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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 10-029

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 212.44-1850

Center for Medicaid and CHIP Services

March 26, 2012

Mr. Albert Delia
Secretary
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

RE: SPA *NC* 10-029

Dear Secretary Delia:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 10-029. Effective October 1, 2010 this amendment will provide supplemental payments to the University of North Carolina Health Care System hospitals up the Medicare upper payment limit. The payments will be made quarterly based on Medicaid services provided in that quarter.
.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(l3), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2010. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

//s//

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-029**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2010**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. **FFY 2011** **$37,356,970**
b. **FFY 2012** **$34,274,245**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 13a, Attachment 4.19-A, Page 14, Attachment 4.19-A, Page 15, Attachment 4.19-A, Page 16, Attachment 4.19-A, Page 22 and Attachment 4.19-B, Section 2, Page 1e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 14, Attachment 4.19-A, Page 15, Attachment 4.19-A, Page 16, Attachment 4.19-A, Page 22 and Attachment 4.19-B, Section 2, Page 1e

10. SUBJECT OF AMENDMENT:

UNC Medicare UPL

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED: 12/30/10

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/30/10

18. DATE APPROVED: 06/26/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME: Cindy Mann

22. TITLE:
Director, CMS

23. REMARKS: Approved with follow changes as authorized by state agency;

Block # 8 changed to read: Attachment 4.19-A Pages 13a, 14, 15, 16, 19, thru 19i and 22; Attachment 4.19-B Section 2, page 1e

Block # 8 changed to read: Attachment 4.19-A Pages 13a, 14, 15, 16, 19 and 22; Attachment 4.19-B Section 2, page 1e

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

University of North Carolina Hospital Adjustment

(h) In addition to the payments made elsewhere in this plan, hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. § 116-37, are eligible for a supplemental payment for inpatient hospital services. For a hospital eligible under this Paragraph, the payment in this Paragraph supersedes the requirement, in the REIMBURSEMENT PRINCIPLES and in Paragraph (b) of this Section, that such a hospital be paid allowable costs.

The total payment available for hospitals eligible under this Paragraph will be determined by aggregating the difference between what Medicare would pay for each eligible hospital's Medicaid fee-for-service inpatient charges and inpatient Medicaid payments as otherwise calculated under this State Plan. For purposes of calculating this difference, each unit in a hospital with a different Medicare payment system (e.g. acute, psychiatric, rehabilitation) will be treated separately. The difference between what Medicare would pay and inpatient Medicaid payments will be calculated as follows (for exact calculations and cost report references, refer to Exhibit 1, 4.19 –A, page 19):

(1) Using the most current available Medicare cost report data, Medicare payments to each hospital shall be divided into Medicare Payments Subject to the Case Mix Index (including base rate, IME, DSH, and capital payments), Medicare Payments Not Subject to the Case Mix Index (including GME, organ acquisition, costs associated with teaching physicians, and routine service and other ancillary pass-through payments) and outlier payments.

(2) Medicare Payments Subject to the Case Mix Index shall be divided by the transfer-adjusted Medicare case mix index for the hospital, obtained from the Medicare PS&R for the appropriate time period, to obtain Case Mix Adjusted Medicare Payments Subject to the Case Mix Index.

(3) An Outlier Adjustment will be computed by applying the percentage of Medicaid payments from the Medicaid PS&R that are attributable to outlier payments to the total Medicare Payments Not Subject to the Case Mix Index.

(4) The Outlier Adjustment and Case Mix Adjusted Medicare Payments Subject to the Case Mix Index shall be added to Medicare Payments Not Subject to the Case Mix Index to obtain Case Mix Adjusted Medicare Payments.

(5) Case Mix Adjusted Medicare Payments shall be divided by the number of Medicare discharges (from the Medicare cost report) to obtain the Adjusted Medicare Payments Per Discharge. The Adjusted Medicare Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(6) The Medicaid Payment Per Discharge shall be calculated using data from a Medicaid PS&R for the same year as the Medicare cost report and run no less than nine (9) months after the close of the cost report year. Total Medicaid Inpatient Fee-For-Service Payments from the Medicaid PS&R shall be divided by Total Medicaid Discharges from the Medicaid PS&R to obtain the Unadjusted Medicaid Payment Per Discharge.

(7) The Unadjusted Medicaid Payment Per Discharge shall be divided by the Case Mix Index for the Medicaid population calculated using MMIS data to obtain the Adjusted Medicaid Payment Per Discharge. The Adjusted Medicaid Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(8) The inflated Adjusted Medicaid Payment Per Discharge shall be subtracted from the inflated Adjusted Medicare Payment Per Discharge to obtain the Per Discharge Differential.

(9) The Per Discharge Differential shall be multiplied by the Case Mix Index for the Medicaid population and Total Medicaid Discharges to calculate the Available Room Under the UPL.

(10) The Available Room Under the UPL for each eligible hospital will be aggregated to create the Supplemental Payment Amount. The total calculated Supplemental Payment Amount will be paid to eligible hospitals in payments made no more frequently than each quarter.

If payments in this section would result in payments to any category of hospitals in excess of the upper payment limit calculation required by 42 C.F.R. 447.272, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the upper payment limit.

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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

With respect to hospitals that are licensed by the State of North Carolina, that are qualified to certify public expenditures (CPEs) and do certify in accordance with 42 CFR 433.51(b), that qualify for disproportionate share hospital status under Paragraph (c) of the "Disproportionate Share Hospital Payment" Section and that do not meet the criteria described in Subparagraph (d)(5) of the "Disproportionate Share Hospital Payment" Section , the expenditures claimable for Federal Financial Participation (FFP) for the 12-month period ending September 30 each year will be (i) the hospitals' uncompensated care expenditures for serving uninsured patients up to the State's available DSH allotment after allowing for DSH payments for the State-owned Institutes for Mental Diseases, Division of Vocational Rehabilitation Services DSH, Basic DSH, HMO DSH, and Teaching Hospital DSH; plus (ii) the State's expenditures for Medicaid Health Maintenance Organization (HMO) DSH payments as described below; plus (iii) Division of Vocational Rehabilitation Services' DSH expenditures as described below. Each hospital's allowable uncompensated care costs for the rate year will be determined on an interim basis by calculating the hospital's inpatient and outpatient cost-to-charge ratios determined from the hospitals' most recent available as-filed CMS 2552 cost report and multiplying the ratios by the hospital's inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the fiscal year. The Division will then subtract payments hospitals received from uninsured patients for services rendered during the fiscal period to which the gross charges referred to in the preceding sentence relate. The Division will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for services provided to uninsured patients will be determined in accordance with Medicare cost principles by using the hospitals' routine per diems and ancillary cost-to-charge ratios for inpatient cost and outpatient cost-to-charge ratios for outpatient costs from audited CMS 2552 cost reports for the year for which final FFP is being determined by hospitals' inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the same fiscal year and then subtracting payments hospitals received from uninsured patients for services rendered during the fiscal year. The difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the cost was incurred and initial claim was made. Final cost is determined in accordance with Attachment A beginning on page 19c of this section.

(a) In accordance with the Social Security Act, Title XIX, Section 1923(g)(1) total disproportionate share payments to a hospital shall not exceed the percentage specified by the Social Security Act, Title XIX, Section 1923(g) of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less all payments received for services to Medicaid and uninsured patients. The total of all disproportionate share hospital payments shall not exceed the limits on disproportionate share hospital funding as established for this State by CMS in accordance with the provisions of the Social Security Act, Title XIX, Section 1923(f).

(b) The payments authorized by this section shall be effective in accordance with GS 108A-55(c).

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(c) No hospital may receive disproportionate share hospital payments unless it:

(1) Has a Medicaid inpatient utilization rate of not less than one percent, defined as the percentage resulting from dividing Medicaid patient days by total patient days, based on the most current available information; and

(2) Has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals eligible for Medicaid. In the case of a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric services procedures. This requirement does not apply to a hospital which did not offer non-emergency obstetric services as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age.

(d) The following Subparagraphs describe additional criteria, at least one of which a hospital must meet to be eligible for disproportionate share hospital payments under certain paragraphs of this Section, as specified in those paragraphs.

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals that receive Medicaid payments in the state; or

(2) The hospital's low income utilization rate exceeds 25 percent. The low-income utilization rate is the sum of:

(A) The ratio of the sum of Medicaid net revenues for patient services plus cash subsidies received from the State and local governments divided by the hospital's net patient revenues; and

(B) The ratio of the hospital's gross inpatient charges for charity care less the cash subsidies for inpatient care received from the State and local governments, divided by the hospital's total inpatient charges; or

(3) The sum of the hospital's total Medicaid gross revenues, bad debts allowance net of recoveries, and charity care exceeds 20 percent of total gross patient revenues; or

(4) The hospital, in ranking of hospitals in the state from most to least in number of Medicaid patient days provided, is among the top group that accounts for 50 percent of the total Medicaid patient days provided by all hospitals in the state; or

(5) The hospital is a Psychiatric Hospital operated by the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH/DD/SAS) or a hospital owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37.

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BASIC DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

(e) Each hospital that qualifies for disproportionate share status under Paragraph (c) of the "Disproportionate Share Hospital Payment" section of this plan and (i) is described in subparagraph (d)(5) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan, except for hospitals owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37; (ii) is a Critical Access Hospital pursuant to 42 USC 1395i-4 that is not qualified to certify public expenditures or a hospital owned or controlled by UNCHCS that meets at least one of the criteria outlined in subparagraphs (d)(1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan; (iii) prior to October 1, 2006, meets at least one of the criteria outlined in subparagraphs (d) (1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan and is qualified to certify public expenditures but does not certify; or (iv) Effective October 1, 2006, meets at least one of the criteria outlined in subparagraphs (d)(1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan and is qualified to certify public expenditures, shall receive a payment for the 12-month period ending September 30 each year, that is calculated annually and paid monthly. The basic DSH rate adjustment is equal to 2.5 percent plus one fourth of one percent for each percentage point that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation of the mean Medicaid inpatient utilization rate in the state. The basic DSH payment shall be calculated as follows:

(1) For Medicaid inpatients cases paid on a per case basis under the DRG system, the Division will multiply the Medicaid inpatient unit or hospital-specific payment rate in effect for the period for which the basic DSH payment applies, by each eligible hospital's DRG case-mix index for Medicaid inpatients served during the most recent 12-month period available before the rate adjustment payment is calculated. The Division will then multiply each hospital's case-mix adjusted per case payment amount by its basic DSH rate adjustment, and then multiply this product by the hospital's total number of Medicaid inpatient cases for the most recent 12-month period available before the basic DSH payment is calculated.

(2) For Medicaid inpatient cases paid on a per diem basis, the Division will multiply the Medicaid inpatient per diem payment in effect for the period for which the basic DSH payment applies, by each hospital's basic DSH rate adjustment. The Division will then multiply each hospital's adjusted per diem payment amount by the hospital's Medicaid inpatient days for the most recent 12-month period available before the basic DSH payment is calculated.

If a payment to a hospital under this section would cause a hospital to exceed the hospital-specific limits on disproportionate share hospital payments at 42 U.S.C. § 1396r-4(g)(1)(A), payments under this section will be reduced to ensure compliance with the hospital-specific limit.

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Exhibit 1

This exhibit contains a table which defines the calculation and source documents for the adjustments based on the difference between what Medicare would pay and inpatient Medicaid payments as otherwise calculated under this state. All cost report line references are based upon the Medicare Cost Report (MCR) CMS 2552 - 96 and should be adjusted for any CMS approved successor Medicare Cost Report (MCR). Table 1 identifies the calculation for acute care hospitals, excluding any psychiatric and rehabilitation distinct part units.

Table 1

Hospital – Specific UPL Calculation – per case method; inpatient only	Data Source: MCR – 2552 – 96 or its successor; if a calculation, defines the line(s) and operation; other documents.	
Step 1: Find the Medicare per case rate with case mix removed.	Include all Medicare payments from the most recent as filed cost report.	
1. Portions of Medicare payments for most recent year subject to Case Mix Index.		
a. Other than Outlier payments (base rate)	Wksht E; Part A; Line 1 (may be total of a number of lines)	$
b. IME Adjustment	Wksht E; Part A; Line 3.24	$
c. DSH Adjustment (include Medicare DSH)	Wksht E; Part A; Line 4.04	$
d. Additional payment for high percentage of ESRD Beneficiary Discharges	Wksht E, Part A; Line 5.06	$
e. Capital Adjustment	Wksht E; Part A; Line 9	$
f. Total Medicare payments subject to case mix index	Total lines 1a through 1~~d~~e	$
2. Adjustment for Case Mix Index.		
a. Medicare Case Mix Index	From the CMS website for the MCR period	0.0000
b. Case mix adjusted total payments	Line 1f ÷ 2a	$
3. Medicare Payments not subject to case mix index.		
a. GME adjustment	Wksht E; Part A; Line 11	$
b. Organ Acquisition cost	Wksht E; Part A; Line 12	$
c. Cost of Teaching Physicians	Wksht E; Part A; Line 13	$
d. Routine service pass-through	Wksht E; Part A; Line 14	$

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Exhibit 1 Continued

Table 1 Continued

e. Other ancillary other pass-through	Wksht E; Part A; Line 15	$
f. SCH or MDH hospital payment	Wksht E; Part A; Line 8	$
g. Exception Payment for IP Program Capital	Wksht E; Part A; Line 10	$
h. Special Add-On for New Technologies	Wksht E, Part A, Line 11.02	$
i. Nursing and Allied Health Managed Care Payment	Wksht E; Part A; Line 11.01	$
j. Total Medicare payments not subject to case mix index	Total lines 3a through 3if	$
4. Total Medicare payment with case mix removed and outliers omitted	Line 2b + Line 3j	$
5. Medicaid Outlier Payment Adjustment		
a. Total Medicaid Outlier Pmts	Medicaid PS&R and Fiscal Agent	$
b. Total inpatient Medicaid payments included on the Medicaid PS&R	Medicaid PS&R	$
c. Percentage of Medicaid Outlier Payments to Total Medicaid Payments exclusive of outliers	Line 5a ÷ (Line 5b – Line 5a)	0.00%
6. Calculation of Medicare payment including Medicaid Outlier Payment Adjustment	Line 4 x (1+Line 5c)	$
7. Calculate per case payment		
a. Medicare Discharges	From MCR	0000
b. Per case Medicare rate with case mix removed.	Line 6 ÷ Line 7a	$
c. CMS supplied inflation factor 2009	CMS website; Market Basket Data	0.00%
d. CMS supplied inflation factor 2010	CMS website; Market Basket Data	0.00%
e. Inflation adjusted per case Medicare rate with case mix removed.	Line 7b x Line 7c x Line 7d	$
Step 2. Find the Medicaid per case rate with case mix removed.	Include all Medicaid payments made directly by the Medicaid agency (i.e. exclude Medicaid managed care)	
8. Medicaid Rate per case		
a. Total Medicaid inpatient FFS payments (exclude DSH)	Medicaid PS&R and Fiscal Agent	$
b. Number of Medicaid Cases	Medicaid PS&R	0000
c. Rate per case	Line 8a ÷ Line 8b	$

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Exhibit 1 Continued

Table 1 Continued

9. Adjusted for Case Mix		
a. Medicaid case mix	Annual Medicaid Calculation for Recalibration of DRG Weights	0.000
b. Medicaid rate per case with case mix removed	Line 8c ÷ Line 9a	$
c. CMS supplied inflation factor 2009	CMS website; Market Basket Data	0.00%
d. CMS supplied inflation factor 2010	CMS website; Market Basket Data	0.00%
e. Inflation adjusted per case Medicaid rate with case mix removed	Line 9b x Line 9c x Line 9d	$
Step 3: Calculate UPL Gap		
10. Per Case Differential from Medicare Payments	Line 7e – Line 9e	$
11. Per Case differential adjusted for Medicaid case Mix	Line 10 x Line 9a	$
12. Available Room under UPL for UPL payment	Line 11 x Line 8b	$

Exhibit 1 – Notes

General Notes for Tables 1

- The payments must also be in compliance with 42 CFR 447.271 – charge limits.
- The table uses two years of inflation to trend 2009 cost report data to 2011. The inflation calculation would be adjusted based upon the year of the MCR used and the year of the payments being calculated.
- The cost report data used to calculate the Upper Payment Limit will be the latest available as filed or desk reviewed version.
- The table uses Medicaid payments and cases from the latest available Medicaid PS&R produced by the DMA Fiscal Agent for the cost report year.
- Cost of Teaching Physicians, Line 3c, shall include only the cost of the teaching component and exclude the professional component.

UPL calculation for Psychiatric and Rehabilitation Distinct Part Units

- The Upper Payment Limit for psychiatric and rehabilitation distinct part units will be calculated by taking each distinct part unit's Medicaid cost per discharge multiplied by the Medicaid distinct part unit discharges.

UPL calculation for Critical Access Hospitals (CAH)

- The Upper Payment Limit for CAH facilities will be 101% of the Medicare allowed cost per discharge multiplied by the Medicaid discharges for the cost report period.

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Attachment A

Certified Public Expenditures incurred in Providing services to Medicaid and Uninsured Patients
With respect to hospitals that the State of North Carolina determines eligible to certify public expenditures, and do certify, in accordance with 42 CFR 433.51(b), the expenditures claimable for Federal Financial Participation (FFP) will be the hospital's allowable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare cost principles. This computation of establishing interim Medicaid hospital payments must be performed on an annual basis.

Medicaid Hospital Costs:
(Effective January 1, 2011, this methodology will no longer apply for public hospitals with the approval of SPA 11.003.)
Inpatient Hospital Services—CPE Protocol
Rate Computation for Governmental Facilities – First and Final Reconciliation

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1:
Total hospital costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2:
The hospital's total inpatient days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3:
For each inpatient routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P)routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.
The inpatient per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4:
To determine the inpatient routine cost center costs for the payment year, the hospital's inpatient Medicaid days by cost center, as obtained from MMIS and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each routine respective cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

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Step 5:
To determine ancillary cost center costs for the payment year, the hospital's inpatient Medicaid allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid allowable charges for observation beds must be included in line 62. These Medicaid allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid allowable costs for each cost center. The Medicaid allowable charges used should only pertain to inpatient hospital services, and should exclude charges pertaining to outpatient hospital services, any professional services, or non-hospital component services such as hospital-based providers.

Step 6:
The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs to total usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. For this calculation, a usable organ is defined as the number of organs transplanted into a recipient, plus the number of organs excised and furnished to an organ procurement organization. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance and no payment (self pay or free care). A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or from Steps 4 and 5 of the Uninsured portion of this protocol.

Step 7:
The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6. Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital cost computation described above, must be offset against the computed Medicaid inpatient hospital cost before a per diem is calculated.

Step 8:
Net Cost is trended forward to payment year based on the Global Insight.

Step 9:
The projected annual cost will be claimed not more than four times during a federal fiscal year.

Step 10:
Medicaid provider assessments, as defined by 42 CFR 433.55, paid by the hospital shall be considered an allowable cost when determining the total allowable cost.

First Interim Payment Reconciliation:
The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

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Steps 1 – 3:
Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5:
Actual Medicaid paid days and charges from the MMIS Provider Statistical an Reimbursement (PS&R) report for services furnished during the payment year are used.

Step 6:
Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

Step 7:
Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient services of which the costs are already included in the Medicaid inpatient hospital cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid inpatient hospital per diem) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

Final Cost Report Reconciliation:
Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. As well, any Supplement Enhancements related to payment year are offset. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.
In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;
2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and
3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly exempt for Medicaid.
If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if is determined that a hospital received an underpayment, the underpayment will be properly claimed from the federal government.
The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6.
Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital cost computation described above must be offset against the computed Medicaid inpatient hospital cost.

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For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State plan rate year the costs of two cost report periods encompassing the State Plan payment year. To do so, the State will obtain the actual Medicaid FFS days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS cost for the reporting periods; this Medicaid FFS cost will then be proportionally allocated to the State plan rate year. All allocations will be made based upon number of months. (For example, for a hospital reporting period ending 12/31/07, the Medicaid FFS cost and days/charges from that period encompass three-fourths of the State plan rate year ending 9/30/2007, and one-fourth of the State plan rate year ending 9/30/2008. To fulfill reconciliation requirements for State plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS costs from its reporting period ending 12/31/2006, to the State plan rate year.) The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Outpatient Hospital Services—CPE Protocol
Rate Computation for Governmental Facilities – First and Final Reconciliation

For the payment year, ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary. The cost-to-charge ratios are calculated as follows:

Step 1:
Total hospital costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2:
The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3:
For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2.

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4:
To determine ancillary cost center costs for the payment year, the hospital's outpatient Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. These Medicaid allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid allowable costs for each cost center. (Note that for the computation of the cost-to-charge ratio for cost center #62/Observation Beds, the cost amount is reported on worksheet C, Part I, column 1, instead of worksheet B.

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Medicaid allowable hospital outpatient charges for observation beds are then applied to this cost-to-charge ratio to compute the Medicaid outpatient observation bed costs.) The Medicaid allowable FFS charges used should only pertain to outpatient hospital services, and should exclude charges pertaining to inpatient hospital services, any professional services, or non-hospital component services.

Step 5:
The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid ancillary costs from Step 4. All payments for Medicaid FFS outpatient services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost.

Step 6:
Net Cost is trended forward to payment year based on the Global Insight factor.

Step 7:
The projected annual cost will be claimed not more than four times during a federal fiscal year.

Step 8:
Medicaid provider assessments, as defined by 42 CFR 433.55, paid by the hospital shall be considered an allowable cost when determining the total allowable cost.

First Interim Payment Reconciliation:

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3:
Costs and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4:
Actual Medicaid charges from the MMIS Provider Statistical and Reimbursement (PS&R) report for services furnished during the payment year are used.

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Step 5:
All payments for Medicaid FFS outpatient hospital services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost (along with the interim Medicaid payments) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

Final Cost Report Reconciliation:
Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. As well, any Supplement Enhancements related to payment year are offset. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.

In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid outpatient hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments unless expressly exempt for Medicaid.

If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if is determined that a hospital received an underpayment, the underpayment will be properly claimed from the federal government.

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid ancillary costs from Step 4. All payments for Medicaid FFS outpatient hospital services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost.

For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State plan rate year the costs of two cost report periods encompassing the State Plan payment year. To do so, the State will obtain the actual Medicaid FFS outpatient hospital charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS outpatient hospital cost for the reporting periods; this Medicaid FFS outpatient hospital cost will then be proportionally allocated to the State plan rate year. All allocations will be made based upon number of months. (For example, for a hospital reporting period ending 12/31/07, the Medicaid FFS outpatient hospital cost and charges from that period encompass three-fourths of the State plan rate year ending 9/30/2007, and one-fourth of the State plan rate year ending 9/30/2008. To fulfill reconciliation requirements for State plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS costs from its reporting period ending 12/31/2006, to the State plan rate year. The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

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CPEs Incurred in Providing Services to Uninsured patients (Uncompensated Care):

The North Carolina Division of Medical Assistance collects information on hospitals' charges for services they provide to uninsured patients and any payments hospitals receive by or on behalf of those patients. The Division collects this information on a supplemental Schedule A for uncompensated care that the hospitals' CEO, CFO or their designee must sign and certify to the accuracy of the reported information.

The Division will determine the inpatient uncompensated care costs on an interim basis by multiplying the inpatient charges by a charge-to-cost conversion factor as calculated using Medicare cost principles and detailed in the protocol above for Medicaid inpatient cost.

The Division will determine the outpatient uncompensated care cost on an interim basis by multiplying the outpatient uncompensated charges by the outpatient cost-to-charge ratio as calculated in the above protocol for Medicaid outpatient cost.

Final Cost Report Reconciliation

The Division will use the protocol as outlined above for the final cost report reconciliation between the estimated CPEs and the actual CPEs incurred by the hospital for uncompensated care.

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UNIVERSITY OF NORTH CAROLINA DSH PAYMENT

(k) Hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. § 116-37, and that qualify under Paragraph (c) of this Section shall be eligible to receive disproportionate share hospital payments that, when combined with other disproportionate share hospital payments described in this Section, will equal 100 percent of their unreimbursed uninsured except as otherwise provided for in (2) and (3) below, and as limited by Paragraph (a). These DSH payments shall be calculated after accounting for all other Medicaid payments, including payments under Paragraph (h) of the EXCEPTIONS TO DRG REIMBURSEMENT, and after accounting for all other DSH payments to hospitals in North Carolina, including the hospitals eligible for payments under this Paragraph. The aggregate payment to eligible hospitals under this Paragraph shall not exceed the total cost incurred by the University of North Carolina Hospitals at Chapel Hill dba UNC Hospitals for providing care to patients who have no insurance for the services provided.

(1) Unreimbursed uninsured costs shall be calculated based on the hospitals' gross charges and payments for uninsured inpatient and outpatient hospital services as filed with and certified to the Division for the most recent fiscal year available at the time of data collection. The Division will convert hospitals' gross charges to costs by multiplying them by a cost-to-charge ratio determined from the hospitals' most recent cost reports available at the time of data collection and subtracting payments the hospitals received from uninsured patients. The Division will bring the unreimbursed uninsured cost data forward to the end of the payment period by applying an inflation factor calculated based on the most current information available at the time on the CMS website for the CMS PPS Hospital Input Price Index.

(2) Effective January 1, 2004, for State fiscal years 2004 and 2005, these hospitals shall receive disproportionate share hospital payments that, when combined with other disproportionate share payments described in this Section, shall equal 150 percent of their unreimbursed uninsured costs.

(3) To the extent the limits on disproportionate share hospital funding for this State established by CMS in accordance with 42 U.S.C. § 1396r-4(f) do not allow payments to all eligible hospitals up to 100 percent of each hospital's unreimbursed costs, this percentage shall be reduced to comply with such limits.

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2.a.3. OUTPATIENT HOSPITAL SERVICES BY UNIVERSITY OF NORTH CAROLINA HOSPITALS

In addition to the payments made elsewhere in this plan, hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. § 116-37, are eligible for supplemental payments for all outpatient hospital services, excluding outpatient laboratory services. For a hospital eligible under this subparagraph, the payment in this subparagraph supersedes the requirement, in Paragraph 2.a. of this Section, that such a hospital be paid allowable costs.

The total payment available for hospitals eligible under this subparagraph will be determined by aggregating the difference between what would be paid under Medicare payment principles for each eligible hospital's Medicaid fee-for-service outpatient hospital charges, i.e. each hospital's upper payment limit, and the outpatient Medicaid payments as otherwise calculated under this State Plan. Since Medicare reasonable cost principles will be used to estimate what would be paid under Medicare payment principles, each hospital's upper payment limit will be Medicaid cost. For each eligible hospital, both Medicaid cost and Medicaid payments will be estimated using data from the latest available Medicare cost report and a Medicaid PS&R for the same year as the Medicare cost report and run no less than nine (9) months after the close of the cost report year.

Medicaid cost will be determined by applying a cost to charge ratio from the Medicare cost report to the Medicaid charges on the PS&R and inflating into the current fiscal year using the CMS PPS hospital market basket index. Medicaid payments will be taken from the Medicaid PS&R and inflated into the current fiscal year using the CMS PPS hospital market basket index.

The total calculated supplemental payment amount will be paid to eligible hospitals in payments made no more frequently than each quarter.

If payments in this section would result in payments to any category of hospitals in excess of the upper payment limit calculation required by 42 C.F.R. 447.321, payments for each eligible hospital receiving payments under this section will be reduced proportionately to ensure compliance with the upper payment limit.

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