TEMPORARY RULE-MAKING FINDINGS OF NEED

[Authority G.S. 150B-21.1]

ORIGINAL

APR 01 2014

OAH USE ONLY
VOLUME:
ISSUE:

1. Rule-Making Agency: N.C. Medical Care Commission

2. Rule citation & name: 10A NCAC 13B .3110 Itemized Charges

3. Action: ☐ Adoption ☒ Amendment ☐ Repeal

4. Was this an Emergency Rule: ☐ Yes ☒ No Effective date:

5. Provide dates for the following actions as applicable:

   a. Proposed Temporary Rule submitted to OAH: 2/17/2014

   b. Proposed Temporary Rule published on the OAH website: 2/21/2014

   c. Public Hearing date: 3/11/2014

   d. Comment Period: 2/22/2014-3/14/2014

   e. Notice pursuant to G.S. 150B-21.1(a3)(2): 2/17/2014

   f. Adoption by agency on: 3/18/2014

   g. Proposed effective date of temporary rule |if other than effective date established by G.S. 150B- 21.1(b) and G.S. 150B-21.3|: 5/1/2014

   h. Rule approved by RRC as a permanent rule: 4/17/2014

FILED
2014 APR -1 PM 2:36
OFFICE OF ADMIN HEARINGS

6. Reason for Temporary Action. Attach a copy of any cited law, regulation, or document necessary for the review.

   ☐ A serious and unforeseen threat to the public health, safety or welfare.
   ☒ The effective date of a recent act of the General Assembly or of the U.S. Congress.
   Cite: N.C.G.A. Session Law 2013-382, Part XIII Fair Health Care Facility Billing and Collections Practices
   Effective date: 10/1/2013
   ☐ A recent change in federal or state budgetary policy.
   Effective date of change:
   ☐ A recent federal regulation.
   Cite:
   Effective date:
   ☐ A recent court order.
   Cite order:
   ☐ State Medical Facilities Plan.
   ☐ Other:

Explain:

The proposed temporary amendments to rules in Chapters 10A NCAC 13B *Licensing of Hospitals* are in response to a recent act of the General Assembly, specifically Session Law 2013-382, Part XIII. *Fair Health Care Facility Billing and Collections Practices*, which became effective on October 1, 2013. The intent of this Act is to improve transparency in the cost of health care provided by hospitals and ambulatory surgical facilities and to provide for fair health care facility billing and collections practices. Section 13.1 of this Act requires the N.C. Medical Care Commission to adopt rules to ensure that the provisions of the law are properly implemented.

7. Why is adherence to notice and hearing requirements contrary to the public interest and the immediate adoption of the rule is required?

The availability of information related to health care pricing and transparency of that information is of significant importance to the citizens of North Carolina. The proposed temporary rules address billing and collections practices for hospitals and ambulatory surgical centers to ensure that these practices are transparent, fair and reasonable to the health care consumer as intended by the General Assembly. In fact, these rules protect patients' rights to be fully informed of charges they have incurred or may incur, and also empower patients to make informed health care decisions. In light of the complexity of health care, the proposed rules also seek to require providers to present patient billing information and financial assistance resources in a manner that is comprehensible to an 'ordinary' lay person.

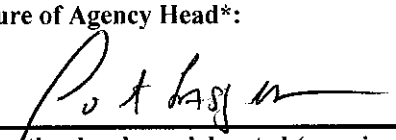
These proposed amendments require a facility's governing body to assure that written policies and procedures are developed in order to implement the requirements of S.L. 2013-382 regarding transparency, fair billing and collections practices. They also, in accordance with the session law, provide for a way for the Division of Health Service Regulation to verify that a facility is in compliance with the law prior to licensure or renewal of a facility's license.

Transparency in health care pricing and billing is important to North Carolinians. These proposed rules are the first step to achieving it in a manner that is meaningful and useful to the public.

8. Rule establishes or increases a fee? (See G.S. 12-3.1)

☐ **Yes**
Agency submitted request for consultation on:
Consultation not required. Cite authority:

☒ **No**

9. Rule-making Coordinator: Megan Lamphere 3 **Phone: 919-855-3974** **E-Mail: Megan.Lamphere@dhhs.nc.gov**	**10. Signature of Agency Head*:**  *** If this function has been delegated (reassigned) pursuant to G.S. 143B-10(a), submit a copy of the delegation with this form.** **Typed Name: Dr. John A. Fagg, M.D.** **Title: Chair, N.C. Medical Care Commission**
Agency contact, if any: Nadine Pfeiffer **Phone: 919-855-3811** **E-Mail: Nadine.Pfeiffer@dhhs.nc.gov**	

RULES REVIEW COMMISSION USE ONLY	
Action taken: ☐ Date returned to agency:	Submitted for RRC Review:

Session Law authorizing the Medical Care Commission to create Rules beginning in Part X of the bill.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

SESSION LAW 2013-382
HOUSE BILL 834

AN ACT ENHANCING THE EFFECTIVENESS AND EFFICIENCY OF STATE GOVERNMENT BY MODERNIZING THE STATE'S SYSTEM OF HUMAN RESOURCES MANAGEMENT AND BY PROVIDING FLEXIBILITY FOR EXECUTIVE BRANCH REORGANIZATION AND RESTRUCTURING AND TO IMPROVE TRANSPARENCY IN THE COST OF HEALTH CARE PROVIDED BY HOSPITALS AND AMBULATORY SURGICAL FACILITIES; TO TERMINATE SET-OFF DEBT COLLECTION BY CERTAIN STATE AGENCIES PROVIDING HEALTH CARE TO THE PUBLIC; TO MAKE IT UNLAWFUL FOR HEALTH CARE PROVIDERS TO CHARGE FOR PROCEDURES OR COMPONENTS OF PROCEDURES THAT WERE NOT PROVIDED OR SUPPLIED; TO PROVIDE FOR FAIR HEALTH CARE FACILITY BILLING AND COLLECTIONS PRACTICES; AND TO PROVIDE THAT HOSPITALS RECEIVING MEDICAID REIMBURSEMENTS PARTICIPATE IN THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE NETWORK.

The General Assembly of North Carolina enacts:

PART I. ORGANIZATIONAL AND ADMINISTRATIVE CHANGES

SECTION 1.1. G.S. 126-3(a) reads as rewritten:

"(a) There is hereby established the Office of State Personnel (hereinafter referred to as 'the Office') which shall be placed for organizational purposes within the ~~Department of Administration.~~ Office of the Governor. Notwithstanding the provisions of North Carolina State government reorganization as of January 1, 1975, and specifically notwithstanding the provisions of Chapter 864 of the 1971 North Carolina Session Laws, Chapter 143A of the General Statutes, the Office of State Personnel shall exercise all of its statutory powers in this ~~Chapter independent of control by the Secretary of Administration and~~ Chapter, which shall be under the administration and supervision of a State Personnel Director (hereinafter referred to as 'the Director') appointed by the Governor and subject to the supervision of the Commission for purposes of this Chapter. The salary of the Director shall be fixed by the Governor. The Director shall serve at the pleasure of the Governor."

SECTION 1.2. G.S. 126-3(b)(8) reads as rewritten:

"(8) Developing criteria and standards to measure the level of compliance or noncompliance with established Commission policies, rules, procedures, criteria, and standards in agencies, departments, and institutions to which authority has been delegated for classification, salary ~~administration~~administration, performance management, development, evaluation, and other decentralized programs, and determining through routine monitoring and periodic review process, that agencies, departments, and institutions are in compliance or noncompliance with established Commission policies, rules, procedures, criteria, and standards."

SECTION 1.3. G.S. 126-4(5) reads as rewritten:

"**§ 126-4. Powers and duties of State Personnel Commission.**

Subject to the approval of the Governor, the State Personnel Commission shall establish policies and rules governing each of the following:

…

(5) Hours and days of work, holidays, vacation, sick leave, and other matters pertaining to the conditions of employment. The legal public holidays established by the Commission as paid holidays for State employees shall

20.	G.S. 126-16.1	Equal employment opportunity training.
21.	G.S. 126-22	Personnel files not subject to inspection under § 132-6.
22.	G.S. 126-74	Work Options Program established.
23.	G.S. 128-15.3	Discrimination against handicapped prohibited in hiring; recruitment, etc., of handicapped persons.
24.	G.S. 135-4	Creditable service.
25.	G.S. 138A-3	Definitions.
26.	G.S. 143-49	Powers and duties of Secretary.
27.	G.S. 143-64.70	Personal service contracts – reporting requirements.
28.	G.S. 143-215.107C	State agency goals, plans, duties, and reports.
29.	G.S. 143-345.21	State employee suggestion program.
30.	G.S. 143-345.22	Allocation of suggestion program funds; nonmonetary recognition.
31.	G.S. 143-345.23	Suggestion and review process; role of agency coordinator and agency evaluator.
32.	G.S. 143-345.24	State Suggestion Review Committee.
33.	G.S. 143-345.25	Innovations deemed property of the State; effect of decisions regarding bonuses.
34.	G.S. 143-583	Model program; technical assistance; reports.
35.	G.S. 143B-10	Powers and duties of heads of principal departments.
36.	G.S. 143B-53.2	Salaries, promotions, and leave of employees of the North Carolina Department of Cultural Resources.
37.	G.S. 143B-146.21	Policies, reports, and other miscellaneous provisions.
38.	G.S. 143B-394.15	Commission established; purpose; membership; transaction of business.
39.	G.S. 143B-417	North Carolina Internship Council creation; powers and duties.
40.	G.S. 143B-806	Duties and powers of the Division of Juvenile Justice of the Department of Public Safety.
41.	G.S. 147-54.3	Land records management program.
42.	G.S. 148-22.1	Educational facilities and programs for selected inmates.

SECTION 9.2. No action or proceeding pending on the effective date of this section, brought by or against the State Personnel Commission, the Director of the Office of State Personnel, or the Office of State Personnel, shall be affected by any provision of this section, but the same may be prosecuted or defended in the new name of the Commission, Director, and Office. In these actions and proceedings, the renamed Commission, Director, or Office shall be substituted as a party upon proper application to the courts or other public bodies.

SECTION 9.3. Any business or other matter undertaken or commanded by the former State Personnel Commission, State Personnel Director, or Office of State Personnel regarding any State program, office, or contract or pertaining to or connected with their respective functions, powers, obligations, and duties that are pending on the date this act becomes effective may be conducted and completed by the Commission, Director, or Office in the same manner and under the same terms and conditions and with the same effect as if conducted and completed by the formerly named commission, director, or office.

SECTION 9.4. This Part is effective when it becomes law.

PART X. TRANSPARENCY IN HEALTH CARE COSTS

SECTION 10.1. Chapter 131E of the General Statutes is amended by adding a new Article to read:

"Article 1B.

"Transparency in Health Care Costs.

"**§ 131E-214.5. Title.**

This article shall be known as the Health Care Cost Reduction and Transparency Act of 2013.

"**§ 131E-214.6. Purpose; Department to publish price information.**

(a) It is the intent of this Article to improve transparency in health care costs by providing information to the public on the costs of the most frequently reported diagnostic related groups (DRGs) for hospital inpatient care and the most common surgical procedures

and imaging procedures provided in hospital outpatient settings and ambulatory surgical facilities.

(b) The Department of Health and Human Services shall make available to the public on its internet Web site the most current price information it receives from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-214.7. The Department shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

(1) Information for each hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the North Carolina Medical Care Commission in rules adopted pursuant to G.S. 131E-214.7.

(2) Information for each hospital outpatient department and each ambulatory surgical facility shall be listed separately.

(c) Any data disclosed to the Department by a hospital or ambulatory surgical facility pursuant to the Health Care Cost Reduction and Transparency Act of 2013 shall be and will remain the sole property of the facility that submitted the data. Any data or product derived from the data disclosed pursuant to this act, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Department shall not allow proprietary information it receives pursuant to this act to be used by any person or entity for commercial purposes.

"**§ 131E-214.7. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(4) Health insurer. – As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.

(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the quarter ending June 30, 2014, and quarterly thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the Commission:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.

(4) The amount of Medicare reimbursement for each DRG.

(5) For the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before March 1, 2014, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.

(d) Beginning with the quarter ending September 30, 2014, and quarterly thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before June 1, 2014, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the list of the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

"**§ 131E-214.8. Disclosure of charity care policy and costs.**

(a) Requirements. – A hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code must provide the public access to its financial assistance policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted annually to the Department in the time, manner, and format required by the Department. The Department must post the information on its internet Web site. The information must also be displayed in a conspicuous place in the organization's place of business.

(b) Definitions. – The following definitions apply in this section:

(1) Code. – Defined in G.S. 105-228.90.

(2) Financial assistance costs. – The information reported on Schedule H, federal form 990, related to the organization's financial assistance at cost and the amounts reported on that schedule related to the organization's bad debt expense and the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy.

(3) Financial assistance policy. – A policy that meets the requirements of section 501(r) of the Code."

SECTION 10.2. The State Health Plan for Teachers and State Employees shall establish a workgroup to examine the best way to provide teachers and State employees greater transparency in the costs of health services provided under the State Health Plan. The State Health Plan for Teachers and State Employees shall report the findings and recommendations of the workgroup to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Committee on Governmental Operations on or before December 31, 2013, and annually thereafter through December 31, 2016.

SECTION 10.3. Not later than September 1, 2013, the Department of Health and Human Services shall communicate the requirements of Section 2 of this act to all hospitals licensed pursuant to Article 5 of Chapter 131E of the General Statutes, Article 2 of Chapter 122C of the General Statutes, and to all ambulatory surgical facilities licensed pursuant to Part 4 of Article 6 of Chapter 131E of the General Statutes.

SECTION 10.4. G.S. 131E-97.3(a) reads as rewritten:

"**§ 131E-97.3. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals and ambulatory surgical facilities are required to report under G.S. 131E-214.6. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section."

SECTION 10.5. G.S. 131E-99 reads as rewritten:

"**§ 131E-99. Confidentiality of health care contracts.**

~~The~~ Except for the information a hospital or an ambulatory surgical facility is required to report under G.S. 131E-214.6, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does not affect the confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information."

SECTION 10.6. Section 10.4 and Section 10.5 of this Part become effective January 1, 2014. The remainder of this Part is effective when it becomes law.

PART XI. CERTAIN CHARGES/PAYMENTS PROHIBITED

SECTION 11.1. Article 16 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-273. Certain charges/payments prohibited.**

It shall be unlawful for any provider of health care services to charge or accept payment for any health care procedure or component of any health care procedure that was not performed or supplied."

SECTION 11.2. This Part becomes effective December 1, 2013, and applies to health care procedures and services rendered on or after that date. This Part shall not apply to administrative actions or litigation filed before the effective date of this Part.

PART XII. HOSPITAL DEBT COLLECTION

SECTION 12.1. G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:

a. A unit of the executive, legislative, or judicial branch of State ~~government.~~government, except for the following:

1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public.

2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.

b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.

c. A community college."

SECTION 12.2. This Part becomes effective January 1, 2014, and applies to tax refunds determined by the Department of Revenue on or after that date.

PART XIII. FAIR HEALTH CARE FACILITY BILLING AND COLLECTIONS PRACTICES

SECTION 13.1. G.S. 131E-91 reads as rewritten:

"**§ 131E-91. ~~Itemized charges on discharged patient's bill~~Fair billing and collections practices for hospitals and ambulatory surgical facilities.**

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter shall, upon request of the ~~patient~~patient, ~~within 30 days of discharge,~~present an itemized list of charges to all discharged ~~patients.~~patients detailing in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient. Patient bills that are not itemized shall include notification to the patient of the right to request, free of charge, an itemized bill. A patient may request an itemized list of charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill. Each hospital and ambulatory surgical facility shall establish a method for patients to inquire about or dispute a bill.

(b) If a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, health care facility billing error, or other cause, and the overpayment is not in dispute or on appeal, the hospital or ambulatory surgical facility shall provide the patient with a refund within 45 days of receiving notice of the overpayment.

(c) A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

(d) Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

(1) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.

(2) A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.

(3) A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.

(4) A hospital or ambulatory surgical facility shall require a collections agency, entity, or other assignee to obtain the written consent of the hospital or ambulatory surgical facility prior to the collections agency, entity, or other assignee filing a lawsuit to collect the debt.

(5) For debts arising from the provision of care by a hospital or ambulatory surgical center, the doctrine of necessaries as it existed at common law shall apply equally to both spouses, except where they are permanently living separate and apart, but shall in no event create any liability between the spouses as to each other. No lien arising out of a judgment for a debt owed a hospital or ambulatory surgical facility under this section shall attach to the judgment debtors' principal residence held by them as tenants by the entireties or that was held by them as tenants by the entireties prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse.

(6) For debts arising from the provision of care by a hospital or ambulatory surgical center to a minor, there shall be no execution on or otherwise forced sale of the principal residence of the custodial parent or parents for a judgment obtained for the outstanding debt until such time as the minor is either no longer residing with the custodial parent or parents or until the minor reaches the age of majority, whichever occurs first.

(e) The Commission shall adopt rules to ensure that this section is properly ~~implemented~~ implemented. ~~and that patient bills which are not itemized include notification to~~

~~the patient of his right to request an itemized bill.~~The Department shall not issue ~~nor~~ or renew a license under this~~Chapter~~ Article unless the applicant has demonstrated that the requirements of this ~~section~~ subsection are being met.

SECTION 13.2. Article 2A of Chapter 131E of the General Statutes is repealed.

SECTION 13.3. Part 4 of Article 6 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-147.1. Fair billing and collections practices for ambulatory surgical facilities.**

All ambulatory surgical facilities licensed under this Part shall be subject to the fair billing and collections practices set out in G.S. 131E-91."

SECTION 13.4. G.S. 58-3-245 reads as rewritten:

"**§ 58-3-245. Provider ~~directories.~~directories; cost tools for insured.**

(a) Every health benefit plan utilizing a provider network shall maintain a provider directory that includes a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. The health benefit plan shall ensure that a patient is provided accurate and current information on each provider's network status through the telephone system and any electronic or online system. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory listing may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each directory listing shall include the following network information:

(1) The provider's name, address, telephone number, and, if applicable, area of specialty.

(2) Whether the provider may be selected as a primary care provider.

(3) To the extent known to the health benefit plan, an indication of whether the provider:

a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under G.S. 58-3-230.

(d) A health care provider shall provide to a patient or prospective patient, upon request, information on that provider's network status with a particular health benefit plan."

SECTION 13.5. This Part becomes effective October 1, 2013, and applies to hospital and ambulatory surgical facility billings and collections practices occurring on or after that date.

PART XIV. PARTICIPATION IN NORTH CAROLINA HEALTH INFORMATION EXCHANGE

SECTION 14.1. Article 29A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-413.3A. Required participation in NC HIE for some providers.**

(a) The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program is of significant importance to the State, its taxpayers, and its Medicaid recipients.

(2) That the State needs timely access to claims and clinical information in order to assess performance, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending Medicaid dollars.

(3) That making this clinical information available through the North Carolina Health Information Exchange will improve care coordination within and

11

across health systems, increase care quality, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health cost-containment.

(b) Notwithstanding any other provision of law, based upon the findings set forth in subsection (a) of this section, any hospital, as defined in G.S. 131E-76(c), that has an electronic health record system shall connect to the NC HIE and submit individual patient demographic and clinical data on services paid for with Medicaid funds."

SECTION 14.2. This Part becomes effective January 1, 2014.

PART XV. EFFECTIVE DATE

SECTION 15. Unless otherwise provided, this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 25th day of July, 2013.

s/ Tom Apodaca
Presiding Officer of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 11:05 a.m. this 21st day of August, 2013

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: All rules

DEADLINE FOR RECEIPT: Friday, April 11, 2014

***NOTE WELL:* This request when viewed on computer extends several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

> *In Box 5, these Rules have not been approved by the RRC as permanent rules. Please resubmit the forms, leaving Item h blank.*

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .3110

DEADLINE FOR RECEIPT: Friday, April 11, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

On line 6, delete the comma after "bills" and replace "which" with "that"

On line 7, I read S.L. 2013-382, Section 13.1, 131E-91(a) to require an itemized bill after patient request within three years or so long as the hospital or its collection agent or assignee asserts the patient has an obligation to pay the bill. You need to add that language to the Rule in (a).

In Paragraph (b), delete the comma after "patient" on line 8.

Also in Paragraph (b), I understand you are reciting statutory language, but I do want to make sure that your regulated public will understand what will qualify as "layman's terms"?

In Paragraph (c), I read 131E-91(a) to require an itemized bill for all charges incurred. I take it that this Rule is intended to give guidance, rather than give a list, so I think you should delete "at a minimum" on line 11 and instead, why not state "<u>all</u> charges incurred, <u>including those</u> incurred in the following areas:"?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

10A NCAC 13B .3110 is temporarily adopted, without changes as published on the OAH website, as follows:

10A NCAC 13B .3110 ITEMIZED CHARGES

(a) The facility shall either present an itemized list of charges to all discharged patients or the facility shall include on patients' bills, which are not itemized, notification of the right to request an itemized bill within ~~30 days~~ three years of receipt of the non-itemized bill.

(b) If requested, the facility shall present an itemized list of charges to each patient, or the patient's responsible party. This list shall detail in layman's terms the specific nature of the charges or expenses incurred by the patient.

(c) The itemized listing shall include, at a minimum, those charges incurred in the following service areas:

(1) room rates;
(2) laboratory;
(3) radiology and nuclear medicine;
(4) surgery;
(5) anesthesiology;
(6) pharmacy;
(7) emergency services;
(8) outpatient services;
(9) specialized care;
(10) extended care;
(11) prosthetic and orthopedic appliances; and
(12) professional services provided by other independently billing medical personnel.

History Note: *Authority G.S. 131E-79; 131E-91; S.L. 2013-382(s.13.1);*
Eff. January 1, ~~1996.~~ 1996;
Temporary Amendment Eff. May 1, 2014.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13B .3502

DEADLINE FOR RECEIPT: Friday, April 11, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 6, delete "As a minimum," unless you have a compelling need to keep it. Rules set the minimum standard, so this language is redundant.

In Subparagraph (a)(1), what do you mean by "the general and specific goals of the facility"?

In Subparagraph (a)(8), replace "as described" with "as set forth" on lines 21-22.

Also in that Subparagraph, when is compliance with G.S. 131E-117 not applicable?

In Subparagraph (b)(2), where you speak of "appeal" are you relying upon 131E-91(b) as the authority for this requirement?

In Subparagraph (b)(3), I think you should insert "to the patient" after "refund" on line 36.

On Page 2, Paragraph (c), delete "at least" on line 7, unless you have a compelling reason to keep it.

In Paragraph (d), please explain to me the process for licensure or renewal. You are allowing the hospitals to submit attestation of the requirements within six months of the application. However, G.S. 131E-91(e) states that the Department cannot issue the license until the requirements are met. Does it typically take six months for the Department to issue the license or renewal?

Also in Paragraph (d), what do you mean by "a format approved by the Department"? Do you mean on a form provided by the Department? Do you mean electronic versus paper? This needs to be clarified. In addition, please confirm that you intend for the Department and not the Division to be the approving body.

In the History Note, I take it the reference to S.L. 2013-382, s. 10.1 is to clarify the language in Subparagraph (b)(5) regarding the Schedule H, federal form 990?

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

Rearrange the History Note so that it reads: 131E-79; 131E-91; S.L. 2013-382(s.10.1); S.L. 2013-382(s.13.1);

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

10A NCAC 13B .3502, originally published on the OAH website as 10A NCAC 13B .1906, is temporarily adopted as follows:

10A NCAC 13B .3502 REQUIRED POLICIES, RULES, AND REGULATIONS

(a) The governing body shall adopt written policies, rules, and regulations in accordance with all requirements contained in this Subchapter and in accordance with the community responsibility of the facility. As a minimum, the written policies, rules, and regulations shall:

(1) state the general and specific goals of the facility;

(2) describe the powers and duties of the governing body officers and committees and the responsibilities of the chief executive officer;

(3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;

(4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral, or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;

(5) require Board approval of the bylaws of any auxiliary organizations established by the hospital;

(6) require the governing body to review and approve the bylaws of the medical staff organization;

(7) establish a procedure for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;

(8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights as described in Rule .3302 of this Subchapter and in compliance with G.S. 131E-117 where applicable; and

(9) require the governing body to institute procedures to provide for:

(A) orientation of newly elected board members to specific board functions and procedures;

(B) the development of procedures for periodic reexamination of the relationship of the board to the total facility community; and

(C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, on a regular basis to all members of the governing body.

(b) The governing body shall adopt written policies and procedures to assure billing and collection practices in accordance with G. S. 131E-91. These policies and procedures shall include:

(1) how a patient or patient’s representative may dispute a bill;

(2) how a patient or patient’s representative may appeal a decision made by the facility regarding a bill;

(3) issuance of a refund resulting from overpayment of a bill;

(4) providing written notification to the patient or patient's responsible party prior to submitting a delinquent bill to a collection agency;

(5) providing the patient or patient's responsible party with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990; and

(6) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or responsible party.

~~(b)~~ (c) The written policies, rules, and regulations shall be reviewed at least every three years, revised as necessary, and dated to indicate when last reviewed or revised.

(d) To qualify for licensure or license renewal, each facility must provide to the Division, within six months of application, an attestation statement in a format approved by the Department verifying compliance with the requirements in Paragraph (b) of this Rule.

History Note: *Authority G.S. 131E-79; S.L. 2013-382(s.10.1),(s.13.1); G.S. 131E-91;*
Eff. January 1, ~~1996.~~ 1996;
Temporary Amendment Eff. May 1, 2014.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0202

DEADLINE FOR RECEIPT: Friday, April 11, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), I take it your regulated public knows the acronyms "JCAHO" "AAAHC" and "AAAASF"? In addition, please confirm the Joint Commission on Accreditation on Healthcare Organizations is not currently called the Joint Commission.

In Paragraph (b), line 12, insert a comma after "Subchapter"

In Paragraph (c), line 13, you state the Department must be notified of the changes. However, on line 22, you state that a new application must be submitted if there are changes. Do you mean for the notice on line 13 to be the application?

In Subparagraph (c)(1), why not just state "any change of the operator or owner"?

In Paragraph (d), line 23, insert a "the" before "plans" delete the comma after specifications and the "which are stated" so the sentence reads, "license until the plans and specifications in Section .1400 of this Subchapter, covering…"

In (f), insert a period after "Plans" on line 28.

I am not sure of the purpose of (f)(3). I don't know why you need it in this Rule. Aren't you already require schematic plans (which I understand to be electoral or mechanical systems from my Google research) already required in (f)(1)?

In (f)(4), please confirm you wish to use "plot plan" instead of "site plan"

In (f)(5), write this in active voice. "Plans shall be submitted in duplicate. The Division…"

In (f)(5), do you mean the Division <u>shall</u> distribute a copy? If not, then when won't the Division give a copy of the plan to the Department of Insurance?

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

In Paragraph (g), you state that each facility must provide to the Division at the time of application an attestation of compliance. However, the proposed rule governing hospitals, 13B . 3502, requires this information within six months of application.

G.S. 131E-149 states:

§ 131E-149. Rules and enforcement.

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this Part. These rules shall be no stricter than those issued by the Commission under G.S. 131E-79 of the Hospital Licensing Act.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to ambulatory surgical facilities. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1.)

In order to comply with this statutory mandate, I believe you must revert to the language as published, which was within six months or have the same requirement in Rule 13B . 3502. Otherwise, I do not see the authority to have the stricter standard in this Rule.

Further in Paragraph (g), what do you mean by "a format approved by the Department"? Do you mean on a form provided by the Department? Do you mean electronic versus paper? This needs to be clarified. In addition, please confirm that you intend for the Department and not the Division to be the approving body.

Reformat the History Note to be in proper numerical order. Put the Session Law last.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

10A NCAC 13C .0202 is temporarily adopted, with changes as published on the OAH website, as follows:

10A NCAC 13C .0202 REQUIREMENTS FOR ISSUANCE OF LICENSE

(a) Upon application for a license from a facility never before licensed, a representative of the Department shall make an inspection of that facility. Every building, institution or establishment for which a license has been issued shall be inspected for compliance with the rules found in this Subchapter. An ambulatory surgery facility shall be deemed to meet licensure requirements if the ambulatory surgery facility is accredited by JCAHO, AAAHC or AAAASF. Accreditation does not exempt a facility from statutory or rule requirements for licensure nor does it prohibit the Department from conducting inspections as provided in this Rule to determine compliance with all requirements.

(b) If the applicant has been issued a Certificate of Need and is found to be in compliance with the Rules found in this Subchapter then the Department shall issue a license to expire on December 31 of each year.

(c) The Department shall be notified at the time of:

(1) any change as to the person who is the operator or owner of an ambulatory surgical facility;

(2) any change of location;

(3) any change as to a lease; and

(4) any transfer, assignment or other disposition or change of ownership or control of 20 percent or more of the capital stock or voting rights thereunder of a corporation which is the operator or owner of an ambulatory surgical facility, or any transfer, assignment, or other disposition of the stock or voting rights thereunder of such corporation which results in the ownership or control of more than 20 percent of the stock or voting rights thereunder of such corporation by any person.

A new application shall be submitted to the Department in the event of such a change or changes.

(d) The Department shall not grant a license until plans and specifications, which are stated in Section .1400 of this Subchapter, covering the construction of new buildings, additions, or material alterations to existing buildings are approved by the Department.

(e) The facility design and construction shall be in accordance with the licensure rules for ambulatory surgical facilities found in this Subchapter, the North Carolina State Building Code, and local municipal codes.

(f) Submission of Plans

(1) Before construction is begun, plans and specifications covering construction of the new buildings, alterations, renovations or additions to existing buildings, shall be submitted to the Division for approval.

(2) The Division shall review the plans and notify the licensee that said buildings, alterations, additions, or changes are approved or disapproved. If plans are disapproved the Division shall give the applicant notice of deficiencies identified by the Division.

(3) In order to avoid unnecessary expense in changing final plans, as a preliminary step, proposed plans in schematic form shall be reviewed by the Division.

(4) The plans shall include a plot plan showing the size and shape of the entire site and the location of all existing and proposed facilities.

(5) Plans shall be submitted in duplicate in order that the Division may distribute a copy to the Department of Insurance for review of the North Carolina State Building Code requirements.

(g) To qualify for licensure or license renewal, each facility must provide to the Division, {~~within six months of application,~~} upon application, an attestation statement in a format approved by the Department verifying compliance with the requirements defined in Rule .0301(d) of this Subchapter.

History Note: *Authority G.S. 131E-147; 131E-149; S.L. 2013-382; G.S. 131E-91;*
Eff. October 14, 1978;
Amended Eff. April 1, ~~2003.~~ 2003;
Temporary Amendment Eff. May 1, 2014.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0205

DEADLINE FOR RECEIPT: Friday, April 11, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 6, I read S.L. 2013-382, Section 13.1, 131E-91(a) to require an itemized bill after patient request within three years or so long as the hospital or its collection agent or assignee asserts the patient has an obligation to pay the bill. You need to add that language to the Rule and make a conforming change to Paragraph (d) of this Rule.

In Paragraph (b), line 7, delete the comma after "patient."

Also in (b), I take it the regulated public knows what the "responsible party" is?

In Paragraph (b), I understand you are reciting statutory language, but I do want to make sure that your regulated public will understand what will qualify as "layman's terms"?

In Paragraph (c), I read 131E-91(a) to require an itemized bill for all charges incurred. I take it that this Rule is intended to give guidance, rather than give a list, so I think you should delete "at a minimum" on line 9 and instead, why not state "<u>all</u> charges incurred, <u>including those</u> incurred in the following areas:"?

Insert an "and" after the semicolon on line 15.

In Paragraph (d), do you have this requirement for hospitals? I am referring to G.S. 131E-149 here, so is this a stricter standard than you have for hospitals?

In the History Note, I'd add G.S. 131E-147.1. And there is no need to repeat 131E-91 in the Note.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

10A NCAC 13C .0205 is temporarily adopted, without changes as published on the OAH website, as follows:

10A NCAC 13C .0205 ITEMIZED CHARGES

(a) The facility shall either present an itemized list of charges to all discharged patients or the facility shall include on patients' bills which are not itemized notification of the right to request an itemized bill within ~~30 days~~ three years of receipt of the non-itemized bill.

(b) If requested, the facility shall present an itemized list of charges to each patient, or his or her responsible party. This list shall detail in layman's terms the specific nature of the charges or expenses incurred by the patient.

(c) The listing shall include, at a minimum, those charges incurred in the following service areas:

(1) Surgery (facility fee);

(2) Anesthesiology;

(3) Pharmacy;

(4) Laboratory;

(5) Radiology;

(6) Prosthetic and Orthopedic appliances;

(7) Other professional services.

(d) The facility shall indicate on the initial or renewal license application that patient bills are itemized, or that each patient or responsible party is formally advised of the patient's right to request an itemized listing within ~~30 days~~ three years of receipt of a non-itemized bill.

History Note: *Authority G.S. 131E-91; S.L. 2013-382(s.13.1);G.S. 131E-91:*
Eff. December 1, ~~1991.~~ 1991;
Temporary Amendment Eff. May 1, 2014.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Medical Care Commission

RULE CITATION: 10A NCAC 13C .0301

DEADLINE FOR RECEIPT: Friday, April 11, 2014

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 5, replace "which" with "that"

In Subparagraph (a)(1), the individual will be held responsible for what?

In Subparagraph (a)(2), delete "at least" unless you have a compelling reason to keep it. And if there is only one member of the governing authority, there is no need to have the meetings, right?

In (a)(3), the governing authority won't just maintain a manual, will they? Won't they also create it?

Further in (a)(3), delete "at least" on line 12. And I'd rewrite the entire sentence as "The manual shall be reviewed annually and revised when necessary." If you are trying to make sure the manual is reviewed more than annually (in the event of issues necessitating a change to the policies), then why not keep at least and state "The manual shall be reviewed at least annually and revised when necessary."?

In Paragraph (d), why isn't the language here parallel with Rule 13B .3502? Replace the first "assure" on line 22 with "adopt" or "create"

In Subparagraph (d)(2), where you speak of "appeal" are you relying upon 131E-91(b) as the authority for this requirement?

In Subparagraph (d)(3), I think you should insert "to the patient" after "refund" on line 36.

In the History Note, I take it the reference to S.L. 2013-382, s. 10.1 is to clarify the language in Subparagraph (b)(5) regarding the Schedule H, federal form 990?

Rearrange the History Note: 131E-91; 131E-149; S.L. 2013-382(s.10.1); S.L. 2013-382(s.13.1);

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: April 4, 2014

10A NCAC 13C .0301 is temporarily adopted, with changes as published on the OAH website, as follows:

10A NCAC 13C .0301 GOVERNING AUTHORITY

(a) The facility's governing authority shall adopt bylaws or other appropriate operating policies and procedures which shall:

(1) specify by name the person to whom responsibility for operation and maintenance of the facility is delegated and methods established by the governing authority for holding such individuals responsible;

(2) provide for at least annual meetings of the governing authority if the governing authority consists of two or more individuals. Minutes shall be maintained of such meetings;

(3) maintain a policies and procedures manual which is designed to ensure professional and safe care for the patients. The manual shall be reviewed, and revised when necessary, at least annually. The manual shall include provisions for administration and use of the facility, compliance, personnel quality assurance, procurement of outside services and consultations, patient care policies and services offered; and

(4) provide for annual reviews and evaluations of the facility's policies, management, and operation.

(b) When services such as dietary, laundry, or therapy services are purchased from others, the governing authority shall be responsible to assure the supplier meets the same local and state standards the facility would have to meet if it were providing those services itself using its own staff.

(c) The governing authority shall provide for the selection and appointment of the professional staff and the granting of clinical privileges and shall be responsible for the professional conduct of these persons.

(d) The governing {~~board~~} authority shall assure written policies and procedures to assure billing and collection practices in accordance with G. S. 131E-91. These policies and procedures shall include:

(1) how a patient or patient's representative may dispute a bill;

(2) how a patient or patient's representative may appeal a decision made by the facility regarding a bill;

(3) issuance of a refund resulting from overpayment of a bill;

(4) providing written notification to the patient or patient's responsible party prior to submitting a delinquent bill to a collection agency;

(5) providing the patient or patient's responsible party with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990; and

(6) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or responsible party.

History Note: *Authority G.S. 131E-149; S.L. 2013-382(s.10.1),(s.13.1); G.S. 131E-91;*
Eff. October 14, 1978;
Amended Eff. November 1, 1989; November 1, 1985; December 24, ~~1979.~~ 1979;

Temporary Amendment Eff. May 1, 2014.