Table of Contents

State/Territory Name: North Carolina

State Plan Amendment (SPA) #:10-35B

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 25, 2014

Ms. Sandra Terrell, MS, R.N., Acting Director
Division of Medical Assistance
Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: North Carolina Title XIX State Plan Amendment, Transmittal 10-035B

We have reviewed the proposed State Plan Amendment NC-10-035B, which was initially submitted as part of NC-10-035 for the purpose of providing a medical home for pregnant women. Issues came up with the reimbursement pages and the cost report. In an effort to not hold up the approvable portion of NC-10-035, it was split into two separate SPAs (NC-10-035A and NC-10-035B). NC-10-035 was approved on March 21, 2011. NC-10-035B was simultaneously opened to work on resolution of the reimbursement pages and the cost report. The State responded to the Request for Additional Information (RAI) on February 18, 2014.

Based on the information provided, the Medicaid State Plan Amendment NC-10-035B was approved on April 25, 2014. The effective date of this amendment is March 1, 2011. We are enclosing the HCFA Form 179 and the approved plan pages.

If you have any additional questions or need further assistance, please contact Clarence Lewis at 803-898-7647, or Donald Graves at 919-828-2999.

Sincerely,

//s//

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPR
OMB NO. 09

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **10-035B**	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 **March 1, 2011**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDME

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Section 1915(g)(1)	7. FEDERAL BUDGET IMPACT: a. **FFY 2011 $1,937,208** b. **FFY 2012 ($3,607,536)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Section 9, Page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTIO OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B, Section 9, Page 1

10. SUBJECT OF AMENDMENT:

Pregnancy Medical Home

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, North Carolina 27699-2001
13. TYPED NAME: Lanier M. Cansler	
14. TITLE: Secretary	
15. DATE SUBMITTED:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03-15-11	18. DATE APPROVED: 04-25-14
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 03-01-11	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 8 and 9 as authorized by State Agency e-mail dated 06/22/12:
Block #8 changed to read: Attachment 4.19-B Section 9, pages 1, 1.2, 1.3, 1.4, 1.5 and Supplement 2, page 1g.
Block #9 changed to read: Attachment 4.19-B Section 9, pages 1, 1.2(new), 1.3(new), 1.4(new), 1.5 and Supplement 2, page 1g (new).

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

9. Clinic Services provided by Health Departments

a. Payments for Clinic Services covered under Attachment 3.1-A.1 are equal to the lower of the submitted charge or the appropriate fee from the North Carolina Medicaid Health Department Fee Schedule. The agency's interim rates were set as of March 1, 2011 and are effective on or after that date. All rates are published on the website at http://www.ncdhhs.gov/dma/fee/index.htm. Except as otherwise noted in the plan, State developed fee schedule rates are the same for all governmental and non-governmental providers. Payments will be based on settled cost, while interim rates will be based on the North Carolina fee schedule.

Effective March 1, 2011 Health Department Services rates shall be set at 100% of the North Carolina Medicaid Physician Services Fee Schedule in effect on March 1, 2011.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplemental 2, Page 1g of the State Plan.

To assure payments do not exceed the upper payment limits set forth at 42 CFR 447.321, Health Department services reimbursed under a fee schedule and furnished to Medicaid recipients will be cost settled annually to Medicaid allowable costs. Effective for cost reporting periods beginning on or after July 1, 2011, Medicaid-allowable cost will be determined by the Division of Medical Assistance using a CMS approved cost reporting methodology in accordance with 42 CFR § 413 and the CMS Provider Reimbursement Manual.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

Notwithstanding Attachment 4.19-B, Section 5, Page 3, services for ante partum codes, delivery codes and post partum codes which are billed by Health Departments for physicians, nurse midwives, and nurse practitioners who are salaried employees of a Health Department and whose compensation is included in the service cost of a Health Department when the Health Department is a Pregnancy Medical Home (PMH) as described in Attachment 3.1-B, Page 7(a) and Attachment 3.1-F shall be settled to cost in accordance with the provisions of this Section.

Additionally this cost methodology does not apply to the reimbursement for services furnished to Medicaid recipients for Laboratory Services as described in Attachment 4.19-B, Section 3, Page 1. These services are reimbursed fee-for-service only and Health Department costs for these services shall be excluded from cost settlement.

A. Direct Medical Services Payment Methodology:

The annual cost settlement methodology will consist of a CMS approved cost report, actual time report and reconciliation. If Medicaid payments exceed Medicaid-allowable costs, the excess will be recouped and the Federal share will be returned on the CMS-64 report.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid recipients receiving Clinic, Family Planning and Family Planning Waiver services in the Health Department the following steps are performed:

(1) Direct costs for medical service include payroll costs and other costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services of personnel providing direct medical services.

Other direct costs include non-personnel costs directly related to the delivery of medical services, such as purchased services, capital outlay, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

(2) Total direct costs for direct medical services from Item A 1 above are reduced on the cost report by any restricted public health service grant payments as defined in CMS Publication 15-1 resulting in adjusted direct costs for direct medical services.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

(3) Indirect costs include payroll costs and other costs related to the administration and operation of the Health Department. Indirect payroll costs include total compensation of Health Department administrative personnel providing administrative services.

Other indirect costs include non-personnel costs related to the administration and operation of the health department such as purchased services, capital outlay, materials and supplies. Other indirect costs also include indirect costs allocated from the county to the Health Department via the county Cost Allocation Plan.

(4) Total indirect costs from Item A 3 above are reduced on the cost report by any restricted public health service grant payments as defined in CMS Publication 15-1 resulting in adjusted indirect costs.

(5) Clinical Administrative costs include payroll costs and other costs which directly support medical service personnel furnishing direct medical services. Clinical administrative payroll costs include total compensation of clinical administrative personnel furnishing direct support services.

Other clinical administrative costs include non-personnel costs related to the support of direct medical services such as purchased services, capital outlay, materials and supplies.

(6) Total clinical administrative costs from Item A 5 above are reduced on the cost report by any restricted public health service grant payments as defined in CMS Publication 15-1 resulting in adjusted clinical administrative costs.

(7) Total adjusted indirect costs from Item A 4 above are allocated based on accumulated cost to Direct, Clinical Administrative, Laboratory, and Non-Reimbursable cost centers.

(8) Total adjusted Clinical Administrative costs from Item A 7 above are allocated based on accumulated cost from Item A 7 to Direct and Laboratory cost centers.

(9) An actual time report is used to determine the percentage of time spent by medical service personnel on Medicaid covered services, administrative duties, and non-reimbursable activities.

(10) The total allowable cost for Direct Medicaid covered services is calculated by multiplying the percentage of actual time spent on Medicaid covered services from Item A 9 by the accumulated cost in Direct service cost centers from Item A 8 above.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

(11) For cost reporting periods beginning on or after July 1, 2010 and ending on or before June 30, 2012, the Medicaid percentage of covered services is calculated by dividing the Total Medicaid Encounters by Total Encounters. For cost reporting periods beginning on or after July 1, 2012, the Medicaid percentage of covered services shall use usual and customary charges and is calculated by dividing Total Medicaid Charges by Total Charges.

(12) Total Medicaid allowable cost is calculated by multiplying the Medicaid percentage of covered services from Item A 11 above by the total allowable cost for Direct Medicaid covered services from Item A 10 above.

(13) Total Medicaid Clinic cost is calculated by multiplying Total Medicaid allowable cost from Item A 12 by the ratio of Medicaid clinic charges to Medicaid total charges from Exhibit 2 of the cost report.

Total Medicaid Family Planning cost is calculated by multiplying Total Medicaid allowable cost from Item A 12 by the ratio of Medicaid Family Planning charges to Medicaid total charges from Exhibit 2 of the cost report.

Total Medicaid Family Planning Waiver cost is calculated by multiplying Total Medicaid allowable cost from Item A 12 by the ratio of Medicaid Family Planning Waiver charges to Medicaid total charges from Exhibit 2 of the cost report.

B. Certification of Expenditures:

On an annual basis, each Health Department will certify through its cost report its total actual, incurred Medicaid allowable costs. Providers are only permitted to certify Medicaid allowable costs.

C. Annual Cost Report Process:

For Medicaid covered services each health department shall file an annual cost report as directed by the Division of Medical Assistance in accordance with 42 CFR 413 Subpart B and 42 CFR 447.202. The Medicaid cost report is due five (5) months after the provider's fiscal year end. Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by the Division of Medical Assistance or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Division, may be subject to withhold penalties for non-compliance. A 20 percent withhold of Medicaid payments will be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to the Division of Medical Assistance and has received a written approval from the Division of Medical Assistance. The withholding of monies will continue until the Medicaid cost report filing requirements have been satisfied. Once, all requirements have been satisfied withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

The primary purposes of the governmental cost report are to:

(1) Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid covered services using a CMS-approved cost allocation methodology and cost report.

(2) Reconcile annual interim payments to total CMS-approved, Medicaid - allowable costs using a CMS approved cost allocation methodology and cost report.

D. The Cost Reconciliation Process:

The cost reconciliation process must be completed within twelve months of the end of the reporting period covered by the annual Health Department Cost Report. The total Medicaid-allowable costs are determined based in accordance with 42 CFR 413 Subpart B and the CMS Provider Reimbursement Manual methodology and are compared to the Health Department Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

E. The Cost Settlement Process:

If a provider's interim payments exceed the provider's certified cost for Medicaid services furnished in health departments to Medicaid recipients, the provider will remit the excess federal share of the overpayment at the time the cost report is submitted. The federal share will be returned via CMS-64 Report.

If the certified cost of a health department provider exceeds the interim payments, the Division of Medical Assistance will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

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

Payments for Medical and Remedial Care and Services

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