North Carolina Department of Health and Human Services

Pat McCrory
Governor

Richard O. Brajer
Secretary

March 21, 2016

Jackie Glaze
Associate Regional Administrator
Division of Medicaid
Centers for Medicare and Medicaid Services
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2016-002

Dear Ms. Glaze.

Please find attached amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Attachment 4.19-B, Section 9, Pages 1.2, 1.4, and 1.5.

The state plan change will implement Session Law 2015 – 241, Section 12H.30(a) which was amended with new Section 89. S.L. 2015-264 for the purpose of including a reimbursement methodology to cost settle covered laboratory services rendered by Local Health Departments to Medicaid recipients, not to exceed the Medicare Laboratory Fee Schedule.

This amendment is effective July 1, 2016.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact Teresa Smith or me at 919-855-4116.

Sincerely,

Richard O. Brajer
Secretary

ROB:tjs

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

Notwithstanding Attachment 4.19-B, Section 3, Page 1, Local Health Departments shall be reimbursed their allowable Medicaid costs for covered Laboratory services furnished to Medicaid recipients, not to exceed the Medicare Laboratory Fee Schedule rates. Allowable Medicaid costs for covered laboratory services shall be determined using the CMS approved cost report identified in this Section.

A. Direct Medical Services Payment Methodology:

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

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

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

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

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

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

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

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

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

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

B. Certification of Expenditures:

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

C. Annual Cost Report Process:

For Medicaid covered services each health department shall file an annual cost report as directed by the Division of Medical Assistance in accordance with 42 CFR 413 Subpart B and 42 CFR 447.202. The Medicaid cost report is due eight (8) months after the provider's fiscal year end. Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by the Division of Medical Assistance or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Division, may be subject to withhold penalties for non-compliance. A 20 percent withhold of Medicaid payments will be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to the Division of Medical Assistance and has received a written approval from the Division of Medical Assistance. The withholding of monies will continue until the Medicaid cost report filing requirements have been satisfied. Once, all requirements have been satisfied withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

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The primary purposes of the governmental cost report are to:

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

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

D. The Cost Reconciliation Process:

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

E. The Cost Settlement Process:

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

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