level or status shall be communicated to interested parties within North Carolina's HIV community (e.g., persons living with HIV disease, their families and caregivers, advocates and service providers, relevant local and state agencies) by the Program via electronic or print mechanisms.

~~(d) A person is financially eligible for the Kidney Program if the net family income is at or below the following scale:~~

~~Family Size 1: \$6,400;~~

~~Family Size 2: \$8,000;~~

~~Family Size 3: \$9,600;~~

~~Family Size 4: \$11,000;~~

~~Family Size 5: \$12,000;~~

~~Family Size 6 and over: add \$800 per family member.~~

~~(e) A person is financially eligible for the Cancer Program if gross family income is at or below 115 percent of the federal poverty level in effect on July 1 of each year.~~

~~(f) A child is financially eligible for Children's Special Health Services if the child is approved for Medicaid when applying or reapplying for program coverage, except for children eligible under Paragraph (g) and (h) of this Rule.~~

~~(g) A child approved for Children's Special Health Services post adoption coverage pursuant to 10A NCAC 43F .0800, is eligible for services under Children's Special Health Services if the child's net income is at or below the federal poverty level in effect on July 1 of each year.~~

~~(h) A person is financially eligible for services under the Adult Cystic Fibrosis Program if the net family income is at or below the federal poverty level in effect on July 1 of each year.~~

(i) The financial eligibility requirements of this Subchapter do not apply to:

~~(1) Migrant Health Program;~~

~~(2)(1) School Health Fund financial eligibility determinations performed by a local health department which has chosen to use the financial eligibility standards of the Department of Public Instruction's free lunch program;~~

~~(3)(2) Prenatal outpatient services sponsored through local health department delivery funds, 10A NCAC 43C .0200; or through Perinatal Program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300; and~~

~~(4)(3) Diagnostic assessments for infants up to 12 months of age with sickle cell syndrome.~~

(j) Except as provided in ~~Paragraphs Paragraph~~ (k) and (l) of this Rule, once an individual is determined financially eligible for payment program benefits, the individual remains financially eligible for a period of one year after the date of application for financial eligibility unless there is a change in the individual's family size pursuant to Rule .0204 of this Subchapter or there is a change in his family's financial resources or expenses during that period. If there is a change, financial eligibility for payment program benefits must be redetermined. Financial eligibility must be redetermined at least once a year.

(k) For purposes of the ~~Kidney Program and~~ HIV Medications Program, once an individual is determined to be financially eligible, if the application for financial eligibility was received by the Department in the fourth quarter of the fiscal year, the individual remains financially eligible for benefits until the end of the next fiscal year unless there is a change in the individual's family size pursuant to Rule .0204 of this Subchapter or his family's financial resources or expenses during that period.

~~(l) Children eligible for Children's Special Health Services Program benefits under Paragraph (f) of this Rule are financially eligible for a service if they were Medicaid eligible on the date the requested service was initiated.~~

~~(m)(1) If the most current financial eligibility form on file with the Department shows that the patient was financially eligible on the date an Authorization Request for payment for drugs was received, the Authorization Request shall be approved so long as the Authorization Request is received prior to the expiration of financial eligibility and the authorized service does not extend more than 30 days after the expiration of financial eligibility.~~

History Note: Authority G.S. 130A-4.2; 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205

10A NCAC 45A .0204 is proposed for amendment as follows:

10A NCAC 45A .0204 DETERMINATION OF FAMILY SIZE

(a) For the purpose of determining eligibility for benefits provided by any of the payment programs, a patient's family shall be defined as the patient and all individuals living in the same household with the patient who are:

- (1) parents, not including step-parents, of the patient, if the patient is unmarried and less than 18 years of age;
- (2) siblings or half-siblings of the patient, but not step-siblings, if the siblings are unmarried and less than 18 years of age;
- (3) siblings or half-siblings of the patient, but not step-siblings, if the siblings are 18 years of age or over and have no income;
- (4) the spouse of the patient; and
- (5) individuals related to the patient by blood, marriage, or adoption, if the individual has no income, and if no parent(s) or spouse of the individual lives in the same household and has income;

(b) Individuals who are students and are temporarily living away from their permanent home while attending school are for the purposes of the Rule considered to be living in the household of the permanent home.

~~(c) An adopted child who has received approval for Children's Special Health Services support pursuant to 10A NCAC 43F .0800 shall be considered a family of one for purposes of this Rule.~~

(c) An adopted child shall be considered the same as a biological child and an adoptive parent shall be considered the same as a biological parent.

~~(d) Except as provided in Paragraph (c) of this Rule, an adopted child shall be considered the same as a biological child and an adoptive parent shall be considered the same as a biological parent.~~

(d) For the purpose of this Rule, a half-sibling is a child who has one biological parent in common with the patient. A step-sibling is the child of a step-parent who has no biological parent in common with the patient.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; ~~130A-177~~; 130A-205

10A NCAC 45A .0302 is proposed for amendment as follows:

10A NCAC 45A .0302 AUTHORIZATIONS AND CLAIMS PROCESSING TIME FRAMES

The following time frames shall apply to all payment programs:

- (1) An Authorization Request must be received by the Department within one year after the date of service or it will be denied. ~~denied, except in the Migrant Health Program where authorizations are not used.~~
- (2) The Department shall respond to an Authorization Request within 45 days after receipt.
- (3) If additional information is requested, this information must be received within one year after the date of service or within 30 days after the date of the Department's request, whichever is later, or the Authorization Request will be denied.
- (4) The Department shall approve or deny an Authorization Request within 45 days after receipt of all necessary information.
- (5) A claim for payment must be received by the Department within one year after the date of service or within 45 days after the date of authorization approval, whichever is later, or the claim will be denied. Corrections to claims and requests for payment adjustment must be received by the Department within one year after the date of service or within 45 days after the date the claim is paid or returned for additional information, whichever is later, or the claim will be denied.
- (6) If there are other third party payors, a claim must show payments by those payors or it must include copies of the denials of payment from those payors. Providers must bill other payors and wait at least six months after the date of service to receive payment or denial of payment before billing the Department. If no response has been received within six months after the date of service, the provider may bill the Department, but the claim must state the date that the other payors were billed. ~~Providers of pharmacy outpatient services are required to bill Medicaid. However, they are not required to bill other third party payors and wait six months before billing the Department but are required to refund the Department if other third party payments are received.~~
- (7) The Department shall pay or deny a claim within 45 days after receipt of a completed claim.
- (8) Authorization Requests and claims for payment shall be submitted on forms approved by the Department.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205

10A NCAC 45A .0303 is proposed for amendment as follows:

10A NCAC 45A .0303 PAYMENT LIMITATIONS

(a) Payment program payments shall be made for authorized services only when funds are available.

(b) During the last six months of the fiscal year, the State Health Director may limit payment program benefits that can be authorized when the total amount of outstanding authorizations, plus the estimated authorizations for the remainder of the fiscal year, less estimated cancellations, exceeds 100 percent of the program's cash balance. The State Health Director shall rescind the limitations at the end of the fiscal year, or prior to the end of the fiscal year if sufficient funds become available to authorize full program benefits for the remainder of the fiscal year. ~~The Director of the Office of Research, Demonstrations, and Rural Health Development may limit payment program benefits for the Migrant Health Program when the cost of the services is projected to surpass the program's cash balance within the fiscal year. The Director of the Office of Research, Demonstrations, and Rural Health Development shall rescind the limitations if sufficient funds become available to reimburse for program benefits for the Migrant Health Program.~~

c) Payment program benefits shall be available only for services or appliances which are not covered by another third party payor or which cannot be paid for out of funds received in settlement of a civil claim. Patients shall apply for Medicaid or Medicare benefits to which they may be entitled. ~~However, payment program benefits shall be available for Children's Special Health Services sponsored clinic patients who cannot reasonably be examined or treated by a Medicaid provider or an authorized provider for another third party payor because of transportation problems, a need for emergency care, or similar exceptional situations. All exceptions must be approved by the Children's Special Health Services program's medical director. Also, Children's Special Health Services may make payments for services provided to Medicaid patients when acting as a Medicaid provider under an agreement making the program eligible for reimbursement from Medicaid.~~ However, Early Intervention Program payment shall be available for services based on Title 35, Code of Federal Regulations, Part 303.520, which is hereby incorporated by reference along with all subsequent amendments and editions. A copy of 34 C.F.R. Part 303.520 is available for inspection at the Department of Health and Human Services, Division of Public Health, Women's and Children's Health Section, Early Intervention Branch, 5605 Six Forks Road, Raleigh, North Carolina. Copies of 34 C.F.R. Part 303.520 may be downloaded and printed from the Internet at <http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf>. Providers shall take reasonable measures to collect other third party payments. For the purposes of this Subchapter, third party payor means any person or entity that is or may be indirectly liable for the cost of services or appliances furnished to a patient. Third party payors include the following:

- (1) School services, including physical or occupational therapy, speech and language pathology and audiology services, and nursing services for special needs children;
- (2) Medicaid;
- (3) Medicare, Part A and Part B;
- (4) Insurance;
- (5) Social Services;
- (6) Worker's compensation;
- (7) CHAMPUS; and
- (8) Head Start programs.

(d) The Department shall not pay Medicaid co-payments or in any other way supplement Medicaid payments.

(e) If prior to the Department's payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third party payor, or receives funds in settlement of a civil claim, the Department shall pay only the amount, if any, by which the Department's payment rate exceeds the amount received by the person. For the purpose of this Rule the Department's payment rate means the rate of reimbursement established in 10A NCAC 45A .0400.

(f) Notwithstanding Paragraph (e) of this Rule, when the provider, the patient or a person responsible for the patient receives other third party payments equal to or exceeding the Department's payment rate, the Department shall pay the difference between the other third party payments and the provider's charge for an adopted child that meets the requirements of 10A NCAC 43F .0801. The Department's payment shall not exceed the payment rate in Section .0400 of the Subchapter.

(g) If after the Department makes payment for particular services or appliances, the provider, the patient, or a person responsible for the patient receives partial or total payment for the services or appliances from a third party payor, or receives funds in settlement of a civil claim which are available to pay for the services or appliances, the person receiving the payment shall reimburse the Department to the extent of the amount received by the person without exceeding the amount of the Department's prior payment to the provider. This reimbursement shall be made to the Department within 45 days after receipt of the third party payment.

(h) Notwithstanding Paragraph (g) of this Rule, if after the Department makes payment for particular services or appliances for an adopted child that meets the requirements of 10A NCAC 43F .0801, the provider receives partial or total payment from a third party payor, the provider shall only be required to reimburse the Department the amount by which the total of payments exceeds the provider's charge.

(i) If the Department requests a refund of a payment made to a provider, the refund shall be made to the Department within 45 days after the date of the refund request.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205

10A NCAC 45A .0401 is proposed for amendment as follows:

10A NCAC 45A .0401 GENERAL

(a) The purpose of this Section is to establish rates of reimbursement for services provided under the Department's payment programs.

(b) The reimbursement rates established in the rules of this Section shall not apply to local health department delivery funds, 10A NCAC 43C .0200, perinatal program high risk maternity clinic reimbursement funds, 10A NCAC 43C .0300, or school health funds, 10A NCAC 43E .0100. Rates of reimbursement for these programs are individually negotiated with providers by the Department's contractor, usually a local health department. These rates shall be negotiated and established in accordance with guidelines found in the respective program rules, and shall not exceed the Medicaid rate of reimbursement in effect ~~at the time the claim is received by the Department.~~ on the date of service.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; ~~130A-177~~; 130A-205

10A NCAC 45A .0402 is proposed for amendment as follows:

10A NCAC 45A .0402 REIMBURSEMENT FOR INPATIENT HOSPITALIZATION

~~(a) The Department shall reimburse providers of authorized inpatient hospitalization services at 80 percent of the hospital's inpatient cost rate, which is then applied to the amount billed for authorized services. The inpatient cost rate is a ratio of cost to charges that is derived from audited cost reports and is obtained from the Division of Medical Assistance. The Department shall use the cost rate in effect on the date a claim is received, and retroactive adjustments to claims paid shall not be made. If a cost rate cannot be obtained for an out of state hospital, the Department shall reimburse the hospital at 75 percent of the billed amount for authorized services. The cost rates and any subsequent amendments and editions are incorporated herein by reference in accordance with G.S. 150B-21.6. The cost rates can be obtained from the Office of the Controller, Department of Health and Human Services, 1904 Mail Service Center, Raleigh, NC 27699-1904. The Department shall reimburse providers of authorized inpatient services at the Medicaid rate in effect on the date of service.~~

~~(b) In addition to the requirements of Paragraph (a) of this Rule, in the Cancer Program there shall be a limit on the payment for an inpatient admission of 1 percent of the program's current annual budget.~~

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205; 130A-223

10A NCAC 45A .0403 is proposed for amendment as follows:

10A NCAC 45A .0403 REIMBURSEMENT FOR PROFESSIONAL, OUTPATIENT, OTHER SERVICES

(a) The Department shall reimburse providers of authorized outpatient services, professional services, and all other services not otherwise covered in the rules of this Section at the Medicaid rate in effect ~~at the time the claim is received by the Department.~~ Department, except in the Migrant Health Program on the date of service.

~~(b) The Migrant Health Program shall reimburse providers of program covered outpatient, professional, and other services at the Medicaid rate in effect at the time the claim is received minus the allowable patient copayment to a maximum program payment of one hundred fifty dollars (\$150.00) per claim, per date of service. The allowable patient copayment is six dollars (\$6.00) per claim for each prescribed drug and supply, six dollars (\$6.00) per claim for all durable medical equipment, and five dollars (\$5.00) per claim, per date of service for all other services. The one hundred fifty dollar (\$150.00) limit shall not apply to drugs, supplies, and durable medical equipment.~~

(c) ~~(b)~~ In addition to the requirements of Paragraph (a) of this Rule, for professional and outpatient services under the Cancer Program, there shall be a per claim payment limit of one percent of the program's current annual budget.

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205; 130A-223

10A NCAC 45A .0404 is proposed for amendment as follows:

10A NCAC 45A .0404 REIMBURSEMENT FOR SERVICES NOT COVERED BY MEDICAID

- (a) The Department shall reimburse providers of authorized mobility systems (including components and accessories), environmental control units, and custom seating systems for which there are no Medicaid reimbursement rates at the manufacturer's catalog price less five percent.
- (b) The Department shall reimburse providers of authorized prosthetics and orthotics at the Medicare rate of reimbursement when there is no Medicaid rate of reimbursement for the item. When there is neither a Medicaid rate nor a Medicare rate for the item, the Department shall reimburse at the provider's usual charge to the general public.
- (c) The Department shall reimburse providers of authorized equipment repair services for which there are no Medicaid reimbursement rates at forty five dollars (\$45.00) per hour.
- (d) The Department shall reimburse physicians and dentists for authorized services for which there are no Medicaid rates at the Medicaid rate for a comparable procedure as determined by the program's medical director or at 80 percent of the amount billed, whichever is less.
- (e) The Department shall reimburse providers of authorized assistive listening devices and those types of hearing aids for which there are no Medicaid rates at invoice cost plus the Medicaid dispensing fee for a new hearing aid(s).
- (f) The Department shall reimburse providers of authorized amplification-related services for which there are no Medicaid rates at the rates paid for audiology services under Medicaid's Independent Practitioner Program.
- (g) The Department shall reimburse providers of authorized services not otherwise specified in this Section, for which there are no Medicaid reimbursement rates, at the provider's usual charge to the general public.
- ~~(h) The Department shall reimburse providers under the Migrant Health Program at the rates specified in this rule. Services do not have to first be authorized; however, reimbursement is contingent upon client eligibility, the provision of services covered by the program, and availability of funds.~~

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205

10A NCAC 45A .0405 is proposed for amendment as follows:

10A NCAC 45A .0405 BILLING THE PATIENT PROHIBITED

If a provider has accepted partial or total payment from the Department for particular services, the Department's reimbursement rate for those services shall be considered payment in full for those authorized services for all payment ~~programs~~ programs, ~~except the Maternal and Child Health Program Delivery Fund, the School Health Fund, and the Migrant Health Program. A provider who has accepted partial or total payment from the Department under the Maternal and Child Health Delivery Fund or the School Health Fund shall not bill the patient or his family for any amount greater than the amount by which the Medicaid rate exceeds the Department's payment for the particular services. A provider who has accepted payment from the Department under the Migrant Health Program may bill the patient for copayments established in this Section.~~

History Note: Authority G.S. 130A-5(3); 130A-124; 130A-127; 130A-129; 130A-205

10A NCAC 43H .0111 is proposed for amendment as follows:

10A NCAC 43H .0111 MEDICAL SERVICES COVERED

The following medical services are covered under the N.C. Sickle Cell Syndrome Program if the Program Supervisor determines that these services are related to sickle cell disease:

- (1) hospital outpatient care including emergency room visits. The total number of days per year for emergency room visits shall not exceed triple the Program average for each for the previous two years;
- (2) physicians' office visits;
- (3) drugs on a formulary established by the program based upon the following factors: the medical needs of sickle cell patients, the efficacy and cost effectiveness of the drugs, the availability of generic or other less costly alternatives, and the need to maximize the benefits to patients utilizing finite program dollars. A copy of this formulary may be obtained free of charge by writing to the N. C. Sickle Cell Syndrome Program, 1929 Mail Service Center, Raleigh, North Carolina, 27699-1929.
- (4) medical supplies and equipment;
- (5) preventive dentistry including education, examinations, cleaning, and X-rays; remedial dentistry including tooth removal, restoration, and endodontic treatment for pain prevention; and emergency dental care to control bleeding, relieve pain, and treat infection;
- (6) eye care (when the division of services for the blind will not provide coverage); and
- (7) inpatient care. The cost of inpatient care per client per year for a maximum of ~~seven days~~ two admissions per fiscal year.

History Note: Authority G.S. 130A-129.