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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 20-0004

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

November 9, 2020

Mr. Dave Richard
Deputy Secretary
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: North Carolina State Plan Amendment 20-0004

Dear Mr. Richard:

We have completed our review of State Plan Amendment (SPA) 20-0004. This SPA modifies Attachment 4.19-A of North Carolina's Title XIX State Plan. Specifically this amendment proposes to change methodologies for calculating the inpatient UPL. The state will change from a DRG methodology to a per diem methodology.

We conducted our review of this SPA according to the statutory requirements at sections 1902(a)(3), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are approving North Carolina State plan amendment 20-0004 with an effective date of February 1, 2020. We are enclosing the CMS-179 (HCFA-179) and the amended plan pages.

If you have any questions, or require additional information, please call Anna Dubois at (850) 878-0916.

Sincerely,

[redacted]

For

Rory Howe
Acting 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: 20-0004

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
February 1, 2020

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 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2020 ~~$36,072,108~~ See box 23
b. FFY 2021 $48,361,631

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 13b;13c
Add page 1a (new) see box 23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 13b;13c

10. SUBJECT OF AMENDMENT:

Hospital Inpatient Per Diem 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:
[redacted]

13. TYPED NAME:
Mandy Cohen, MD, MPH

14. TITLE:
Secretary

15. DATE SUBMITTED:
3/31/2020

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:

18. DATE APPROVED: 11/9/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
2/1/20

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted] For

21. TYPED NAME:
Rory Howe

22. TITLE:
Acting Director, FMG

23. REMARKS:

The state has provided authorization for pen and ink changes as follows:
Box 7 - revise the fiscal impact for FFY 2020 due to FMAP increase $40,720,217
Box 8 - add page 1a as a new page to block 8

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

North Carolina has designated several classes of hospitals as non-state-owned public hospitals for Medicaid purposes, each with slightly different structures based on how the hospital relates to the governmental unit as authorized by North Carolina statute. Specifically, hospitals are in one of the following three classes:

1. Hospital is a division/department of a county or municipal government or hospital is a governmental unit that is either hospital authority formed under the North Carolina Hospital Authorities Act (N.C. Gen. Stats. Chapter 131E, Article 2, Part 2) or hospital district formed under the North Carolina Hospital District Act (N.C. Gen. Stats. Chapter 131E, Article 2, Part 3);

2. Hospital is owned by a governmental unit and operated by entities that are instrumentalities of governmental units as authorized under the North Carolina Municipal Hospital Act (N.C. Gen. Stats. Article 131E, Section 7); and

3. Hospital is owned and operated by a separate entity that is controlled[i] by the county or municipality as authorized under the North Carolina Municipal Hospital Act (N.C. Gen. Stats. Article 131E, Section 8).

[1] "Control" means that a majority of the members of the hospital's governing board are serving by virtue of their appointment by a governmental entity or combination of governmental entities, thereby ensuring that the hospital is under the control of a governmental entity. The board of directors is responsible for the operation and finances of the entity. In the event that the entity were to cease operations or fail to operate the facility as a community general hospital open to the general public, free of discrimination, and serving the indigent, all assets would revert back to the governmental entity and appear on the governmental entity's balance sheet.

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. All Medicare cost report worksheet, column, or 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). The amount that Medicare would pay shall be calculated as follows:

(1) Using the most current available Medicare cost report data, Total Medicare Payments to each hospital shall be derived from the reported Total Medicare Prospective Payments on Worksheet E, Part A, Column 1, Line 59 minus the managed care component of the Direct Graduate Medical Education (DGME). The managed care component of the DGME shall be calculated using the following formula:

a. Worksheet E, Part A, Line 52 minus ((Worksheet E-4, Column 2, Line 29 minus Worksheet E-4, Column 2, Line 30) multiplied by Worksheet E-4, Column 2, Line 46)

(2) Each hospital's Total Medicare Payments shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(3) Each hospital's Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Line 14 of the same cost report as the Total Medicare Payments Total Medicare Patient Days shall not include swing bed days.

(4) Each hospital's Imputed Medicare Per Diem Payment Rate shall be calculated by dividing the inflated Total Medicare Payments by the hospital's Total Medicare Patient Days

(5) Each hospital's Imputed Medicare Per Diem Payment Rate shall be multiplied by the total Medicaid Patient Days of the same cost report period as the Total Medicare Payments to derive the hospital's Upper Payment Limit.

(6) The data source for each hospital's total number of Medicaid Patient Days and Total Medicaid Payments shall be the hospital's Medicaid PS&R for the same cost report period as the Total Medicare Payments and run no less than six (6) months after the close of the cost report period.

(7) Each hospital's Total Medicaid Payments shall be inflated from midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(8) Each hospital's inflated Total Medicaid Payments shall be subtracted from the hospital's UPL to obtain the Available Room Under the UPL.

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**.** All Medicare cost report worksheet, column, or 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). 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) Each hospital's Total Medicare Payments shall be inflated from the midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(3) Each hospital's Total Medicare Patient Days shall be derived from Worksheet S-3, Part I, Column 6, Line 14 of the same cost report as the Total Medicare Payments. Total Medicare Patient Days shall not include swing bed days.

(4) Each hospital's Imputed Medicare Per Diem Payment Rate shall be calculated by dividing the inflated Total Medicare Payments by the hospital's Total Medicare Patient Days.

(5) Each hospital's Imputed Medicare Per Diem Payment Rate shall be multiplied by the total Medicaid Patient Days of the same cost report period as the Total Medicare Payments to derive the hospital's Upper Payment Limit.

(6) The data source for each hospital's total number of Medicaid Patient Days and Total Medicaid Payments shall be the hospital's Medicaid PS&R for the same cost report period as the Total Medicare Payments and run no less than six (6) months after the close of the cost report period.

(7) Each hospital's Total Medicaid Payments shall be inflated from midpoint of the hospital's cost report period to the midpoint of the UPL demonstration period using the CMS PPS hospital market basket index.

(8) Each hospital's inflated Total Medicaid Payments shall be subtracted from the hospital's UPL to obtain the Available Room Under the UPL.

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.