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)~~(l) 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.~~

~~(e)~~ (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 .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*