DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street SW, Suite 4T20
Atlanta, Georgia 30303

June 7, 2011

Craigan Gray, MD, MBA, JD
Director
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Attn: Teresa Smith

Re: North Carolina State Plan Amendment 10-014

Dear Dr. Gray:

We have reviewed the proposed amendment to the North Carolina Medicaid State Plan NC 10-014 that was received in the Regional Office on September 28, 2010. This State plan amendment allows for Physician Services supplemental payments up to the Average Commercial Rate (ACR) for the medical professional providers employed by or affiliated with state-operated medical schools for the University of North Carolina and East Carolina University.

Based on the information provided, we are now ready to approve the Medicaid State Plan Amendment NC 10-014. This SPA was approved on June 6, 2011. The effective date of this amendment is July 1, 2010. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions, please contact Yvette Moore at 404-562-7327.

Sincerely,

/s/

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

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: **10-014**

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: **July 1, 2010**

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 447.201

7. FEDERAL BUDGET IMPACT:
a. **FFY 2010 $1,594,493**
b. **FFY 2011 $5,999,447**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Section 5, Page 1, Attachment 4.19-B, Section 5, Page 2, and Attachment 4.19-B, Section 5, Page 3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, Section 5, Page 1, Attachment 4.19-B, Section 5, Page 2

10. SUBJECT OF AMENDMENT:

Physician Services

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:

13. TYPED NAME:
Lanier M. Cansler

14. TITLE:
Secretary

15. DATE SUBMITTED:
9/22/10

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/28/10

18. DATE APPROVED: 06/06/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

PHYSICIAN'S FEE SCHEDULE

(a) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Physician Services. The agency's fee schedule rates were set as of October 1, 2009 and are effective for services provided on or after that date. All rates are published on the agency's website at http://www.ncdhhs.gov/dma/fee/fee.

(b) Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, shall be reimbursed based on the North Carolina Medicaid Fee Schedule which is based on 86 percent of the Medicare Fee Schedule Resource Based Relative Value System (RBRVS) in effect January 1 of each year, but with the following clarifications and modifications:

(1) A maximum fee is established for each service and is applicable to all specialties and settings in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered.

(2) Fees for services deemed to be associated with adequacy of access to health care services may be adjusted based on administrative review. The service must be essential to the health needs of the Medicaid recipients, no other comparable treatment available and a fee adjustment must be necessary to maintain physician participation within the geographic area at a level adequate to meet the needs of Medicaid recipients and for which no other provider is available.

(3) Fees for new services are established based on this Rule, utilizing the most current RBRVS, if applicable. If there is no relative value unit (RVU) available from Medicare, fees shall be established based on the fees for similar services. If there is no RVU or similar service, the fee shall be set at 75 percent of the provider's customary charge to the general public. For codes not covered by Medicare that Medicaid covers, annual changes in the Medicaid payments shall be applied each January 1 and fee increases shall be applied based on the forecasted Gross National Product (GNP) Implicit Price Deflator. Said annual changes in the Medicaid payments shall not exceed the percentage increase granted by the North Carolina General Assembly.

(4) 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.

MEDICAL ASSISTANCE
State: NORTH CAROLINA
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES
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(c) Supplemental Payments

(1) Supplemental payments will be made to Eligible Medical Professional Providers. These supplemental payments will equal the difference between the Medicaid payments otherwise made under this state plan and the Average Commercial Rate Payment. These supplemental payments will, for the same dates of service, be reduced by any other supplemental payments for professional services found elsewhere in the state plan.

(2) Eligible Medical Professional Providers must meet all of the following requirements. An Eligible Medical Professional Providers must be:

(i) Physicians paid under this Section 5, and other professionals paid under Section 6a-d or Section 17 of this Attachment; and

(ii) Licensed in the State of North Carolina and eligible to enroll in the North Carolina Medicaid program as a service provider; and

(iii) Employed by, contracted to provide a substantial amount of teaching services, or locum tenens of the state-operated school of medicine (SOM) at East Carolina University or the University of North Carolina at Chapel Hill, or employed or locum tenens within the University of North Carolina Health Care System. A professional "contracted to provide a substantial amount of teaching services" is a professional where all or substantially all of the clinical services provided to patients by that contracted professional involves supervision and/or teaching of medical students, residents, or fellows.

Except for professional providers in a Hospital-Based Group Practice, Eligible Medical Professional Providers shall exclude any professional provider that is a member of a group practice acquired or assimilated by the UNC HCS after July 1, 2010. A Hospital-Based Group Practice includes professional providers with the following hospital-based specialties: anesthesiology, radiology, pathology, neonatology, emergency medicine, hospitalists, radiation-oncology, and intensivists.

For a group practice that does not consist of professional providers employed by the SOM, is not a Hospital-Based Group Practice, and was included within the UNC HCS on or before July 1, 2010, the number of Eligible Medical Professional Providers in the group practice may not increase beyond the number of Eligible Medical Professional Providers in the group practice as of July 1, 2010.

(3) Supplemental payments will be made quarterly and will not be made prior to the delivery of services.

(4) The Quarterly Average Commercial Rate to be paid will be determined in accordance with the following calculation.

(i) Compute Average Commercial Fee Schedule: Compute the average commercial allowed amount per procedure code for the top five payers with payment rates. The top five commercial third party payers will be determined by total billed charges. If there are any differences in payment on a per billing code basis for services rendered by different types of medical professionals, the Department will calculate separate Average Commercial Fee Schedules to reflect these differences. The data used to develop the Average Commercial Fee Schedule(s) will be based upon payments from the most recently completed state fiscal year. The Average Commercial Fee Schedules will be computed at least once per fiscal year.

(ii) Calculate the Quarterly Average Commercial Payment Ceiling: For each quarter of the current fiscal year, multiply the Average Commercial Fee Schedule amount, as determined in Paragraph (c)(4)(i) above, by the number of times each procedure code was rendered and paid in the quarter to the Eligible Medical Professional Providers on behalf of Medicaid beneficiaries as reported by the MMIS. If applicable, a separate payment ceiling will be set when payment for the same service differs according to the type of professional rendering the service. The sum of the product for all procedure codes will determine the Quarterly Average Commercial Payment Ceiling.

(5) Supplemental Payments to be paid will be determined in accordance with the following calculation:

(i) Determine the Quarterly Supplemental Payment Ceiling at the Average Commercial Rate using the following formula:

(Quarterly Average Commercial Payment per CPT Code) as calculated x (Medicaid Volume per CPT Code) = Quarterly Supplemental Payment Ceiling at the Average Commercial Rate calculated as outlined in section (4) paragraph (i).

(ii) Supplemental Payments will equal the Quarterly Supplemental Payment Ceiling at the Average Commercial Rate less the total Medicaid payments made for the quarter to Eligible Medical Professional Providers for the procedure codes included in the calculation of the Average Commercial Fee Schedule in paragraph (4)(i) above, as reported from the MMIS. Medicaid volume and payments shall include all available payments and adjustments.