Fiscal Impact Analysis of
Permanent Rule Readoption – 10A NCAC 22L

Agency Proposing Rule Change

North Carolina Department of Health and Human Services, Division of Medical Assistance

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Impact Summary

Federal Government:	No Impact
State Government:	No Impact
Local Government:	No Impact
Private Individuals/Entities:	No Impact
Substantial Impact:	No

Title of Rules Changes and Statutory Citations

10A NCAC 22L – Managed Care and Prepaid Plans

Section .0100 – Managed Care

- 10A NCAC 22L .0101 – Program Definition (Amend)
- 10A NCAC 22L .0102 – Coordination Fee (Readopt)
- 10A NCAC 22L .0103 – Access to Care (Readopt)
- 10A NCAC 22L .0104 – Enrollment (Readopt)

Section .0200 – Prepaid Plans

- 10A NCAC 22L .0201 – Program Definition (Amend)
- 10A NCAC 22L .0203 – Access to Care (Readopt)

See proposed text of these rules in Appendix 1.

Statutory Authority

NCGS §§ 108A-25(b), 108A-54, 108A-54.1B

Background

Under authority of NCGS § 150B-21-3A, periodic review and expiration of existing rules, the Division of Medical Assistance, Rules Review Commission, and the Joint Legislative Administrative Procedure Oversight Committee approved the subchapter report with classifications for the rules located at 10A NCAC 22L – Managed Care and Prepaid Plans. The following four rules were classified as necessary with substantive public interest in this report: 10A NCAC 22L .0102, .0103, .0104, and .0203.

The agency is presenting 22L .0103 and .0104 for readoption with substantive changes and 22L .0102 and .0203 for readoption with minor, non-substantive changes. In addition, the agency is presenting two rules for amendment that were deemed necessary without substantive public interest, 22L .0101 and .0201.

Pursuant to NCGS § 150B-21.3A(d)(2), an agency is not required to prepare a fiscal note if a rule is readopted without substantive change or if the rule is amended to impose a less stringent burden on regulated persons. In addition, pursuant to NCGS § 150B-21.4(d), agencies are not required to prepare a fiscal note when proposing to repeal an existing rule. For that reason, this fiscal note focuses on the following rules: 22L .0101, .0103, .0104, and .0201. The agency has also prepared a brief explanation for the non-substantive changes made to 22L .0102 and .0203.

Rule Summaries and Anticipated Fiscal Impact

Rule .0101 – Program Definition

10A NCAC 22L .0101 describes the agency's primary care case management program. The agency is proposing to readopt this rule with two substantive changes. First, the language was clarified to apply generally to the Division's primary care case management contractor, rather than Carolina Access specifically. This makes the rule more adaptable. Second, the language was clarified to define which "certain categories" of Medicaid beneficiaries the rule is referring to. This does not impact how the rule is implemented.

Fiscal Impact

All changes to this rule are minor, technical changes to clarify language. There is no fiscal impact to federal government, state government, local governments, or private industry associated with the amendment of this rule.

Rule .0102 –Coordination Fee

10A NCAC 22L .0102 describes the coordination fee that the agency pays to participating providers. The agency is proposing to readopt this rule with two minor, non-substantive changes, clarifying the coordination fee and adding the word "(Division)" as short for Division of Medical Assistance.

Fiscal Impact

The changes to this rule are minor, non-substantive, technical changes. There is no fiscal impact to federal government, state government, local governments, or private industry associated with the readoption of this rule.

Rule .0103 – Access to Care

10A NCAC 22L .0103 describes the access to care for beneficiaries enrolled in primary care case management. The agency is proposing to readopt this rule with several changes. First, as was described in Rule .0101, the language was clarified to apply generally to the Division's primary care case management contractor, rather than Carolina Access specifically. This is a non-substantive, technical change. Second, the final sentence of the rule was deleted. The agency is no longer denying payment under these circumstances. Although substantive, this language

change reduces the burden on regulated persons. All other changes to this rule are minor, technical changes intended to update and clarify language.

Fiscal Impact
As this rule is being updated with minor, non-substantive technical changes and changes to impose a less stringent burden on regulated persons, there is no fiscal impact to federal government, state government, local governments, or private industry associated with the readoption of this rule.

Rule .0104 – Enrollment
10A NCAC .0104 describes enrollment in the primary care case management program. The agency proposes to readopt this rule with substantive changes. Other than conforming changes described above, there are two main substantive changes to this rule. The first is removing AFDC as an eligibility category. The second is removing the entire last sentence of this section and replacing it with what is currently in Medicaid State Plan.

Fiscal Impact
There is no fiscal impact associated with change of removing AFDC as an eligibility category because those beneficiaries moved to the category AFDC-related. Medicaid is no longer linked to AFDC/TANF. There is no fiscal impact to the second change because, pursuant to N.C.G.S. § 108A-54.1B(d), the Medicaid State Plan separately has the force and effect of administrative rule.

Rule .0201 – Program Definition
10A NCAC 22L .0201 describes the agency's ability to contract with prepaid health plans. The Division proposes to re-adopt this rule with minor, non-substantive, technical changes that are intended to update and clarify language. This includes clarifying that the "contract specifications" an HMO must demonstrate its ability to meet refers to the qualifications set out in the Medicaid Provider Administrative Agreement. This is merely a clarification, not a change in practice. The agency is also changing the way the Division of Medical Assistance is referred to throughout this rule from "DMA" to "Division."

Fiscal Impact
All changes to this rule are minor, non-substantive, technical changes. There is no fiscal impact to federal government, state government, local governments, or private industry associated with the amendment of this rule.

Rule .0203 – Access to Care
10A NCAC 22L .0203 describes the access to care for beneficiaries enrolled in prepaid plans. The Division proposes to re-adopt this rule with minor, non-substantive, technical changes. First, as described in .0201, references to "DMA" are being replaced with "Division." Second, the policies and procedures referred to in paragraph (a) are being clarified as the Medicaid State Plan. Third, the reference to 42 USC 1932 is being changed to 1396u-2. 1932 is the Section of the Social Security Act, while 1396u-2 is the codified section in the United States Code. Fourth, the final sentence of paragraph (c) is being deleted because it does not apply. Rule .0201 describes the contract that may be awarded for HMOs under these rules. In other circumstances the Medicaid State Plan will apply. Other changes to this rule are minor, technical changes made

to add clarity and update rule formatting and terminology.

Fiscal Impact

All changes to this rule are minor, non-substantive, technical changes. There is no fiscal impact to federal government, state government, local governments, or private industry associated with the amendment of this rule.

Appendix 1

10A NCAC 22L .0101 is proposed for amendment as follows:

SUBCHAPTER 22L - MANAGED CARE AND PREPAID PLANS

SECTION .0100 - MANAGED CARE

10A NCAC 22L .0101 PROGRAM DEFINITION

~~Carolina ACCESS~~ The Division's primary care case management contractor ~~will~~ shall contract with primary care physicians in participating counties to deliver and coordinate the health care of certain categories of Medicaid ~~recipients.~~ beneficiaries listed in 10A NCAC 22L .0104.

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Amended Eff. March 31, 2018.

10A NCAC 22L .0102 is proposed for readoption without substantive change as follows:

10A NCAC 22L .0102 COORDINATION FEE

In addition to normal Medicaid payments, the Division ~~of Medical Assistance~~ has the authority to pay participating physicians a monthly fee to provide case management ~~coordination fee~~ for providing or coordinating the health care services of enrollees who have selected them as their primary care physician.

History Note: *Authority G.S. 108A-25(b);* ~~*Section 93(h) of Chapter 689, 1991 North Carolina Session laws;*~~ *Eff. August 3, 1992.* ~~*1992.*~~ *Readopted Eff. March 31, 2018.*

10A NCAC 22L .0103 is proposed for readoption with substantive changes as follows:

10A NCAC 22L .0103 ACCESS TO CARE

~~Carolina ACCESS~~ The Division's primary care case management enrollees ~~are~~ shall be eligible to receive ~~all~~ health care services that ~~all~~ Medicaid ~~recipients~~ beneficiaries are eligible for. ~~They~~ Beneficiaries receive ~~their~~ services through their primary care physician who either provides or coordinates ~~their~~ health care. ~~The Division of Medical Assistance has the authority to deny payment for covered services that are not authorized by the primary care physician.~~

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992; ~~1992.~~
Readopted March 31, 2018.

10A NCAC 22L .0104 is proposed for readoption with substantive changes as follows:

10A NCAC 22L .0104 ENROLLMENT

All Medicaid beneficiaries ~~recipients~~ in participating counties who are eligible for ~~Carolina ACCESS~~primary care case management shall enroll. ~~in Carolina ACCESS.~~ Eligible Medicaid beneficiaries ~~recipients eligible for Carolina ACCESS~~ include ~~AFDC,~~ AFDC-related, MIC, Aged, Blind and Disabled categories, unless exempt due to institutional placement. Institutional placement includes nursing home, mental institutions, ~~institutions~~ and domiciliary care. The following beneficiaries have the option to enroll in primary care case management: Medicaid for Pregnant Women, benefit diversion beneficiaries, beneficiaries with end stage renal disease, and Native Americans/Alaska Natives. ~~Medicaid recipients who are Medicaid Pregnant Women, foster children or who are also on Medicare, have the option to enroll in Carolina ACCESS.~~

History Note: *Authority G.S. 108A-25(b); ~~Section 93(h) of Chapter 689, 1991 North Carolina Session laws;~~*
Eff. August 3, 1992; ~~1992.~~
Readopted March 31, 2018.

10A NCAC 22L .0201 is proposed for amendment as follows:

SECTION .0200 - PREPAID PLANS

10A NCAC 22L .0201 PROGRAM DEFINITION

The Division ~~of Medical Assistance (DMA)~~ may contract with Federally qualified Health Maintenance Organizations (HMOs) and State licensed and certified HMOs to provide and coordinate medical services for Medicaid eligibles. Prior to the Division ~~DMA~~ awarding a contract to an HMO, the HMO shall ~~must submit an application in which it demonstrates~~ demonstrate its ability to meet all ~~contract specifications.~~ qualifications set forth in the Medicaid Provider Administrative Participation Agreement.

History Note: *Authority G.S. 108A-25(b);*
Eff. August 3, 1992;
Amended Eff. April 1, 1999;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 22, 2015;~~2015.~~
Amended Eff. March 31, 2018.

10A NCAC 22L .0203 is proposed for readoption without substantive change as follows:

10A NCAC 22L .0203 ACCESS TO CARE

(a) In-plan and out-of-plan services shall be listed in the contract between the HMO and the Division. ~~DMA.~~ The HMO shall pay for all in-plan services when provided in accordance with the HMO's policies and procedures. The Division ~~DMA~~ shall pay for all out-of-plan services provided in accordance with the Medicaid State Plan. ~~policies and procedures.~~ The Division ~~of Medical Assistance has the authority to~~ shall deny payment for in-plan services not provided nor authorized by the HMO.

(b) HMO members shall receive all in-plan services from their HMO or its subcontractors except:

(1) emergency medical services as defined in 42 U.S.C. 1396u-2(b)(2)(B) ~~1932(b)(2)(B)~~ and (C) ~~(C),~~ ~~which~~ that could not be provided by the HMO because the time to reach the in-plan provider capable of providing such services would have meant risk of serious damage or injury to the member's health;

(2) Medicaid-covered family planning services and supplies;

(3) services provided by a public health department for the screening, diagnosis, counseling, or treatment of sexually transmitted diseases, tuberculosis, ~~tuberculosis~~ or HIV; ~~and~~ or

(4) services for which the HMO has referred the member to an out-of-plan provider.

(c) The HMO shall make payment for in-plan services in Paragraph (b) ~~(b),~~ of this Rule ~~Rule,~~ in an amount agreed upon by the provider and the HMO. ~~In the absence of such an agreement, payment shall be made in the amount of the Medicaid allowable fee.~~

History Note: *Authority G.S. 108A-25(b); 42 U.S.C. 1396u-2(b)(2)(B),(C);*
Eff. August 3, 1992;
Amended Eff. April 1, 1999; ~~1999.~~
Readopted March 31, 2018.