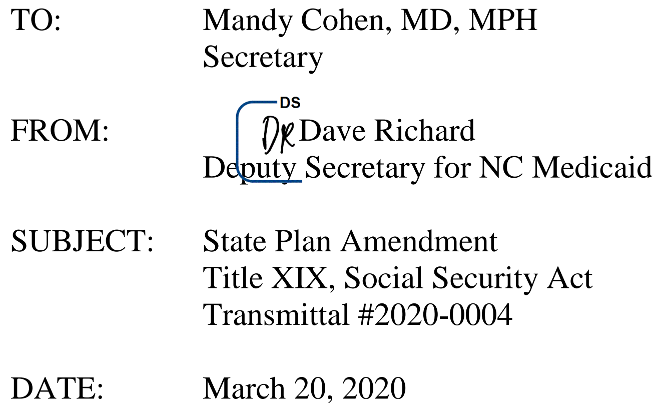
DocuSign Envelope ID: 779B216C-44D5-4AA0-AE6E-C701DF77CD2C

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

M E M O R A N D U M

TO: Mandy Cohen, MD, MPH
Secretary



FROM: Dave Richard
Deputy Secretary for NC Medicaid

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2020-0004

DATE: March 20, 2020

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-A, Pages 13b;13c.

This state plan change outlines measures taken by Medicaid to revise the methodology for calculating the Upper Payment Limit (UPL) for Private and Non-State Government inpatient hospitals. The revised methodology will compute the UPL base on an imputed Medicare payment per diem rather than a Medicare payment per discharge.

This amendment is effective February 1, 2020.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Betty J. Staton at 919-527-7093.

DR:bjs

NC MEDICAID
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS
LOCATION: 1985 Umstead Drive, Kirby Building, Raleigh NC 27603
MAILING ADDRESS: 2501 Mail Service Center, Raleigh NC 27699-2501
www.ncdhhs.gov • TEL: 919-855-4100 • FAX: 919-733-6608
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

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.

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.