UNC HEALTH CARE

October 17, 2012

Senator Charles E. Grassley
United States Senate
Committee on the Judiciary
Washington, DC 25010-6275

Republican Staff Office
Senator Charles E. Grassley
Attention: Erika Smith
152 Senate Dirkson Building
Washington, DC 20512

Dear Senator Grassley:

The University of North Carolina Hospitals at Chapel Hill has received your September 28, 2012 letter regarding the Federal 340B Drug Pricing Program. We share your commitment to ensuring the proper and efficacious use of this important program and welcome the opportunity to share our experiences with the 340B program. UNC Hospitals, an 804-bed facility located in Orange County, NC, is the flagship academic medical institution of the State of North Carolina-owned UNC Health Care System. UNC Hospitals is part of the UNC Health Care System, which is a governmental entity comprised of owned and managed hospitals, physician practices and post-acute care facilities. This year, the Health Care System is proudly celebrating the 60th anniversary of our first 4-year medical school graduating class and the construction of our main hospital.

UNC Hospitals is the only State-owned teaching hospital in North Carolina. It is the State teaching institution for the University of North Carolina School of Medicine. As such, UNC Hospitals treats many of the most complex patients from all 100 North Carolina counties.

UNC Hospitals appreciates the concern expressed by you about the 340B program, and we also recognize the importance of this program for North Carolinians. We embrace our mission to care for the underserved as evidenced by our serving as the safety net referral hospital for North Carolina for over 60 years.

On the pages that follow, we have responded to the questions posed to UNC Hospitals. Please let me know if we can provide any additional information or clarification.

Sincerely,

William L. Roper

William L. Roper
Chief Executive Officer
University of North Carolina Health Care System

cc. Mr. Gary Park, President UNC Hospitals
Mr. John Lewis, CFO UNC Health Care System

Specifically, you have asked UNC Hospitals at Chapel Hill to respond to the following questions:

1. **Please provide a summary of all revenue received from participating in the 340B program from 2008, broken down by year.**

REVENUE

UNC Hospitals outpatient and retail pharmaceutical revenues are derived primarily from four sources:

- Medicare reimburses outpatient pharmaceuticals through the Outpatient Prospective Payment System (OPPS) methodology. Within this methodology, some pharmaceuticals are reimbursed as part of a total "packaged" payment with no specific attribution to individually billed line items. Some pharmaceuticals are paid based on the quantity billed, not the charges applied. Others are reimbursed on a "pass through" formula based on the Medicare Cost Report calculated cost-to-charge ratio, or essentially at acquisition cost.
- North Carolina Medicaid reimburses outpatient pharmaceuticals through a calculation of a hospital's cost-to-charge ratio. In the aggregate this ratio equates to the acquisition cost for a given entity. Any medications without a National Drug Code (NDC) are considered non-covered and not reimbursed.
- UNC Hospitals contracts with managed care insurance carriers which offer differing reimbursement methodologies. In some cases, the hospital ambulatory areas are reimbursed based on a percentage of charges as described in greater detail below. In other cases, the pharmaceuticals are included as part of a global or packaged payment and not reimbursed separately by line item. In the retail pharmacy setting, payment is generally based on a percentage of Average Wholesale Price plus a dispensing fee. UNC Hospitals' charges are low relative to most quanternary care centers.
- Patients without insurance can qualify for financial assistance. UNC Health Care's financial assistance policies are among the most generous in North Carolina and have been objectively described as setting an ideal standard. Patients qualifing for financial assistance pay only modest co-payments (the details of our financial assistance policies are delienated in response to question #4). Patients who do not qualify to financial assistance receive a 35% discount from charges.

Payments to UNC Hospitals do not generally specify payments for pharmaceuticals as a line item. Payments for procedures and other services provided to outpatients are consolidated with pharmaceuticals. We calcululated revenues in accordance with the Financial Statement Audit directives from the North Carolina Office of the State Auditor. The following table represents the revenue (payments) resulting from providing services to outpatients receiving 340B pharmaceuticals plus associated services:

Fiscal Year 2012	$65,391,050 (July 1, 2011 – June 30, 2012)
Fiscal Year 2011	$52,580,763 (July 1, 2010 – June 30, 2011)
Fiscal Year 2010	$38,451,076 (July 1, 2009 – June 30, 2010)
Fiscal Year 2009	$33,087,329 (July 1, 2008 – June 30, 2009)

We have defined revenue in a manner consistent with our annual governmental financial audits as gross charges less required contractual deductions, bad debt and charity. This amount is not "profit" or "margin" on the specific pharmaceutical line item; it represents total revenue. It should be noted that the revenue component of providing outpatient pharmaceuticals would not change significantly whether or not the facility participates in the 340B program. The only reimbursement, or revenue, that is tied directly to acquisition cost is from Medicare and Medicaid.

OUTPATIENT RETAIL PHARMACY

Due to the manner in which we are paid for our services and our internal data systems, we are not able to specifically complete a profit and loss statement on the 340B program. We can state that the program allows UNC Hospitals to obtain pharmaceuticals at a discount to our normal purchasing prices which, in turn, allows UNC Hospitals to reinveste resources for the care of those who cannot pay.

UNC Hospitals outpatient retail pharmacy information system allowed us, for fiscal years 2011 and 2012, to obtain the cost of 340B medications and compare that to charges and payments specifically. The charges, payments and cost are inclusive of pharmaceutical accounts only and do not include other services. The data below shows the 340B account reimbursement to be slightly more than the acquisition cost. However, the costs stipulated below do not include labor or other overhead expenses, which substantially increase the overall cost of the Outpatient Retail Pharmacy program.

Fiscal Year 2012	
340B Pharmaceutical Cost	$3,895,000
Payments	$4,275,000
Charges (see below)	$17,492,000

Fiscal Year 2011	
340B Pharmaceutical Cost	$3,257,000
Payments	$3,639,000
Charges (see below)	$16,014,000

PATIENT CHARGES

Your letter also questions UNC Hospitals' patient charges. Since some insurance companies and private individuals reimburse UNC Hospitals based on our billed charges, we strive to keep these rates as low as feasible. Charge levels at UNC Hospitals are set to achieve a nominal profit for reinvestment into the system for our overall healthcare mission. Profits are used to fund hospital operations and invest in necessary capital. UNC Hospitals increase in net assets (profit) for fiscal year 2012 was approximatly 3.6% net of State Appropriations. The FY2012 NC State financial audit is still in process. Beginning in Fiscal Year 2013, UNC Hospitals will not receive a state appropriation.

UNC Hospitals' service area includes two large teaching hospitals that benefit from 340B certification - Duke University Medical Center and WakeMed Health & Hospitals. Both organizations are members of the Association of American Medical Colleges' Council of Teaching Hospitals (COTH).

A review of hospital charges compiled by Clevery and Associates shows the general charge levels for outpatients computed in a "Hospital Charge Index." This index was updated using 2011 Medicare payer data compared to the US Median. The results of this review demonstrates that UNC Hospitals charges to be lower than the national average and significantly lower than other hospitals in our primary market. It is importatant to note that UNC Hospitals charge levels when compared to other Council of Teaching Hospitals ranks in the lowest quartile.

	Outpatient Charge Index	Inpatient Charge Index	Overall Index
US Median	100.00	100.00	103.60
UNC Hospitals	**76.19**	**92.77**	**85.51**

Further, when charges to Medicare beneficiaries are compared on a case mix and wage index adjusted basis the relationships are consistent, UNC Hospitals has the lowest overall charge structure in the Raleigh/Durham North Carolina market.

2. Please explain whether, to what extent, and how UNC Hospital has reinvested those savings for the benefit of uninsured patients.

Regardless of a patient's ability to pay, we have a state-mandated mission to provide care to all North Carolinians. In our 2011 fiscal year, UNC Hospitals provided approximately $173,874,000 in community benefit (table follows later in this section). Included in this amount is more than $133,000,000 in uncompensated care costs – on a base of $1.0 billion in revenues. Our parent company, the UNC Health Care System, provided more than $300 million of uncompensated care costs.

All of UNC Hospitals' fund balance is encumbered by the State. The State provides $0 annually to support capital investment or debt service, yet it demands that we provide high quality care to all North Carolinians, despite their ability to pay. UNC Hospitals' excess reserves are reinvested into the provision of health care and related services. UNC Hospitals' fund balance combines funds designated for capital projects, funds restricted by our current bond covenants, and funds required to maintain hospital operations. Our operating reserve represents approximately 100 days of cash. For an operation as large and as complex as ours, we should maintain much more than 100 days in reserve.

340B Program Reinvestment

The intent of the 340B program is to help facilities provide care to patients who do not have the means to pay for their health care. Based on lower drug acquisition cost accessed through the 340B program, UNC Hospitals is able to provide more and better care to uninsured patients.

Nearly 80% of the prescriptions that are filled in UNC Hospitals' outpatient pharmacy are for patients who earn less than 200% of the federal poverty limit and/or do not have insurance – the under and uninsured population of North Carolina. We charge only a $4 co-pay, and UNC Hospitals subsidizes the balance.

For our Medicaid patients, we pass along our 340B cost plus a dispensing fee to cover overhead, so we earn no margin on these drugs.

Approximately 6% of the total population served by our outpatient pharmacy holds some form of insurance other than Medicare or Medicaid. We are able to buy the drugs for these patients at a lower cost, charge the same as a non-340B pharmacy would charge, and use the additional margin to pay for the overhead for the large majority who cannot pay for their prescriptions. The 340B program is integral to our ongoing ability to serve those who cannot afford their medications.

We offer several additional services as a result of the 340B program to patients who cannot afford their medications:

- Our Medication Assistance Team helps patients obtain co-pay assistance, and in some cases, obtain free branded medications from manufacturers. These patients will not qualify for charity care programs but still cannot pay the high price of medications - often referred to as underinsured patients. We employ a team of 14 pharmacy professionals for this specific program who work with these patients to get proper authorization for further assistance. Last fiscal year alone, this assistance enabled these patients to get more than $5 million in medications that were otherwise unobtainable.

- We developed a Transition in Care Team through our outpatient pharmacy that focuses on high risk patient populations, such as solid organ and bone marrow transplant patients, ensuring patients leave our facility with appropriate medications. The team makes sure the patients have all that discharge needs before they leave the hospital, including a thorough understanding of their medications. The team ensures prescriptions have been filled and are ready to be picked up at the pharmacy. The Transitions in Care Team has proven to reduce readmissions and improve medication adherence.

Without the 340B program, we would not have had the funds to maintain these programs: financial assistance, medication assistance and care transitions. Without the 340B program, we would have to evaluate closing our outpatient pharmacy due to the significant financial losses we would incur. With no comparable programs in North Carolina, our citizens would have no affordable means of obtaining their pharmaceuticals.

Community Benefits Statement

UNC Hospitals annually submits to the North Carolina Hospital Association a standardized statement of community benefits along with many other North Carolina Hospitals. This submission is commonly structured for all hospitals to show the costs of care associated with our chartibale mission. UNC Hospitals submission, along with other voluntary participants, can be found at www.ncha.org.

Fiscal Year 2011 Community Benefits	
Estimated Cost of Treating Charity Care Patients	$ 74,862,000
Estimated Unreimbursed Costs of Treating Medicare Patients	$ 15,677,000
Estimated Unreimbursed Costs of Treating Medicaid Patients	$ 33,395,000
Health Professions Education Costs	$ 37,653,000
Estimated Unreimbursed Costs of Treating Other Govt Patients	$ 9,056,000
Other Subsidized Services	$ 2,800,000
Community Health Improvement Services	$ 352,000
Total Community Benefits Without Settlements	$173,874,000

3. **Please provide the payor mix for all 340B drugs from 2008-2012. Please list the price at which UNC Hospital purchase each 340B drug, and the price at which it sold the drug, per payor mix.**

A file is included in this electronic package named [redacted] which includes the 340B purchase price and UNC Hospitals' charge for the pharmaceutical by individual drug as requested. Charges do not vary by payor. Therefore, all charges per perscription are the same for every patient regardless of payor.

The file reflects Fiscal Year 2009 - 2011 average 340B purchase price per prescription and average charge per prescription. The costs and charges reflected are averages throughout the course of the year as they vary each week based on the Average Wholesale Price downloads from the wholesaler.

UNC Hospitals is eligible to participate in the 340B program for all outpatients. Below, we have provided the overall outpatient payor mix for patients with pharmaceutical charges and singularly the payor mix of our outpatient retail pharmacy. This is not a common request and our data is not formatted in such a way that we are able to easily retrieve outpatients accounts with pharmaceutical charges only. We have used our best efforts to provide this information available data.

Payor Mix by Year:

Fiscal Year 2012 (through June 30, 2012)	**Total OP Pharmacy Payor Mix**	**Retail Pharmacy Payor Mix**
Commercial/Managed Care	29.6%	5.2%
Medicare	32.9%	11.0%
Medicaid	12.5%	4.5%
State Health Plan	6.7%	0.8%
Self-Pay	13.7%	78.5%
All Other	4.6%	0.0%
Fiscal Year 2011 (through June 30, 2011)		
Commercial/Managed Care	22.6%	4.8%
Medicare	23.1%	10.1%
Medicaid	9.7%	4.1%
State Health Plan	12.0%	0.8%
Self-Pay	12.0%	71.8%
All Other	4.1%	0.0%
Fiscal Year 2010 (through June 30, 2010)		
Commercial/Managed Care	28.0%	4.6%
Medicare	16.8%	9.8%
Medicaid	7.2%	4.0%
State Health Plan	4.9%	0.8%
Self-Pay	10.3%	70.1%
All Other	3.5%	0.0%

Fiscal Year 2009 (through June 30, 2009)	Total OP Pharmacy Payor Mix	Retail Pharmacy Payor Mix
Commercial/Managed Care	27.9%	5.0%
Medicare	27.5%	10.5%
Medicaid	10.3%	4.3%
State Health Plan	8.4%	0.8%
Self-Pay	20.0%	75.1%
All Other	5.9%	0.0%

UNC Hospitals pricing methodology for pharmaceuticals is included in this electronic package under file name [redacted] The 340B purchase price is calculated using Average Wholesale Price (AWP) and Medicaid rebate amounts. The AWP of a drug may drop dramatically when a generic version of the drug enters the market or when a new manufacturer enters the market. However, it takes a longer period of time for the Medicaid rebate to drop accordingly. As a result the 340B price calculation can be a negative number. Rather than "sell" a drug at a negative price, the manufacturer sets the price at $0.01 until the equation equilibrates. This pricing may be in effect for one or more quarters.

Retail Pharmacy Charges

The charging equation for retail prescriptions is based upon Average Wholesale Price rather than the 340B acquisition cost. It is a standard practice for insurance payers to agree to reimburse the pharmacy at a rate based upon the AWP. For instance, a given contract may provide reimbursement at AWP +/- 20% plus a dispensing fee. This methodology is common in retail pharmacies.

Ambulatory Clinic and other Outpatients Charges

The charging methodology for both inpatients and ambulatory clinic outpatients is based upon non-340B group purchasing organization (GPO) price rather than the 340B acquisition cost. Because the determination of a patient's status may shift from Outpatient to Inpatient (or vice versa) as a result of the coding process, using a non-340B price in the equation allows for consistency in billing and compliance with relevant standards. A patient is charged the same price for a given medication as an outpatient or inpatient using the same charge data master.

The table below shows a few examples of the differences in 340B cost, Average Wholesale Price, and UNC Hospitals charge for the pharmaceutical.

[redacted]

4. **Please describe and provide documentation on UNC Hospital's indigent care population and composition. What is UNC Hospital policy on charitable care? Please provide documents on UNC Hospital's charitable care policies.**

The hospitals within UNC Health Care System were recognized by the North Carolina Justice Center/North Carolina Health Access Coalition in a 2010 publication, *"How Charitable are North Carolina Hospitals? A Look at Financial Assistance Policies for the Uninsured*." This publication specifically notes that of the 112 hospitals in NC, 7 hospitals and systems were recognized for providing, "charity care levels that exceeded the cost of living for their region." Of the 7 listed in the report, all UNC Health Care facilities were included in the special recognition:

> "We applaud those hospitals that post comprehensive policies online for their openness and accountability. Novant Health, UNC Health Care, University Health Systems of Eastern Carolina, Iredell Memorial Hospital, The Outer Banks Hospital, High Point Regional Health System, and Margaret R. Pardee stand out as providing excellent charity care policies." *(emphasis added)*

Specifically, the UNC Pharmacy Assistance Program ensures that any North Carolina resident who receives care at UNC Hospitals and lacks prescription benefits, and has an income less than 200% of the Federal Poverty Guidelines, is able to obtain the necessary prescription medications. Pharmacy assistance is available for all prescription medications that are part of the UNC Hospitals drug formulary and used in accordance with formulary requirements.

As requested, the UNC Hospitals chartible care policies follow.

1. ADM 0192 Patient Finanacial Assistance
2. PHARM 0834 Pharmacy Assistance Program for Ambulatory Care Patients
3. TPX 0301 Solid Organ Transplant Financial Policy

Policy Name	**Patient Financial Assistance**
Policy Number	**ADMIN 0192**
Date this Version Effective	**February 2012**
Responsible for Content	**Financial Assistance Oversight Committee**

Description

Policy and procedures for providing financial assistance to patients for services at the University of North Carolina Health Care System ("UNC HCS")

Rationale

As part of its mission, UNC HCS provides care for residents of North Carolina who are uninsured or underinsured and do not have the ability to pay for medically necessary healthcare services. The purpose of this policy is to use financial assistance resources available to UNC HCS to maximize the availability of health care services to the people of North Carolina in a consistent, equitable and effective manner. As part of the annual budget process, Senior Management will estimate the level of patient financial assistance expected for the fiscal year.

This policy does not affect or limit UNC HCS's dedication and obligation under EMTALA to treat patients with emergency medical conditions.

Policy

UNC HCS shall have an organized patient financial assistance program designed to help provide necessary health care for North Carolina residents to the extent that resources are available. For this purpose, a Financial Assistance Oversight Committee will oversee all aspects of the patient financial assistance program, including pharmacy financial assistance and transplant financial assistance. The policy in effect at the time of the approval/denial will be used to determine eligibility for financial assistance.

Patient Financial Assistance consists of the following components:

I. Discounts for Uninsured Services
II. Payment Arrangements
III. Charity Care
IV. Catastrophic Charity Care
V. Dental Services
VI. Psychiatry Psychotherapy Resident Clinic

Discounts for Uninsured Services

Persons who have no health insurance coverage or who obtain services not covered by their health insurance will be eligible for a 35% discount of their UNC Hospitals (UNCH) and UNC Physicians & Associates (P&A) charges, except for Category 3 services in the Financial Assistance Exceptions Table (Appendix A). This discount will be given regardless of income or North Carolina residency.

Payment Arrangements

If a patient does not qualify for UNC HCS's Charity Care program (see section III below), the patient will be expected to make payment in full or make reasonable payment arrangements for charges already incurred, less any approved uninsured discounts, and the usual collection procedures will apply.

1. Payment arrangements will require separate monthly payments for P&A and UNCH patient balances and will be evaluated independently using the schedules below. The first month's payment is required before a payment arrangement is considered valid.
2. If a patient defaults on his/her established payment arrangement, the entire remaining amount will become due and the collection process will resume. Patients who wish to re-establish a payment plan after they have defaulted will be expected to make the first month's payment again.
3. Payment arrangements are variable, and arrangements can be reset if the amount due from the patient has grown such that the current monthly arrangement amount is no longer sufficient to satisfy the debt within the number of months required by the table.
4. UNCH and/or UNC P&A may consider negotiated settlement of balances on a case-by-case basis.

P&A Balance Payment Arrangements

Amount Due	Monthly Payment Amount	Months to Pay
<$25	Payment in full	1
$25-250	1/6th of amount due	up to 6
$251-500	1/12th of amount due	up to 12
$501-1500	1/24th of amount due	up to 24 months
$1501 -	1/36th of amount due	up to 36 months

UNCH Balance Payment Arrangements

Amount Due	Monthly Payment Amount	Months to Pay
< $29	Payment in Full	1
$30-899	$25 per month	Amount due ÷ $25
$900 -	Amount due ÷ 36	36

Charity Care

Charity Care is a benefit where 100% of the patient's balance will be written off except for limitations in the Financial Assistance Exceptions Table (Appendix A) and those balances covered by external funding sources. Charity Care is available for North Carolina residents who meet family income and residency criteria as determined by Medicaid eligibility criteria. Any resident of North Carolina may apply for financial assistance and all applications will be considered without regard to race, color, gender, national origin or religious preference.

1. Availability

    a. A Charity Care application will be made available to anyone who requests it or is identified with a need AND meets eligibility screening criteria as outlined on the Charity Care Screening Tool (Appendix C).

    b. Patients may submit an application for Charity Care prior to their first visit to UNC HCS. The application will be held until initial services are rendered.

    c. UNC HCS will post notices as required by law regarding the availability of financial assistance. Patients requiring financial assistance or thought to require such assistance will be referred to a Financial Counselor or Financial Assistance Specialist.

    d. Patients may only receive Charity Care after all other financial resources available to the patient have been exhausted AND the patient is without sufficient income to cover out-of-pocket expenses as defined by UNC HCS. Other financial resources include, but are not limited to, private health insurance, CHIP, agency funding, Medicare and/or Medicaid.

    e. If the Charity Care application is approved, Charity Care will apply to balances after all third-party coverage has been collected. Whenever agency funding is available, whether or not the patient has been approved for Charity Care, agency funding must be secured prior to the service being scheduled and covered by Charity Care. If the service is scheduled prior to the completion of the agency funding process, the service must be flagged for exclusion from Charity Care.

    f. A determination of eligibility for Charity Care will be effective for 12 months and will be applicable toward all applicable patient balances incurred prior to an approved Charity Care application.

    g. Charity Care covers only services deemed “medically necessary” by Medicare, Medicaid, or industry standards. All medically necessary services will be considered Category 1 unless approved as Category 2 or 3 in the Financial Assistance Exceptions Table (Appendix A) by the Financial Assistance Oversight Committee.

    h. For services in Categories 2 and 3 in the Financial Assistance Exceptions Table (Appendix A), medical necessity will be determined by the treating physician. In instances where medical necessity is unclear, the Financial Assistance Oversight Committee will make a final determination.

    i. Medicare patients who are eligible for the Medicaid programs MQB-B and MQB-E qualify for a Charity Care adjustment of the balance remaining after payment by Medicare and any other applicable third-party payer. Confirmation of the patient’s eligibility for Medicaid MQB-B or MQB-E on the date of service via an electronic Medicaid eligibility verification system is used in lieu of the Charity Care application.

2. Rights and Responsibilities

    a. If a patient does not have Medicaid or other private agency funding, but may qualify, the patient must cooperate with the application process to be considered for Charity Care. If a patient does not cooperate with the application process for any available funding, Charity Care will be denied or, if active approval is on file, revoked, and the patient will be responsible for any balances. The patient is required to provide documentation, including but not limited to evidence of third-party coverage, employment status, verification of employment, proof of North Carolina residency, income, and family size.

    b. For patients actively receiving Medicaid except for Family Planning and EMS Medicaid, a complete application is one that has the guarantor and dependent sections filled in,

bears the patient's signature, and is supported with a copy of the valid Medicaid card or a copy of proof of eligibility by a valid source. For Medicaid patients completing this process, the Charity Care eligibility date will be the effective date on the Medicaid card.

c. Only patient balances will be considered for Charity Care write-off. Patient balance is the amount for which there is no third-party coverage or other funding available, or balances after insurance. Accounts in a Liability status are not eligible for Charity Care.

d. If the patient's household income is less than or equal to 250% of the current Federal Poverty Guidelines for the patient's family size, the patient may be eligible for Charity Care.

e. Once the final determination has been made regarding Charity Care eligibility, the patient will be notified in writing.

f. If a patient's income or family size changes, a new Charity Care application may be submitted with supporting documentation for re-evaluation of Charity Care status.

g. Any payments made to date will be counted toward the amount due and will not be refunded.

h. The patient has the right to appeal a denied application for Charity Care. The appeal will be reviewed by the Financial Assistance Oversight Committee Clinical and/or Administrative Appeals Group. The patient will be notified in writing of the appeal outcome.

3. Extraordinary Circumstances/Other Applicant Categories

Qualification under extraordinary circumstances not outlined below requires approval by the Financial Assistance Oversight Committee.

a. Homeless Persons – A homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible, even if they are unable to provide all of the documentation required for the Charity Care application. The Charity Care application needs to indicate in the address field that the patient is homeless, and the application must be signed by the patient.

b. TROSA Patients – A TROSA patient is an individual who resides at the TROSA facility and depends on that facility for all of his or her care and does not receive monies when outside of the facility. Written proof from TROSA that the patient is a resident, including date of entry, along with the completed and signed demographic section of the application shall suffice as a complete Charity Care application. TROSA patients are exempt from Charity Care copays.

c. Deceased Patients - The charges incurred by a patient who has died may still be considered eligible for Charity Care. For the Charity Care application, the deceased patient will count as a family member, but the deceased patient's income will be zero. Accounts in an Estate status are not eligible for Charity Care.

d. Inmates – Charges incurred by a patient who has subsequently become incarcerated may still be considered eligible for Charity Care. His/her income will be deemed as zero for the purposes of the Charity Care application from the date of entry into the correctional facility until the date of release from the correctional facility. Written proof from the correctional facility that the patient is an inmate, including date of entry and proposed date of release, shall suffice as the Charity Care application. Note: All charges incurred during the incarceration are the responsibility of the correctional facility.

e. Transplant Services – are addressed in a separate Transplant Program Financial Guidelines Policy.

f. Pharmacy Services – are addressed in a separate Pharmacy Assistance Policy.

g. International Patients – are not eligible for Charity Care, and are addressed in a separate International Patient Policy. An international patient is defined as one who resides in a foreign country and is visiting the United States and has a Visa of any type.

h. Rex Healthcare Patients – If a patient is deemed eligible for Charity Care at Rex Healthcare by means of firsthand income validation, upon receipt of a valid letter of approval and supporting documentation, the patient will be eligible for UNC HCS Traditional Charity Care. A patient who is deemed eligible for Charity Care at Rex Healthcare by means of a pass through other than Medicaid (see item C(2)(b), above), such as a local support group agreement specific to Rex Healthcare, will not be eligible for Charity Care at UNC HCS unless the patient applies directly for UNC HCS Charity Care.

i. Eating Disorders – North Carolina Residents of Orange, Person, and Chatham counties may apply for traditional Charity Care. Otherwise, eating disorders treatments are addressed in a separate Eating Disorders Treatment Program Policy.

5. Notification

   a. Once complete and submitted, an application will be reviewed within 15 business days against UNC HCS's eligibility criteria.

   b. Once approved or denied, a notification letter will be sent to the patient.

   c. If additional information is required to reach a determination, a request for additional information will be sent to the patient.

   d. Patients approved for Charity Care will be required to pay a copay for each encounter. See Appendix B.

6. Changes to the Policy or Eligibility Criteria

   Charity Care eligibility criteria will be reviewed annually by the Financial Assistance Oversight Committee and is updated to reflect published changes in the Federal Poverty Guidelines. Revisions may be made at any time to the criteria or the policy based on changes in UNC HCS's financial ability to provide financial assistance or changes in state or federal regulations.

7. Default Criteria Definition

   In the absence of specific program description language defined in this policy, the current North Carolina Department of Health and Human Services, Division of Medical Assistance Medicaid Manual will be used as the default.

Catastrophic Charity Care

1. Policy

   The purpose of this policy is to use financial assistance resources available to UNC HCS to provide health care services needed by people who may incur a catastrophic medical event regardless of their residency status and to do so as consistently, equitably, and effectively as possible.

   a. UNC HCS shall have a Catastrophic Charity Care Program designed to help provide necessary health care to the extent that resources are available.

b. The Financial Assistance Oversight Committee will oversee all aspects of the Catastrophic Charity Care Program.

c. This policy is for UNCH and UNC P&A balances only. This policy does not apply to Rex Hospital, the UNC Community-Based Clinics, or any other UNC affiliate.

d. The policy in effect at the time of the approval/denial will be used to determine eligibility for Catastrophic Charity Care.

2. Eligibility Criteria

a. Patients who are denied Traditional Charity Care based on income exceeding 250% of the Federal Poverty Guidelines or based on residency status will be considered for Catastrophic Charity Care. Any patient or guarantor thereof may be considered without regard to race, color, gender, national origin or religious preference.

b. Existing patient balances of UNCH and UNC P&A, after all other financial resources available to the patient have been exhausted, should produce a medical debt-to-income ratio of greater than or equal to 20%. For example, if a household of 2 has an annual income of $75,000, the combined balances after all other means of payment must be at least $15,000. Other financial resources include, but are not limited to, private health insurance, agency funding, Medicare and/or Medicaid.

c. If the Catastrophic Charity Care application is approved, Catastrophic Charity Care will apply to balances after all third-party coverage has been ruled out, including Medicaid and any private agency payers.

d. For approved Catastrophic Charity Care applications, the patient's medical debt after insurance will be reduced to 20% of the patient's income. If a patient has no income, the patient's medical debt after insurance will be reduced by eighty percent (80%).

e. Catastrophic Charity Care may be awarded once every 12 months from the date of last Catastrophic Charity Care approval. If financial and/or family size situations change, a new Charity Care Application must be submitted.

f. Balances in bad debt or already with collection agencies and/or the Attorney General's Office will be considered. Prospective balances will not be considered.

g. The calculation of medical debt will include balances that may have been decreased due to the Self Pay Uninsured Discount.

h. For Catastrophic Charity Care, all accounts for which the guarantor is responsible will be considered in the calculation of medical debt. Services otherwise excluded from Charity Care may be included in the Catastrophic calculation.

i. When Catastrophic Charity Care is approved, the approval date is recorded. If there are balances pending third-party payment, the adjustment of the balances will be postponed until all third-party coverage has paid. Any patient balances left that were from dates of service on or prior to the approval date will then be adjusted.

j. For patients pending Medicaid, Catastrophic Charity Care determination will be postponed until after final Medicaid disposition to allow for full and accurate accumulation of charges.

Dental Services

3. Policy

a. In order to be eligible for financial assistance for Dental Services, the patient must be approved for UNC HCS financial assistance.

b. Dental Services that are eligible for full charity care coverage are those that would be covered by Medicare. Charity care coverage includes the following:
   i. When the severity of the underlying illness requires hospitalization
   ii. A secondary service that is integral and necessary to treat a non-dental condition, such as tumor removal, and is provided at the same time as the primary service and by the same physician/dentist
   iii. The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease
   iv. An oral or dental examination performed on an inpatient basis as part of a comprehensive work-up prior to renal transplant surgery or performed in a RHC/FQHC prior to heart valve replacement

c. All services, except cosmetic procedures, are eligible for the self-pay discount and the interest-free payment plan.

Psychiatry Psychotherapy Resident Clinic

The UNC Psychiatry Resident clinic provides care for patients who require repetitive and frequent psychotherapy counseling sessions. These patients often have exhausted their psychiatry benefits. In some cases, the benefits have not yet been exhausted but the commercial insurance copays would exceed the patient's ability to afford the needed care. Patients seen in this clinic are subject to the charity care copay.

1. Eligibility Criteria:
   a. Patient consents to be treated by a UNC Psychiatry resident under the general supervision of a UNC Psychiatry faculty physician
   b. Patient follows all requirements from his or her insurance carrier so that UNC P&A can bill for the care that is covered.
   c. Patient applies for standard UNC HCS Charity Care and provides all required documentation so a determination can be made.
   d. UNC Psychiatry staff evaluate the patient and determine if he or she would benefit from routine care within the psychotherapy clinic; patient is officially accepted into the resident practice.
   e. Patient complies with all clinic requirements regarding treatment.
   f. Patient pays the standard charity care copay prior to each visit.

Appendix A
Financial Assistance Exceptions Table

Category	Definition	Program Eligibility		Service Definitions
		Discount	**Charity Care**	
Category 1	Medically Necessary	Y	Y	Most Services
Category 2	High Cost Treatment; Other Alternatives Usually Available	Y	N	Cochlear implant Elective infant circumcision LDL apheresis Transplants Bariatric surgery Deep brain stimulation Penile or testicular implant Vasectomy or vasectomy reversal Left Ventricular Assist Device (see Transplant policy) Pediatric Hearing aids (ages to 21) Preservation reproductive opportunities after cancer treatment (IVF for PROACT) Any other procedure which does not meet medical necessity criteria
Category 3	Excluded Services	N	N	Cosmetic surgery/procedures* In-vitro fertilization Non-medically necessary obstetric ultrasound Optical Shop products Routine eye exams Contact lenses or exams* Hearing aids Acupuncture Non-medically necessary virtual colonoscopy Non-medically necessary full body MRI

*Cosmetic surgery is not eligible for a payment plan. Full payment required prior to service.

Appendix B

Charity Care Copayments

SERVICE	COPAYMENT AMOUNT
Services Credited to/Billed by P&A	
Primary Care Clinic Visit (per appointment even if on same day) (excludes Children's Primary Care – See "Children's Primary Care" below)	$25
Specialty Care Clinic Visit (per appointment even if on same day) (includes Allied Health Hearing & Communications) (excludes Hospital Recurring – see "Recurring" below)	$35
Services Credited to/Billed by Hospital	
Emergency Department (ED)	$50
Inpatient Admission	$100
Ambulatory Surgery	
▪ ACC Day Op (780)	$75
▪ Adult Bronchoscopy (283)	$75
▪ Cardiac Cath (581)	$75
▪ Children's Short Stay Unit (065)	$75
▪ Cystoscopy (997)	$75
▪ Day Op Surgery (400)	$75
▪ GI Manometry (104)	$75
▪ GI Procedures (146)	$75
▪ Outpatient Cystoscopy (099)	$75
▪ Pediatric Cath & EP (485)	$75
▪ VIR (481)	$75
Ancillary (except PT/OT)	$20
Children's Primary Care	$25
Recurring (monthly by case)	
▪ Cardiac Therapy	$20
▪ Eating Disorders	$0
▪ PT/OT	$20
▪ Radiation Oncology	$75
▪ Wound/Podiatry	$35
Psychiatry Psychotherapy Resident Clinic	$25

*Primary care is defined as visits occurring in Family Medicine, Children's Primary Care, or General Internal Medicine clinics.

When applicable, insured patients who are also eligible for Charity Care will pay their insurance carrier's required copay, not the Charity Care copay.

Appendix C

Requirement Definitions for Charity Care

NC Residency – In order to meet North Carolina state residency requirements to be Medicaid eligible, an individual must be domiciled in North Carolina with the intention to remain here permanently or for an indefinite period or show that he entered North Carolina to seek employment or with a job commitment. A person is domiciled in North Carolina if North Carolina is his fixed, established, or permanent place of residence with the intention to remain there permanently or for an indefinite period.

REQUIREMENT: To verify residency, two documents from two of the categories below need to be provided. This means a document or proof must be from two of the little letters below. Example: An item from c and d would be acceptable. Two documents in b are not acceptable. Applicants who do not have two of the documents must complete and sign the declaration on the back of this form, subject to prosecution, that they do not have two of the documents listed.

a. A valid North Carolina drivers' license or other identification card issued by the North Carolina Division of Motor Vehicles
b. A current North Carolina rent, lease, or mortgage payment receipt, two bank statements, or current utility bill in the name of the applicant or the applicant's legal spouse, showing a North Carolina address.
c. A current North Carolina motor vehicle registration in the applicant's name and showing the applicant's current North Carolina address.
d. A document verifying that the applicant is employed in North Carolina.
e. One or more documents proving that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.
f. The tax records of the applicant or the applicant's legal spouse, showing a current North Carolina address.
g. A document showing that the applicant has registered with a public or private employment service in North Carolina.
h. A document showing that the applicant has enrolled his children in a public or private school or a child care facility located in North Carolina.
i. A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residence in North Carolina. Work First and Energy Assistance do not currently require proof of NC residency.
j. Records from a health department or other health care provider located in North Carolina which shows the applicant's current North Carolina address.
k. A written declaration from an individual who has a social, family, or economic relationship with the applicant, and who has personal knowledge of the applicant's intent to live in North Carolina permanently, for an indefinite period of time, or residing in North Carolina in order to seek employment or with a job commitment.
l. A current North Carolina voter registration card.
m. A document from the US Department of Veteran's Affairs, US Military or the US Department of Homeland Security verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.
n. Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or with a job commitment.
o. A document issued by the Mexican consular or other foreign consulate verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.
p. UNC HCS has the authority to determine what is considered satisfactory proof, and retains the right to deny eligibility and/or declare that the documents provided are unacceptable if UNC HCS believes that the documentation is false or otherwise finds the documentation to be unsatisfactory. UNC HCS can require the provision of additional supporting documentation.

North Carolina Residency Applicant Declaration

I, _____, verify that I cannot provide two North Carolina state residency verification documents.

I hereby declare that the above information is true and accurate. I understand that this declaration form is used to help verify that I meet North Carolina state residency requirements for UNC Health Care Charity Care. I understand that a false or misleading declaration by me may result in Charity Care adjustments for which I would not otherwise have qualified, and may subject me to civil and criminal penalties.

_____
Signature

_____
Date

Address:_____

_____

_____

Telephone No._____

Third Party Coverage - All patients will be screened for third-party sources of coverage and assistance that may include, but are not limited to:

1) Personal or Employee Sponsored Health Insurance
2) Medicare, Medicaid, CHIP, commercial, or any other third party coverage
3) Eligibility for public assistance programs
4) Third party coverage from an employer or family member's employer
5) Workers' Compensation

Income/Employment Status – Income includes total cash receipts from all sources before taxes. Verification of income is not required for dependents under age 18.

The following are considered income:

1) Wages and salaries before deductions
2) Self-employment income
3) Social security benefits
4) Pensions and retirement income/distribution
5) Unemployment compensation
6) Strike benefits from union funds
7) Workers' Compensation
8) Veterans' payments
9) Public Assistance payments
10) Training stipends
11) Alimony
12) Military family allotments
13) Income from dividends, royalties, & interest income
14) Income from estates and trusts
15) Income from legal settlements
16) Regular insurance or annuity payments
17) Support from an absent family member or someone not living in the household
18) Lottery winnings
19) One third of liquid assets drawn down as a withdrawal from a bank. The most recent checking and savings account statements from the guarantor are required. Stocks, bonds and non-retirement investments are considered available liquid assets to be used for this calculation. Long-term retirement annuities are <u>not</u> included when considering liquid assets. Examples of liquid assets include, but are not limited to checking, saving, & money market accounts, CDs, and bonds.
20) Non-liquid assets as defined by requirements according to North Carolina Department of Health and Human Services' Medicaid MA-2230 Financial Resources definition for countable real property will be considered in assessing financial assistance eligibility. A patient's equity in real property, when compared to the tax value, plus any rental income profit/loss will be considered a non-liquid asset. The patient's primary residence will be excluded.

The following will not be considered income:

1) Food or rent received in lieu of wages
2) Non-cash benefits
3) Payments from student loans and grants
4) Child Support payments

The following may be used to prove income:

1) Federal and state income tax returns for the prior calendar year.
   Self-employed patients are to provide Schedule C of their federal income tax return. The following deductions will not be allowed in determining income:
   a. Depreciation
   b. Travel, Meals, & Entertainment
   c. Expenses listed as ”Other” on Schedule C will be evaluated on an individual basis
2) W-2 Form(s), or other IRS income forms, included with the prior calendar year tax return filing.
3) Payroll check stubs covering the last six weeks are required. When check stubs are unavailable, telephone verification from employer verifying employment and income is acceptable. Telephone verification may only be performed by an authorized UNC HCS employee to the applicant's Human Resource Representative, not vice-versa. The UNC HCS employee must document in the system and/or record the following:
   a. Company name
   b. Date, time of phone call
   c. Phone number called
   d. Person at applicant's place of employment verifying income
4) Other current income from any source not directly related to employment, such as retirement or disability benefits, Social Security, or Veteran's Benefits must be verified with check stubs or other documentation.
5) The most recent checking & savings account statements.
6) Patients who are employed, but due to a temporary medical condition rendering them unable to work are not drawing an income, will have their annual income reduced by the period of inability to work. This pro-rated income will be used in determining the patient's eligibility for financial assistance.
   Example: The income of a patient with an annual income of $40,000 who is unable to work for 12 weeks will have a pro-rated annual income of $30,000 for the purposes of determining eligibility for financial assistance.
7) In instances when the patient states that the above supporting documentation does not exist, the patient will be required to provide a statement attesting to their income.

Unemployment may be documented by presentation of:

1) North Carolina Employment Security Commission documents
2) Letters from state and local agencies on their letterhead
3) In the absence of any of the above, patients who are unemployed are required to document how their expenses are being paid. Credit reports will be obtained when additional information is needed. These requirements will be waived for patients of retirement age as published by Social Security.

The following calculations will be used to determine income:

1) Checking and Savings Accounts - Excluding deposits of income already calculated or excluded due to policy (child support, student loans or grants), take ending balance from each statement and add all other deposits. Add the three monthly subtotals and divide the amount by three to obtain a monthly average. The average amount is then added as a one-time amount to annual income.
2) Money Markets, Stocks, Bonds, and Certificates of Deposit - Add 100% of value toward annual income.
3) Individual Retirement Accounts - Do not count when funds not being drawn. When funds being drawn, take amount received per month and multiply by number of months received in a year. Add to annual income.

4) Pay Stubs, Retirement Accounts, Social Security Disability (SSD), and Supplement Security Income (SSI) – Take amount received per month and multiply by number of months received in a year. If paystubs are hourly, take hourly amount and multiply by number of hours worked per week. Use table below to calculate monthly amount. Multiply monthly amount times the number of months worked per year. If salaried, use table below to calculate monthly amount, as needed. Multiply monthly amount times the number of months worked per year.

Converting income to a gross monthly amount

If paid weekly	Multiply by 4.3
If paid biweekly	Multiply by 2.15
If paid semimonthly	Multiply by 2
If paid monthly	Use the gross monthly amount

5) Real Estate Owned (other than primary residence) - Take the tax value minus the remaining mortgage amount due to calculate the equity. Equity is then added to total annual income.
6) Self Employment - Includes meals, travel, gifts entertainment, and up to $10,000 in depreciation obtained from Schedule C.

Family Size - A family is a group of two or more persons related by birth, marriage, or adoption that live together. All such related persons are considered as members of one family. Family members are defined as follows:

1) The patient and, if married, his/her spouse
2) Any natural, or adopted minor child of the patient, or spouse who has not been emancipated by a court and who is not, or has never been, married
3) Any minor for whom the patient or patient's spouse has been given the legal responsibility by a court
4) Any person designated as "dependent" on the patient's latest tax return
5) Any student over 18 years old who is dependent on the patient's family income for over 50 percent support
6) Any other person dependent on the patient's family income for over 50 percent support
7) Any minor child of a minor who is solely, or partially, supported by the minor who is a member of the patient's family

Dependency is determined by one of the following documents that contain the patient's or patient's spouse's name:

1) Current tax return
2) Court-ordered guardian/conservator ship
3) Birth certificate
4) Baptismal record
5) Social Security award letter
6) U.S. Immigration documentation
7) In the absence of any of the above, a signed affidavit from the patient witnessed by a UNC HCS representative attesting to the dependency of minor child or other family member
8) A minor is one who has not reached his/her eighteenth (18th) birthday and who is not and has never been married. When the marital status of the minor cannot be determined, or when there is no documentation indicating the patient is an emancipated minor, the parents or legal guardian should be designated as the responsible party. The parent's or guardian's income and residence should be used to determine eligibility for financial assistance. Legal guardianship must be supported by fully executed and valid legal documents.

Proof of family size will be based on the most current filed Federal Tax form in accordance with the IRS tax laws. A birth certificate(s) must be presented to validate an increase in the family unit above the total claimed on the most recent tax return. If no tax return is provided, the family size will be calculated as one (1).

I. Description

Describes procedures that are followed in administration of the UNC pharmacy assistance program (PAP) for ambulatory care patients

Table of Contents

II. Rationale

These procedures ensure consistency in qualifying patients for pharmacy assistance.

III. Policy/Procedure

A. Policy

Assistance with medications on the UNC Hospitals drug formulary is provided through the UNC Hospitals Outpatient Pharmacies for qualifying patients. Application and qualification for pharmacy assistance are independent of other assistance programs provided by the UNC Hospitals or UNC Physicians and Associates. Medication Assistance Program (MAP)_Specialistsadminister the PAP in accordance with criteria established by the Department of Pharmacy and approved by the Financial Assistance Oversight committee. Patients who fail to meet criteria for application or qualification for pharmacy assistance may use the UNC Ambulatory Pharmacy Care Network by paying full cash price for their prescriptions at the time of dispensing.

The UNC PAP is the payer of last resort for qualifying patients who have other assistance or benefit plans covering medications.

The Pharmacy Assistance Program consists of two (2) components:

a. Fourteen (14) days of temporary assistance until enrollment in the benefit plan for qualifying patients.
b. An extended term of assistance (3, or 12 months) following enrollment in the benefit plan for qualifying patients.

A pharmacy benefit management company (PharmAvail) is used to help manage the PAP.

To ensure consistency with the intent of North Carolina General Statutes applicable to indigent patients, UNC Ambulatory Pharmacy Care Network Services will not be denied to any patient with active coverage by the benefit plan (even those with Medicare B or D benefits) due to their inability to pay co-payments due.

North Carolina 10 NCAC 26k.0106
"PROVIDER BILLING OF PATIENTS WHO ARE MEDICAID RECIPIENTS:
(E) A provider who accepts a patient as a Medicaid patient shall agree to accept Medicaid payment plus any authorized deductible, co-insurance, co-payment and third party payment as payment in full for all Medicaid covered services provided, except that a provider may not deny services to any Medicaid patient on account of the individual's inability to pay a deductible, co-insurance or co-payment amount as specified in 10 NCAC 26C.0003. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. A provider may actively pursue recovery of third party funds that are primary to Medicaid." Effective January 1, 1998.

B. Procedure

- **Requesting Assistance – Application Process and Criteria**

a. The patient, the patient's guarantor, or the patient's authorized representative contacts a MAP Specialist and requests assistance in one of the following ways:
    - Face-to-face: presentation to one of the Ambulatory Pharmacy Care Network Pharmacies
    - Via phone: applicable to patients visiting an off-site clinic or hospitalized with contact precautions
    - Bedside: applicable to patients opting into Carolina Care at Home Discharge Services.

b. The MAP Specialist interviews the patient (or patient's guarantor / representative) to determine:

(1) If the patient is eligible for a 14-day temporary benefit
(2) The type of supporting documentation the patient must submit with his pharmacy assistance application.
(3) If the patient has any other type of prescription drug benefit or is potentially eligible for such (e.g., commercial insurance, Medicare A or B, Medicare Part D, AIDS Drug Assistance Program, NC Health Choice, Medicaid, etc.)

c. Based on information provided during the interview, the MAP Specialist advises the patient
regarding options for getting medications. These options may include:

(1) Enrollment of the patient in a 14-day temporary benefit to allow time to complete the UNC PAP Application.
    (a) Only North Carolina residents as defined by North Carolina Medicaid (Attachment 1) that have no prescription benefit (other than ADAP or Medicare A, B or D) may receive a 14-day temporary benefit.
    (b) Only one 14-day temporary benefit is allowed in any 12-month period; unless the patient's insurance status has changed during the course of year which would necessitate an allowance of a second 14-day temporary benefit (e.g. patient no longer eligible for current insurance. Note: this does not apply to Medicare Part D patients who drop their plans in the middle of the year) Example: patient presents to MAP Specialist in April with no insurance coverage, receives 14-day temporary benefit. In June, patient is eligible for Medicaid and no longer eligible for PAP. In September, patient qualifies for disability and Medicaid coverage is dropped. Patient presents to MAP Specialist given lapse in coverage and requests PAP until Medicare Part D is effective. At this point, patient would qualify for a second 14-day temporary PAP benefit.
(2) Completing the UNC PAP Application and returning to the MAP Specialist with all required supporting documentation. Qualifying for an extended term of assistance in the PAP benefit.
    (a) The MAP Specialist reviews how to complete the application in detail with the patient or
        patient's representative and provides all of the forms needed to apply for PAP.
(3) Enrolling in a Medicare Part D Prescription Drug Plan through the Department of Social Services or county SHIIP coordinator (Senior Health Insurance Information Program)
    (a) The MAP Specialist provides the patient with information for contacting the county SHIIP coordinator.
(4) Applying for the AIDS Drug Assistance Program (ADAP).
    (a) The MAP Specialist directs the patient to the Infectious Diseases Clinic Financial
        Counselor for application to ADAP.
(5) Applying for NC Medicaid or NC Health Choice.
    (a) The MAP Specialist directs the patient to the Department of Social Services to inquire
        about Medicaid or NC Health Choice.
(6) Applying for medication assistance through a Manufacturer Assistance Program
    (a) The MAP Specialist assists the patient through the manufacturer application process.

2. Fourteen (14) Day Temporary Assistance in the PAP Benefit

a. UNC patients who need medication but have not submitted a completed application for the PAP may be given a 14-day temporary benefit by the MAP Specialist provided that the patient meets the following screening criteria:

(1) They have no active Medicaid coverage

(2) They have no insurance coverage with prescription drug benefits or have totally exhausted their prescription drug benefits for the term of their benefit.

(a) Lack of drug coverage due to formulary or benefit limitations is not considered exhaustion of prescription drug benefits.

(b) Exceeding an annual cap on ALL drug charges specified for a benefit plan is considered exhaustion of prescription drug benefits.

(c) Exceeding an annual cap for only trade name drug charges yet still having benefit coverage for generic drugs is **not** considered exhaustion of the prescription benefit.

(3) They are eligible for Medicare Part D but are not currently enrolled and this is the first time the patient has presented for the PAP. (For more information, please see Section 9 Patients Eligible for Medicare Part D)

(4) They are a permanent resident of North Carolina as defined by the NC Division of Medical Assistance (Medicaid) (see Attachment 1).

(a) The patient must be domiciled in North Carolina.

i. A person is domiciled in North Carolina if North Carolina is his fixed, established, or permanent place of residence with the intention to remain in North Carolina permanently or for an indefinite period.

(b) The patient must intend to remain in North Carolina permanently or for an indefinite period or show that he entered North Carolina to seek employment or with a job commitment.

b. The MAP Specialist interviews the patient or patient's representative for relevant information and reviews information in available databases (SMS, Blue-E, Medicaid IVR system,

Medicare Part D / TechRX J screen inquiries, WebCIS, MedConnect/MedData, etc.) to determine if the patient qualifies for the 14-day temporary benefit. Only MAP Specialists, MAP managers, or the Ambulatory Care Pharmacy Network Assistant Directormay

approve or deny the provision of the 14-day temporary benefit.

c. The MAP Specialist enrolls qualifying patients in the 14-day temporary benefit in PharmAvail using the third party number 14000 with expiration date corresponding to the 14 day benefit

(1) The MAP Specialist updates notes on the patient's medication profile in each of the outpatient pharmacies indicating approval of the 14-day temporary benefit.

Example: "Approved for 14d temp benefit through 7/15/11

(2) The MAP Specialist describes to the patient details of the PAP benefit and the required co-

payments (Attachment 2). The MAP Specialist asks the patient or patient's representative

"How will you be paying the co-payments today?"

(3) All required co-payments are due in full at the time medications are dispensed.
(a) Patients who indicate they are unable to pay the co-pays may set up an A/R payment plan with the MAP Specialist or Pharmacists. Payment plans end (term) on the same day/date that pharmacy assistance ends (terms). The minimum payment plan allowed is $10 per month.
(b) The MAP Specialist updates notes in the patient's TechRx profile in each of the outpatient pharmacies indicating the term of the payment plan and the monthly payment. The term date will always coincide with the term date of the patient's pharmacy assistance. (Example: Payment plan through xx/xx/xx @ $10 / month)
(c) If a patient becomes delinquent in paying his/her A/R account, the billing office will alert the pharmacy by placing a note in TechRx. At this time, no further medications shall be dispensed to the patient until the account is up-to-date.
(d) Patients for whom that MAP Specialist has determined AI = 0 are not set up on a payment plan. Instead, pharmacy assistance co-payments for these patients are placed on a co-pay voucher if the patient indicates he cannot pay.

(4) During a 14-day temporary benefit, no more than a 14-day supply of medication is dispensed for each prescription "fill" occurring within the benefit period. The patient may have a prescription refilled during the temporary benefit (for up to a 14-day supply) if the pharmacist determines that the medication has been used appropriately and at least 75% of the previous fill has been consumed.

(5) The MAP Specialist will approve no more than one 14-day temporary benefit in a 12-month period for each requesting patient unless extenuating circumstances are determined to exist by the MAP SpecialistAll such cases believed to warrant an additional 14-day temporary benefit will be forwarded to the Assistant Director of the Ambulatory Pharmacy Care Network or MAP Manager for review and consideration. Only the Assistant Director or MAP Manager may approve an additional 14-day temporary benefit. Exception: patients with Medicare Part may receive a 14 day temporary benefit once each CALENDAR year.

(6) Patients failing to return a completed assistance application to the MAP Specialist before the end of his/her temporary benefit will be required to pay the full price of their medications at the time of dispensing. No grace period for completion of the application or supplies of free medication will be provided to the patient unless the dispensing pharmacist deems a one-time 3 day supply of medication is warranted (e.g. life sustaining medication such as lovenox)

3. PAP 100% Benefit for 3, 5, or 12 months

a. A term of three (3), five (5), or twelve (12) months of assistance in the PAP 100% Benefit will be approved by the MAP Specialist if review of the submitted application indicates that the patient meets criteria for enrollment.

b. The patient must meet the following criteria to qualify for enrollment in the PAP 100% benefit:

(1) Submits a completed PAP application with all required supporting documentation including patient signature and application date.

(2) Has no active coverage by Medicaid
(3) Has no active coverage by NC Health Choice.
(4) Has no commercial insurance with prescription drug benefits or prescription drug coverage is severely limited by an annual cap of $500 (total).
    (a) Patients with a Medicare Part D benefit may apply to the PAP for secondary coverage should they exhaust the primary benefit of their Medicare D plan (e.g. patient is in the coverage gap or "donut" hole)
(5) Has no VA benefits or meets the criteria in section 11 of this procedure.
(6) Is a permanent North Carolina resident as defined by the NC Division of Medical Assistance (Medicaid) (see attachment 1).
(7) Gross income for the family unit is less than or equal to 200% of the federal poverty guidelines.
(8) Patient fully cooperates with the MAP Specialist in applying for other assistance programs that pay for medications (e.g., state ADAP program, Medicaid, Medicare, manufacturer assistance programs, state sickle cell program, etc.)

c. Assistance in the PAP 100% Benefit is approved for twelve (12) months for qualifying patients
unless:

(1) The patient is self-employed and is unable to supply detailed documentation of income in support of stated income on the submitted application (Guarantor's Financial Statement or GFS).
(2) The patient's application is largely complete with supporting documentation except for one item that is unlikely to have an impact on the calculation of annual income and is not considered by the MAP Specialist to be essential for determining the patient's qualification for assistance.
(3) The patient has a pending application to North Carolina Medicaid or North Carolina Health Choice.
(4) The patient is determined by the MAP Specialist to be potentially eligible for the state HIV program (ADAP), sickle cell program, or other state agency program that pays for drugs.
(5) The patient is determined by the MAP Specialist to be potentially eligible for Medicaid.
(6) The patient is determined to be potentially eligible for Medicare Part D (see 8 of this procedure).
(7) The patient is determined by the MAP Specialist to have confirmed VA health care benefits and the patient has not used the UNC pharmacies within the previous two (2) years and is not under the care of a UNC attending physician. (See section 11 of this procedure).
(8) The patient has a pending worker's compensation claim before a review panel.
(9) The MAP Specialist determines that the patient's indigent status is likely to be temporary (e.g., patient is temporarily unemployed).

d. Three (3) months of 100% assistance are approved when:

(1) Qualifying patients are self-employed and are unable to supply detailed documentation of income in support of stated income on the submitted GFS, and the MAP Specialist determines that information from the assistance application and patient interview warrant assistance until the applicant can provide the required documentation of income. The patient must provide supporting documentation as described in attachment 4. No further assistance will be provided if the

documentation of income (DOI) indicates the patient exceeds income criteria or the patient fails to submit the required supporting documentation.

(2) Qualifying patients indicate that they have a North Carolina Medicaid or North Carolina Health Choice application in process and pending a decision by DSS. The patient must submit a Medicaid/Health Choice denial letter to the MAP Specialist by the end of the three (3) month term of assistance. No further assistance will be provided without a Medicaid or Health Choice denial letter.

(3) Qualifying patients are determined by the MAP Specialist to be potentially eligible for the state HIV program or other North Carolina state program (e.g., sickle cell program) and application to these programs has not been completed. No further assistance will be provided without submission of additional information described in attachment 4.

(4) Qualifying patients have a pending worker's compensation claim. The patient must submit to the MAP Specialist a letter on company letterhead or from legal counsel indicating that the claim is pending. No further assistance will be provided beyond 3 months without submission of additional information described in attachment 4.

(5) Qualifying patients are missing 1 item of supporting documentation required to complete their assistance application but it is not considered essential for calculating annual income or determining the patient's qualification for assistance. No further assistance will be provided without submission of the missing information.

(6) The MAP Specialist determines that the patient's indigent status is likely to be temporary (e.g., patient is temporarily unemployed). No further assistance will be provided without submission of another pharmacy assistance application, in full, updating the patient's current financial situation.

e. Five (5) months of 100% assistance is approved when:

(1) Qualifying patients are considered by the MAP Specialist to be potentially eligible for Medicaid or North Carolina Health Choice and need time to present to DSS, make application, and receive a decision from DSS. The patient must visit his county Department of Social Services and seek to make application for Medicaid/North Carolina Health Choice during the five (5) months of assistance. No further assistance will be provided unless the patient submits to the MAP Specialist a Medicaid/North Carolina Health Choice denial letter or a copy of the DSS encounter form dated within the past 12 months indicating the patient:

i. Is ineligible

ii. Will have a deductible to meet prior to eligibility

iii. Or an application was taken and is pending.

(2) Qualifying patients have confirmed VA benefits but do not have a VA primary care physician, have not used the UNC pharmacies within the previous two (2) years, and are not under the care of a UNC attending. The MAP Specialist determines that the patient needs time to get an appointment with a VA physician. The patient must visit the VA facility of his choice and make arrangements to get a primary care physician at the VA in order to use VA pharmacy services. Continued pharmacy assistance after the 5 month period will require submission of a VA appointment slip or other information confirming the date of the patient's appointment with the VA physician. No further assistance will be provided beyond the date of the VA appointment.

f. The MAP Specialist enrolls qualifying patients in the PAP 100% Benefit in PharmAvail for the approved term of assistance.
g. The MAP Specialist updates notes in the patient's TechRx profile in each of the outpatient pharmacies indicating the term of assistance and/or required documentation. (*Example*: "100% benefit approved for 3 months through 10/12/11. AI = $xxx, FU = xxx. Will need to supply Medicaid denial letter or DSS inquiry form").
h. All required co-payments are due in full at the time medications are dispensed.
    (1) If AI>0, patients who indicate they are unable to pay the co-payments may set up an A/R payment plan with the MAP Specialist. Payment plans end (term) on the same day/date that pharmacy assistance ends (terms). The minimum payment plan allowed is $10 per month.
    (2) The MAP Specialist updates notes on the patient's medication profile in each of the outpatient pharmacies indicating the term of the payment plan and the monthly payment. The term date will always coincide with the term date of the patient's pharmacy assistance. (Example: Payment plan through xx/xx/xx @ $10 / month)
    (3) If the A/R account becomes delinquent, the patient will no longer be allowed to place co-payments and all co-payments will be due at time of medication delivery, unless approved by either the Assistant Director of Ambulatory Pharmacy Care Network or MAP Manager.
    (4) If AI=0, patients who indicate they are unable to pay co-payments may have their co-payments waived using the co-payment voucher.
i. Details of the 100% benefit and required co-payments are described in Attachment 2.

4. Completing the PAP Application

a. An application is considered to represent a request for assistance for the person listed as the patient on the Guarantor's Financial Statement (GFS) and no one else in the family unit unless expressly requested in writing on the application.

b. A completed application includes at least the following:

(1) A GFS with all required information including the signature of the patient and the date of the patient's signature**.**
    (a) If the MAP Specialist determines that the patient is unable to sign/date the
        application, he may accept the signature of the patient's authorized representative. The MAP Specialist documents the inability of
        the patient to sign by noting such on the GFS.
    (b) A parent of a minor or legal guardian may sign/date the application as guarantor for the patient.
    (c) A spouse may sign/date the application as guarantor for the patient.
(2) Proof of North Carolina residency as described in Attachment 1.
(3) Documentation of Income (DOI) as described in Attachment 3.
    (a) Items considered as income are the following:
        i. Gross wages and salaries (before deductions)
        ii. Self-employment income
        iii. Social security benefits
        iv. Pensions and retirement income/distributions
        v. Unemployment compensation
        vi. Strike benefits from union funds

vii. Worker's compensation payments
viii. Public assistance payments
ix. Training stipends
x. Veteran payments
xi. Alimony
xii. Military family allotments
xiii. Income from dividends, rents, royalties, and interest
xiv. Income from estates and trusts
xv. Income from legal or insurance settlements
xvi. Regular insurance or annuity payments
xvii. Support from an absent family member or someone not living in the household
xviii. Lottery winnings
xix. Tips
xx. Commissions
xxi. Research and similar grants/ subsidies for work under contract
xxii. One third of total liquid assets averaged over a 3 month period will be considered for income calculation. The most recent checking and savings account statements from the guarantor are required. Stocks, bonds, and non-retirement investments are considered available liquid assets to be used for this calculation. Long-term retirement annuities are <u>not</u> included when considering liquid assets. Examples of liquid assets include (but are not limited to) checking, saving, money market accounts, CDs and bonds. (Example scenario: patient presents paperwork representing 3 months from all liquid assets which average $12,000. $4,000 would be included in income assessment.)
xxiii. Non-liquid assests as defined by requirements according to North Carolina Department of Health and Human Services' Medicaid MA-2230 Financial Resources definition for countable real property will be considered in assessing financial assistance eligibility. A patient's equity in real property, when compared to the tax value, will be considered a non-liquid asset. The patient's primary residence will be excluded. Patients will be made aware of this provision at time of application for financial assistance.

(b) The following items will not be considered income:

i. Food or rent received in lieu of wages
ii. Non-cash benefits
iii. Payments from student loans and grants
iv. Child support payments
v. Food stamp allotments

(4) UNC Authorization Form for Release of Medical Information signed by the patient or his authorized representative if needed to obtain information or release information relative to the patient's PAP application.

(5) A letter of agreement signed by the patient or his authorized representative to:

a. Cooperate fully in making application to other assistance programs within time lines established by the MAP Specialist.

b. Pay in full the usual and customary charge for all medications provided as part of a temporary assistance benefit should the patient:

i. Fail to complete the assistance application within the required 14-day time line.
ii. Fail to qualify for assistance.
iii. Fail to fully cooperate with the MAP Specialist in applying to other assistance programs.

(6) A Consent and Signature Waiver Form signed and dated by the applicant and a witness to the applicant's signature. Consent is required, signature waiver is recommended but optional.

(7) Additional information may be required in support of the assistance application when judged necessary by the MAP Specialist to confirm information submitted in the GFS or clearly establish that the patient meets the criteria of pharmacy assistance. Examples of such information include but are not limited to the items listed in Attachment 4.

(1) The completed PAP application is submitted to the MAP Specialist for review

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5. MAP Specialist Review of the PAP Application

a. The MAP Specialist reviews the submitted application and supporting documentation within 7 days so as to ensure availability of assistance when needed by qualifying patients. When possible, the MAP Specialist interviews the patient or patient's representative to identify additional information useful to the review process (e.g., insurance benefits, VA benefits, residency information, status of Medicaid coverage, status of Medicare coverage, current employment status, information regarding dependents, details of worker's compensation claims, etc.).

b. The MAP Specialist completes the Application Checklist and reviews the DOI Checklist to confirm that all required elements of the application have been submitted.

c. Applications are deemed incomplete if:

(1) Information is omitted in part or in whole from the GFS.
(2) The patient fails to sign and date the GFS.
(3) Any of the required documentation of income (DOI) is missing in part or in whole.
(4) Submitted information is inconsistent with that obtained by the MAP Specialist via patient interview or review of available databases and resolution is required to ensure accuracy of the application.
(5) The signed Authorization for Release of Medical Information is missing in part or in whole AND is essential to getting the information needed for application review.
i. If this authorization is not necessary, then it is not needed to complete the application.
(6) The signed Letter of Agreement is missing in part or in whole.

(7) The Signature Waiver Form is missing or incomplete.
(8) Proof of North Carolina residency or the Residency Declaration form is missing or incomplete.
(9) Any supporting documentation required by the MAP Specialist is missing in part or in whole.

d. For incomplete applications, the MAP Specialist will mail the patient a form letter requesting missing information within 3 business days of application review,

(1) The MAP Specialist updates the patient's medication profile with notes in each of the outpatient pharmacies to indicate the date the patient was notified of the incomplete application. *Example*: "GFS incomplete. Missing signed Letter of Agreement and proof of residency documents 4/11/11."

e. The MAP Specialist reviews completed applications using the GFS Processing Check List to determine if the applicant meets criteria for enrollment in the PAP.

(1) The MAP Specialist calculates gross annual income and monthly income for the patient or family unit based on DOI submitted with the application. The MAP Specialist records the details and end results of both calculations on the MAP Specialist Recommendation form.
(2) The MAP Specialist totals monthly living expenses listed by the applicant on the GFS (unless already totaled by the applicant) and records the result on the MAP Specialist Recommendation form.
(3) The MAP Specialist compares total monthly living expenses with calculated monthly income. If the gap between the two amounts exceeds $500, the MAP Specialist requests supporting information to explain how they are meeting their monthly living expenses. Supporting information may include:

i. A personal statement written and signed/dated by the patient explaining how he is managing his monthly living expenses. The signature of the patient does not need to be notarized.
ii. Notarized statements from those providing assistance to the patient with monthly living expenses.

(4) The MAP Specialist determines the number of individuals in the family unit using the definitions and algorithm for dependents described in the instructions for the federal tax forms for the most recent tax year. The MAP Specialist records this number on the MAP Specialist Recommendation form. A "family" is a group of two or more persons related by birth, marriage, or adoption that live together as part of the same household. All such related persons are considered as members of one family. Family members are defined as follows:

(a) The patient and, if married, his/her spouse.
(b) Any natural, or adopted minor child of the patient, or spouse who has not been emancipated by a court and who is not, or has never been, married.
(i) A minor is one who has not reached his/her eighteenth (18^{th}) birthday and who is not and has never been married. When the marital status of the minor cannot be determined, or when there is no documentation indicating the patient is an emancipated minor, the parents or legal guardian should be designated as the responsible party. The parents or guardian's income and residence should be used to determine eligibility for financial assistance. Legal guardianship must be supported by fully executed and valid legal documents

(c) Any minor for whom the patient or patient's spouse has been given legal responsibility by a court.
(d) Any full time student (related by birth, marriage, or adoption) over 18 years old and less than 24 years old who is dependent on the patient's family income for over 50 percent support.
(e) Any minor child of a minor who is solely, or partially, supported by the minor who is a member of the patient's family (and is living in the same household).
(f) Any adult dependent on the patient's family income for over 50% support and who meets the qualifying relative test in the most current IRS tax rules for exemption of dependents or for whom there exists legal guardianship supported by legal documents.

(5) The MAP Specialist checks the MedConnect/MedData database for information regarding N.C. Medicaid coverage or BCBS coverage of the applicant and documents findings on the MAP Specialist Recommendation form and in TechRx notes. If coverage is identified via MedConnect inquiry, the MAP Specialist prints the information and adds to the application file in the Sovera imaging system.

(6) The MAP Specialist performs a "J inquiry" in TechRx to determine if the patient has Medicare Part D coverage. If yes, this is noted on the MAP Specialist Recommendation form and documented in TechRx notes.

(7) The MAP Specialist calls the vendor maintaining the NC Medicaid database as needed to determine if the patient has NC Medicaid benefits. Alternatively, the MAP Specialist calls the patient's county Department of Social Services for such information, as needed. Results of these inquiries are documented on the MAP Specialist Recommendation form and in TechRx notes.

(8) The MAP Specialist checks SMS for information regarding the applicant's home address and insurance coverage.

i. Discrepancies regarding permanent home address are clarified with the applicant. Supporting documentation may be required to confirm the applicant is a permanent NC resident.

(9) The MAP Specialist contacts the VA to confirm VA benefits and the patient's use of the VA health care system. Details of such are noted in TechRx notes on the patient's medication profile.

(10) The MAP Specialist contacts identified insurers by phone for details of insurance benefits relating to drug coverage. Such details include co-pays due, deductibles, annual caps, etc. The MAP Specialist documents the details of prescription drug coverage (or the lack of such coverage) in the assistance application file and in TechRx notes.

(11) The MAP Specialist reviews notes in the patient's TechRx profile in the outpatient pharmacy and WebCIS, as needed, to identify other pertinent information that may relate to the applicant's current application for assistance.

(12) The MAP Specialist confers with other MAP Specialists, Patient Accounts representatives, UNC P&A Financial Counselors, Department of Social Services case workers, etc., as needed for pertinent information that may relate to the applicant's current application for assistance.

(13) The MAP Specialist reviews other information on file in the Sovera imaging system as needed for pertinent information that may relate to the patient's current application for assistance.

(14) The MAP Specialist determines if the patient may be potentially eligible for other assistance programs that pay for or provide medications (e.g., state HIV program, Medicaid, Medicare, state sickle cell program, free drug programs offered by manufacturers, etc.).

f. The patient is approved for the PAP 100% Benefit if he submits a completed application and the MAP Specialist determines the gross annual income for the family unit is within or equal to 200% if the Federal Poverty Guidelines. The MAP Specialist documents approval for assistance and the term of assistance plus any other requirements for the patient (e.g., inquire about Medicaid) on the MAP Specialist Recommendation form.

(1) The MAP Specialist prepares and mails an approval letter describing the details of the PAP 100% Benefit and the term (expiration date) of assistance plus any other requirements of the patient.

g. The MAP Specialist updates notes on the patient's TechRx profile in each of the outpatient pharmacies with details regarding the benefit and the term of assistance. If the patient is required to submit additional information for continued assistance beyond a specified date, the requirement will also be described in notes added to the TechRx profile.

Example: "Approved for 100% benefit through 3/1/11. AI = $xxx, FU=xxx May be Medicaid eligible. Must provide Medicaid denial letter or DSS encounter form when seeks continued assistance."

h. The MAP Specialist updates the third party list for the patient in TechRx with account number 39000 (PharmAvail) and the expiration date for the term of pharmacy assistance. The MAP Specialist will deactivate the current 14000 account number in TechRx.

i. The MAP Specialist notifies the patient by letter regarding his approval for assistance and the details for the benefit that will be provided through the UNC outpatient pharmacies (e.g., term of assistance, co-payments due, etc.). This same letter will identify a suggested date by which the patient/guarantor should make re-application for assistance should continued assistance be needed. A copy of the letter is kept on file with the patient's completed PAP application and supporting documentation. See example in Attachment 5.

(1) When the approval letter indicates that the term of assistance is less than 12 months and additional information will be required for continued assistance, the MAP Specialist may elect to send the approval letter to the patient by certified mail. When certified mail is used, the signature card documenting receipt of the letter is scanned into the patient's electronic file.

j. In the event assistance is denied, the MAP Specialist notifies the patient by letter and includes a statement summarizing pharmacy charges that are due.

(1) All decisions made by the MAP Specialist to deny pharmacy assistance are documented on the MAP Specialist Recommendation form and submitted to the Assistant Director of the Ambulatory Pharmacy Care Network (or their designee) with the completed application for review before such decisions become final. The Assistant Director of the Ambulatory Pharmacy Care Network provides the MAP Specialist with a denial letter if they concur with the MAP Specialist decision. Once a decision to deny assistance is approved by the Assistant Director, the MAP Specialist documents the denial in TechRx notes and mails the denial letter to the patient. In addition, any active term of assistance in PharmAvail (e.g., active temporary benefit) is terminated by the PAC. A copy of the denial letter is kept on file with the patient's completed PAP application and supporting documentation (Attachment 6).

Example: "Patient denied assistance 4/13/11, lives in South Carolina"

Example: "Patient denied assistance 5/12/11, over income AI = 30,000 FU = 1"

(2) If the patient is denied assistance, the Assistant Director of the Ambulatory Pharmacy Care Network re-bills to CASH all medications that were originally assigned to the temporary assistance benefit and requests the Pharmacy Billing Office to place the amounts due on the A/R account. The Pharmacy Billing Office bills the patient for the amounts on the A/R account. If the patient is discovered to have Medicaid, the Assistant Director of the Ambulatory Pharmacy Care Network submits the necessary prescription information to the Pharmacy Billing Office with a request to re-bill NC Medicaid.

k. The MAP Specialist completes the GFS Processing Checklist after each item on the checklist is completed.

6. Patient Application to Other Assistance Programs

a) The MAP Specialist screens patients who are approved for the PAP for potential eligibility in other assistance programs (e.g., state HIV program, state sickle cell program, Medicaid, N.C. Health Choice, Medicare Part D, etc.).
b) Patients who are potentially eligible for Medicaid or N.C. Health Choice are referred to the Department of Social Services to pursue application for benefits.
c) Patient application to other assistance programs proceeds as follows:
    1) State Sickle Cell program – The MAP Specialist completes the application with the cooperation of the patient and submits the application and required supporting documentation to Purchase of Medical Care Services (POMCS) with the NC Department of Health and Human Services for review and processing.
    2) State HIV Program (ADAP) – The MAP Specialist refers the patient to the Infectious Diseases financial counselor, as appropriate, for making application to the state HIV program.
    3) Medicare Part D – The MAP Specialist refers the patient to their county SHIP (Seniors' Health Insurance Information Program) coordinator or DSS, as appropriate, to apply for Medicare Part D.
    4) Migrant Farm Worker Health Program – The MAP Specialist refers the patient to one of the entry points designated by the NC Department of Health and Human Services, Purchase of Medical Care Services (POMCS), for the Migrant Farm Worker Health Program.
d) The MAP Specialist forwards all approval letters from POMCS indicating enrollment of the patient in the state HIV program, Migrant Farm Worker Health Program, or state sickle cell program to the Pharmacy Billing Office.
    1) The Pharmacy Billing Office keeps the approval letter on file, updates information in TechRX (profile notes and third party list) with pertinent information regarding patient coverage by the program(s), and re-bills prescriptions previously charged to the PAP (when possible).

7. Maintenance of Files for Patients Approved or Denied Pharmacy Assistance

a. The MAP Specialist will maintain the following on file for each patient approved or denied pharmacy assistance. As of June 2006, all such documents are scanned and indexed in the Sovera imaging system.
    1) Most current signed and dated GFS application and all supporting documentation.

2) Documents proving NC residency
3) Documentation of Income (DOI)
4) Signed Authorization for Release of Medical Information, if required to obtain information for the assistance application.
5) Letter of Agreement signed by the patient or his legal representative
6) Signature Waiver form, completed as required by applicant and witness.
7) Proof of North Carolina Residency or Residency Declaration Form
8) All supporting documentation required by the MAP Specialist to process the assistance application, including:
    a. Application Checklist as completed by the MAP Specialist
    b. DOI checklist as completed by the MAP Specialist
    c. SMS (a2k) print outs and other database printouts applicable to the application
    d. GFS Processing Checklist as completed by the MAP Specialist
    e. Certified mail receipts and signature cards for items sent to the applicant (if applicable)
    f. Copies of all written communications with the patient (e.g., approval / denial letters, requests for additional information, memos regarding requirements to apply for Medicare D, etc).
    g. Pertinent information, as appropriate and available, documenting that the MAP Specialist (or other person) has helped the patient apply to other assistance programs within the previous 12 months (e.g., stat HIV program, etc.)
    h. MAP Specialist Recommendation form as completed by the MAP Specialist
9) Individual prescriptions will be filed in accordance with UNC Ambulatory Pharmacy Care Network Outpatient Pharmacies policies and procedures. Prescriptions will be made available in accordance with PHARM0129 Storage of Pharmacy Records.

8. Updating Income Criteria based on Revisions in the Federal Poverty Guidelines

a. Federal Poverty Guidelines (FPG) are revised annually and generally published in the Federal Register in February.

b. Income limits for the PAP are revised by the Assistant Director of the Ambulatory Pharmacy Care Network to reflect changes in the Federal Poverty Guidelines as soon as the FPG are received by the Department of Pharmacy.

9. Patients eligible for Medicare Part D

a. Patients covered by Medicare A or B must enroll in and maintain Medicare Part D as primary coverage for medications in order to be considered and qualify for UNC PAP as secondary coverage. Secondary coverage by the UNC PAPwill apply only when the patient has exhausted his Medicare Part D benefits (if the patient is not in the gap, no coverage will be provided for co-payments which includes catastrophic period). The UNC PAP is not used to cover excluded CMS medications (e.g. benzodiazepines, folic acid, etc) or those drugs that are unavailable to the Medicare Part D patient as a result of formulary limitations associated with his benefit).

b. When a patient with Medicare A or B, but no Medicare Part D, seeks pharmacy assistance:

1) The MAP Specialist will inform the patient of the need to enroll in Medicare Part D and direct him to his county SHIIP coordinator to apply and to return documentation proving application/enrollment.

2) A 14 day Temporary Benefit may be provided to the patient as long as the patient meets PAP eligibility and this is the first attempt to obtain pharmacy assistance. (i.e. the patient had no knowledge they should have enrolled into a Medicare part D plan) to allow the patient time to enroll into a plan. Note: if the patient has allowed his/her Part D plan coverage to expire due to failing to pay the monthly premium, the temporary benefit will not be provided.

3) The patient must submit proof of enrollment in a Medicare Part D plan and its effective date along with his PAP application in order to qualify for a longer term of pharmacy assistance. If the patient qualifies, PAP is provided to carry the patient to the effective date for Medicare Part D benefits.

   Example: Patient meets screening criteria for temporary pharmacy assistance benefit, then the patient is enrolled for 14 days and given PAP application. Patient returns PAP application and letter indicating Medicare Part D benefits will begin in 2 months. If patient qualifies for pharmacy assistance, he is given assistance for 2 months until the start date for his Medicare Part D benefits.

10. Patients with Medicare Part D coverage and needing CMS "excluded" medications

a. If the patient should require medications that are "excluded" by CMS from coverage under Medicare Part D, the patient will be required to pay the cash price for these medications.

b. All other drugs (i.e., other than those defined by CMS "excluded" drugs) are billed to the patient's Medicare Part D benefit.

11. Patients in the gap of Medicare Part D coverage and needing medications

a. Patients in the gap ("donut hole") of their Medicare Part D coverage may apply for secondary coverage by the UNC PAP.

b. The MAP Specialist confirms that the patient is in the gap of their Medicare Part D coverage and documents on the MAP Specialist Recommendation form and in TechRx.

c. If the patient qualifies, the PAPwill provide medications until the patient's Medicare Part D benefit resumes provided the patient maintains their enrollments in Medicare Part D. The PAP 100% Benefit will be deactivated each year beginning January 1st to coincide with start of new Medicare Part D plan.

d. Co-payments will be due at time of medication dispensing, unless the following occurs:

   a. The patient is a dual eligible (Medicare Part D and Medicaid) and states he/she is unable to afford the co-payment(s). All co-payments may be placed on an A/R account by the MAP Specialist as long as the account does not become delinquent. If the account becomes delinquent, no further medications will be dispensed without co-payment collection.

e. Patients with Medicare Part D may not be granted pharmacy assistance for the sole reason of being unable to afford Medicare Part D co-payments (including during the catastrophic period).

f. Patients with active Medicare Part D coverage, who allow such coverage to expire as a result of non-payment of premium, are not eligible to enroll in the PAP.

12. Patients with VA Benefits

a. Veterans with confirmed VA benefits will be allowed access to the UNC PAP if they meet all of the following criteria:

1) Their primary care physician is a UNC faculty (attending) physician.
2) They have been in a continuing relationship with this physician for over two (2) years.
3) They have made regular visits to the UNC outpatient pharmacies for medications for over two (2) years.
4) They qualify for enrollment in the UNC assistance program based on criteria for income and residency in North Carolina.
5) They fully cooperate with the MAP Specialist in pursuing application for Medicare, Medicaid, and other state assistance programs, as appropriate.

b. Veterans with confirmed VA benefits that do not meet the above criteria will be denied enrollment in the UNC PAP. They may choose to use the UNC Ambulatory Pharmacy Care Network pharmacies and pay full price for needed medication.

13. Verification of Staff Eligibility to Administer Program

a. The MAP Manager will perform a verification of staff eligibility to administer this program against the Department of Health and Human Services Office of Inspector General Exclusion list and the General Services Administration List of Parties Excluded from Federal Programs for all employees that perform functions on behalf of the program prior to initial hire and annually thereafter each February.

IV. Original Policy Date

Jul 2003

Attachment 1 : NC Residency Requirements (as Defined by NC Medicaid)

1. An individual must be domiciled in NC with the intention to remain there permanently or for an indefinite period or show that he entered NC to seek employment or with a job commitment. A person is domiciled in NC if NC is his fixed, established, or permanent place of residence with the intention to remain there permanently or for an indefinite period.

2. An applicant for pharmacy assistance who is capable of stating his intent to remain in NC either permanently or for an indefinite period must provide satisfactory proof that he is a resident of North Carolina and that he is not maintaining a temporary residency (the person intends to return when the purpose of the absence has been accomplished) in order to receive pharmacy assistance. The two exceptions are in a and b below:

   a. An applicant who is incapable of stating his intent to remain in NC is a resident of the state in which he is physically located. No statement of intent or proof is needed.

   b. An applicant who is institutionalized and capable of stating his intent to remain in NC is a resident of NC if he lives in an institution in NC, and states his intent to remain in NC permanently or for an indefinite period of time. No additional proof of residence is necessary.

3. An individual who claims to be a resident of NC but is temporarily absent in another state must show satisfactory proof of residence in NC before he can be considered temporarily absent for pharmacy assistance purposes.

4. The Pharmacy Assistance Counselor (PAC) asks all pharmacy assistance applicants to provide two of the documents listed below as proof of NC residency. Applicants who state that they do not have two of the documents must sign a declaration, subject to prosecution, that they do not have two of the documents listed. However, this declaration from the individual applying may be insufficient if there is other evidence that verifies residence outside of NC.

   To verify residency, two documents from two of the categories below must be provided by the applicant. This means a document or proof must be from two of the letters below. Example: An item from c and d would be acceptable. Two documents in b are not acceptable.

   a. A valid North Carolina drivers' license or other identification card issued by the North Carolina Division of Motor Vehicles

   b. A current North Carolina rent, lease, or mortgage payment receipt, or current utility bill in the name of the applicant or the applicant's legal spouse, showing a North Carolina address.

   c. A current north Carolina motor vehicle registration in the applicant's name and showing the applicant's current North Carolina address.

   d. A document verifying that the applicant is currently employed in North Carolina.

   e. One or more documents proving within the most recent 12 months that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.

   f. The tax records for the most current tax year of the applicant or the applicant's legal spouse, showing a current North Carolina address.

g. A document in the most recent 12 months showing that the applicant has registered with a public or private employment service in North Carolina.

h. A document within the most recent 12 months showing that the applicant has enrolled his children in a public or private school or a child care facility located in North Carolina.

i. A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residency in North Carolina. (Note: Work First, Energy Assistance, and Presumptive Medicaid for pregnancy, etc. do not currently require proof of NC residency.)

j. Records from a health department or other health care provider located in North Carolina which show the applicant's current North Carolina address.

k. A written declaration from an individual who has a social, family, or economic relationship with the applicant, and who has personal knowledge of the applicant's intent to live in NC permanently, for an indefinite period of time, or residing in NC in order to seek employment or with a job commitment.

l. A current NC voter registration card.

m. A document from the US Department of Veterans Affairs, US Military or the US Department of Homeland Security verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in NC to seek employment or has a job commitment.

n. Official NC school records, signed by school officials, or diplomas issued by NC schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live in NC permanently or for an indefinite period of time, or that the applicant is residing in NC to seek employment or with a job commitment.

o. A document issued by the Mexican consular or other foreign consulate verifying the applicant's intent to live in NC permanently or for an indefinite period of time, or that the applicant is residing in NC to seek employment or has a job commitment.

The Department of Pharmacy retains the right to deny pharmacy assistance and/or declare that the documents provided are unacceptable if it is believed that the documentation is false or is found to be unsatisfactory. The Department of Pharmacy can require that supporting documentation be provided. The Department of Pharmacy has the authority to determine what is considered satisfactory proof.

Attachment 2: PAP 100% Benefit

- Up to one (1) month supply if prescribed by a UNCprescriber and medication is on the UNC PAP formulary.
- Additional limits on quantities dispensed for selected drugs.
- Prior authorization and/or step therapy required for selected drugs.
- Only prescriptions written by UNC prescribers pursuant to care provided in an UNC-owned clinic or discharge from UNC Hospitals are covered.
- Co-payments required for prescription items:
  - $4 for quantities up to a 30-day supply for either trade name or generic products.
  - $8 for a 60-day supply
  - $12 for a 90-day supply
- Selected ostomy and diabetic supply items on formulary are covered.
- Full price for all over-the-counter items (e.g., aspirin) due at the time of purchase

Attachment 3: Documentation of Income Required for Completing a GFS Application

- **Requirements for supporting documentation for pharmacy assistance applications will include federal and state tax forms for the current tax year (all pages and all schedules) <u>if</u> filed by the patient. If tax forms have not been filed, alternative-supporting documentation of income as defined by the pharmacy assistance counselor and in accordance with this policy and procedure is acceptable. In the absence of alternative supporting documentation of income substantiating need and eligibility for assistance, federal and state tax forms will be required if the patient meets filing criteria described in the filing instructions for the current tax year.**
- **All of the items listed below that apply to the patient/guarantor, his/her spouse, and dependents must be submitted to complete the GFS.**
- Applicants who indicate they live in the same household with dependents (as defined by the Federal Tax Code) that have income must submit DOI for themselves as well as the dependents with income.
- Applicants who indicate they are separated (legally or otherwise) and living at an address different from their spouse are considered to be "single" applicants and responsible for submitting DOI that applies to them only. Applicants indicating they are separated yet living at the same address as their spouse are considered as "married" applicants **unless they present a legal separation agreement.**
- Applicants who are married must submit all applicable DOI for both the patient/guarantor and spouse.

If Retired	If Unemployed	If Employed
1. Last 3 months (most recent) bank statements for all bank accounts (all pages; 3 consecutive statements required unless documented exception by PAC). This includes all liquid asset statements: bank accounts (checking, savings, money market, CD, stocks, bonds).	1. Last 3 months (most recent) bank statements for all bank accounts (all pages; 3 consecutive statements required unless documented exception by PAC). This includes all liquid asset statements: bank accounts (checking, savings, money market, CD, stocks, bonds).	1. Last 3 months (most recent) bank statements for all bank accounts (all pages; 3 consecutive statements required unless documented exception by PAC). This includes all liquid asset statements: bank accounts (checking, savings, money market, CD, stocks, bonds).
2. Copy of disability check or statement of disability benefits from SSA or proof of deposit.	2. Copy of unemployment check or statement of unemployment benefits or proof of deposit.	2. Last 1-3 most recent pay stubs (3 consecutive pay stubs required unless documented exception by PAC).
3. Copy of Social Security check or statement of benefits or proof of deposit.	3. Copy of disability check or statement of disability benefits from SSA or proof of deposit.	3. Filed tax return plus W-2 forms for all jobs for most recent tax year (federal and state).
4. Copy of retirement pension check or statement of benefits or proof of deposit.	4. Other statements of benefits or copies of checks that apply (VA benefits, alimony, worker's compensation, interest/dividends, food stamps, AFDC).	4. Copy of disability check or statement of disability benefits from SSA or proof of deposit.
5. Other statements of benefits or copies of checks that apply (VA benefits, alimony, worker's compensation, interest/dividends, food stamps, AFDC).	5. Filed tax return plus W-2 forms for all jobs for most recent tax year (federal and state).	5. Copy of Social Security check or statement of benefits or proof of deposit.
6. Filed tax return for most recent tax year (federal and state).	6. Copy of rental agreement(s) or rent check documenting rental income (e.g., farmland, houses, condos, trailers, rooms, equipment, etc.).	6. Copy of retirement pension check or statement of benefits or proof of deposit.
7. Copy of rental agreement(s) or rent check documenting rental income (e.g., farmland, houses, condos, trailers, rooms, equipment, etc.).		7. Other statements of benefits or copies of checks that apply (VA benefits, alimony, worker's compensation, interest/dividends, food stamps, AFDC).
		8. Copy of rental agreement (s) or rent check documenting rental income (e.g., farmland, houses, condos, trailers, rooms, equipment, etc.).

Other DOI or supporting documentation required:

1. IRS form verifying nonfiling of taxes or requesting tax transcript if pt. has SSN – signed/dated by pt.

Attachment 4: Additional Information That May Be Required in Support of an Application for Pharmacy Assistance

One or more of the following will be required to support PAP applications from patients in the categories listed below:

A. For patient indicating they are homeless:
   1. Letter from a bona fide homeless shelter on letterhead stating that patient is a current resident.
   2. MAP Specialist confirmation by phone with a shelter manager that the patient is a current resident and documentation of such on the GFS by the PAC.
   3. Letter from the person providing shelter for the patient documenting such and bearing the provider's notarized signature and date of signature.
   4. Letter of explanation or personal statement from patient describing how he/she is managing with expenses in excess of income, signed and dated by the patient. (e.g. patient living in a vehicle who is not established at the shelter) (Note: patient's signature does not need to be notarized.)

B. For patients indicating they receive support for their living expenses:

   1. Letter from the person paying or helping pay for the patient's living expenses and bearing the provider's notarized signature and date of signature.

C. For patients indicating that they no longer have prescription drug coverage through an insurance plan that is identified upon interview with the patient or review of available databases:

   1. Letter from insurance company on company letterhead indicating the date coverage expired.
   2. MAP Specialist confirmation by phone with insurance company that coverage has expired and documentation of such in the pharmacy assistance application by the MAP Specialist or on the MAP Specialist RECOMMENDATION form.

D. For patients indicating their health insurance plan does not include prescription drug benefits or all prescription benefits have been exhausted for the current term of coverage:

   1. Letter from insurance company on company letterhead detailing benefits/coverage of the insurance plan.
   2. Copy of pages from the insurance company's brochure describing the details of benefits/coverage.
   3. MAP Specialist confirmation by phone with the insurance company that no prescription drug benefits are provided or have been exhausted for the current term of coverage and documentation of such in the PAP application by the MAP Specialist or on the MAP Specialist RECOMMENDATION form.

E. For patients claiming permanent residency in North Carolina despite information to the contrary provided by the patient, the patient's representative, or review of available databases see attachment 1, section 4 of this procedure.

F. For patients who may be eligible for NC Medicaid or NC Health Choice:

   1. Copy of encounter form showing meeting with Department of Social Services (DSS) case worker in the past 12 months to review candidacy for Medicaid or NC Health Choice.
   2. Copy of Medicaid/NC Health Choice denial letter dated within the past 12 months.

3. MAP Specialist calls county DSS office / case worker to confirm encounter with the patient and documents if it has occurred, name of case worker, and outcome of encounter in PAP application or on the MAP Specialist RECOMMENDATION form.

G. For patients with a Medicaid or NC Health Choice application pending decision by DSS:

1. Copy of the DSS encounter form or other official correspondence indicating Medicaid/NC Health Choice application is pending a decision.
2. MAP Specialist calls county DSS or UNC MAC worker, confirms that the Medicaid/NC Health Choice application is pending, and documents such along with the name of the DSS / UNC MAC worker in the PAP application or on the MAP Specialist RECOMMENDATION form.

H. For patients who claim self employment:

1. Federal and state tax forms plus all schedules (e.g., schedules A, B, C, etc.) and W-2's for all jobs for the most recent tax year.
2. Receipts for all jobs worked or sales showing amount due and amount paid by customer for the most recent three (3) months.
3. Itemized listing of business expenses and receipts documenting such for the same three (3) month period.
4. Appointment book listing dates, description of work performed plus amounts paid or schedule of fees collected for types of work performed for most recent three (3) months.
5. Records of all income and business expense for current tax year prepared by a certified public accountant (CPA) on CPA's letterhead or bearing notarized signature of CPA and date of signature.
6. Letters from all clients documenting amounts they pay the applicant for type of work performed and frequency of payment.

I. For patients who are residents of TROSA:

1. MAP Specialist confirmation of residency via telephone with TROSA manager and documentation of such in the PAP application or the MAP Specialist RECOMMENDATION form.
2. TROSA listing of residents on TROSA letterhead.

J. For patients who have a diagnosis of HIV infection or AIDs or sickle cell disease and gross income is less than 200% of Federal Poverty Guidelines:

1. Copy of completed application submitted to the state HIV program or sickle cell program.
2. MAP Specialist confirmation with appropriate persons that application has been made or is in process of being made to the state HIV program or sickle cell program (e.g., Infectious Diseases Clinic financial counselor; Department of Health and Human Services, Purchase of Medical Care Services).
3. Copy of the letter from Purchase of Medical Care Services approving enrollment for current year in the state program.
4. MAP Specialist confirmation by phone of application to, enrollment in, or addition to wait list for current year for the state program and documentation of such in the pharmacy assistance application or the MAP Specialist RECOMMENDATION form.

K. For patients who have a pending worker's compensation claim before a review panel / judge:

1. Copy of documentation for claim submitted to the review panel.

2. MAP Specialist confirmation by phone with employer or attorney regarding status of claim and documentation of details in the PAP application or on the MAP Specialist RECOMMENDATION form.
3. Letter on company letterhead or from legal counsel indicating claim has been denied or still pending with estimated timeframe for review/decision.

L. For patients that may have VA benefits:

1. MAP Specialist confirmation of VA benefits and VA primary care physician by contacting the VA Health Care System and documentation of details in the PAP application or on the MAP Specialist RECOMMENDATION form.
2. MAP Specialist consultation with pharmacists to determine if patient has used the UNC Outpatient pharmacies consistently within the previous two (2) years and if the patient is being followed by a UNC attending physician for his primary care (not specialty care) with MAP Specialist documentation of details in the PAP application or on the MAP Specialist RECOMMENDATION form.

M. For patient claiming grandchildren, foster children, others as dependents:

1. Documentation of legal guardianship or adoption for identified dependent(s) plus DOI for same.
2. Documentation of responsibility as foster parent for identified dependent(s) plus DOI for same.
3. Federal tax forms filed for current tax year documenting dependents (only if patient indicates that tax forms were filed).

N. For patients claiming recent unemployment and no income from unemployment or disability benefits:

1. MAP Specialist confirmation by phone with former employer of patient that patient is no longer employed.
2. Copy of letter on company letterhead indicating patient is no longer employed

3. If no spouse, note from person paying for all living expenses bearing the provider's notarized signature and date of signature.

Attachment 5: Example of Patient Letter Approving Pharmacy Assistance

Date

Patient Name

Address

RE: Patient Name:

Medical Record Number:

Dear

Thank you for completing and returning the Guarantor's Financial Statement. Based on UNC Hospitals guidelines, the Department of Pharmacy has found the patient listed above to be eligible for financial assistance for current outpatient medication charges starting _____ and future charges at the UNC Outpatient Pharmacies until _____. This assistance will be provided through enrollment in the UNC Prescription Benefit Plan. **A description of this benefit plan and required co-payments is enclosed.**

Application for continued financial assistance with outpatient medication charges is required every twelve (12) months. The Medication Assistance Program Specialist will provide the necessary application forms upon request. It is suggested that re-application for assistance be made by _____ (if still needed).

Determinations regarding financial assistance for hospital charges are made by the UNC Hospitals Patient Accounts Department. Determinations regarding financial assistance for physician charges are made by UNC Physicians and Associates. Determinations by these two groups are completely independent from those made by the Department of Pharmacy. Please note approval for assistance from one of these groups does not guarantee assistance from the others.

If you have questions regarding the above information, please contact me at _____. Please keep a copy of this letter for your records.

Sincerely,

Medication Assistance Program Specialist
Department of Pharmacy

UNC Prescription Benefit

100% Benefit for drugs on the UNC Pharmacy Assistance Program formulary

- All prescriptions are limited to a one month supply. If prescriber approves additional quantities (e.g. 90 day supply), only a one month supply will be dispensed and additional quantities will be made available via a refill.
- There may be additional quantity limits on selected drugs (e.g. Viagra)
- Only prescriptions written by UNC Physicians for care in a UNC-owned clinic or at discharge from the UNC Hospitals are covered
- Prior authorization and/or step-therapy required for selected drugs
- Required co-payments
    - $4 for quantities up to a 1 month supply
      ($8 for 2 months supply, $12 for 3 months supply)
    - Full price for all Over-the-Counter items (e.g., aspirin) due at the time of purchase

- **If you have any other prescription benefit coverage or insurance (e.g., State Health Plan, Medicaid, Medicare Part D, etc.), that benefit must be used for primary coverage for your drugs. The UNC Prescription Benefit is not available to those possessing primary coverage through another insurance plan.**
- **Any co-payments required by your insurance or the pharmacy assistance benefit will be payable in full at the time your medications are dispensed.**
- **Please bring all insurance cards (e.g. Medicaid, Medicare Part D etc.) to each pharmacy visit to show the pharmacist.**

Attachment 6: Example of Patient Letter Denying Pharmacy Assistance

UNC Department of Pharmacy

Date

Address

RE: Patient Name
Medical Record #:

Dear

Thank you for completing and returning the Guarantor's Financial Statement.

Based on the information provided on your statement, review / confirmation of health insurance information, and in accordance with the Department of Pharmacy's policies, you do not qualify for financial assistance at this time for your outpatient medication charges. You may re-apply for assistance with medications if a substantial decrease in household income occurs or there is a change in health insurance coverage.

Other options for getting medications may include manufacturer assistance programs for brand name drugs and the assistance programs offered by retail pharmacies such as Wal-Mart and Kroger for selected generic drugs (commonly known as the Wal-Mart or Kroger $4 programs). If you would like to speak to someone to determine if there may be a manufacturer assistance program available for your brand name medication, please call a UNC Medication Assistance Program Specialist at (919) 966-0119.

Your account balance for medications previously dispensed is _____. You will soon receive a bill requesting payment for this amount. Should you have questions about this bill, please contact:

Pharmacy Business Office
Telephone: (919) 966-5127

No additional medications may be obtained at the UNC Outpatient Pharmacies until all amounts currently due are paid in full. Going forward, all outpatient medication charges will be due at the time of dispensing by the pharmacist.

If you have questions regarding the above, please contact me by telephoning _____, Monday through Friday, between the hours of 9a.m. and 6p.m.

Sincerely,

Medication Assistance Program Specialist
Department of Pharmacy

UNC CENTER FOR TRANSPLANT CARE	Policy Name	**Solid Organ Transplant Financial Policy**
	Policy Number	**TXP 0301**
	Date this Version Effective	**October 2010**
	Responsible for Content	**Transplant Center/Financial Assistance Oversight Committee (FAOC)/Managed Care**

1. Description

This policy provides guidelines for establishing financial eligibility for Solid Organ Transplant and/or Ventricular Device (VAD) implantation.

Table of Contents

2. Rationale

Determining financial eligibility for transplant care (including pre-transplant evaluation & services, the transplant event and post transplant care) and/or VAD implantation, is a critical and necessary part of the transplant process of care. This policy will ensure fair and equal treatment for all potential candidates and provide an effective and efficient process to ensure financial viability of the solid organ transplant program. Additionally, the policy covers those emergent situations when a patient must be listed for transplant or receive a VAD implant before full financial approval may be obtained.

3. Policy/Procedure

a. Policy

8. Patients may be approved for transplantation when medical, psychosocial and financial criteria are met. Any patient unable to meet the financial criteria as listed in this policy will be ineligible for transplant and/or VAD implant. An annual review of the patient's ability to continue to meet financial criteria will be performed while the patient remains on the waiting list.
9. Patients are required to have medical insurance that will cover the transplant event and related pre and post care. Patients, who are out-of-network, lack a single case agreement approving in-network benefits, have inadequate benefits or require non-covered services are considered self-pay and therefore subject to the deposit criteria. In some situations, patients may be eligible for financial assistance for services not directly associated with the

transplant event. Refer to Patient Financial Assistance Policy ADMIN #0192 and/or Pharmacy Assistance Program for Ambulatory Care Patients.

10. The UNC Center for Transplant Care does not accept out of state Medicaid. These patients are considered self-pay and therefore subject to the deposit criteria.
11. In the event a resident of NC presents with life-threatening organ failure and meets the program's clinical and psychosocial criteria, but does not meet the financial criteria or is waiting for insurance authorization, a request to the Clinical Appeals Subcommittee of the Financial Assistance Oversight Committee (FAOC) must be made and approval for transplant listing or VAD implantation obtained.

b. Procedure

Insurance Verification

4. The assigned Transplant Financial Coordinator (TFC) is responsible for verifying patient insurance benefits (all policies) upon referral; annually, and anytime when notified of a significant change in patient's financial or employment status.
    a. Patients who need a transplant must have the following minimum insurance coverage in their transplant health benefit plan available:
        i. Heart & Lung - $500K
        ii. Liver $400K
        iii. Kidney - $175K

These amounts reflect the 35% discount of charges.

    b. Patients lacking the minimum amount of insurance coverage will be required to make a deposit with the hospital in order to meet this minimum level of coverage prior to the transplant evaluation.
    c. The appropriate insurance coverage for patients requiring a pancreas or double organ transplant will be decided on a case-by-case basis.
    d. Patients who need VAD implant as Destination Therapy or as a Bridge to Transplant must have a minimum of $1M of insurance coverage in their health benefit plan available. (VAD implantation may be covered under the patient's general medical policy).

Note: These amounts reflect the 35% discount of charges.

    e. Note: VAD Implantation may lead the patient to require heart transplant, therefore the patient's benefits should be verified for both. Patients lacking the minimum amount of coverage will be required to make a deposit with the hospital in order to meet this minimum level of coverage prior to the VAD/transplant evaluation.
    f. Persons who have no health insurance coverage or who obtain services not covered by their health insurance will be eligible for a 35% discount of the UNC Hospitals (UNCH) and UNC Physicians & Associates (P&A) charges. This discount will be given regardless of income or North Carolina residency. Payment arrangements are made in the manner outlined in the Administrative Policy entitled Patient Financial Assistance (#0192). The Transplant Financial Coordinator will work closely with each patient/family

to identify financial needs and assist the patient and/or family to complete the necessary paperwork for financial assistance eligibility for transplant services.

g. Patients must have a verifiable prescription plan benefit that covers the expense of medications for the first year post-transplant. In the absence of a prescription benefit the patient must deposit with hospital an amount equal to 12 months of estimated prescription drug expense. A patient with a prescription plan with substantial out of pocket expenses will be required to sign the Transplant Financial Agreement, and may be required to make a deposit equal to the amount of the difference between prescription costs and coverage for the first year. Deposit amounts for outpatient prescription charges shall be discounted according to the current Pharmacy Department Financial Policy. Refer to Patient Financial Assistance Policy ADMIN #0192 and/or Pharmacy Assistance Program for Ambulatory Care Patients.

   i. Extenuating patient circumstances (i.e. if the patient is out-of-state) may require an alternative deposit plan for medication funds. The Transplant Financial Coordinator will work with Transplant Administration to identify alternative deposit plans when warranted.

   ii. Note: Veteran's Affairs (VA) patients should receive their prescriptions through the VA.

h. As required by the individual insurance carrier, the TFC will obtain authorization for all transplant related and/or VAD implant services requested. Some government payers do not require authorization for services. Authorization will be documented in the patient's medical record in TransChart, and in Siemens

Transplant Financial Waiver

1. There are a number of situations where approval for a Transplant and/or VAD implant may be needed on an urgent or emergent basis.
2. A patient with life threatening organ failure, who is a North Carolina resident, and meets the program clinical and psychosocial criteria, but who does not meet financial criteria or is awaiting insurance authorization, may be considered for urgent approval for transplant listing through the Clinical Appeals Subcommittee of the Financial Assistance Oversight Committee (FAOC) if:

   a. The patient has been deemed by the attending/consulting UNC transplant physician to require an emergent transplant or VAD implant to save their life, AND:

      i. The patient is without financial means to make a deposit, OR

      ii. The patient's commercial insurance has been verified and the patient meets the financial criteria as outlined, but there is insufficient time to obtain full authorization from the insurance company (e.g. weekend situation), OR

      iii. The patient has North Carolina Medicaid, or is Medicaid Pending, but there is insufficient time to obtain full authorization from the Medicaid Case manager (e.g., weekend situation).

   b. If the patient meets these criteria, a request for emergent approval may be made to the Clinical Appeals Subcommittee of the Financial Assistance Oversight Committee.

3. To request a FAOC approval:

   a. Notify the Director of Clinical Transplant Services, or designee, e.g., Transplant Program Manager, and provide the following information:

i. Summary of the patient's current medical condition and transplant evaluation test results. To the extent possible, all tests that are required by the insurance carrier should be completed.

ii. Disclose any concerns regarding possible non-coverage for medical issues, or non-adherence with care of the transplanted organ(s) (e.g., lack of family support post-transplant, prior history of substance abuse without adequate counseling, etc.)

iii. Provide documentation by the transplant medical physician outlining the patient's current life-threatening clinical status and clearly stating the emergent need (VAD Implant or emergent transplant listing). Transplant Surgeon must have also approved candidate for transplant listing and/or VAD implant.

iv. Provide documentation by the Transplant Financial Coordinator outlining the current status of Insurance authorization, and/or financial assessment - (e.g., likelihood that Medicaid will be approved based on financial status, etc.)

4. The Director of Clinical Transplant Services (or designee) will contact the Associate Vice President or Sr. Vice President for transplant, (as representatives of the Clinical Appeals Subcommittee), present the case and request a decision, e.g., for listing a patient.
5. The Director of Clinical Transplant Services (or designee) will notify the requesting physician and on-call nurse of the decision, as well as sending an email to the TFC group, the Transplant Business Manager, Patient Accounts, P&A and the Managed Care Office and will document the request and decision in the patient's TransChart record.
6. The assigned TFC will communicate via email the outcome of the request for insurance approval from the respective payer to the Director of Clinical Transplant Services. The TFC will email the Managed Care Office when an approved request has been deemed in-active. Reasons for inactivity include, but are not limited to, death, clinical condition no longer warrants transplantation, insurance authorization obtained, time frame for waiver has expired (no more than 1 year post –transplant or event).
7. The Director of Transplant Clinical Services will notify the FAOC group by email of the final outcome post-decision.
8. The Transplant Business Manager will maintain the FAOC Request Log - (see attached example Exhibit 1), and email the log after each approved event to all contacts as listed on the form:
    a. Email will include an updated FAOC Request log
    b. Requests denied by the FAOC will be documented on the log, but do not require further notification this group.

5. Related Policies

Patient Financial Assistance Policy ADMIN 0192

Pharmacy Assistance Program for Ambulatory Care Patients

6. Reviewed/Approved by

Financial Assistance Oversight Committee, October 2010

7. Original Policy Date and Revisions

Original Policy Date: July 2005

8. Comments

For comments or questions about the contents of this policy, contact: UNC Transplant Center, Director, Clinical Transplant Services, at 919-966-1633.

Exhibit 1: FAOC Request Log -Example

Request Date	Pt Name (Last, First)	MRN	Organ Type or VAD	Pharmacy	VAD (Type)	FAOC Decision	Outcome	Inactive Date*
3/25/10	Last Name, First name	00001234567-8	Heart	Post Tx prescriptions	Heart Mate II	Approved	Insurance Approval Received 3/26/10	3/26/10

***Inactive Date may be NO later than 1 year post transplant or event date**

Email Notification to:

Pharmacy: Elizabeth Forshay, Randy Bowling, Jeremy Strong.

Hospital Patient Accounts: Craig Wade

UNC P&A: Kathryn Grant and Scott Trott,

Managed Care Office: Barbara Bieszka

5. Has the Health and Human Services Administration ever audited UNC Hospital's 340B program?

UNC Hospitals 340B program has not been audited by the Health and Human Services Administration.