Table of Contents

State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 17-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

November 15, 2017

Mr. Dave Richard
Deputy Secretary
Division of Medical Assistance
2001 Mail Service Center
Raleigh, NC 27699-2501

Attention: Teresa J. Smith

RE: State Plan Amendment NC 17-0007

Dear Mr. Richard:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-0007. Effective July 8, 2017 this amendment modifies the State's reimbursement methodology for calculating the upper payment limit for inpatient hospital services. Specifically, it updates the methodology to be consistent with changes made by Medicare in the treatment of uncompensated care cost.

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 July 8, 2017. 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//

Kristin Fan
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**	1. TRANSMITTAL NUMBER: 17-0007	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION	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** July 7, 2017	

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 CFR 447	7. FEDERAL BUDGET IMPACT: a. FFY 2018 $0.00 b. FFY 2019 $0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Page 13a, Attachment 4.19-A, Page 13b, Attachment 4.19-A, Page 13c, Attachment 4.19-A, Page 19, Attachment 4.19-A, Page 19a, and Attachment 4.19-A, Page 19b	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A, Page 13a, Attachment 4.19-A, Page 13b, Attachment 4.19-A, Page 13c, Attachment 4.19-A, Page 19, Attachment 4.19-A, Page 19a, and Attachment 4.19-A, Page 19b

10. SUBJECT OF AMENDMENT:

Inpatient Hospital- Upper Payment Limit

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//	16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, NC 27699-20014
13. TYPED NAME: Mandy Cohen, MD, MPH	
14. TITLE: Secretary	
15. DATE SUBMITTED: 09/28/17	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:09/28/17	18. DATE APPROVED: 11/15/17
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/08/17	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS: Approved with following changes to block # 4.

Block # 4 changed to read: July 8, 2017

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 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 specific worksheet and line of the CMS 2552 cost report from which the data is pulled, if applicable, will be identified in the annual upper payment limit (UPL) demonstration. The difference between what Medicare would pay and inpatient Medicaid payments will be calculated as follows:

(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 DSH additional payment for uncompensated care, 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 specific worksheet and line of the CMS 2552 cost report from which the data is pulled, if applicable, will be identified in the annual upper payment limit (UPL) demonstration. The amount that Medicare would pay shall be calculated as follows:

(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 DSH additional payment for uncompensated care, 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
Medical Assistance Program
State: NORTH CAROLINA

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 specific worksheet and line of the CMS 2552 cost report from which the data is pulled, if applicable, will be identified in the annual upper payment limit (UPL) demonstration. The amount that Medicare would pay shall be calculated as follows:

(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 DSH additional payment for uncompensated care, 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.

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

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.

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

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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

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