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

HOSPITAL INPATIENT REIMBURSEMENT PLAN

REIMBURSEMENT PRINCIPLES

With respect to hospitals licensed by the State of North Carolina that are qualified to certify public expenditures in accordance with 42 CFR 433.51(b), other than hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. 116-37, State hospitals described in Paragraph (b) and hospitals described in Paragraph (a) of the Exceptions to DRG reimbursement and Critical Access Hospitals pursuant to 42 USC 1395i-4, the expenditures claimable for Federal Financial Participation (FFP) will be the hospitals' reasonable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare principles. Payments to these hospitals will be made in stages (the first stage payment will be based on the DRG methodology applicable to private hospitals; the second stage payment will be for the difference between the hospital's reasonable costs and the first stage payment). Each hospital's allowable inpatient costs will be determined on an interim basis by multiplying the hospital's Medicaid inpatient ratio of cost-to-charges (RCCs), as derived from the hospital's most recent available as-filed CMS 2552 cost report by the hospital's allowable Medicaid inpatient charges for services provided during the same fiscal year as the filed cost report and paid not less than nine months after the end of that same fiscal year. This cost data will be brought forward to the end of the period for which FFP is being claimed by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for serving Medicaid inpatients will be determined using audited CMS 2552 cost reports for the year for which final FFP is being determined. 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.

All hospitals that are state-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools, freestanding rehabilitation hospitals that are qualified to certify public expenditures, and Critical Access Hospitals pursuant to 42 USC 1395i-4 will be reimbursed their allowable costs in accordance with the EXCEPTIONS TO DRG REIMBURSEMENT section of this plan.

All other hospitals will be paid for acute care general hospital inpatient services using the DIAGNOSIS RELATED GROUPS (DRG) RATE-SETTING METHODOLOGY described below, except as noted in the EXCEPTIONS TO DRG REIMBURSEMENT. Hospitals that are not qualified to certify public expenditures will also be paid using the enhanced payments for inpatient services methodologies described below.

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Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

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ENHANCED PAYMENTS FOR INPATIENT HOSPITAL SERVICES

(e) Hospitals that are licensed by the State of North Carolina, are not qualified to certify expenditures and that received payment for more than 50 percent of their Medicaid inpatient discharges under the DRG methodology for the most recent 12-month period ending September 30, shall be entitled to the following enhanced payments, for inpatient services for the 12-month period ending September 30 of each year, paid annually in up to four installments.

(e.1) Base Enhanced Payment

(1) The base enhanced payment to hospitals shall equal a percent, not to exceed the State's federal financial participation rate in effect for the period for which the payment is being calculated, of the hospital's inpatient "Medicaid deficit." At least 10 calendar days in advance of the first payment of the payment plan year, the Division will determine, and notify eligible hospitals of, the percent of the inpatient "Medicaid deficit" to be paid as the base enhanced payment for inpatient services.

(2) The "Medicaid deficit" is calculated by subtracting Medicaid payments from reasonable Medicaid costs as follows:

(A) Reasonable costs of inpatient hospital Medicaid services including the reasonable direct and indirect costs attributable to inpatient Medicaid services of operating Medicare approved graduate medical education programs shall be determined annually by:

i. Calculating a hospital's inpatient charge to cost conversion factor, based on the Medicaid per diems and the ancillary cost-to-charge ratios, using the Medicaid cost from the Title XIX D-1, Part II worksheet using the most recent available CMS 2552 cost report,

ii. Multiplying the Medicaid inpatient charge to cost conversion factor calculated above by the hospital's Medicaid allowable charges for inpatient services provided during the same fiscal year as the filed cost report and paid within nine months after the end of the fiscal year,

iii. Applying the applicable CMS PPS Hospital Input Price Indices to bring the cost data forward to the end of the payment period.

(B) Subtracting from the reasonable Medicaid costs for inpatient services, Medicaid payments received (excluding all Medicaid disproportionate share hospital payments received) for the same fiscal year covered by the cost report and the Medicaid allowable charges for inpatient services referred to in 2. A. ii above. The payments shall be brought forward to the end of the payment period using the same percentage by which the Division increased Medicaid DRG and per diem payment rates between the year to which the DRG and per diem payments apply and the payment year for which the enhanced payments are being calculated.

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

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(e.2) Equity Enhanced Payments

(1) The Equity enhanced payment shall, when added to the Base enhanced payment described above in this Section equal one hundred percent of the hospital's inpatient "Medicaid deficit".

(2) Assessments collected under this section are considered an allowable cost and are not subject to cost settlement.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Upper Payment Limit Payment for Inpatient Services (Private Hospitals)

(i) In addition to the payments made elsewhere in this plan, except for hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. §116-37, hospitals that are not qualified to certify public expenditures and are licensed by the State of North Carolina that received payment for more than 50 percent of their Medicaid inpatient discharges under per discharge DRG methodology for the most recent 12-month period ending September 30, are eligible for a supplemental payment for inpatient hospital services (the "UPL Payment") that is calculated annually and paid in up to four (4) installments. The UPL Payment for each hospital shall equal that hospital's Medicaid Inpatient costs times a fraction, the numerator of which is the aggregate UPL Payment for all hospitals qualified to receive payments under this section and the denominator of which is the aggregate Medicaid Inpatient costs for all such hospitals. Medicaid inpatient costs are the reasonable costs of inpatient hospital services as defined in Section (e.1)(2)(A) of this Attachment 4.19-A. The aggregate UPL Payment for all hospitals qualified to receive payments under this section will be determined by adding for each hospital the difference between what Medicare would pay for the hospital's Medicaid fee-for-service inpatient services and the hospital's Medicaid inpatient costs. The amount that Medicare would pay shall 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's) 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 group, obtained from the Medicare Case Mix Index published by CMS for the appropriate time period, to obtain Medicare Payments without the Case Mix Index adjustment.

(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 Medicare Payments without the Case Mix Index adjustment shall be added to Medicare Payments Not Subject to the Case Mix Index for the group to obtain Base Medicare Payments.

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

(6) The inflated Base Medicare Payment Per Discharge shall be multiplied by the Case Mix Index for the hospital's Medicaid population times the hospital's current year Medicaid Discharges to calculate what Medicare would pay.

If payments in this section would result in payments to all hospitals qualified to receive payments under this section 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.

Assessments collected under this section are considered an allowable cost and are not subject to cost settlement.

State Plan Under Title XIX of the Social Security Act
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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Upper Payment Limit Payment for Inpatient Services (Non-State Governmental Hospitals)

(j) In addition to the payments made elsewhere in this plan, except for hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. §116-37, hospitals that are qualified to certify public expenditures and are licensed by the State of North Carolina that received a first-stage interim payment for more than 50 percent of their Medicaid inpatient discharges under per discharge DRG methodology for the most recent 12-month period ending September 30, are eligible for a supplemental payment for inpatient hospital services (the "UPL Payment") that is calculated annually and paid in up to four (4) installments. The UPL Payment for each hospital shall equal that hospital's Medicaid Inpatient costs times a fraction, the numerator of which is the aggregate UPL Payment for all hospitals qualified to receive payments under this section and the denominator of which is the aggregate Medicaid Inpatient costs for all such hospitals. Medicaid inpatient costs are the reasonable costs of inpatient hospital services as defined in Section (e)(2)(A) of this Attachment 4.19-A. The aggregate UPL Payment for all hospitals qualified to receive payments under this section will be determined by adding for each hospital the difference between what Medicare would pay for the hospital's Medicaid fee-for-service inpatient services and the hospital's Medicaid inpatient costs. The amount that Medicare would pay shall 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's) 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 group, obtained from the Medicare Case Mix Index published by CMS for the appropriate time period, to obtain Medicare Payments without the Case Mix Index adjustment.

(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 Medicare Payments without the Case Mix Index adjustment shall be added to Medicare Payments Not Subject to the Case Mix Index for the group to obtain Base Medicare Payments.

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

(6) The inflated Base Medicare Payment Per Discharge shall be multiplied by the Case Mix Index for the hospital's Medicaid population times the hospital's current year Medicaid Discharges to calculate what Medicare would pay.

If payments in this section would result in payments to all hospitals qualified to receive payments under this section 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.

Assessments collected under this section are considered an allowable cost and are not subject to cost settlements.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

2.a OUTPATIENT HOSPITAL SERVICES

With respect to hospitals licensed by the State of North Carolina that are qualified to certify public expenditures in accordance 42 CFR 433.51(b), other than hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. 116-37, hospitals that are State-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools and Critical Access Hospitals pursuant to 42 USC 1395i-4, the expenditures claimable for Federal Financial Participation (FFP) will be the hospitals' reasonable costs incurred in serving Medicaid outpatients, as determined in accordance with Medicare principles. Payment to these hospitals will be made in stages (the first stage payment will be 80% of reasonable cost determined on an interim basis; the second stage payment will be for the difference between the hospital's reasonable costs determined on an interim basis and the first stage payment). Each hospital's allowable Medicaid outpatient costs for the rate year will be determined on an interim basis by multiplying the hospital's Medicaid outpatient ratio of cost-to-charges (RCCs) as specified on lines 37-68 of Worksheet C or D from the hospital's most recent available as-filed CMS 2552 cost report by the hospital's allowable Medicaid outpatient charges for services provided during the same fiscal year as the cost report and paid not less than nine months after the end of that same fiscal year. This cost data will be brought forward to the end of the period for which FFP is being claimed by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs of serving Medicaid outpatients will be determined using audited CMS 2552 cost reports for the year for which final FFP is being determined. The difference between the final and interim allowable Medicaid cost will be an adjustment(s) to the applicable period for which the cost was incurred and initial claim was made.

All hospitals that are state-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools and Critical Access Hospitals pursuant to 42 USC 1395i-4 will be reimbursed their allowable outpatient costs as determined using the CMS 2552 in accordance with the provisions of the Medicare Provider Reimbursement Manual. All other hospitals will be reimbursed 80 percent of their allowable outpatient costs as determined using the CMS 2552 cost report and in accordance with the Medicare Provider Reimbursement Manual. Hospitals that are not qualified to certify public expenditures will also be paid using the enhanced payments for outpatient services methodologies described below.

2.a.1. ENHANCED PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES

Hospitals that are licensed by the State of North Carolina, are not qualified to certify expenditures and that received payment for more than 50 percent of their Medicaid inpatient discharges under the DRG methodology for the most recent 12-month period ending September 30, shall be entitled to the following enhanced payments, for outpatient services for the 12-month period ending September 30 of each year, paid annually in up to four installments.

Base Enhanced Payments

(1) The base enhanced payment to hospitals shall equal a percent, not to exceed the State's federal financial participation rate in effect for the period for which the payment is being calculated, of the hospital's outpatient "Medicaid deficit." At least 10 calendar days in advance of the first payment of the payment plan year, the Division will determine, and notify eligible hospitals of, the percent of the outpatient "Medicaid deficit" to be paid as the base enhanced payment for outpatient services.

(2) The "Medicaid deficit" is calculated as follows:

A. Reasonable costs of outpatient hospital Medicaid services shall be determined annually by calculating a hospital's Medicaid outpatient cost-to-charge ratio using the most recent available as-filed hospital fiscal year CMS 2552 cost report data available before payments are calculated and multiplying the Medicaid outpatient cost-to-charge ratio by the hospital's Medicaid allowable charges for outpatient services provided during the same fiscal year as the filed cost report and paid within nine months after the end of the fiscal year .

B. 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 to bring the cost data forward to the end of the payment period.

C. Multiplying the Medicaid outpatient costs by 20 percent.

Equity Enhanced Payments

(1) The Equity enhanced payment shall, when added to the enhanced payment described in Paragraph 2.A.1 of this Section, equal one hundred percent of the hospital's outpatient "Medicaid deficit" as that term is defined in Subparagraph 2.a.1(2) of this Section 2.

(2) Assessments collected under this section are considered an allowable cost and are not subject to cost settlement.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Payments calculated under Paragraph 2.a.1. (when added to other Medicaid payments received or to be received for these services) shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.321 to exceed the maximum allowed aggregate upper limits for that category established by applicable federal law and regulation.

The payments authorized under Paragraph (e) shall be effective in accordance with GS 108A-55(c).

OS Notification

State/Title/Plan Number:	**NC-11-003**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**05/03/2012**
Fiscal Impact:	**FY 2011 $303,873,002** **FY 2012 $391,115,730**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0
Number of Potential Newly Eligible People: 0
Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No
Number of People Losing Medicaid Eligibility: 0
Reduces Benefits: No

Detail:

Effective January 1, 2011 this amendment proposes to revise the payment methodology for inpatient and outpatient hospital services. Specifically, this amendment proposes to provide supplemental payments to the non-state government and private hospital's up to the Medicare upper payment limit, eliminate the CPE funding method for Medicaid services provided by non-state government hospitals and implement a provider assessment. The payments will be made quarterly based on Medicaid services provided in that quarter.

Other Considerations:	**This OSN has been reviewed in the context of the Affordable Care Act (ACT) and approval of the OSN is not in violation of the ACT provisions.** **The State has responded satisfactorily to the funding questions.** **Tribal consultation was conducted for this amendment.** **We do not recommend the Secretary contact the governor.**
CMS Contact:	**Stanley Fields, NIRT 502-223-5332**