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**State/Territory Name: NORTH CAROLINA**

**State Plan Amendment (SPA) #: NC-23-0022**

This file contains the following documents in the order listed:


1) Approval Letter
2) CMS 179 Form/Summary Form
3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

**Financial Management Group**

March 28, 2024

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

RE: **North Carolina State Plan Amendment (SPA) Transmittal Number SPA # 23-0022**

Dear Deputy Director Ludlam,

We have reviewed the proposed North Carolina State Plan Amendment (SPA) to Attachment 4.19-B which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 29, 2023 This plan amendment updates payment to Federally Qualified Health Centers (FQHC) providers.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Ysabel Gavino at maria.gavino@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23 — 0022

2. STATE: NC

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 01, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 431.50 42 CFR 431.51 42 CFR 440.230

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 4,832,656
b. FFY 24 $ 14,844,199

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Section 2, Page 2i,2j, 2k, 2l, 2m, 2m(1), 2m(2), 2m(3), ~~2m(4)~~, 2n, 2o

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Section 2, Page 2i,2j, 2k, 2l, 2m, 2m(1), 2m(2), 2m(3), ~~2m(4)~~, 2n, 2o

9. SUBJECT OF AMENDMENT
Federally Qualified Health Centers (FQHC)

10. 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

11. SIGN DocuSigned by: [redacted] AGENCY OFFICIAL

12. TYPED NAME
Jay Ludlam

13. TITLE
Deputy Secretary

14. DATE SUBMITTED
09/18/23 | 9:57 AM EDT

15. RETURN TO
Office of the Deputy Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

***FOR CMS USE ONLY***

16. DATE RECEIVED
September 29, 2023

17. DATE APPROVED
March 28, 2024

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 01, 2023

19. SIGNATURE OF APPROVING OFFICIAL [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS
The State authorizes CMS the following -
Block 7 and 8: a pen-and-ink change to delete 2m(4), MYLG 3/25/24



***Instructions on Back***

(2) At the beginning of each center's fiscal year, subsequent to January 1, 2001, the PPS rates shall be increased by the percentage increase in the Medicare Economic Index for primary care services and adjusted to take into account any increase (decrease) in the scope of services furnished during that fiscal year.

(A) A rate adjustment due to change in the scope of services must be supported by the preponderance of evidence by the provider.

(B) The Division of Health Benefits shall make rate adjustments due to change in the scope of services.

(C) The MEI rate adjustment shall take effect on the first day of the provider's fiscal year.

(D) Rates may also be adjusted to take into consideration reasonable changes in the industry's cost of service.

(3) FQHCs which are newly qualified after December 31, 2018, will have their initial rates established by reference to rates paid to other centers with similar scope of services and caseload in the closest geographical proximity. Unique rates will be established for newly qualified FQHCs according to subparagraph (3)(A) below. The unique rate in subsequent fiscal years shall be updated according to the same update methods reflected in subparagraph (2) above.

(A) The newly qualified FQHCs' unique rate will be established based on the average cost per visit established by their first two full twelve-month cost reporting periods.
(B) FQHCs meeting the definition of newly qualified under subparagraph (3) which are in operation as FQHCs prior to July 1, 2021, will have their unique rates established based on the cost per visit established by their first full twelve month cost reporting period.

(4) If the Core Service Provider Number has a Change of Ownership, the new provider will be reimbursed under the PPS methodology established in subparagraph (3) above. The following situations typically constitute a change of ownership:

(A) Asset sale or transfer: The sale or transfer of title and property to another party (that party can be a related, affiliated, subsidiary entity or a non-related entity) and a new EIN is established; or

(B) Partnership: The removal, addition, or substitution of a partner (unless the partners expressly agree otherwise as permitted by applicable State law) and a new EIN is established; or

(C) Corporation: The merger of a corporate entity that holds a Medicare contract into another corporate entity, or the consolidation of a corporate entity that holds a Medicare contract with one or more other corporations, resulting in a new corporate body and new EIN.

1. If one or more FQHC, all subsidiaries of a larger FQHC (a holding company), consolidate into a separate FQHC (a new legal entity with a new EIN), and the former FQHCs are fully dissolved, this constitutes a change in ownership for all consolidated FQHCs and the PPS rate shall be established as defined in subparagraph (3) above.

2. If an FQHC acquires an FQHC or RHC and either of the acquired is dissolved, it shall absorb the EIN and rate of the acquiring FQHC.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Alternative Payments

(5) Enhanced Payments for Pregnancy Medical Home services will be made to FQHC providers as specified in Attachment 3.1-B, Page 7(a) and Attachment 3.1-F. The Pregnancy Medical Home will be paid these enhanced payments in additional to their regular reimbursement.

Two enhanced payments may be made to FQHCs for services provided by a Pregnancy Medical Home. Upon completion of the high risk screening, an enhanced payment of $50.00 will be made to the PMH. Upon completion of the recipient's post partum visit, an enhanced payment of $150.00 will be made to the PMH provider. The PMH provider will receive a maximum of $200 enhanced payments per recipient per pregnancy even if there are multiple births.

Additionally, the PMH provider receives an enhanced rate for a vaginal delivery by paying the same rate for the vaginal delivery as for an uncomplicated c-section. Only the physician rates for the delivery codes are enhanced. The enhanced rates were determined by applying a 13.2% increase to the NC Medicaid Physician Fee Schedule rate as established in Attachment 4.19-B Section 5, Page 1 of the State Plan.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 3, Page 1 of the State Plan.

Alternative Payments

(6) FQHC Alternate Payment Methodology (APM) Reimbursement.

(A) Effective for dates of service beginning July 1, 2023, and after, FQHCs Reimbursed under this APM will receive a single APM per visit rate for all eligible encounters. Eligible encounters include the following:

1. Core Services (T1015)
2. Well Child Visits (99381EP-99385EP, 99391EP-99395EP)

(B) The APM per visit rate for each individual FQHC will be determined triennially each July 1st based on the following methodology:

1. For the first year of each triennial period:
    a. Sum total of Medicaid allowable costs for covered services from the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., the provider's fiscal year end 2021 cost report shall serve as the basis for the APM rate beginning July 1, 2023). Medicaid allowable costs for purposes of calculating the APM rate shall exclude the following non-Core Service costs, which are separately reimbursable:
        i. Pharmacy services (Attachment 4.19B, Section 12, Pages 1a and 2)
        ii. Physician-provided services at a hospital inpatient and outpatient location (Attachment 4.19B, Section 5, Page 1)
        iii. Diagnostic Laboratory Services (Attachment 4.19B, Section 3, Page 1)
    b. Divide Medicaid allowable cost by the total number of Medicaid face to face encounters (Core Service, Well Child (NC Health Check), and Dental visits) to determine a base year Medicaid cost per encounter.
    c. Inflate the base year Medicaid cost per encounter amount from the prior step to July 1st of the current year by compounding the months between the end of the fiscal year for the FQHC's cost report (as described in subparagraph (6)(B)1.a) through July 1st of the current year. The inflationary factor shall be the greater of:
        i. The Medicare FQHC Market Basket; or
        ii. The Consumer Price Index (CPI) for medical care.
    d. Multiply the Medicaid cost per encounter from the prior step by one and thirteen one hundredths (1.13).

2. Annually on July 1st for the second and third years of each triennial period:
    a. Adjust the previous year's APM rate to account for any increase (or decrease) in the scope of services in the FQHCs full fiscal year Medicaid cost report of the second prior calendar year (e.g., APM rates beginning July 1, 2024, shall consider changes in scope of service from the provider's Medicaid cost report period ended in calendar year 2022); and
    b. Inflate the amount by the greater of:
        i. The Medicare FQHC Market Basket; or
        ii. The CPI for medical care.

3. In the first year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)1. For the second and third year of all subsequent triennial periods, each FQHC's APM rate shall be established based on the process described in subparagraph (6)(B)2.

4. FQHC's that are newly qualified or fail to submit a cost report by the beginning of the triennial period will preliminarily receive a "like provider" APM rate established by reference to rates paid to other FQHCs with a similar scope of services and caseload in the closest geographical proximity.
    a. FQHCs meeting these criteria will default to a like provider APM rate but will have the opportunity to elect the PPS rate described in subparagraph (1).
    b. For FQHCs that submit a full 12-month Medicaid cost report by March 1 of a year during the triennial period, the Division will calculate a center-specific APM rate to be applied on a prospective basis beginning with the start of the next state fiscal year.
    c. FQHCs that submit the required cost report during the triennial period will remain subject to the same triennial cycle as other FQHCs in subsequent years (i.e., submitting a cost report in the middle of a triennial period does not start a unique triennial period for that FQHC; the FQHC would still be required to submit a subsequent cost report within the same timeframe as other FQHCs prior to the start of the next statewide triennial period).

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(C) Reimbursement processes

1. For the period of July 1, 2023, through April 30, 2024, FQHCs shall continue to be reimbursed using the payment methodology in effect on June 30, 2023. At the conclusion of the July 1, 2023, to April 30, 2024 period, the Division shall make a lump sum payment to each FQHC equal to the difference between what each FQHC would have received under the APM rate (as calculated in subparagraph (6)(B)) for the same services and actual payments made during the July 1, 2023 through April 30, 2024 period.

2. Fee-for service
    a. Beginning May 1, 2024, FQHCs shall be reimbursed as follows for services covered under Medicaid fee-for-service :
        i. The APM rate for each encounter for Core Services (T1015) and Well Child Visits (99381EP-99385EP, 99391EP-99395EP).
        ii. Medicaid Fee Schedule rates for dental services plus quarterly supplemental wraparound payments up to the APM rate for each dental claim, up to a limit of one claim per day.
            1. The Division shall reimburse FQHCs/RHCs for dental claims on an interim basis at the applicable Medicaid Fee Schedule rate upon adjudication.

            2. At the conclusion of each quarter, the Division shall calculate the difference between (1) total interim dental claim payments during the quarter and (2) the number of dental claim encounters (up to a maximum of one per day per enrollee) multiplied by the FQHC's APM rate. If the total amount owed under the APM reimbursement is greater than total interim dental claim payments, the Division shall make a supplemental wraparound payment to the FQHC for the amount. If the total amount owed under the APM reimbursement is less than or equal to total interim dental claim payments, no supplemental wraparound payments shall be made.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(C) Reimbursement processes

3. Managed care
   a. Beginning May 1, 2024, payment will include supplemental wraparound payments, paid concurrently with base payment rates, that are equal to the difference between the base payment rate ($117.32 for each encounter for T1015 Core Services or the base payment rate from the applicable Medicaid fee schedule for Well Child Visits billed using codes 99381EP-99385EP or 99391EP-99395EP) and the APM rate for the individual FQHC.
   b. Payments for non-Core Services (non-scope) are separately reimbursable at the rates applicable for pharmacy services through Attachment 4.19B Section 12 Pages 1a and 2, physician provided services at an inpatient or outpatient hospital location through Attachment 4.19B Section 5 Page 1, and diagnostic lab services through Attachment 4.19B Section 3 Page 1.

4. To ensure providers receive no less under the APM reimbursement methodology than under PPS, the Division shall annually compare the amount owed under the provider's APM reimbursement to what the provider would have received under PPS reimbursement described in subparagraph(1).

Alternative Payments

(7) Alternate Payment Methodology Election

(A) Established FQHC Providers as of July 1, 2023, and which do not qualify as new FQHC providers under subparagraph (3) shall have 30 days from approval of State Plan Amendment #23-0022 to elect to be reimbursed under PPS or the APM methodology described in subparagraph (6) and they shall remain with that election beginning July 1, 2023.

(B) New FQHC providers under subparagraph (3) shall have 30 days from date of enrollment to elect to be reimbursed under PPS or the APM methodology described in subparagraph (6).

(C) New FQHC providers under subparagraph (3) shall have 30 days from date of receipt of their unique provider rates to elect to be reimbursed under PPS or APM methodology described in subparagraph (6), and they shall remain with that election beginning with the date of that election.

(D) FQHCs that do not make an election within the required timeframe will be defaulted to the APM methodology described in subparagraph (6). Such FQHCs may elect to switch to the PPS methodology at any time.

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