

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

HOSPITAL INPATIENT REIMBURSEMENT PLAN

REIMBURSEMENT PRINCIPLES

With respect to hospitals licensed by the State of North Carolina that are qualified to certify public expenditures in accordance with 42 CFR 433.51(b), other than hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. 116-37, State hospitals described in Paragraph (b) and hospitals described in Paragraph (a) of the Exceptions to DRG reimbursement and Critical Access Hospitals pursuant to 42 USC 1395i-4, the expenditures claimable for Federal Financial Participation (FFP) will be the hospitals' reasonable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare principles. Payments to these hospitals will be made in stages (the first stage payment will be based on the DRG methodology applicable to private hospitals; the second stage payment will be for the difference between the hospital's reasonable costs and the first stage payment). Each hospital's allowable inpatient costs will be determined on an interim basis by multiplying the hospital's Medicaid inpatient ratio of cost-to-charges (RCCs), as derived from the hospital's most recent available as-filed CMS 2552 cost report by the hospital's allowable Medicaid inpatient charges for services provided during the same fiscal year as the filed cost report and paid not less than six months after the end of that same fiscal year. This cost data will be brought forward to the mid-point of the period for which FFP is being claimed by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for serving Medicaid inpatients will be determined using audited CMS 2552 cost reports for the year for which final FFP is being determined. The difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the cost was incurred and initial claim was made.

All hospitals that are state-owned and operated by the Department of Health and Human Services, all primary affiliated teaching hospitals for the University of North Carolina Medical Schools, freestanding rehabilitation hospitals that are qualified to certify public expenditures, and Critical Access Hospitals pursuant to 42 USC 1395i-4 will be reimbursed their allowable costs in accordance with the EXCEPTIONS TO DRG REIMBURSEMENT section of this plan.

All other hospitals will be paid for acute care general hospital inpatient services using the DIAGNOSIS RELATED GROUPS (DRG) RATE-SETTING METHODOLOGY described below, except as noted in the EXCEPTIONS TO DRG REIMBURSEMENT. Hospitals that are not qualified to certify public expenditures will also be paid using the enhanced payments for inpatient services methodologies described below.

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DRG RATE SETTING METHODOLOGY

(a) Diagnosis Related Groups is a system of classification for hospital inpatient services. For each hospital admission, a single DRG category shall be assigned based on the patient's diagnosis, age, procedures performed, length of stay, and discharge status. For claims with dates of services prior to January 1, 1995 payments shall be based on the reimbursement per diem in effect prior to January 1, 1995. However, for claims related to services where the admission was prior to January 1, 1995 and the discharge was after December 31, 1994, then the greater of the total per diem for services rendered prior to January 1, 1995, or the appropriate DRG payment shall be made.

(b) The Division of Medical Assistance (Division) shall use the DRG assignment logic of the Medicare Grouper to assign individual claims to a DRG category. Medicare revises the Grouper each year in October. The Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each following rate year. Effective October 1, 2012, the Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each rate year. The initial DRG in Version 12 of the Medicare Grouper, related to the care of premature neonates and other newborns numbered 385 through 391, shall be replaced with the following classifications:

385	Neonate, died or transferred, length of stay less than 3 days
801	Birth weight less than 1,000 grams
802	Birthweight 1,000 – 1,499 grams
803	Birthweight 1,500 – 1,999 grams
804	Birthweight \geq 2,000 grams, with Respiratory Distress Syndrome
805	Birthweight \geq 2,000 grams premature with major problems
810	Neonate with low birthweight diagnosis, age greater than 28 days at admission
389	Birthweight \geq 2,000 grams, full term with major problems
390	Birthweight \geq 2,000 grams, full term with other problems or premature without major problems
391	Birthweight \geq 2,000 grams, full term without complicating diagnoses

Effective October 1, 2008, the premature neonates and other newborn DRGs listed above are replaced by the premature neonates and other newborn DRGs in Version 25 of the Medicare Grouper (i.e. DRGs 789-795).

DRG 789 Neonate, died or transferred, length of stay less than 3 days.

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(c) DRG relative weights are a measure of the relative resources required in the treatment of the average case falling within a particular DRG category. The average DRG weight for all discharges from a particular hospital is known as the Case Mix Index (CMI). The statewide average CMI for all hospitals is utilized for out-of-state providers.

- (1) The Division shall establish relative weights for each utilized DRG based on a recent data set of historical claims submitted for Medicaid recipients. Charges on each historical claim shall be converted to estimated costs by applying the hospital specific cost to charge ratio from each hospital's submitted Medicaid cost report. Cost estimates are standardized by removing direct and indirect medical education costs at the appropriate rates for each hospital.
- (2) Relative weights shall be calculated as the ratio of the average cost in each DRG to the overall average cost for all DRGs combined. Prior to calculating these averages, low statistical outlier claims shall be removed from the data set, and the costs of claims identified as high statistical outlier shall be capped at the statistical outlier threshold. The Division of Medical Assistance shall employ criteria for the identification of statistical outliers which are expected to result in the highest number of DRGs with statistically stable weights.
- (3) The Division of Medical Assistance shall employ a statistically valid methodology to determine whether there are a sufficient number of recent claims to establish a stable weight for each DRG. For DRGs lacking sufficient volume, the Division shall set relative weights using DRG weights generated from the North Carolina Medical Data Base Commission's discharge abstract file covering all inpatient services delivered in North Carolina hospitals. For DRGs in which there are an insufficient number of discharges in the Medical Data Base Commission data set, the Division sets relative weights based upon the published DRG weights for the Medicare program.
- (4) Relative weights shall be recalculated when the new version of the DRG Grouper is installed by the Division of Medical Assistance to be effective October 1 of the rate year. When relative weights are recalculated, the overall average CMI will be kept constant. Then a two and one-tenth percent (2.1%) reduction factor shall be applied uniformly to the case weighting factor assigned to each DRG.

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- (d) The Division of Medical Assistance shall establish a unit value for each hospital which represents the DRG payment rate for a DRG with a relative weight of one. This rate is established as follows:
- (1) Using the methodology described in Paragraph (c) of this plan, the Division shall estimate the cost less direct and indirect medical education expense on claims for discharges occurring during calendar year 1993, using cost reports for hospital fiscal years ending during that period or the most recent cost report available. All cost estimates are adjusted to a common 1994 fiscal year and inflated to the 1995 rate year.

The average cost per discharge for each provider is calculated. (See Exhibit page 25 of the plan). The state reserves the right to rebase based upon a year selected by the state.
 - (2) Using the DRG weights to be effective on January 1, 1995, a CMI is calculated for each hospital for the same population of claims used to develop the cost per discharge amount in Subparagraph (d)(1) of this plan. Each hospital's average cost per discharge is divided by its CMI to get the cost per discharge for a service with a DRG weight of one.
 - (3) The amount calculated in Subparagraph (d)(2) of this plan is reduced by 7.2% to account for outlier payments.
 - (4) For State Fiscal Year ending June 30, 2015, effective January 1, 2015, the individualized base DRG rates for hospital inpatient services are equal to the statewide median rate as of June 30, 2014. All primary affiliated teaching hospitals for the University of North Carolina Medical Schools' base rates shall not be included in the calculation of the statewide median rate and shall have their base rate equal to their respective base rate in effect June 30, 2014. New hospitals inpatient rates will be established based on the statewide median rate. Existing hospitals that enter into a Change of Ownerships (CHOW) shall have the hospital's rates established based on the previous hospital's rates. Critical Access Hospitals' (CAH) rates will be established based on the same hospital's Acute Care Hospital rates. The actual reimbursement amount for a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH and outliers).
 - (5) The hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated annually by the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management. This annual update shall not exceed the update amount approved by the North Carolina General Assembly. Effective October 1, 1997, for fiscal year ended September 30, 1998 only the hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated by the lower of the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management or the Medicare approved Inpatient Prospective Payment update factor. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-A, Supplement 1, Page 3 of the Sate Plan.
 - (5) Allowable and reasonable costs will be reimbursed in accordance with the provisions of the Medicare Provider Reimbursement Manual referred to as CMS Publication 15-1.

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- (e) Reimbursement for capital expense is included in the DRG hospital rate described in Paragraph (d) of this plan.
- (f) Hospitals operating Medicare approved graduate medical education programs shall receive a DRG payment rate adjustment which reflects the reasonable direct and indirect costs of operating those programs.
- (1) The Division defines reasonable direct medical education costs consistent with the base year cost per resident methodology described in 42 CFR Part 413 Subpart F. The ratio of the aggregate approved amount for graduate medical education costs as determined in accordance with 42 CFR Part 413 Subpart F to total reimbursable costs (per Medicare principles) is the North Carolina Medicaid direct medical education factor. The direct medical education factor is based on information supplied in the 1993 cost reports and the factor will be updated annually as soon as practicable after July 1 based on the latest cost reports filed prior to July 1.
 - (2) Effective October 1, 2001, and for each subsequent year, the North Carolina Medicaid indirect medical education factor is equal to the Medicare indirect medical education factor in effect on October 1 each year.
 - (3) Hospitals operating an approved graduate medical education program shall have their DRG unit values increased by the sum of the direct and indirect medical education factors.
- (g) Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services. These payments shall be subject to retrospective review by the Division of Medical Assistance, on a case-by-case basis. Cost Outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs for services that were not medically necessary or was for services not covered by the North Carolina Medical Assistance program.
- (1) A cost outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of twenty-five thousand dollars (\$25000) or mean cost for the DRG plus 1.96 standard deviations.
 - (2) Charges for non-covered services and services not reimbursed under the inpatient DRG methodology (such as professional fees) shall be deducted from total billed charges. The remaining billed charges are converted to cost using a hospital specific total cost to total charge ratio not from the cost report but developed. The cost to charge ratio excludes medical education costs.
 - (3) If the net cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at 75% of the costs above the threshold.

TN. No. 05-015
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(h) Day outlier payments are an additional payment made for exceptionally long lengths of stay on services provided to children under six at disproportionate share hospitals and children under age one at non-disproportionate share hospitals. These payments shall be subject to retrospective review by the Division of Medical Assistance, on a case-by-case basis. Day outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs or was for services that were not medically necessary or for services not covered by the North Carolina Medical Assistance program.

- (1) A day outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical average length of stay for the DRG plus 1.50 standard deviations.
- (2) A day outlier per diem payment may be made for covered days in excess of the day outlier threshold at 75% of the hospital's payment rate for the DRG rate divided by the DRG average length stay.

(i) Services which qualify for both cost outlier and day outlier payments under this plan shall receive the greater of the cost outlier or day outlier payment.

(j) Rates established under this Paragraph shall be prospectively determined and shall not be subject to retrospective settlement.

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EXCEPTIONS TO DRG REIMBURSEMENT

(a) Covered psychiatric and rehabilitation inpatient services provided in either specialty hospitals, Medicare recognized Long Term Acute Care Hospitals (LTCH), Medicare recognized distinct part units (DPU), or other beds in general acute care hospitals shall be reimbursed on a per diem methodology.

(1) Prior to October 1, 2008, psychiatric inpatient services are defined as admissions where the primary reason for admission would result in the assignment of a psychiatric DRG code in the range 424 through 437 and 521 through 523. Effective October 1, 2008, the assignment of a psychiatric DRG code is in the range 880 through 887 or 894 through 897 or 876. All services provided by specialty psychiatric hospitals are presumed to come under this definition.

Prior to October 1, 2008, rehabilitation inpatient services are defined as admissions where the primary reason for admissions would result in the assignment of DRG 462. Effective October 1, 2008, the assignment of a rehabilitation DRG code is 945 or 946. All services provided by specialty rehabilitation hospitals and Medicare recognized Long Term Acute Care Hospitals (LTCH) are presumed to come under this definition.

(2) When a patient has a medically appropriate transfer from a medical or surgical bed to psychiatric or rehabilitative distinct part unit within the same hospital or to a specialty hospital the admission to the distinct part unit or the specialty hospital shall be recognized as a separate service which is eligible for reimbursement under the per diem methodology.

Transfers occurring within general hospitals from acute care services to non-DPU psychiatric or rehabilitation services are not eligible for reimbursement under this Section. The entire hospital stay in these instances shall be reimbursed under the DRG methodology.

(3) The per diem base rate for psychiatric services is established at the lesser of the actual cost or the calculated median rate of all hospitals providing psychiatric services, as derived from the 2003 Medicaid cost report or the most recent as filed cost report, trended forward to the rate year. Providers that routinely provide psychiatric services and whose base rate trended forward to State Fiscal Year 2005 is less than their rate as of October 1, 2004, shall have their base rate established at the October 1, 2004 amount and trended forward in subsequent years.

(4) Hospitals that do not routinely provide psychiatric services shall have their rate set at the median rate for all other psychiatric hospitals in paragraph (3) above.

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- (5) The per diem rate for rehabilitation services is established at the lesser of the actual cost trended to the rate year or the calculated median rate of all hospitals providing rehabilitation services as derived from the most recent filed cost reports.
- (6) Rates established under this Paragraph are adjusted for inflation consistent with the methodology under Subparagraph (d)(5) of the DRG RATE SETTING METHODOLOGY.
- (7) Rates established under this Paragraph shall be prospectively determined and shall not be subject to retrospective settlement.

(b) Hospitals operated by the Department of Health and Human Services, all the primary affiliated teaching hospitals for the University of North Carolina Medical Schools will be reimbursed their reasonable costs in accordance with the provisions of the Medicare Provider Reimbursement Manual. Critical Access Hospital pursuant to 42 USC 1395i-4 will be reimbursed their reasonable costs for acute care services in accordance with the provision of the Medicare Provider Reimbursement Manual. This Manual referred to as (CMS Publication #15-1) is hereby incorporated by reference including any subsequent amendments and editions. Interim payment rates will be estimated by the hospital and provided to the Division of Medical Assistance (DMA) subject to DMA review. These rates will be set at a unit value that can best be expected to approximate 100% of reasonable cost. Interim payments made under the DRG methodology to these providers shall be retrospectively settled to reasonable cost.

(c) Hospitals operating Medicare approved graduate medical education programs shall receive a per diem rate adjustment which reflects the reasonable direct and indirect costs of operating these programs. The per diem rate adjustment will be calculated in accordance with the provisions of DRG Rate Setting Methodology.

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Payment for Hospital Acquired Conditions:

Effective January 1, 2011 and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFRs 434, 438, and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Condition (HCAC) and Never Events (NE).

In accordance with N.C. State Plan, Attachment 3.1-A, Page 1, Hospital Services payments are allowed except for the following conditions outlined below.

The above effective date and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Present on Admission (POA) conditions will be reimbursed for allowable charges. Peer Review Organization (PRO) review for Present on Admission (POA) is not required.

Provider Preventable Conditions (PPC), which includes Healthcare Acquired Condition (HCAC), with diagnose codes with Y or W, or as defined by CMS, will be considered in the DRG calculation. Conversely, any diagnoses codes with N or U, or as defined by CMS, will not be considered in the DRG calculation. Provider Preventable Conditions (PPC) will not be approved by the Peer Review Organization (PRO). Providers must identify and report PPC occurrences.

Never Events (NE) are defined by the National Coverage Determination (NCD) manual for Inpatient Hospitals and practitioners, and these providers will be required to report NEs. Never Events (NE) for Inpatient Hospital claims will bill separate claims using by Bill Type 110 or as designated by the National Uniform Bill Committee for a non-payment/zero claim. The non-covered Bill Type 110 must have one of the ICD-9 diagnosis codes.

- E876.5 – Performance of wrong operation (procedure) on correct patient
- E876.6 – Performance of operation (procedure) on patient not scheduled for surgery
- E876.7 – Performance of correct operation (procedure) on wrong side/body part

The provider may file a separate claim for the same Medicaid recipient with the same dates of service to include the allowable charges for reimbursement. Providers must identify and report NE occurrences.

Prohibition on payments for PPCs, HCACs and NEs shall not result in a loss of access to care or services for Medicaid beneficiaries. This policy applies to all Medicaid reimbursement provisions, contained in 4.19A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

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ENHANCED PAYMENTS FOR INPATIENT HOSPITAL SERVICES

(e) Hospitals that are licensed by the State of North Carolina, are not qualified to certify expenditures and that received payment for more than 50 percent of their Medicaid inpatient discharges under the DRG methodology for the most recent 12-month period ending September 30, shall be entitled to the following enhanced payments, for inpatient services for the 12-month period ending September 30 of each year, paid annually in up to four installments.

(e.1) Base Enhanced Payment

(1) The base enhanced payment to hospitals shall equal a percent, not to exceed the State's federal financial participation rate in effect for the period for which the payment is being calculated, of the hospital's inpatient "Medicaid deficit." At least 10 calendar days in advance of the first payment of the payment plan year, the Division will determine, and notify eligible hospitals of, the percent of the inpatient "Medicaid deficit" to be paid as the base enhanced payment for inpatient services.

(2) The "Medicaid deficit" is calculated by subtracting Medicaid payments from reasonable Medicaid costs as follows:

(A) Reasonable costs of inpatient hospital Medicaid services including the reasonable direct and indirect costs attributable to inpatient Medicaid services of operating Medicare approved graduate medical education programs shall be determined annually by:

- i. Calculating a hospital's inpatient charge to cost conversion factor, based on the Medicaid per diems and the ancillary cost-to-charge ratios, using the Medicaid cost from the Title XIX D-1, Part II worksheet using the most recent available CMS 2552 cost report,
- ii. Multiplying the Medicaid inpatient charge to cost conversion factor calculated above by the hospital's Medicaid allowable charges for inpatient services provided during the same fiscal year as the filed cost report and paid not less than six months after the end of the fiscal year,
- iii. Applying the applicable CMS PPS Hospital Input Price Indices to bring the cost data forward to the mid-point of the payment period.

(B) Subtracting from the reasonable Medicaid costs for inpatient services, Medicaid payments received (excluding all Medicaid disproportionate share hospital payments received) for the same fiscal year covered by the cost report and the Medicaid allowable charges for inpatient services referred to in 2. A. ii above. The payments shall be brought forward to the end of the payment period using the same percentage by which the Division increased Medicaid DRG and per diem payment rates between the year to which the DRG and per diem payments apply and the payment year for which the enhanced payments are being calculated.

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(e.2) Equity Enhanced Payments

- (1) The Equity enhanced payment shall, when added to the Base enhanced payment described above in this Section equal one hundred percent of the hospital's inpatient "Medicaid deficit".
- (2) Assessments collected under this section are considered an allowable cost and are not subject to cost settlement.

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ENHANCED PAYMENTS TO TEACHING HOSPITALS FOR INPATIENT HOSPITAL SERVICES

(f) Hospitals that are not qualified to certify public expenditures, are licensed by the State of North Carolina, qualify for disproportionate share hospital status under Paragraph (c) of this Section, and, for the fiscal year immediately preceding the period for which payments under this Paragraph are being calculated:

- i. Qualify to receive inpatient hospital rate adjustment payments described in Paragraph (g) of the section of this plan entitled “INPATIENT HOSPITAL RATE ADJUSTMENT PAYMENT TO HOSPITALS SERVING HIGH PORTIONS OF LOW INCOME PATIENTS;” and
 - ii. Operate at least two Medicare approved graduate medical education programs and report on cost reports filed with the Division, Medicaid costs attributable to such programs shall be entitled to additional enhanced payments for inpatient services paid annually in up to four installments.
- (1) The additional enhanced payment for Medicaid inpatient services shall satisfy the portion of the inpatient “Medicaid deficit” equal to 7.22 percent of the hospital’s estimated uncompensated care cost of providing inpatient and outpatient services to uninsured.
- (2) The “Medicaid deficit” shall be calculated by subtracting Medicaid payments from reasonable Medicaid costs as follows:
- (A) Reasonable costs of inpatient hospital Medicaid services including the reasonable direct and indirect costs attributable to inpatient Medicaid services of operating Medicare approved graduate medical education programs shall be determined annually by:
- i. Calculating a hospital’s Medicaid inpatient cost-to-charge ratio using the most recent available as-filed CMS 2552 cost report,
 - ii. Multiplying the Medicaid inpatient cost-to-charge ratio by the hospital’s Medicaid allowable inpatient charges for inpatient services provided during the same fiscal year as the filed cost report, and paid not less than six months after the end of the fiscal year,
 - iii. Applying the applicable CMS PPS Hospital Input Price Indices to bring the cost data forward to the mid-point of the payment period.

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- (B) Subtracting from the reasonable Medicaid costs for inpatient services, Medicaid payments received (excluding all Medicaid disproportionate share hospital payments received) for the same fiscal year covered by the cost report and the Medicaid allowable charges for inpatient services referred to in 2.A.i and ii above. The payments shall be brought forward to the mid-point of the payment period using the same percentage by which the State increased Medicaid DRG and per diem payment rates between the year to which the DRG and per diem payments apply and the payment year for which the enhanced payments are being calculated.
- (3) Uncompensated care costs are calculated using hospitals' gross charges for services provided to uninsured patients as filed with and certified to the Division for the same fiscal year as the CMS cost report used in determining reasonable costs in 2. A. i and ii above. The Division shall convert hospitals' gross charges for uninsured patients to costs by multiplying them by the facility cost-to-charge ratio determined using hospitals' CMS 2552 cost reports for the same fiscal year used in determining reasonable cost in 2.A. i through ii above and then subtracting payments hospitals received from uninsured patients.
- (4) Payments calculated under Paragraph (f) (when added to Medicaid payments received or to be received for these services) shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.272(a) to exceed the maximum allowed aggregate upper limits for that category established by applicable federal law and regulation.
- (5) The payments authorized under Paragraph (f) shall be effective in accordance with GS 108A-55(c).

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Inpatient Hospital Rate Adjustment Payment to Hospitals Serving High Portions of Low Income Patients

(g) Hospitals that are not qualified to certify public expenditures, that are not Critical Access Hospitals pursuant to 42 USC 1395i-4, and that, based on the most recent fiscal year data available at the time of data collection, qualify for disproportionate share status under Paragraph (c) of the “Disproportionate Share Hospital Payment” section of this plan and meet at least one of the criteria outlined in Subparagraphs (d)(1) through (4) of the disproportionate share hospital payment section of this plan shall receive an inpatient rate adjustment payment for the 12-month period ending September 30 each year. This inpatient rate adjustment payment shall be calculated annually and paid monthly. The rate adjustment is equal to 2.5 percent plus one fourth of one percent for each percentage point that the hospital’s Medicaid inpatient utilization rate exceeds one standard deviation of the mean Medicaid inpatient utilization rate in the state. The rate adjustment payment shall be calculated as follows:

- i. For Medicaid inpatient cases paid on a per case basis under the DRG methodology, the Division will multiply the Medicaid inpatient unit or hospital-specific payment rate in effect for the period for which the rate adjustment applies, by each eligible hospital’s DRG case-mix index for Medicaid inpatients served during the most recent 12-month period available before the rate adjustment payment is calculated. The Division will then multiply each hospital’s case-mix adjusted per case payment amount by its rate adjustment, and then multiply this product by the hospital’s total number of Medicaid inpatient cases for the most recent 12-month period available before the rate adjustment payment is calculated.
- ii. For Medicaid inpatient cases paid on a per diem basis, the Division will multiply the Medicaid inpatient per diem payment in effect for the period for which the rate adjustment applies by each hospital’s rate adjustment. The Division will then multiply each hospital’s adjusted per diem payment amount by the hospital’s Medicaid inpatient days for the most recent 12-month period available before the rate adjustment payment is calculated.

Payments calculated under Paragraph (g) (when added to Medicaid payments received or to be received for these services) shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.272(a) to exceed the maximum allowed aggregate upper limits for that category established by applicable federal law and regulation.

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University of North Carolina Hospital Adjustment

(h) In addition to the payments made elsewhere in this plan, hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. § 116-37, are eligible for a supplemental payment for inpatient hospital services. For a hospital eligible under this Paragraph, the payment in this Paragraph supersedes the requirement, in the REIMBURSEMENT PRINCIPLES and in Paragraph (b) of this Section, that such a hospital be paid allowable costs.

The total payment available for hospitals eligible under this Paragraph will be determined by aggregating the difference between what Medicare would pay for each eligible hospital's Medicaid fee-for-service reimbursement as otherwise calculated under this State Plan. For purposes of calculating this difference, each unit in a hospital with a different Medicare payment system (e.g. acute, psychiatric, rehabilitation) will be treated separately. The difference between what Medicare would pay and inpatient Medicaid payments will be calculated as follows (for exact calculations and cost report references, refer to Exhibit 1, 4.19 –A, page 19):

(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 GME, organ acquisition, costs associated with teaching physicians, and routine service and other ancillary pass-through payments) and outlier payments.

(2) Medicare Payments Subject to the Case Mix Index shall be divided by the transfer-adjusted Medicare case mix index for the hospital, obtained from the Medicare PS&R for the appropriate time period, to obtain Case Mix Adjusted Medicare Payments Subject to the Case Mix Index.

(3) An Outlier Adjustment will be computed by applying the percentage of Medicaid payments from the Medicaid PS&R that are attributable to outlier payments to the total Medicare Payments Not Subject to the Case Mix Index.

(4) The Outlier Adjustment and Case Mix Adjusted Medicare Payments Subject to the Case Mix Index shall be added to Medicare Payments Not Subject to the Case Mix Index to obtain Case Mix Adjusted Medicare Payments.

(5) Case Mix Adjusted Medicare Payments shall be divided by the number of Medicare discharges (from the Medicare cost report) to obtain the Adjusted Medicare Payments Per Discharge. The Adjusted Medicare Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(6) The Medicaid Payment Per Discharge shall be calculated using data from a Medicaid PS&R for the same year as the Medicare cost report and run no less than nine (9) months after the close of the cost report year. Total Medicaid Inpatient Fee-For-Service Payments from the Medicaid PS&R shall be divided by Total Medicaid Discharges from the Medicaid PS&R to obtain the Unadjusted Medicaid Payment Per Discharge.

(7) The Unadjusted Medicaid Payment Per Discharge shall be divided by the Case Mix Index for the Medicaid population calculated using MMIS data to obtain the Adjusted Medicaid Payment Per Discharge. The Adjusted Medicaid Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(8) The inflated Adjusted Medicaid Payment Per Discharge shall be subtracted from the inflated Adjusted Medicare Payment Per Discharge to obtain the Per Discharge Differential.

(9) The Per Discharge Differential shall be multiplied by the Case Mix Index for the Medicaid population and Total Medicaid Discharges to calculate the Available Room Under the UPL.

(10) The Available Room Under the UPL for each eligible hospital will be aggregated to create the Supplemental Payment Amount. The total calculated Supplemental Payment Amount will be paid to eligible hospitals in payments made no more frequently than each quarter.

If payments in this section would result in payments to any category of hospitals 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.

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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. The amount that Medicare would pay shall be calculated as follows (for exact calculations and cost report references, refer to Exhibit 1, 4.19 –A, page 19):

(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 GME, organ acquisition, costs associated with teaching physicians and routine service and other ancillary pass-through’s) and outlier payments.

(2) Medicare Payments Subject to the Case Mix Index shall be divided by the transfer-adjusted Medicare case mix index for the group, obtained from the Medicare Case Mix Index published by CMS for the appropriate time period, to obtain Medicare Payments without the Case Mix Index adjustment.

(3) An Outlier Adjustment will be computed by applying the percentage of Medicaid payments from the Medicaid PS&R that are attributable to outlier payments to the total Medicare Payments Not Subject to the Case Mix Index.

(4) The Outlier Adjustment and Medicare Payments without the Case Mix Index adjustment shall be added to Medicare Payments Not Subject to the Case Mix Index for the group to obtain Base Medicare Payments.

(5) Base Medicare Payments for the group shall be divided by the number of Medicare discharges (from the Medicare cost report) to obtain the Base Medicare Payments Per Discharge. The Base Medicare Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(6) The inflated Base Medicare Payment Per Discharge shall be multiplied by the Case Mix Index for the hospital’s Medicaid population times the hospital’s current year Medicaid Discharges to calculate what Medicare would pay.

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.

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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. The amount that Medicare would pay shall be calculated as follows (for exact calculations and cost report references, refer to Exhibit 1, 4.19 –A, page 19):

(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 GME, organ acquisition, costs associated with teaching physicians and routine service and other ancillary pass-through’s) and outlier payments.

(2) Medicare Payments Subject to the Case Mix Index shall be divided by the transfer-adjusted Medicare case mix index for the group, obtained from the Medicare Case Mix Index published by CMS for the appropriate time period, to obtain Medicare Payments without the Case Mix Index adjustment.

(3) An Outlier Adjustment will be computed by applying the percentage of Medicaid payments from the Medicaid PS&R that are attributable to outlier payments to the total Medicare Payments Not Subject to the Case Mix Index.

(4) The Outlier Adjustment and Medicare Payments without the Case Mix Index adjustment shall be added to Medicare Payments Not Subject to the Case Mix Index for the group to obtain Base Medicare Payments.

(5) Base Medicare Payments for the group shall be divided by the number of Medicare discharges (from the Medicare cost report) to obtain the Base Medicare Payments Per Discharge. The Base Medicare Payment Per Discharge shall be inflated into the current year using the CMS PPS hospital market basket index.

(6) The inflated Base Medicare Payment Per Discharge shall be multiplied by the Case Mix Index for the hospital’s Medicaid population times the hospital’s current year Medicaid Discharges to calculate what Medicare would pay.

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.

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DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

With respect to hospitals that are licensed by the State of North Carolina, that are qualified to certify public expenditures (CPEs) and do certify in accordance with 42 CFR 433.51(b), that qualify for disproportionate share hospital status under Paragraph (c) of the "Disproportionate Share Hospital Payment" Section and that do not meet the criteria described in Subparagraph (d)(5) of the "Disproportionate Share Hospital Payment" Section, the expenditures claimable for Federal Financial Participation (FFP) for the 12-month period ending September 30 each year will be (i) the hospitals' uncompensated care expenditures for serving uninsured patients up to the State's available DSH allotment after allowing for DSH payments for the State-owned Institutes for Mental Diseases, Division of Vocational Rehabilitation Services DSH, Basic DSH, HMO DSH, and Teaching Hospital DSH; plus (ii) the State's expenditures for Medicaid Health Maintenance Organization (HMO) DSH payments as described below; plus (iii) Division of Vocational Rehabilitation Services' DSH expenditures as described below. Each hospital's allowable uncompensated care costs for the rate year will be determined on an interim basis by calculating the hospital's inpatient and outpatient cost-to-charge ratios determined from the hospitals' most recent available as-filed CMS 2552 cost report and multiplying the ratios by the hospital's inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the fiscal year. The Division will then subtract payments hospitals received from uninsured patients for services rendered during the fiscal period to which the gross charges referred to in the preceding sentence relate. The Division will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for services provided to uninsured patients will be determined in accordance with Medicare cost principles by using the hospitals' routine per diems and ancillary cost-to-charge ratios for inpatient cost and outpatient cost-to-charge ratios for outpatient costs from audited CMS 2552 cost reports for the year for which final FFP is being determined by hospitals' inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the same fiscal year and then subtracting payments hospitals received from uninsured patients for services rendered during the fiscal year. The difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the cost was incurred and initial claim was made. Final cost is determined in accordance with Attachment A beginning on page 19c of this section.

(a) In accordance with the Social Security Act, Title XIX, Section 1923(g)(1) total disproportionate share payments to a hospital shall not exceed the percentage specified by the Social Security Act, Title XIX, Section 1923(g) of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less all payments received for services to Medicaid and uninsured patients. The total of all disproportionate share hospital payments shall not exceed the limits on disproportionate share hospital funding as established for this State by CMS in accordance with the provisions of the Social Security Act, Title XIX, Section 1923(f).

(b) The payments authorized by this section shall be effective in accordance with GS 108A-55(c).

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- (c) No hospital may receive disproportionate share hospital payments unless it:
- (1) Has a Medicaid inpatient utilization rate of not less than one percent, defined as the percentage resulting from dividing Medicaid patient days by total patient days, based on the most current available information; and
 - (2) Has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals eligible for Medicaid. In the case of a hospital located in a rural area, the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric services procedures. This requirement does not apply to a hospital which did not offer non-emergency obstetric services as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age.
- (d) The following Subparagraphs describe additional criteria, at least one of which a hospital must meet to be eligible for disproportionate share hospital payments under certain paragraphs of this Section, as specified in those paragraphs.
- (1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals that receive Medicaid payments in the state; or
 - (2) The hospital's low income utilization rate exceeds 25 percent. The low-income utilization rate is the sum of:
 - (A) The ratio of the sum of Medicaid net revenues for patient services plus cash subsidies received from the State and local governments divided by the hospital's net patient revenues; and
 - (B) The ratio of the hospital's gross inpatient charges for charity care less the cash subsidies for inpatient care received from the State and local governments, divided by the hospital's total inpatient charges; or
 - (3) The sum of the hospital's total Medicaid gross revenues, bad debts allowance net of recoveries, and charity care exceeds 20 percent of total gross patient revenues; or
 - (4) The hospital, in ranking of hospitals in the state from most to least in number of Medicaid patient days provided, is among the top group that accounts for 50 percent of the total Medicaid patient days provided by all hospitals in the state; or
 - (5) The hospital is a Psychiatric Hospital operated by the North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH/DD/SAS) or a hospital owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37.

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BASIC DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

- (e) Each hospital that qualifies for disproportionate share status under Paragraph (c) of the "Disproportionate Share Hospital Payment" section of this plan and (i) is described in subparagraph (d)(5) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan, except for hospitals owned or controlled by the University of North Carolina Health Care System (UNCHCS), as defined in N.C. Gen. Stat. § 116-37; (ii) is a Critical Access Hospital pursuant to 42 USC 1395i-4 that is not qualified to certify public expenditures or a hospital owned or controlled by UNCHCS that meets at least one of the criteria outlined in subparagraphs (d)(1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan; (iii) prior to October 1, 2006, meets at least one of the criteria outlined in subparagraphs (d) (1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan and is qualified to certify public expenditures but does not certify; or (iv) Effective October 1, 2006, meets at least one of the criteria outlined in subparagraphs (d)(1)-(4) of the DISPROPORTIONATE SHARE HOSPITAL section of this plan and is qualified to certify public expenditures, shall receive a payment for the 12-month period ending September 30 each year, that is calculated annually and paid monthly. The basic DSH rate adjustment is equal to 2.5 percent plus one fourth of one percent for each percentage point that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation of the mean Medicaid inpatient utilization rate in the state. The basic DSH payment shall be calculated as follows:
- (1) For Medicaid inpatient cases paid on a per case basis under the DRG system, the Division will multiply the Medicaid inpatient unit or hospital-specific payment rate in effect for the period for which the basic DSH payment applies, by each eligible hospital's DRG case-mix index for Medicaid inpatients served during the most recent 12-month period available before the rate adjustment payment is calculated. The Division will then multiply each hospital's case-mix adjusted per case payment amount by its basic DSH rate adjustment, and then multiply this product by the hospital's total number of Medicaid inpatient cases for the most recent 12-month period available before the basic DSH payment is calculated.
 - (2) For Medicaid inpatient cases paid on a per diem basis, the Division will multiply the Medicaid inpatient per diem payment in effect for the period for which the basic DSH payment applies, by each hospital's basic DSH rate adjustment. The Division will then multiply each hospital's adjusted per diem payment amount by the hospital's Medicaid inpatient days for the most recent 12-month period available before the basic DSH payment is calculated.

If a payment to a hospital under this section would cause a hospital to exceed the hospital-specific limits on disproportionate share hospital payments at 42 U.S.C. § 1396r-4(g)(1)(A), payments under this section will be reduced to ensure compliance with the hospital-specific limit.

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STATE-OWNED INSTITUTIONS FOR MENTAL DISEASES DSH PAYMENT

(f) Hospitals operated by the Department of Mental Health that qualify for disproportionate share hospital status under Subparagraph (d)(5) will be eligible for disproportionate share payments, in addition to other payments made under the North Carolina Medicaid Hospital reimbursement methodology, based on bed days of service to low income persons.

- (1) Payment shall equal the facility-specific average per diem cost from its most recent cost report available at the time of data collection multiplied by bed days of service to low income persons.
- (2) “Bed days of service to low income persons” is defined as the number of bed days provided to individuals that have been determined by the hospital as:
 - i. Patients who do not possess the financial resources to pay portions or all charges associated with care provided; and
 - ii. Who do not possess health insurance which would apply to the service for which the individual sought treatment; or
 - iii. Who have insurance but are not covered for the particular service rendered or for the procedure or treatment.
- (3) Payments to Institutes for Mental Diseases under Paragraph (f) shall not exceed the State’s DSH limit for Institutes for Mental Disease.

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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

Audit of Disproportionate Share Payments:

As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Division of Medical Assistance will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit. Funds shall be redistributed to the state hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed first to other state hospitals in the order of MIUR from highest to lowest, then to government non-state hospitals in the order of MIUR from highest to lowest, then to private hospitals in the order of MIUR from highest to lowest.

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State Plan Under Title XIX of the Social Security Act
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State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

Exhibit 1

This exhibit contains a table which defines the calculation and source documents for the adjustments based on the difference between what Medicare would pay and inpatient Medicaid payments as otherwise calculated under this state. All cost report 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). Table 1 identifies the calculation for acute care hospitals, excluding any psychiatric and rehabilitation distinct part units.

Table 1

Hospital – Specific UPL Calculation – per case method; inpatient only	Data Source: MCR – 2552 – 10 or its successor; if a calculation, defines the line(s) and operation; other documents.	
Step 1: Find the Medicare per case rate with case mix removed.	Include all Medicare payments from the most recent as filed cost report.	
1. Portions of Medicare payments for most recent year subject to Case Mix Index.		
a. Other than Outlier payments (base rate)	Wksht E; Part A; Line 1 (may be total of a number of lines)	\$
b. IME Adjustment	Wksht E; Part A; Line 29	\$
c. DSH Adjustment (include Medicare DSH)	Wksht E; Part A; Line 34	\$
d. Total Uncompensated Care	Wksht E; Part A; Line 36	\$
e. Additional payment for high percentage of ESRD Beneficiary Discharges	Wksht E, Part A; Line 46	\$
f. Capital Adjustment	Wksht E; Part A; Line 50	\$
g. SCH or MDH Hospital Payment	Wksht E; Part A; Line 48	\$
h. Total Medicare payments subject to case mix index	Total lines 1a through 1g	\$
2. Adjustment for Case Mix Index.		
a. Medicare Case Mix Index	From the CMS website for the MCR period	0.0000
b. Case mix adjusted total payments	Line 1h ÷ 2a	\$
3. Medicare Payments not subject to case mix index.		
a. GME adjustment	Wksht E; Part A; Line 52	\$
b. Organ Acquisition cost	Wksht E; Part A; Line 55	\$
c. Cost of Teaching Physicians	Wksht E; Part A; Line 56	\$
d. Routine service pass-through	Wksht E; Part A; Line 57	\$

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Exhibit 1 Continued	Table 1 Continued	
e. Other ancillary other pass-through	Wksht E; Part A; Line 58	\$
f. Exception Payment for IP Program Capital	Wksht E; Part A; Line 51	\$
g. Special Add-On for New Technologies	Wksht E, Part A, Line 54	\$
h. Nursing and Allied Health Managed Care Payment	Wksht E; Part A; Line 53	\$
i. Manufacturer Credit on Replacement Devices	Wksht E; Part A; Line 68	\$
j. Total Medicare payments not subject to case mix index	Total lines 3a through 3i	\$
4. Total Medicare payment with case mix removed and outliers omitted	Line 2b + Line 3j	\$
5. Medicaid Outlier Payment Adjustment		
a. Total Medicaid Outlier Pymts	Medicaid PS&R and Fiscal Agent	\$
b. Total inpatient Medicaid payments included on the Medicaid PS&R	Medicaid PS&R	\$
c. Percentage of Medicaid Outlier Payments to Total Medicaid Payments exclusive of outliers	Line 5a ÷ (Line 5b – Line 5a)	0.00%
6. Calculation of Medicare payment including Medicaid Outlier Payment Adjustment	Line 4 x (1+Line 5c)	\$
7. Calculate per case payment		
a. Medicare Discharges	From MCR	0000
b. Per case Medicare rate with case mix removed.	Line 6 ÷ Line 7a	\$
c. CMS supplied inflation factor 2009	CMS website; Market Basket Data	0.00%
d. CMS supplied inflation factor 2010	CMS website; Market Basket Data	0.00%
e. Inflation adjusted per case Medicare rate with case mix removed.	Line 7b x Line 7c x Line 7d	\$
Step 2. Find the Medicaid per case rate with case mix removed.	Include all Medicaid payments made directly by the Medicaid agency (i.e. exclude Medicaid managed care)	
8. Medicaid Rate per case		
a. Total Medicaid inpatient FFS payments (exclude DSH)	Medicaid PS&R and Fiscal Agent	\$
b. Number of Medicaid Cases	Medicaid PS&R	0000
c. Rate per case	Line 8a ÷ Line 8b	\$

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Exhibit 1 Continued

Table 1 Continued

9. Adjusted for Case Mix		
a. Medicaid case mix	Annual Medicaid Calculation for Recalibration of DRG Weights	0.000
b. Medicaid rate per case with case mix removed	Line 8c ÷ Line 9a	\$
c. CMS supplied inflation factor 2009	CMS website; Market Basket Data	0.00%
d. CMS supplied inflation factor 2010	CMS website; Market Basket Data	0.00%
e. Inflation adjusted per case Medicaid rate with case mix removed	Line 9b x Line 9c x Line 9d	\$
Step 3: Calculate UPL Gap		
10. Per Case Differential from Medicare Payments	Line 7e – Line 9e	\$
11. Per Case differential adjusted for Medicaid case Mix	Line 10 x Line 9a	\$
12. Available Room under UPL for UPL payment	Line 11 x Line 8b	\$

Exhibit 1 – Notes

General Notes for Tables 1

- The payments must also be in compliance with 42 CFR 447.271 – charge limits.
- The table uses two years of inflation to trend 2009 cost report data to 2011. The inflation calculation would be adjusted based upon the year of the MCR used and the year of the payments being calculated.
- The cost report data used to calculate the Upper Payment Limit will be the latest available as filed or desk reviewed version.
- The table uses Medicaid payments and cases from the latest available Medicaid PS&R produced by the DMA Fiscal Agent for the cost report year.
- Cost of Teaching Physicians, Line 3c, shall include only the cost of the teaching component and exclude the professional component.

UPL calculation for Psychiatric and Rehabilitation Distinct Part Units

- The Upper Payment Limit for psychiatric and rehabilitation distinct part units will be calculated by taking each distinct part unit's Medicaid cost per discharge multiplied by the Medicaid distinct part unit discharges.

UPL calculation for Critical Access Hospitals (CAH)

- The Upper Payment Limit for CAH facilities will be 101% of the Medicare allowed cost per discharge multiplied by the Medicaid discharges for the cost report period.

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

Attachment A

Certified Public Expenditures incurred in Providing services to Medicaid and Uninsured Patients

With respect to hospitals that the State of North Carolina determines eligible to certify public expenditures, and do certify, in accordance with 42 CFR 433.51(b), the expenditures claimable for Federal Financial Participation (FFP) will be the hospital's allowable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare cost principles. This computation of establishing interim Medicaid hospital payments must be performed on an annual basis.

Medicaid Hospital Costs:

(Effective January 1, 2011, this methodology will no longer apply for public hospitals with the approval of SPA 11.003.)

Inpatient Hospital Services—CPE Protocol

Rate Computation for Governmental Facilities – First and Final Reconciliation

For the payment year, the routine per diems and ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary. The per diems and cost-to-charge ratios are calculated as follows:

Step 1:

Total hospital costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2:

The hospital's total inpatient days by routine cost center are identified from Worksheet S-3 Part 1 Column 6. The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3:

For each inpatient routine cost center, a per diem is calculated by dividing total costs from Step 1 by total days from Step 2. For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2. The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

The inpatient per diems and cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4:

To determine the inpatient routine cost center costs for the payment year, the hospital's inpatient Medicaid days by cost center, as obtained from MMIS and other applicable sources for the period covered by the as-filed cost report will be used. The days are multiplied by the inpatient per diems from Step 3 for each routine respective cost center to determine the Medicaid allowable inpatient costs for each routine cost center. Only hospital routine cost centers and their associated costs and days are used. Other routine cost centers such as nursing facility, skilled nursing facility, and long term care services are excluded.

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Step 5:

To determine ancillary cost center costs for the payment year, the hospital's inpatient Medicaid allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. Medicaid allowable charges for observation beds must be included in line 62. These Medicaid allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid allowable costs for each cost center. The Medicaid allowable charges used should only pertain to inpatient hospital services, and should exclude charges pertaining to outpatient hospital services, any professional services, or non-hospital component services such as hospital-based providers.

Step 6:

The Medicaid allowable share of organ acquisition costs is determined by first finding the ratio of Medicaid usable organs to total usable organs as identified from provider records by the hospital's total usable organs from Worksheet D-6 Part III under the Part B cost column line 54. This ratio is then multiplied by total organ acquisition costs from Worksheet D-6 Part III under the Part A cost column line 53. For this calculation, a usable organ is defined as the number of organs transplanted into a recipient, plus the number of organs excised and furnished to an organ procurement organization. "Medicaid usable organs" are counted as the number of Medicaid patients (recipients) who received an organ transplant. "Uninsured usable organs" are counted as the number of patients who received an organ transplant and had no insurance and no payment (self pay or free care). A donor's routine days and ancillary charges shall not be duplicative of any Medicaid or uninsured days and charges in Steps 4 and 5 above or from Steps 4 and 5 of the Uninsured portion of this protocol.

Step 7:

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6. Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital cost computation described above, must be offset against the computed Medicaid inpatient hospital cost before a per diem is calculated.

Step 8:

Net Cost is trended forward to payment year based on the Global Insight.

Step 9:

The projected annual cost will be claimed not more than four times during a federal fiscal year.

Step 10:

Medicaid provider assessments, as defined by 42 CFR 433.55, paid by the hospital shall be considered an allowable cost when determining the total allowable cost.

First Interim Payment Reconciliation:

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

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Steps 1 – 3:

Days, costs, and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4, 5:

Actual Medicaid paid days and charges from the MMIS Provider Statistical an Reimbursement (PS&R) report for services furnished during the payment year are used.

Step 6:

Organ acquisition costs and total usable organs from the as-filed CMS 2552 cost report for the payment year are used.

Step 7:

Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient services of which the costs are already included in the Medicaid inpatient hospital cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid inpatient hospital per diem) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

Final Cost Report Reconciliation:

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. As well, any Supplement Enhancements related to payment year are offset. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.

In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include:

- 1) computing a per diem for each routine cost center and applying the applicable Medicaid inpatient days from MMIS data to the per diem amount;
- 2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and
- 3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly exempt for Medicaid.

If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if is determined that a hospital received an underpayment, the underpayment will be properly claimed from the federal government.

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid routine costs from Step 4, the Medicaid ancillary costs from Step 5 and the Medicaid organ acquisition costs from Step 6. Medicaid payments that are made independent of the Medicaid inpatient hospital per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital cost computation described above must be offset against the computed Medicaid inpatient hospital cost.

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For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State plan rate year the costs of two cost report periods encompassing the State Plan payment year. To do so, the State will obtain the actual Medicaid FFS days and charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS cost for the reporting periods; this Medicaid FFS cost will then be proportionally allocated to the State plan rate year. All allocations will be made based upon number of months. (For example, for a hospital reporting period ending 12/31/07, the Medicaid FFS cost and days/charges from that period encompass three-fourths of the State plan rate year ending 9/30/2007, and one-fourth of the State plan rate year ending 9/30/2008. To fulfill reconciliation requirements for State plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS costs from its reporting period ending 12/31/2006, to the State plan rate year.) The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

Outpatient Hospital Services—CPE Protocol
Rate Computation for Governmental Facilities – First and Final Reconciliation

For the payment year, ancillary cost-to-charge ratios for the cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary. The cost-to-charge ratios are calculated as follows:

Step 1:

Total hospital costs are identified from Worksheet B Part I Column 25. These are the costs that have already been reclassified, adjusted, and stepped down through the A and B worksheet series.

Step 2:

The hospital's total charges by ancillary cost center are identified from Worksheet C Part I Column 8.

Step 3:

For each ancillary cost center, a cost to charge ratio is calculated by dividing the total costs from Step 1 by the total charges from Step 2.

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's costs for the payment year. The hospital costs for Medicaid for the payment year are determined as follows:

Step 4:

To determine ancillary cost center costs for the payment year, the hospital's outpatient Medicaid FFS allowable charges, as obtained from MMIS for the period covered by the as-filed cost report will be used. These Medicaid allowable charges are multiplied by the cost to charge ratios from Step 3 for each respective ancillary cost center to determine the Medicaid allowable costs for each cost center. (Note that for the computation of the cost-to-charge ratio for cost center #62/Observation Beds, the cost amount is reported on worksheet C, Part I, column 1, instead of worksheet B.

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Medicaid allowable hospital outpatient charges for observation beds are then applied to this cost-to-charge ratio to compute the Medicaid outpatient observation bed costs.) The Medicaid allowable FFS charges used should only pertain to outpatient hospital services, and should exclude charges pertaining to inpatient hospital services, any professional services, or non-hospital component services.

Step 5:

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid ancillary costs from Step 4. All payments for Medicaid FFS outpatient services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost.

Step 6:

Net Cost is trended forward to payment year based on the Global Insight factor.

Step 7:

The projected annual cost will be claimed not more than four times during a federal fiscal year.

Step 8:

Medicaid provider assessments, as defined by 42 CFR 433.55, paid by the hospital shall be considered an allowable cost when determining the total allowable cost.

First Interim Payment Reconciliation:

The CMS 2552 costs determined through the method described for the payment year will be reconciled to the as-filed CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary (FI). If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if an underpayment is determined, the state will make the applicable claim from the federal government. For purposes of this reconciliation the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 3:

Costs and charges from the as-filed CMS 2552 cost report for the payment year are used.

Steps 4:

Actual Medicaid charges from the MMIS Provider Statistical and Reimbursement (PS&R) report for services furnished during the payment year are used.

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Step 5:

All payments for Medicaid FFS outpatient hospital services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost (along with the interim Medicaid payments) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

Final Cost Report Reconciliation:

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare FI with the issuance of a Notice of Program Reimbursement, a reconciliation of the finalized amounts will be carried out. Subsequent reconciliations and adjustments to the CPE claims are also performed for any cost report appeal resolution (including PRRB appeals and intermediary hearings) or cost report reopening that impacts the CPE computation as prescribed in this protocol. As well, any Supplement Enhancements related to payment year are offset. The same method as described for the interim reconciliation will be used except that the updated Medicaid program and payment data and finalized CMS 2552 amounts will be substituted as appropriate.

In the final reconciliation, Medicaid cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series. Worksheet D series include applying Worksheet C cost center-specific cost-to-charge ratios to the applicable Medicaid outpatient hospital charges for each ancillary cost center.

Use of Worksheet D series also includes the application of all Medicare cost report adjustments unless expressly exempt for Medicaid.

If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government and if it is determined that a hospital received an underpayment, the underpayment will be properly claimed from the federal government.

The Medicaid allowable costs eligible as certified public expenditures are determined by adding the Medicaid ancillary costs from Step 4. All payments for Medicaid FFS outpatient hospital services that are made independent of the process described in this cost computation section must be offset against the computed Medicaid FFS outpatient hospital cost.

For hospitals whose cost report year is different from the State's fiscal year, the State will proportionally allocate to the State plan rate year the costs of two cost report periods encompassing the State Plan payment year. To do so, the State will obtain the actual Medicaid FFS outpatient hospital charges for the hospital's cost reporting periods, and compute the aggregate Medicaid FFS outpatient hospital cost for the reporting periods; this Medicaid FFS outpatient hospital cost will then be proportionally allocated to the State plan rate year. All allocations will be made based upon number of months. (For example, for a hospital reporting period ending 12/31/07, the Medicaid FFS outpatient hospital cost and charges from that period encompass three-fourths of the State plan rate year ending 9/30/2007, and one-fourth of the State plan rate year ending 9/30/2008. To fulfill reconciliation requirements for State plan rate year 2007, the hospital would match three-fourths of the Medicaid FFS costs from its reporting period ending 12/31/2007, and one-fourth of the Medicaid FFS costs from its reporting period ending 12/31/2006, to the State plan rate year. The State will ensure that the total costs claimed in a State plan rate year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.

TN. No. 10-029
Supersedes
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Approval Date 03/26/2012

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Payments for Medical and Remedial Care and Services: Inpatient Hospital

CPEs Incurred in Providing Services to Uninsured patients (Uncompensated Care):

The North Carolina Division of Medical Assistance collects information on hospitals' charges for services they provide to uninsured patients and any payments hospitals receive by or on behalf of those patients. The Division collects this information on a supplemental Schedule A for uncompensated care that the hospitals' CEO, CFO or their designee must sign and certify to the accuracy of the reported information.

The Division will determine the inpatient uncompensated care costs on an interim basis by multiplying the inpatient charges by a charge-to-cost conversion factor as calculated using Medicare cost principles and detailed in the protocol above for Medicaid inpatient cost.

The Division will determine the outpatient uncompensated care cost on an interim basis by multiplying the outpatient uncompensated charges by the outpatient cost-to-charge ratio as calculated in the above protocol for Medicaid outpatient cost.

Final Cost Report Reconciliation

The Division will use the protocol as outlined above for the final cost report reconciliation between the estimated CPEs and the actual CPEs incurred by the hospital for uncompensated care.

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DIVISION OF VOCATIONAL REHABILITATION SERVICES DSH PAYMENTS

(i) Effective with dates of payment beginning October 31, 1996, each hospital that provides services to clients of State Agencies are considered to be a Disproportionate Share Hospital (DSH) when the following conditions are met:

- (1) The hospital qualifies for disproportionate share hospital status under Paragraph (c) of this Section;
- (2) The State Agency has entered into a Memorandum of Understanding (MOU) with the Division of Medical Assistance (Division) for services provided after October 31, 1996; and
- (3) The inpatient and/or outpatient services are authorized by the State Agency for which the uninsured patient meets the program requirements

For purposes of this Paragraph uninsured patients are those clients of the State Agency who have no third parties responsible for any hospital services authorized by the State Agency.

- (4) DSH payments are paid for services to qualified uninsured patients on the following basis:
 - (A) For inpatient services the amount of the DSH payment is determined by the State Agency in accordance with the applicable Medicaid inpatient payment methodology as stated in Section 4.19-A of the State Plan.
 - (B) For outpatient services the amount of the DSH payment is determined by the State Agency in accordance with the applicable Medicaid outpatient payment methodology as stated in Section 4.19-B of this State Plan.
 - (C) No federal funds are utilized as the non-federal share of authorized payments unless the federal funding is specifically authorized by the federal funding agency as eligible for use as the non-federal share of payments.
- (5) Based upon this Subsection DSH payments as submitted by the State Agency are to be paid monthly in an amount to be reviewed and approved by the Division of Medical Assistance. The total of all payments may not exceed applicable limits on Disproportionate Share Hospital funding.

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MEDICAID HMO DSH PAYMENTS

(j) Additional disproportionate share hospital payments for the 12-month periods ending September 30 of each year shall be paid to hospitals licensed by the State of North Carolina that qualify for disproportionate share hospital status under Paragraph (c) of the “Disproportionate Share Hospital Payment” section of this Plan and provide inpatient or outpatient hospital services to Medicaid Health Maintenance Organizations (“HMO”) enrollees during the period for which payments under this Paragraph are being ascertained. For purposes of this Paragraph, a Medicaid HMO enrollee is a Medicaid beneficiary who receives Medicaid services through a Medicaid HMO; a Medicaid HMO is a Medicaid managed care organization, as defined in Section 1903(m)(1)(A), that is licensed as an HMO or operates under 42 CFR 438 as a Prepaid Inpatient Health Plan (PIHP), and provides or arranges for services for enrollees under a contract pursuant to Section 1903 (m)(2)(A)(i) through (xi). To qualify for a DSH payment under this Paragraph, a hospital must also file with and certify to the Division for the most recent fiscal year available at the time of data collection, its charges for inpatient and outpatient services provided to Medicaid HMO enrollees on a form prescribed by the Division.

- (1) The payments to qualified hospitals pursuant to this Paragraph shall be based on costs for inpatient and outpatient services provided to Medicaid HMO enrollees for the most recent available hospital fiscal year. Medicaid inpatient HMO costs will be calculated by multiplying the Medicaid charge-to-cost conversion factor calculated using the CMS 2552 cost report for the same fiscal year as used in determining hospitals’ Base Enhanced Payments for Inpatient Hospital Service in (e.1)(2)(A) of this plan, by inpatient charges for Medicaid HMO patients for the same fiscal year. Medicaid outpatient HMO cost will be determined by multiplying the Medicaid cost-to-charge ratio calculated using the CMS 2552 cost report for the same fiscal year as used in determining the hospitals’ Base Enhanced Payments for Outpatient Hospital Service in 4.19-B, 2.a.1(2)A. Each hospital’s payment shall then be determined as follows:
 - (A) The ratio of the sum of Base Enhanced Payment for Inpatient Hospital Services as calculated in accordance with (e.1) 1 and (e.1) 2 of this plan and Base Enhanced Payment for Outpatient Hospital Services as calculated in accordance with 2.a.1 of this plan to the sum of inpatient Medicaid costs as determined in (e.1) (2)(A) i through iii of the Base Enhanced Payment for Inpatient Hospital Services section of this plan and outpatient Medicaid costs as determined in 2.a.1(2).A. through B. of the Base Enhanced Payment for Outpatient Hospital Services section of this plan.
 - (B) Multiply the above ratio by the calculated Medicaid HMO costs as described in subparagraph (j) (1) of this Section.
- (2) Payments authorized by this Paragraph shall be made paid annually, in up to four installments.

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UNIVERSITY OF NORTH CAROLINA DSH PAYMENT

(k) Hospitals owned or controlled by the University of North Carolina Health Care System, as defined in N.C. Gen. Stat. § 116-37, and that qualify under Paragraph (c) of this Section shall be eligible to receive disproportionate share hospital payments that, when combined with other disproportionate share hospital payments described in this Section, will equal 100 percent of their unreimbursed uninsured except as otherwise provided for in (2) and (3) below, and as limited by Paragraph (a). These DSH payments shall be calculated after accounting for all other Medicaid payments, including payments under Paragraph (h) of the EXCEPTIONS TO DRG REIMBURSEMENT, and after accounting for all other DSH payments to hospitals in North Carolina, including the hospitals eligible for payments under this Paragraph. The aggregate payment to eligible hospitals under this Paragraph shall not exceed the total cost incurred by the University of North Carolina Hospitals at Chapel Hill dba UNC Hospitals for providing care to patients who have no insurance for the services provided.

- (1) Unreimbursed uninsured costs shall be calculated based on the hospitals' gross charges and payments for uninsured inpatient and outpatient hospital services as filed with and certified to the Division for the most recent fiscal year available at the time of data collection. The Division will convert hospitals' gross charges to costs by multiplying them by a cost-to-charge ratio determined from the hospitals' most recent cost reports available at the time of data collection and subtracting payments the hospitals received from uninsured patients. The Division will bring the unreimbursed uninsured cost data forward to the end of the payment period by applying an inflation factor calculated based on the most current information available at the time on the CMS website for the CMS PPS Hospital Input Price Index.
- (2) Effective January 1, 2004, for State fiscal years 2004 and 2005, these hospitals shall receive disproportionate share hospital payments that, when combined with other disproportionate share payments described in this Section, shall equal 150 percent of their unreimbursed uninsured costs.
- (3) To the extent the limits on disproportionate share hospital funding for this State established by CMS in accordance with 42 U.S.C. § 1396r-4(f) do not allow payments to all eligible hospitals up to 100 percent of each hospital's unreimbursed costs, this percentage shall be reduced to comply with such limits.

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OUT-OF-STATE-HOSPITALS

- (a) Except as noted in Paragraph (c) below, the Division of Medical Assistance shall reimburse out-of-state hospitals using the DRG methodology. Effective January 1, 2015, the DRG hospital unit value for all out-of state hospitals shall be equal to the unit value of the North Carolina hospitals' statewide median rate as of June 30, 2014. Out-of-state providers are eligible to receive cost and day outlier payments, but not direct medical education payment adjustments.
- (b) Hospitals that are certified for indirect medical education by Medicare may apply for an indirect medical education adjustment to its North Carolina rate.
- (c) Hospitals certified as disproportionate share hospitals by the Medicaid agency in their home state may apply for a disproportionate share adjustment to their North Carolina Medicaid rate. The North Carolina disproportionate share hospital rate adjustment shall be the hospital's home state DSH adjustment, not to exceed 2.5 percent of the DRG or per diem payment. The Division will apply the disproportionate share hospital rate adjustment to Medicaid inpatient claims submitted by qualified out-of-state hospitals.
- (d) The Division of Medical Assistance may enter into contractual relationships with certain hospitals providing highly specialized inpatient services, i.e. transplants in which case reimbursement for inpatient services shall be based upon a negotiated rate.

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SPECIAL SITUATIONS

(a) In order to be eligible for inpatient hospital reimbursement under this hospital inpatient reimbursement plan, a patient must be admitted as an inpatient and stay past midnight in an inpatient bed. The only exceptions to this requirement are those admitted inpatients who die or are transferred to another acute care hospital on the day of admission. Hospital admissions prior to 72 hours after a previous inpatient hospital discharge are subject to review by the Division of Medical Assistance.

Services for patients admitted and discharged on the same day and who are discharged to home or to a non-acute care facility must be billed as outpatient services. In addition patients who are admitted to observations status do not qualify as inpatients, even when they stay past midnight. Patients in observation status for more than 30 hours must either be discharged or converted to inpatient status.

(b) Outpatient services provided by a hospital to patients within the 24 hour period prior to an inpatient admission in the same hospital that are related to the inpatient admission shall be bundled with the inpatient billing.

(c) When a patient is transferred between hospitals, the transferring hospital shall receive a pro-rated payment equal to the normal DRG payment multiplied by the patient's actual length of stay divided by the geometric mean length of stay for the DRG. When the patient's actual length of stay equals or exceeds the geometric mean length of stay for the DRG, the transferring hospital receives full DRG payment. Transfers are eligible for cost outlier payments. The final discharging hospital shall receive the full DRG payment.

(d) For discharges occurring on October 1, 2001 through September 30, 2008, a discharge of a hospital inpatient is considered to be a transfer under paragraph (c) above when the patient's discharge is assigned to one of the following qualifying diagnosis-related groups, DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483 and the discharge is made under any of the following circumstances in (d)(1), (d)(2) or (d)(3) listed below. For discharges occurring on or after October 1, 2008, a discharge of a hospital inpatient is considered to be a transfer under paragraph (c) above when the patient's discharge is assigned to one of the following qualifying diagnosis-related groups, DRGs 28, 29, 30, 40, 41, 42, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, and 956 and the discharge is made under any of the following circumstances in (d)(1), (d)(2) or (d)(3) listed below:

- (1) To a hospital or distinct part hospital unit excluded from the DRG reimbursement system;
- (2) To a skilled nursing facility; or
- (3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

TN. No: 08-012
Supersedes
TN. No: 05-015

Approval Date: 04/09/09

Eff. Date 10/01/2008

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(e) Days for authorized nursing facility level of care rendered in an acute care hospital shall be reimbursed at a rate equal to the average rate for all such Medicaid days based on the rates in effect for the long term care plan year beginning each October 1. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-A, Supplement 1, Page 1 of the Sate Plan.

Days for lower than acute level of care for ventilator dependent patients in swing-bed hospitals or that have been down-graded through the utilization review process may be paid for up to 180 days at a lower level ventilator-dependent rate if the hospital is unable to place the patient in a lower level facility. An extension may be granted if in the opinion of the Division of Medical Assistance the condition of the patient prevents acceptance of the patient. A single all inclusive prospective per diem rate is paid, equal to the average rate paid to nursing facilities for ventilator-dependent services. The hospital must actively seek placement of the patient in an appropriate facility.

(f) The Division of Medical Assistance may make a retrospective review of any transfers to a lower level of care prior to the expiration of the average length of stay for the applicable DRG. The Division of Medical Assistance may adjust the DRG payment if the transfer is deemed to be inappropriate, based on the preponderance of evidence of a case by case review.

(g) In state-operated hospitals, the appropriate lower level of care rates equal to the average rate paid to state operated nursing facilities, are paid for nursing facility level of care patients awaiting placement in a nursing facility bed.

(h) For an inpatient hospital stay where the patient is Medicaid eligible for only part of the stay, the Medicaid program shall pay the DRG payment less the patient's liability or deductible, if any, as provided by 10 NCAC 50B .0406 and .0407. (see page 28-28(c) of this plan)

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COST REPORTING AND AUDITS

(a) Annual cost reports shall be filed as directed by the Division of Medical Assistance in accordance with 42 CFR 447.253 (f) and (g).

(b) The Medicaid Cost Report is due five (5) months after the provider's fiscal year end or 37 days from the date of the PS&R letter, which ever is later. Hospitals 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 penalties for non-compliance. A penalty of 20% withhold of Medicaid payments will be imposed upon the delinquent hospital 30 days after the Medicaid cost report filing deadline unless the hospital 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. Any monies withheld as penalty will not accrue interest to the benefit of the hospital.

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ADMINISTRATIVE RECONSIDERATION REVIEWS

Reconsideration reviews of rate determinations shall be processed in accordance with the provisions of 10 NCAC 26K (See page 29 – 29(a) of this plan). Requests for reconsideration reviews shall be submitted to the Division of Medical Assistance within 60 days after rate notification, unless unexpected conditions causing intense financial hardship arise, in which case a reconsideration review may be considered at any time.

TN. No. 05-015
Supersedes
TN. No. 94-33

Approval Date December 15, 2005

Eff. Date 10/01/2005

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BILLING STANDARDS

- (a) Providers shall use codes from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) to report diagnoses and procedures. This material is hereby incorporated by reference including any subsequent amendments and editions and is available for inspection at the Division of Medical Assistance, 1985 Umstead Drive, Raleigh, NC. Copies may be obtained from the American Medical Association, 515 North State Street, Chicago, IL 60610 at a cost of fifty nine dollars and ninety five cents (\$59.95). Tel: 800-621-8335. Providers shall use the codes which are in effect at the time of discharge. The reporting of ICD-9-CM diagnosis and procedure codes shall follow national coding guidelines promulgated by the Centers for Medicare and Medicaid Services.
- (b) Providers shall generally bill only after discharge. However, interim billings may be submitted on or after 60 days after an admission and on or after every 60 days thereafter.
- (c) The discharge claim is required for Medicaid payment. The purpose of this Rule is to assure a discharge status claim is filed for each Medicaid stay.
- (1) An interim billing must be followed by a successive interim billing or discharge (final) billing within 180 days of the date of services on the most recent claim. When an interim claim is not followed by an additional interim or discharge (final) claim within 180 days of the "to date of services" on the most recent paid claim, all payments made for all claims for the stay will be recouped.
 - (2) After a recoupment is made according to this plan, a subsequent "admit through discharge" or interim claim for payment will be considered for normal processing and payment unless the timely filing requirements of 10 NCAC 26D .0012 are exceeded (See page 30 of this plan).

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PAYMENT OF MEDICARE PART A DEDUCTIBLES

For payment of Medicare Part A claims, the Division of Medical Assistance shall pay the Medicaid DRG payment less the amount paid by Medicare not to exceed the sum of the Medicare Coinsurance and Deductible. For payment of Medicare Part A claims for psychiatric and rehabilitation services, the Division of Medical Assistance shall pay the Medicaid per diem less the amount paid by Medicare not to exceed the sum of Medicare Coinsurance and Deductible.

PAYMENT ASSURANCES

The state shall pay each hospital the amount determined for inpatient services provided by the hospital according to the standards and methods set forth in this plan. In all circumstances involving third party payment, Medicaid shall be the payor of last resort.

PROVIDER PARTICIPATION

Payments made according to the standards and methods described in this plan are designed to enlist the participation of a majority of hospitals in the program so that eligible persons can receive medical care services covered by the North Carolina Medicaid program at least to the extent these services are available to the general public.

PAYMENT IN FULL

Participation in the North Carolina Medicaid program shall be limited to hospitals who accept the amount paid in accordance with this plan as payment in full for services rendered to Medicaid recipients.

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These changes to the payment for general hospital inpatient services reimbursement plan will become effective when:

The Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, approves amendment submitted to CMS by the Director of the Division of Medical Assistance on or about January 1, 1995 as #MA 94-33, wherein the Director proposes amendments of the State Plan to amend payment for general hospital inpatient services.

TN. No. 05-015
Supersedes
TN. No. 94-33

Approval Date December 15, 2005

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During the process of estimating costs on a claim by claim basis, all costs were inflated to State Fiscal Year 1994 using the North Carolina hospital market basket rates of 5.1% for SFY 1993 and 4.7% for SFY 1994. For routine services, this was done by inflating the per diem rate from the cost report fiscal year to SFY 1994. For example:

Assume a routine per diem of \$600 with a hospital cost report fiscal year end of 12/31/93 and an inflation rate of 4.4% per annum.

June 31, 1994 – December 31, 1993 – 181 days

$$\$600 * (1 + (181/365 * 0.047)) = \$613.98$$

For ancillary services, the starting point for any inflation adjustment is the date of service on the claim. This practice assumes that hospitals regularly increase their ancillary charges in response to increased costs, such that the use of the cost to charge ratio from last year's cost report applied to this year's charge should result in a close approximation of costs.

The costs for all ancillary service line items on all claims were adjusted to the midpoint of SFY 1994 (January 1, 1994) using the NC Hospital market basket rates². For example:

- (1) Assume that the discharge date on a claim is 12/15/93, with charges of \$600:

January 1, 1994 - July 15, 1993 = 199 days

$$\$600 * (1 + (199/365) * .047) = \$615.37$$

- (2) Assume that the discharge date on a claim is 3/15/94 with charges of \$600:

January 1, 1994 – March 15, 1994 = 73 days

$$\$600 * (1 + (-73/365) * .047) = \$594.36$$

²Cost estimates for claims with dates of services after the fiscal year midpoint were deflated back to January 1, 1994. However, to avoid biases due to completion rates, we ultimately decided not to use these claims in rate setting.

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Exhibit 5.1

North Carolina DRG Project Data Model Option 1: Statewide DRG Rates Hospitals below 45th Percentile Receive 75/25 Blend of their Rate and 45th %ile Rate
Transfers: Prorated Combined Operating & Capital Rate Hospitals above 45th Percentile Receive 45th %ile Rate with Medical Education Adjustments
Stat. Outliers: Included
Transplant DRGs: Included
ych/Rehab: Excluded

Provider Number	Provider Name	IME Factor	DME Factor	No. of Disch	No. of Days	Medicaid Cost	Cost Less Med Ed	Proj. Decline in Days	Routine Daily Cost	DRG Cost Less Med Ed	Vers. 12 CMI	Cost per CMI-Adj Disch.	Less Out @ 7.2%	Base Rate	Rate with Med Ed
i	b	d	e	f	g	h	i=h*(1+e)/(1+d)	j=g*.08	k	l=i/j*.K	m	n=d*5/m	o=n*0.928	p	q=p*(1+d+e)
1%	3400045	Blowing Rock Hospital		7	16	7,759	7,759	1.3	\$220.23	7,473	0.9546	1,118	\$1,038	1,394	1,394
2%	3400101	Bertie Memorial Hospital		39	144	78,831	78,831	11.5	\$280.20	75,609	1.2387	1,565	\$1,452	1,705	1,705
3%	3400054	District Memorial Hospital		69	242	123,998	123,998	19.4	\$232.03	119,497	1.0475	1,653	\$1,534	1,766	1,766
3%	3400036	Franklin Regional Medical Ctr		113	410	236,664	236,664	32.8	\$294.09	227,018	1.1421	1,759	\$1,632	1,840	1,840
4%	3400036	Beaufort County Hospital		197	752	432,342	432,342	60.2	\$379.24	409,511	1.1332	1,834	\$1,702	1,892	1,892
5%	3400044	Alleghany County Hospital		71	181	108,340	108,340	14.5	\$393.80	102,630	0.7543	1,916	\$1,778	1,949	1,949
6%	3400022	Bladen County Hospital		385	1,093	593,042	593,042	87.4	\$321.28	564,962	0.7373	1,990	\$1,847	2,001	2,001
7%	3400063	Montgomery Memorial Hospital		260	728	375,589	375,589	58.2	\$353.06	355,041	0.6786	2,012	\$1,867	2,016	2,016
8%	3400097	Hugh Chatham Memorial		143	443	246,358	246,358	35.4	\$278.73	236,491	0.8133	2,033	\$1,887	2,031	2,031
8%	3400089	Pungo District Hospital		99	325	204,911	204,911	26.0	\$397.85	194,566	0.9624	2,042	\$1,895	2,037	2,037
9%	3400124	Good Hope Hospital		75	411	194,098	194,098	32.9	\$308.88	183,936	1.1032	2,055	\$1,907	2,048	2,048
0%	3400120	Duplin General Hospital		472	1,321	676,473	676,473	105.7	\$317.95	642,866	0.6538	2,083	\$1,933	2,065	2,065
1%	3400072	Ashe Memorial Hospital		161	441	271,123	271,123	35.3	\$267.29	262,040	0.8253	2,103	\$1,951	2,079	2,079
2%	3400013	Rutherford County Hospital		658	1,729	959,388	959,388	138.3	\$310.08	916,504	0.6545	2,128	\$1,975	2,097	2,097
3%	3400035	Richmond Memorial Hospital		588	1,703	905,815	905,815	136.2	\$298.33	865,183	0.6877	2,139	\$1,985	2,104	2,104
4%	3400017	Pardee Memorial Hospital		377	1,465	788,842	788,842	117.2	\$316.66	751,729	0.9319	2,140	\$1,986	2,104	2,104
4%	3400148	Medical Park Hospital		20	90	79,974	79,974	7.2	\$321.03	77,662	1.8003	2,157	\$2,002	2,116	2,116
5%	3400132	Maria Parham Hospital		610	1,818	1,089,200	1,089,200	145.4	\$311.03	1,043,977	0.7904	2,165	\$2,009	2,122	2,122
6%	3400106	Hamlet Hospital		149	558	316,838	316,838	44.6	\$284.02	304,171	0.9394	2,173	\$2,017	2,128	2,128
7%	3400052	Davie County Hospital		37	150	85,897	85,897	12.0	\$298.13	82,320	1.0237	2,173	\$2,017	2,128	2,128
8%	3400015	Rowan Memorial Hospital		1,032	3,140	1,609,749	1,609,749	251.2	\$384.51	1,513,160	0.6685	2,193	\$2,035	2,142	2,142
9%	3400093	Pender Memorial Hospital		75	312	175,080	175,080	25.0	\$252.85	168,759	1.0205	2,205	\$2,046	2,150	2,150
9%	3400090	Johnston Memorial Hospital		662	2,183	1,107,285	1,107,285	174.6	\$288.58	1,056,899	0.7185	2,222	\$2,062	2,162	2,162
10%	3400085	Community General Hospital		593	1,914	964,121	964,121	153.1	\$264.86	923,571	0.7000	2,225	\$2,065	2,164	2,164
11%	3400122	Our Community Hospital		1	4	3,311	3,311	0.3	\$566.88	3,141	1.3904	2,259	\$2,096	2,187	2,187
12%	3400065	Chowan Hospital		476	1,442	735,490	735,490	115.4	\$329.56	697,459	0.6495	2,256	\$2,094	2,185	2,185
13%	3400003	Northern Hospital of Surry		434	1,244	755,036	755,036	99.5	\$308.49	724,342	0.7351	2,270	\$2,107	2,196	2,196
14%	3400080	Sloop Memorial Hospital		131	363	216,893	216,893	29.0	\$363.29	206,358	0.6918	2,277	\$2,113	2,200	2,200
15%	3400068	Columbus County Hospital		929	2,820	1,722,173	1,722,173	225.6	\$258.83	1,663,781	0.7833	2,286	\$2,122	2,207	2,207
15%	3400159	Person County Hospital		50	218	142,861	142,861	17.4	\$298.89	137,480	1.1969	2,297	\$2,132	2,214	2,214
16%	3400007	Annie Penn Memorial Hosp		436	1,714	833,003	833,003	137.1	\$251.09	798,579	0.7913	2,315	\$2,148	2,226	2,226
17%	3400075	Grace Hospital		742	2,387	1,239,311	1,239,311	191.0	\$364.18	1,169,752	0.6779	2,326	\$2,158	2,234	2,234
18%	3400099	Roanoke Chowan Hospital		947	3,824	1,711,259	1,711,259	305.9	\$224.25	1,642,661	0.7410	2,341	\$2,172	2,245	2,245
19%	3400020	Central Carolina Hospital		688	1,933	1,188,370	1,188,370	154.6	\$288.38	1,143,787	0.7051	2,358	\$2,188	2,256	2,256
10%	3400119	Stanly Memorial Hospital		429	1,348	859,084	859,084	107.8	\$337.52	822,700	0.8072	2,376	\$2,205	2,269	2,269
11%	3400037	Kings Mountain Hospital		60	325	149,235	149,235	26.0	\$320.18	140,911	0.9814	2,393	\$2,221	2,281	2,281
11%	3400019	Stokes Reynolds Memorial Hospi		50	256	150,340	150,340	20.5	\$285.88	144,480	1.2066	2,395	\$2,222	2,282	2,282
12%	3400098	Lexington Memorial		558	1,243	931,899	931,899	99.4	\$431.60	888,998	0.6637	2,400	\$2,227	2,286	2,286
13%	3400016	C.J. Harris Community Hospital		791	2,220	1,372,653	1,372,653	177.6	\$317.71	1,316,228	0.6895	2,413	\$2,239	2,295	2,295
14%	3400084	Anson County Hospital		101	390	256,393	256,393	31.2	\$392.21	244,156	0.9876	2,448	\$2,271	2,319	2,319
15%	3400011	Blue Ridge Hospital System		205	556	420,850	420,850	44.5	\$329.47	406,189	0.8024	2,469	\$2,292	2,334	2,334
16%	3400145	Lincoln County Hospital		679	2,049	1,221,480	1,221,480	163.9	\$361.61	1,162,212	0.6878	2,489	\$2,310	2,347	2,347
16%	3400121	Dosher Memorial Hospital		44	186	119,701	119,701	14.9	\$385.42	113,958	1.0390	2,493	\$2,313	2,350	2,350

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TN No. 05-015
Supersedes
TN No. 00-23

Approval Date December 15, 2005

Eff. Date 10/01/2005

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

Exhibit 5.1

Psych/Rehab: Excluded																
Provider Number	Provider Name	IME Factor	DME Factor	No. of Disch	No. of Days	Medicaid Cost	Cost Less Med Ed	Proj Decline in Days	Routine Daily Cost	DRG Cost Less Med Ed	Vers. 12 CMI	Cost per CMI-Adj Disch	Less Out @ 2.2%	Base Rate	Rate with Med Ed	
a	b	c	d	e	f	g	h=(g)-(f)	i=j/g	k	l/g%	m	n=(m)-c	o=(n)-p	q	r=(q)-(h)	
37%	3400071	Betsy Johnson Memorial		602	1,988	1,168,977	1,168,977	159.0	\$296.72	1,121,481	0.7436	2,505	\$2,325	2,359	2,359	
38%	3400024	Sampson County Memorial		622	2,155	1,269,002	1,269,002	172.4	\$364.93	1,206,088	0.7644	2,537	\$2,354	2,381	2,381	
39%	3400127	Granville Medical Center		286	878	616,778	616,778	70.2	\$324.06	594,029	0.8103	2,563	\$2,379	2,399	2,399	
40%	3400042	Onslow Memorial Hospital		1,046	3,496	2,198,916	2,198,916	279.7	\$364.67	2,096,918	0.7789	2,574	\$2,388	2,407	2,407	
41%	3400018	St. Lukes Hospital		15	43	37,718	37,718	3.4	\$373.05	36,450	0.9418	2,580	\$2,394	2,411	2,411	
42%	3400129	Lake Norman Regional Medical		135	524	335,844	335,844	41.9	\$297.30	323,387	0.9167	2,613	\$2,425	2,434	2,434	
42%	3400031	Swain County Hospital		36	157	119,939	119,939	12.6	\$402.13	114,872	1.2090	2,639	\$2,449	2,452	2,452	
43%	3400021	Cleveland Memorial Hospital		1,011	3,448	2,121,168	2,121,168	275.8	\$415.62	2,006,940	0.7514	2,641	\$2,451	2,454	2,454	
44%	3400111	Chatham County Hospital		21	76	60,651	60,651	6.1	\$403.47	58,190	1.0455	2,648	\$2,457	2,458	2,458	
45%	3400028	Cape Fear Valley Hospital	0.0281	0.0056	3,548	14,591	8,856,654	8,856,334	1167.3	\$251.23	8,273,073	0.8792	2,652	\$2,461	2,461	2,544
46%	3400115	Moore Regional Hospital		1,278	5,192	3,720,968	3,720,968	415.4	\$325.67	3,585,684	1.0422	2,692	\$2,498	2,461	2,461	
47%	3400025	Haywood County Hospital		477	1,585	1,026,348	1,026,348	126.8	\$343.79	982,756	0.7544	2,731	\$2,534	2,461	2,461	
47%	3400160	Murphy Medical Center		191	556	419,532	419,532	44.5	\$315.62	405,487	0.7680	2,764	\$2,565	2,461	2,461	
48%	3400060	Morehead Memorial Hospital		516	1,722	1,118,894	1,118,894	137.8	\$256.39	1,083,563	0.7535	2,787	\$2,586	2,461	2,461	
49%	3400112	Washington County Hospital		73	307	182,679	182,679	24.8	\$294.37	175,438	0.8560	2,807	\$2,605	2,461	2,461	
50%	3400051	Watauga Medical Center		399	1,117	849,393	849,393	89.4	\$360.01	817,208	0.7432	2,827	\$2,623	2,461	2,461	
51%	3400069	Wake Medical System	0.0420	0.0180	3,488	14,635	10,203,114	9,625,032	1170.8	\$379.38	9,180,854	0.9305	2,829	\$2,625	2,461	2,608
52%	3400126	Wilson Memorial Hospital		1,200	3,997	2,694,684	2,694,684	319.8	\$327.22	2,590,039	0.7617	2,834	\$2,630	2,461	2,461	
53%	3400040	Pitt County Memorial	0.2095	0.0867	3,567	17,926	16,747,298	12,741,021	1434.1	\$514.30	12,003,463	1.1857	2,838	\$2,634	3,700	3,700
53%	3400034	Alamance Memorial Hospital		668	2,265	1,606,161	1,606,161	181.2	\$367.38	1,537,968	0.7560	3,045	\$2,826	2,461	2,461	
54%	3400006	Hoots Memorial Hospital		41	127	114,222	114,222	10.2	\$506.87	109,052	0.9311	2,859	\$2,651	2,461	2,461	
55%	3400010	Wayne Memorial Hospital		1,202	4,880	2,977,427	2,977,427	390.4	\$308.52	2,856,960	0.8319	2,857	\$2,651	2,461	2,461	
56%	3400166	University Memorial Hospital		154	573	515,464	515,464	45.8	\$548.76	490,361	1.1137	2,859	\$2,653	2,461	2,461	
57%	3400131	Craven Regional Hospital		1,249	4,970	3,101,950	3,101,950	397.6	\$322.01	2,973,919	0.8316	2,863	\$2,657	2,461	2,461	
58%	3400055	Valdese General Hospital		231	836	653,764	653,764	66.9	\$373.56	628,772	0.9487	2,869	\$2,663	2,461	2,461	
58%	3400023	Park Ridge Hospital		390	1,086	735,893	735,893	86.9	\$402.12	700,949	0.6229	2,885	\$2,678	2,461	2,461	
59%	3400151	Halifax Memorial Hospital		1,348	4,719	3,040,497	3,040,497	377.5	\$335.66	2,913,785	0.7423	2,912	\$2,702	2,461	2,461	
60%	3400064	Wilkes Regional Hospital		716	2,257	1,505,742	1,505,742	180.6	\$323.51	1,447,316	0.6940	2,912	\$2,703	2,461	2,461	
61%	3400067	McDowell Hospital		272	853	619,272	619,272	68.2	\$406.83	591,526	0.7424	2,929	\$2,718	2,461	2,461	
62%	3400050	Southeastern General		1,788	7,361	4,490,982	4,490,982	588.9	\$240.70	4,349,233	0.8289	2,935	\$2,723	2,461	2,461	
63%	3400130	Union Memorial Hospital		843	2,549	1,669,333	1,669,333	203.9	\$382.33	1,591,376	0.6401	2,949	\$2,737	2,461	2,461	
64%	3400088	Transylvania Community		238	710	521,365	521,365	56.8	\$247.61	507,301	0.7094	3,005	\$2,788	2,461	2,461	
64%	3400109	Albemarle Hospital		686	2,547	1,576,499	1,576,499	203.8	\$285.43	1,518,329	0.7907	3,029	\$2,811	2,461	2,461	
65%	3400147	Nash General Hospital		1,098	4,692	3,246,142	3,246,142	375.4	\$294.64	3,135,534	0.9253	3,086	\$2,864	2,461	2,461	
66%	3400104	Crawley Memorial Hospital		2	9	4,667	4,667	0.7	\$274.48	4,475	0.7214	3,101	\$2,878	2,461	2,461	
67%	3400027	Lenoir Memorial Hospital		1,191	4,912	3,063,743	3,063,743	393.0	\$336.00	2,931,695	0.7944	3,099	\$2,875	2,461	2,461	
68%	3400053	Presbyterian Health Services Co		513	2,341	1,966,394	1,966,394	187.3	\$497.97	1,873,124	1.1734	3,112	\$2,888	2,461	2,461	
69%	3400039	Iredell Memorial Hospital		692	2,379	1,814,368	1,814,368	190.3	\$440.73	1,730,497	0.8006	3,124	\$2,899	2,461	2,461	
69%	3400158	Brunswick County Hospital		264	899	636,064	636,064	71.9	\$381.46	608,637	0.7371	3,128	\$2,903	2,461	2,461	
70%	3400041	Caldwell Memorial Hospital		602	1,762	1,391,438	1,391,438	141.0	\$377.11	1,338,265	0.7086	3,137	\$2,911	2,461	2,461	
71%	3400047	N. C. Baptist Hospital	0.3293	0.0829	1,805	13,833	15,594,040	10,832,847	1106.6	\$383.25	10,408,743	1.8307	3,150	\$2,923	2,461	3,475
72%	3400014	Forsyth Memorial Hospital	0.0324	0.0077	3,090	13,003	9,164,320	8,909,053	1040.2	\$336.52	8,459,005	0.8674	3,156	\$2,929	2,461	2,550
73%	3400004	High Point Regional Hospital		1,469	5,518	3,955,418	3,955,418	441.4	\$360.66	3,796,223	0.8010	3,226	\$2,994	2,461	2,461	
74%	3400143	Catawba Memorial Hospital		976	2,751	2,467,864	2,467,864	220.1	\$445.53	2,369,803	0.7472	3,250	\$3,016	2,461	2,461	
75%	3400009	Presbyterian Specialty Hosp		2	5	6,368	6,368	0.4	\$683.72	6,095	0.9355	3,258	\$3,023	2,461	2,461	
75%	3400146	Highland-Cashiers Hospital		4	17	18,976	18,976	1.4	\$876.96	17,748	1.3550	3,275	\$3,039	2,461	2,461	
76%	3400032	Gaston Memorial Hospital		1,633	5,976	4,285,104	4,285,104	478.1	\$361.84	4,112,108	0.7623	3,303	\$3,066	2,461	2,461	

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Psych/Rehab: Excluded															
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a	b	c	d	e	f	g	h=(1+e)(f+g)	i=j/g	k	l=j/k	m	n=k/m	o=(10.000) p	q	r=p*(1+q)
77% 3400012	Angol Community Hospital			88	409	280,544	280,544	32.7	\$374.37	268,302	0.9214	3,309	\$3,071	2,461	2,461
78% 3400142	Carteret General Hospital			562	2,179	1,563,094	1,563,094	174.3	\$287.98	1,512,899	0.8123	3,314	\$3,076	2,461	2,461
79% 3400005	C.A. Cannon Memorial Hospital			104	443	342,397	342,397	35.4	\$292.96	332,027	0.9601	3,325	\$3,086	2,461	2,461
80% 3400105	St. Joseph's Hospital	0.0081	0.0031	278	1,641	1,628,452	1,610,322	131.3	\$404.82	1,557,169	1.6502	3,394	\$3,150	2,461	2,489
81% 3400141	New Hanover Memorial Hospital	0.0609	0.0113	2,422	9,810	8,279,062	7,716,713	784.8	\$374.43	7,422,860	0.9024	3,396	\$3,152	2,461	2,639
81% 3400034	Alamance County Hospital			668	2,265	1,608,161	1,608,161	181.2	\$362.29	1,542,514	0.7560	3,054	\$2,834	2,461	2,461
82% 3400164	Highsmith-Rainey Hospital			191	1,216	1,030,803	1,030,803	97.3	\$436.46	988,336	1.5023	3,444	\$3,196	2,461	2,461
83% 3400116	Frye Regional Medical Center			312	1,439	1,416,275	1,416,275	115.1	\$356.62	1,375,205	1.2716	3,466	\$3,217	2,461	2,461
84% 3400114	Flex Hospital			172	897	775,302	775,302	71.8	\$386.92	752,957	1.2600	3,474	\$3,224	2,461	2,461
85% 3400030	Duke Univ. Medical Center	0.3681	0.0512	3,233	21,462	23,673,724	16,461,360	1717.0	\$442.73	15,701,193	1.3967	3,477	\$3,227	2,461	3,493
86% 3400144	Davis Hospital			536	1,537	1,272,845	1,272,845	123.0	\$390.56	1,224,606	0.6564	3,481	\$3,231	2,461	2,461
86% 3400155	Durham Regional Hospital	0.0483	0.0100	1,061	4,811	3,884,115	3,666,490	384.9	\$389.10	3,518,725	0.9502	3,490	\$3,239	2,461	2,604
87% 3400098	Mercy Hospital			353	1,651	1,551,913	1,551,913	132.1	\$438.08	1,494,042	1.2124	3,491	\$3,239	2,461	2,461
88% 3400091	Moses Cone Memorial	0.0357	0.0183	2,756	12,919	10,316,488	9,781,331	1033.5	\$427.89	9,339,106	0.9707	3,491	\$3,240	2,461	2,594
89% 3400002	Memorial Mission Hospital	0.0466	0.0070	2,436	11,025	9,765,507	9,265,817	882.0	\$458.71	8,861,234	1.0322	3,524	\$3,271	2,461	2,593
90% 3400107	Heritage Hospital			892	3,589	2,391,991	2,391,991	267.1	\$359.61	2,298,747	0.7270	3,524	\$3,271	2,461	2,461
91% 3400006	Scotland Health Group			950	4,785	2,780,168	2,780,168	382.8	\$371.72	2,637,674	0.7769	3,574	\$3,317	2,461	2,461
92% 3400162	Community Hospital-Rocky Mour			66	490	392,420	392,420	39.2	\$327.61	379,578	1.6028	3,588	\$3,330	2,461	2,461
92% 3400123	Randolph Hospital			384	992	966,715	966,715	79.4	\$414.60	933,795	0.6764	3,595	\$3,336	2,461	2,461
93% 3400067	Alexander County Hospital			42	133	158,460	158,460	10.6	\$460.69	153,577	1.0169	3,596	\$3,337	2,461	2,461
94% 3400125	Wesley Long Community			162	671	555,978	555,978	53.7	\$421.52	533,342	0.9121	3,610	\$3,350	2,461	2,461
95% 3400061	UNC Hospital	0.3813	0.0882	3,391	21,779	27,761,047	18,469,070	1742.3	\$503.30	17,592,170	1.4260	3,638	\$3,376	2,461	4,535
96% 3400094	Cape Fear Memorial			132	543	523,075	523,075	42.4	\$401.95	505,831	1.0402	3,683	\$3,417	2,461	2,461
97% 3400153	Orthopedic Hospital			29	163	259,185	259,185	13.0	\$425.65	253,652	2.3051	3,794	\$3,521	2,461	2,461
97% 3400113	Carolinas Medical	0.1420	0.0481	4,932	25,978	25,313,766	21,149,772	2078.2	\$408.59	20,300,640	1.0820	3,804	\$3,530	2,461	2,929
98% 3400001	Cabarrus Memorial Hospital			1,036	3,565	3,415,370	3,415,370	285.2	\$351.84	3,315,025	0.8334	3,840	\$3,563	2,461	2,461
99% 3400073	Raleigh Community Hospital			119	599	630,422	630,422	47.9	\$536.17	604,740	1.2596	4,034	\$3,744	2,461	2,461
100% 3400133	Martin General Hospital			163	641	567,625	567,625	51.3	\$417.09	546,228	0.7958	4,211	\$3,908	2,461	2,461
9999999	Out-of-State													2,461	2,461

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

108A-55. Payments.

(a) The Department may authorize, within appropriations made for this purpose, payments of all or part of the cost of medical and other remedial care for any eligible person when it is essential to the health and welfare of such person that such care be provided, and when the total resources of such person are not sufficient to provide the necessary care. When determining whether a person has sufficient resources to provide necessary medical care, there shall be excluded from consideration the person's primary place of residence and the land on which it is situated, and in addition there shall be excluded real property contiguous with the person's primary place of residence in which the property tax value is less than twelve thousand dollars (\$12,000).

(b) Payments shall be made only to intermediate care facilities, hospitals and nursing homes licensed and approved under the laws of the State of North Carolina or under the laws of another state, or to pharmacies, physicians, dentists, optometrists or other providers of health-related services authorized by the Department. Payments may also be made to such fiscal intermediaries and to the capitation or prepaid health service contractors as may be authorized by the Department. Arrangements under which payments are made to capitation or prepaid health services contracts are not subject to the provisions of Chapter 58 of the General Statutes or of Article 3 of Chapter 143 of the General Statutes.

(c) The Department shall reimburse providers of services, equipment, or supplies under the Medical Assistance Program in the following amounts:

- (1) The amount approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, if that Administration approves an exact reimbursement amount;
- (2) The amount determined by application of a method approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, if that Administration approves the method by which a reimbursement amount is determined, and not the exact amount.

The Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes. A change in a reimbursement amount becomes effective as of the date for which the change is approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(d) No payments shall be made for the care of any person in a nursing home or intermediate care home which is owned or operated in whole or in part by a member of the Social Services Commission, of any county board of social services, or of any board of county commissioners, or by an official or employee of the Department or of any county department of social services or by a spouse of any such persons. (1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1971, c. 435; 1973, c. 476, s. 138, c. 644; 1975, c. 123; ss. 1, 2; 1977, 2ND Sess., c. 1219, c. 25; 1979, c. 702, s. 7; 1981, c. 275, s. 1; c. 849, s. 2; 1991, c. 388, s. 1; 1993, c. 529, s. 7.3)

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

10A NCAC 21B .0406 DEDUCTIBLE

(a) Deductible shall apply to a client in the following arrangements:

- (1) In the community, in private living quarters; or
- (2) In a residential group facility; or
- (3) In a long term care living arrangement when the client:
 - (A) Has enough income monthly to pay the Medicaid reimbursement rate for 31 days, but does not have enough income to pay the private rate plus all other anticipated medical costs; or
 - (B) Is under a sanction due to a transfer of resources as specified in Rule .0311 of this Subchapter; or
 - (C) Does not yet have documented prior approval for Medicaid payment of nursing home care; or
 - (D) Resided in a newly certified facility in the facility's month of certification; or
 - (E) Chooses to remain in a decertified facility beyond the last date of Medicaid payment; or
 - (F) Is under a Veterans Administration (VA) contract for payment of cost of care in the nursing home.

(b) The client or his representative shall be responsible for providing bills, receipts, insurance benefit statements or Medicare EOB to establish incurred medical expenses and his responsibility for payment. If the client has no representative and he is physically or mentally incapable of accepting this responsibility, the county shall assist him.

(c) Expenses shall be applied to the deductible when they meet the following criteria:

- (1) The expenses are for medical care or service recognized under state or federal tax law;
- (2) The are incurred by a budget unit member;
- (3) They are incurred:
 - (A) During the certification period for which eligibility is being determined and the requirements of Paragraph (d) of this Rule are met; or
 - (B) Prior to the certification period and the requirements of Paragraph (e) of this Rule are met.

(d) Medical expenses incurred during the certification period shall be applied to the deductible if the requirements in Paragraph (c) of this Rule are met and:

- (1) The expenses are not subject to payment by any third party including insurance, government agency or program except when such program is entirely funded by state or local government funds, or private source; or
- (2) The private insurance has not paid such expenses by the end of the application time standard; or
- (3) For certified cases, the insurance has not paid by the time that incurred expenses equal the deductible amount; or
- (4) The third party has paid and the client is responsible for a portion of the charges.

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

10A NCAC 21B .0406 DEDUCTIBLE (continued)

(e) The unpaid balance of a Medical expense incurred prior to the certification period shall be applied to the deductible if the requirements in Paragraph (c) of this Rule are met and:

- (1) The medical expense was:
 - (A) Incurred within 24 months immediately prior to:
 - (i) The month of application for prospective or retroactive certification period or both; or
 - (ii) The first month of any subsequent certification period; or
 - (B) Incurred prior to the period described in Subparagraph (e)(1)(A) of this Rule; and a payment was made on the bill during that period; and
- (2) The medical expense:
 - (A) Is a current liability;
 - (B) Has not been applied to a previously met deductible; and
 - (C) Insurance has paid any amount of the expense covered by the insurance.

(f) Incurred medical expenses shall be applied to the deductible in chronological order of charges except that:

- (1) If medical expenses for Medicaid covered services and non-covered services occur on the same date, apply charges for non-covered services first; and
- (2) If both hospital and other covered medical services are incurred on the same date, apply hospital charges first; and
- (3) If a portion of charges is still owed after insurance payment has been made for lump sum charges, compute incurred daily expense to be applied to the deductible as follows:
 - (A) Determine average daily charge excluding discharge date from hospitals; and
 - (B) Determine average daily insurance payment for the same number of days; and
 - (C) Subtract average daily insurance payment from the average daily charge to establish client's daily responsibility.

(g) Eligibility shall begin on the day that incurred medical expenses reduce the deductible to \$0, except that the client is financially liable for the portion of medical expenses incurred on the first day of eligibility that were applied to reduce the deductible to \$0. If hospital charges were incurred on the first day of eligibility, notice of the amount of those charges applied to meet the deductible shall be sent to the hospital for deduction on the hospital's bill to Medicaid.

(h) The receipt of proof of medical expenses and other verification shall be documented in the case record.

History Note: Authority G.S. 108A-54; 42 C.F.R. 435.732; 42 C.F.R. 435.831; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File Number C-C-74-483; Alexander v. Flaherty Consent Order filed February 14, 1992; Eff. September 1, 1984; Amended Eff. June 1, 1994; September 1, 1993; April 1, 1993; August 1, 1990.

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

10A NCAC 21B .0407 PATIENT LIABILITY

(a) Patient liability shall apply to clients who live in facilities for skilled nursing, intermediate nursing, intermediate nursing for mental retardation or other medical institutions.

(b) The client's patient liability for cost of care shall be computed as a monthly amount after deducting the following from his total income:

- (1) An amount for his personal needs as established under Rule .0313 of this Subchapter;
- (2) Income given to the community spouse to provide him a total monthly income from all sources, equal to the "minimum monthly maintenance needs allowance" as defined in 42 U.S.C. 1396r-5(d)(3)(A)(i);
- (3) Income given to family members described in 42 U.S.C. 1396r-5(d)(1), to provide each, from all sources of income, a total monthly income equal to:
 - (A) One-third of the amount established under 42 U.S.C. 1396r-5(d)(3)(A)(i); or
 - (B) Where there is no community spouse, an amount for the number of dependents, based on the income level for the corresponding budget unit number, as approved by the NC General Assembly and stated in the Appropriations Act for categorically and medically needy classifications;
- (4) The income maintenance level provided by statute for a single individual in a private living arrangement with no spouse or dependents at home, for whom the physician of record has provided a written statement that the required treatment is such that the patient is expected to return home within six months, shall be allowed;
- (5) An amount for unmet medical needs as determined under Paragraph (f) of this Rule.

(c) Patient liability shall apply to institutional charges incurred from the date of admission or the first day of the month as appropriate and shall not be prorated by days if the client lives in more than one institution during the month.

(d) The county department of social services shall notify the client, the institution and the state of the amount of the monthly liability and any changes or adjustments.

(e) When the patient liability as calculated in Paragraph (b) of this Rule exceeds the Medicaid reimbursement rate for the institution for a 31 day month:

- (1) The patient liability shall be the institution's Medicaid reimbursement rate for a 31 day month;
- (2) The client shall be placed on a deductible determined in accordance with Federal regulations and Rules .0404, .0405 and .0406 of this Subchapter.

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

10A NCAC 21B .0407 PATIENT LIABILITY (continued)

(f) The amount deducted from income for unmet medical needs shall be determined as follows:

- (1) Unmet medical needs shall be the costs of:
 - (A) Medical care covered by the program but that exceeds limits on coverage of that care and that is not subject to payment by a third party;
 - (B) Medical care recognized under State and Federal tax law that is not covered by the program and that is not subject to payment by a third party; and
 - (C) Medicare and other health insurance premiums, deductibles, or coinsurance charges that are not subject to payment by a third party.
- (2) The amount of unmet medical needs deducted from the patient's monthly income shall be limited to monthly charges for Medicare and other health insurance premiums.
- (3) The actual amount of incurred costs which are the patient's responsibility shall be deducted when reported from the patient's liability for one or more months.
- (4) Incurred costs shall be reported by the end of the six month Medicaid certification period following the certification period in which they were incurred.

History Note: Authority G.S. 108A-54; 42 C.F.R. 435.732; 42 C.F.R. 435.733; 42 C.F.R. 435.831; 42 C.F.R. 435.832; 42 U.S.C. 1396r-5; Eff. September 1, 1984; Amended Eff. September 1, 1994; March 1, 1991; August 1, 1990; March 1, 1990.

State Plan under Title XIX of the Social Security Act
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State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

10A NCAC 22J .0101 PURPOSE AND SCOPE

The purpose of these regulations is to specify the rights of providers to appeal reimbursement rates, payment denials, disallowances, payment adjustments and cost settlement disallowances and adjustments. Provider appeals for program integrity action are specified in 10A NCAC 22F.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 U.S.C. 1396(b);
Eff. January 1, 1988.

10A NCAC 22J .0102 PETITION FOR RECONSIDERATION REVIEW

(a) A provider may request a reconsideration review within 30 calendar days from receipt of final notification of payment, payment denial, disallowances, payment adjustment, notice of program reimbursement and adjustments and within 60 calendar days from receipt of notice of an institutional reimbursement rate. Final notification of payment, payment denial, disallowances and payment adjustment means that all administrative actions necessary to have a claim paid correctly have been taken by the provider and DMA or the fiscal agent has issued a final adjudication. If no request is received within the respective 30 or 60 day periods, the state agency's action shall become final.

(b) A request for reconsideration review must be in writing and signed by the provider and contain the provider's name, address and telephone number. It must state the specific dissatisfaction with DMA's action and should be mailed to: Appeals, Division of Medical Assistance at the Division's current address.

(c) The provider may appoint another individual to represent him. A written statement setting forth the name, address and telephone number of the representative so designated shall be sent to the above address. The representative may exercise any and all rights given the provider in the review process. Notice of meeting dates, requests for information, hearing decisions, etc. will be sent to the authorized representative. Copies of such documents will be sent to the petitioner only if a written request is made.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 U.S.C. 1396(b);
Eff. January 1, 1988.

State Plan under Title XIX of the Social Security Act
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State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

10A NCAC 22J .0103 RECONSIDERATION REVIEW PROCESS

- (a) Upon receipt of a timely request for a reconsideration review, the Deputy Director shall appoint a reviewer or panel to conduct the review. DMA will arrange with the provider a time and date of the hearing. The provider must reduce his arguments to writing and submit them to DMA no later than 14 calendar days prior to the review. Failure to submit written arguments within this time frame shall be grounds for dismissal of the reconsideration, unless the Division within the 14 calendar day period agrees to a delay.
- (b) The provider will be entitled to a personal review meeting unless the provider agrees to a review of documents only or a discussion by telephone.
- (c) Following the review, DMA shall, within 30 calendar days or such additional time thereafter as specified in writing during the 30 day period, render a decision in writing and send it by certified mail to the provider or his representative.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 U.S.C. 1396(b);
Eff. January 1, 1988.

10A NCAC 22J .0104 PETITION FOR A CONTESTED CASE HEARING

If the provider disagrees with the reconsideration review decision he may request a contested case hearing in accordance with 10A NCAC 01.

History Note: Authority G.S. 108A-25(b); 108A-54; 150B-11; 42 U.S.C. 1396(b);
Eff. January 1, 1988.

State Plan under Title XIX of the Social Security Act
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State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

10A NCAC 22B .0104 TIME LIMITATION

(a) To receive payment, claims must be filed either:

- (1) Within 365 days of the date of service for services other than inpatient hospital, home health or nursing home services; or
- (2) Within 365 days of the date of discharge for inpatient hospital services and the last date of service in the month for home health and nursing home services not to exceed the limitations as specified in 42 C.F.R. 447.45; or
- (3) Within 180 days of the Medicare or other third party payment, or within 180 days of final denial, when the date of the third party payment or denial exceeds the filing limits in Subparagraphs (1) or (2) of this Rule, if it can be shown that:
 - (A) A claim was filed with a prospective third-party payor within the filing limits in Subparagraph (1) or (2) of this Rule; and
 - (B) There was a possibility of receiving payment from the third party payor with whom the claim was filed; and
 - (C) Bona fide and timely efforts were pursued to achieve either payment or final denial of the third-party claim.

(b) Providers must file requests for payment adjustments or requests for reconsideration of a denied claim no later than 18 months after the date of payment or denial of a claim.

(c) The time limitation specified in Paragraph (a) of this Rule may be waived by the Division of Medical Assistance when a correction of an administrative error in determining eligibility, application of court order or hearing decision grants eligibility with less than 60 days for providers to submit claims for eligible dates of service, provided the claim is received for processing within 180 days after the date the county department of social services approves the eligibility.

(d) In cases where claims or adjustments were not filed within the time limitations specified in Paragraphs (a) and (b) of this Rule, and the provider shows failure to do so was beyond his control, he may request a reconsideration review by the Director of the Division of Medical Assistance. The Director of Medical Assistance is the final authority for reconsideration reviews. If the provider wishes to contest this decision, he may do so by filing a petition for a contested case hearing in conformance with G.S. 150B-23.

*History Note: Authority G.S. 108A-25(b); 42 C.F.R. 447.45;
Eff. February 1, 1976;
Amended Eff. October 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. June 1, 1993; June 1, 1988; November 1, 1986; July 1, 1985.*

State Plan under Title XIX of the Social Security Act
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Payments for Medical and Remedial Care and Services: Inpatient Hospital

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN. No. 05-015
Supersedes
TN. No. New

Approval Date December 15, 2005

Eff. Date 10/01/2005

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

INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 21 YEARS OF AGE

The Division of Medical Assistance will negotiate prospective facility rates with private and public providers of psychiatric residential treatment facility services. Said negotiated prospective rates shall be based on reasonable cost. Reasonable costs are determined by the Division of Medical Assistance based upon the standards set in the HCFA-15 Provider Reimbursement Manual.

The per diem rates shall be adjusted annually for inflation. Rates shall be updated annually by the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning and Management.

TN. No. 05-015
Supersedes
TN. No. New

Approval Date December 15, 2005

Eff. Date 10/01/2005

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

State: North Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Effective January 1, 2011, Medicaid will make zero payment to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HCAC). Reimbursement for conditions described above is defined in Attachment 4.19A, Page 8a of this State Plan.

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

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19b

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

TN No. 11-001
Supersedes
TN No. NEW

Approval Date: Jan. 17, 2012

Eff. Date 01/01/2011

State Plan Under Title XIX of the Social Security Act
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 X Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied.

TN No. 11-001
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Eff. Date 01/01/2011

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

Payment for Medical and Remedial Care and Services: Inpatient Hospital

Payment for Swing Beds and Lower Level Beds:

FY 2005 and 2006 – No rate increase from the June 30, 2005 rate for all Medicaid private and public providers with the following exceptions: federally qualified health clinics, rural health centers, state institutions, outpatient hospital, pharmacy and the non-inflationary components of the case-mix reimbursement system for nursing facilities.

NC General Assembly legislation mandates that effective July 1, 2005, reimbursement rates for these programs (Head Injury and Ventilator Nursing Beds) for the state fiscal years 2005-2006 and 2006-2007 will remain at the rate in effect as of June 30, 2005, except rates may be adjusted downward.

FY 2008-2009 – No Adjustment for Head and Vent Beds

FY 2009-2010 – The rates for SFY2010 are frozen as of the rates in effect July 1, 2009. Effective October 1, 2009, an overall rate reduction adjustment of 5.65% (annualized over 9 months) for Swing and Lower Level beds.

FY 2010-2011 – As of July 1, 2010, rates will be frozen as in effect June 30, 2010.

SFY 2012 – Rates will be frozen at the rate in effect on June 30, 2011. Effective October 1, 2011, existing rates are adjusted by a negative 2.67% to yield a twelve (12) month two percent (2%) budget reduction in the nine (9) remaining months of this State Fiscal Year.

SFY 2013 – Effective July 1, 2012, the rates will be adjusted such that they will equal 98% of the rate in effect July 1, 2011. There will be no further annual adjustments this state fiscal year

SFY 2014 – Effective August 1, 2013, rates will be frozen at the rates in effect June 30, 2013. There will be no further annual adjustment.

SFY 2015 – Effective July 1, 2014, rates will be frozen at the rate in effect June 30, 2014. There will be no further annual adjustments this state fiscal year.

Reference: Attachment 4.19-A, Page 25

TN. No. 13-032
Supersedes
TN. No. 11-038

Approval Date: 12/20/13

Eff. Date: 08/01/13

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

Payment for Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age:

SFY 2010 – The rates for SFY 2010 are frozen as of the rates in effect at July 1, 2009. Effective October 1, 2009, an overall program reduction of 4.29% was applied. There will be no further annual adjustment.

SFY 2011 – The rates for SFY 2011 are frozen as of the rates in effect at July 1, 2010. There will be no further annual adjustment.

SFY 2012 – Effective July 1, 2011, rates will be frozen at the rate in effect on June 30, 2011. Effective November 1, 2011, existing rates are adjusted by a negative 2.67% to yield a twelve (12) month two percent (2%) reduction in the nine (9) remaining months of this State Fiscal Year.

SFY 2013 – Effective July 1, 2012, the rates will be adjusted such that they will equal 98% of the rate in effect July 1, 2011. There will be no further annual adjustments this state fiscal year.

SFY 2014 – Effective August 1, 2013, the rates will be frozen at the rates in effect on June 30, 2013. There will be no further annual adjustment.

SFY 2015 – Effective July 1, 2014, rates will be frozen at the rate in effect on June 30, 2014. There will be no further annual adjustments this state fiscal year.

Reference: Attachment 4.19-A: Page 44

TN. No. 13-014
Supersedes
TN. No. 11-015

Approval Date: Dec 05 2013

Eff. Date: 8/1/2013

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

State: NORTH CAROLINA

Inpatient Hospital:

SFY 2012 – Rates will be frozen at the rate in effect on June 30, 2011. Effective October 1, 2011, existing hospital rates are adjusted by a negative 9.80%, and non-state-owned freestanding psychiatric and rehabilitation hospitals existing rates are adjusted by a negative 2.67%.

SFY 2013 – Effective July 1, 2012, the hospital rates will be adjusted such that they will equal 92.68% of the rate in effect on June 30, 2011, and non-state-owned freestanding psychiatric and rehabilitation hospitals rates will be adjusted such that they will equal 98% of the rate in effect on June 30, 2011. There will be no further annual adjustments this state fiscal year.

SFY 2014 – Base DRG rates, Base Psychiatric per diem rates, and Base Rehabilitative per diem rates will be frozen at the rate in effect on June 30, 2013. Effective January 1, 2014, the hospital base rates will be adjusted such that they will equal 97% of the rate in effect on June 30, 2013. There will be no further annual adjustments this state fiscal year.

SFY 2016 – Effective July 1, 2015, the rates are frozen at the rate in effect as of June 30, 2015. There will be no further annual adjustments this state fiscal year.

Reference: Attachment 4.19-A, Page 4

TN. No. 14-046
Supersedes
TN. No. 14-013

Approval Date: 05-26-15

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State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Hospital Acquired Condition (HAC) Never Events (NE) / Present on Admission (POA)

For dates of service January 1, 2011 and after, for all Medicaid patients, requests for Diagnosis Related Groups (DRGs) attributable to Medicare identified hospital acquired conditions and never events will not be approved by the Peer Review Organization (PRO) and are not reimbursable. PRO review for present on admission is not required. This policy applies to all Medicaid reimbursement provisions, contained in Attachment 4.19-A, including Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments and complies with Medicare Billing Guidelines for Hospital Acquired Conditions, Never Events and Present on Admission.

TN. No. 11-001
Supersedes
TN. No. NEW

Approval Date: Jan. 17, 2012

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