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State/Territory Name: North Carolina

State Plan Amendment (SPA) #:14-0046

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 21244-1850

Financial Management Group

May 22, 2015

Dr. Robin Cummings, Director
Division of Medical Assistance
North Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

RE: State Plan Amendment NC 14-046

Dear Dr. Cummings:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-046. Effective January 1, 2015 this amendment proposes to revise the payment methodology for inpatient hospital services. Specifically, this amendment proposes to replace each hospital's base diagnosis related groupings (DRG) rates with a single statewide base DRG rate excluding hospitals affiliated with the University of North Carolina Medical School. This amendment also reduces the case weighting factor assigned to each DRG by two and one-tenth percent (2.1%).

This rate reduction to the payments will be offset by an increase in the total computable quarterly supplemental payments up the upper payment limit funded by provider assessments for the non-federal share.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 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 January 1, 2015. 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//

Timothy Hill
Director

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: 14-046

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
January 1, 2015

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 AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR447

7. FEDERAL BUDGET IMPACT:

a. FFY 2015 ($4,537,699)
b. FFY 2016 ($6,050,266)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Page 3, Attachment 4.19-A, Page 4, Attachment 4.19-A, Page 23, and Attachment 4.19-A, Supplement 1, Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A Page 3, Attachment 4.19-A, Page 4, Attachment 4.19-A, Page 23, and Attachment 4.19-A, Supplement 1, Page 3

10. SUBJECT OF AMENDMENT:

Inpatient Hospitals

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:
Aldona Z. Wos, M.D.

14. TITLE:
Secretary

15. DATE SUBMITTED: 10-03-14

16. RETURN TO:

Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09-22-14

18. DATE APPROVED: 05-22-15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-15

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

21. TYPED NAME: Timothy Hill

22. TITLE: Director

23. REMARKS:

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

(c) DRG relative weights are a measure of the relative resources required in the treatment of the average case falling within a particular DRG category. The average DRG weight for all discharges from a particular hospital is known as the Case Mix Index (CMI). The statewide average CMI for all hospitals is utilized for out-of-state providers.

(1) The Division shall establish relative weights for each utilized DRG based on a recent data set of historical claims submitted for Medicaid recipients. Charges on each historical claim shall be converted to estimated costs by applying the hospital specific cost to charge ratio from each hospital's submitted Medicaid cost report. Cost estimates are standardized by removing direct and indirect medical education costs at the appropriate rates for each hospital.

(2) Relative weights shall be calculated as the ratio of the average cost in each DRG to the overall average cost for all DRGs combined. Prior to calculating these averages, low statistical outlier claims shall be removed from the data set, and the costs of claims identified as high statistical outlier shall be capped at the statistical outlier threshold. The Division of Medical Assistance shall employ criteria for the identification of statistical outliers which are expected to result in the highest number of DRGs with statistically stable weights.

(3) The Division of Medical Assistance shall employ a statistically valid methodology to determine whether there are a sufficient number of recent claims to establish a stable weight for each DRG. For DRGs lacking sufficient volume, the Division shall set relative weights using DRG weights generated from the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Data Base Commission data set, the Division sets relative weights based upon the published DRG weights for the Medicare program.

(4) Relative weights shall be recalculated when the new version of the DRG Grouper is installed by the Division of Medical Assistance to be effective October 1 of the rate year. When relative weights are recalculated, the overall average CMI will be kept constant. Then a two and one-tenth percent (2.1%) reduction factor shall be applied uniformly to the case weighting factor assigned to each DRG.

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

(d) The Division of Medical Assistance shall establish a unit value for each hospital which represents the DRG payment rate for a DRG with a relative weight of one. This rate is established as follows:

(1) Using the methodology described in Paragraph (c) of this plan, the Division shall estimate the cost less direct and indirect medical education expense on claims for discharges occurring during calendar year 1993, using cost reports for hospital fiscal years ending during that period or the most recent cost report available. All cost estimates are adjusted to a common 1994 fiscal year and inflated to the 1995 rate year.

The average cost per discharge for each provider is calculated. (See Exhibit page 25 of the plan). The state reserves the right to rebase based upon a year selected by the state.

(2) Using the DRG weights to be effective on January 1, 1995, a CMI is calculated for each hospital for the same population of claims used to develop the cost per discharge amount in Subparagraph (d)(1) of this plan. Each hospital's average cost per discharge is divided by its CMI to get the cost per discharge for a service with a DRG weight of one.

(3) The amount calculated in Subparagraph (d)(2) of this plan is reduced by 7.2% to account for outlier payments.

(4) For State Fiscal Year ending June 30, 2015, effective January 1, 2015, the individualized base DRG rates for hospital inpatient services are equal to the statewide median rate as of June 30, 2014. All primary affiliated teaching hospitals for the University of North Carolina Medical Schools' base rates shall not be included in the calculation of the statewide median rate and shall have their base rate equal to their respective base rate in effect June 30, 2014. New hospitals inpatient rates will be established based on the statewide median rate. Existing hospitals that enter into a Change of Ownerships (CHOW) shall have the hospital's rates established based on the previous hospital's rates. Critical Access Hospitals' (CAH) rates will be established based on the same hospital's Acute Care Hospital rates. The actual reimbursement amount for a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH and outliers).

(5) The hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated annually by the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management. This annual update shall not exceed the update amount approved by the North Carolina General Assembly. Effective October 1, 1997, for fiscal year ended September 30, 1998 only the hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated by the lower of the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management or the Medicare approved Inpatient Prospective Payment update factor. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-A, Supplement 1, Page 3 of the Sate Plan.

(5) Allowable and reasonable costs will be reimbursed in accordance with the provisions of the Medicare Provider Reimbursement Manual referred to as CMS Publication 15-1.

State Plan Under Title XIX of the Social Security Act
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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 reimbursement 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, high percentage of ESRD beneficiary discharges, capital payments, and SCH or MDH 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.

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

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, high percentage of ESRD beneficiary discharges, capital payments, and SCH or MDH 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, high percentage of ESRD beneficiary discharges, capital payments, and SCH or MDH 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 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 - 10 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 – 10 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 29	$
c. DSH Adjustment (include Medicare DSH)	Wksht E; Part A; Line 34	$
d. Total Uncompensated Care	Wksht E; Part A; Line 36	$
e. Additional payment for high percentage of ESRD Beneficiary Discharges	Wksht E, Part A; Line 46	$
f. Capital Adjustment	Wksht E; Part A; Line 50	$
g. SCH or MDH Hospital Payment	Wksht E; Part A; Line 48	$
h. Total Medicare payments subject to case mix index	Total lines 1a through 1g	$
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 1h ÷ 2a	$
3. **Medicare Payments not subject to case mix index.**		
a. GME adjustment	Wksht E; Part A; Line 52	$
b. Organ Acquisition cost	Wksht E; Part A; Line 55	$
c. Cost of Teaching Physicians	Wksht E; Part A; Line 56	$
d. Routine service pass-through	Wksht E; Part A; Line 57	$

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Exhibit 1 Continued — Table 1 Continued

e. Other ancillary other pass-through	Wksht E; Part A; Line 58	$
f. Exception Payment for IP Program Capital	Wksht E; Part A; Line 51	$
g. Special Add-On for New Technologies	Wksht E, Part A, Line 54	$
h. Nursing and Allied Health Managed Care Payment	Wksht E; Part A; Line 53	$
i. Manufacturer Credit on Replacement Devices	Wksht E; Part A; Line 68	$
j. Total Medicare payments not subject to case mix index	Total lines 3a through 3i	$
4. Total Medicare payment with case mix removed and outliers omitted	Line 2b + Line 3j	$
5. Medicaid Outlier Payment Adjustment		
a. Total Medicaid Outlier Pymts	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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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 Table~~s~~ 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.

OUT-OF-STATE-HOSPITALS

(a) Except as noted in Paragraph (c) below, the Division of Medical Assistance shall reimburse out-of-state hospitals using the DRG methodology. Effective January 1, 2015, the DRG hospital unit value for all out-of state hospitals shall be equal to the unit value of the North Carolina hospitals' statewide median rate as of June 30, 2014**.** Out-of-state providers are eligible to receive cost and day outlier payments, but not direct medical education payment adjustments.

(b) Hospitals that are certified for indirect medical education by Medicare may apply for an indirect medical education adjustment to its North Carolina rate.

(c) Hospitals certified as disproportionate share hospitals by the Medicaid agency in their home state may apply for a disproportionate share adjustment to their North Carolina Medicaid rate. The North Carolina disproportionate share hospital rate adjustment shall be the hospital's home state DSH adjustment, not to exceed 2.5 percent of the DRG or per diem payment. The Division will apply the disproportionate share hospital rate adjustment to Medicaid inpatient claims submitted by qualified out-of-state hospitals.

(d) The Division of Medical Assistance may enter into contractual relationships with certain hospitals providing highly specialized inpatient services, i.e. transplants in which case reimbursement for inpatient services shall be based upon a negotiated rate.

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Inpatient Hospital:

SFY 2012 – Rates will be frozen at the rate in effect on June 30, 2011. Effective October 1, 2011, existing hospital rates are adjusted by a negative 9.80%, and non-state-owned freestanding psychiatric and rehabilitation hospitals existing rates are adjusted by a negative 2.67%.

SFY 2013 – Effective July 1, 2012, the hospital rates will be adjusted such that they will equal 92.68% of the rate in effect on June 30, 2011, and non-state-owned freestanding psychiatric and rehabilitation hospitals rates will be adjusted such that they will equal 98% of the rate in effect on June 30, 2011. There will be no further annual adjustments this state fiscal year.

SFY 2014 – Base DRG rates, Base Psychiatric per diem rates, and Base Rehabilitative per diem rates will be frozen at the rate in effect on June 30, 2013. Effective January 1, 2014, the hospital base rates will be adjusted such that they will equal 97% of the rate in effect on June 30, 2013. There will be no further annual adjustments this state fiscal year.

SFY 2016 – Effective July 1, 2015, the rates are frozen at the rate in effect as of June 30, 2015. There will be no further annual adjustments this state fiscal year.

Reference: Attachment 4.19-A, Page 4