NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

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

September 14, 2022

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2022-0022

Dear Mr. Scott:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected page is Attachment 4.19-B Section 2, Page 2k.

The State Plan Amendment requests authority for an amendment to revise the FQHC Cost Based Alternate Payment Methodology (APM) for State Fiscal Year 2022-2023 dates of service. The current Cost Based APM reconciles interim payments received to the greater of the provider specific Prospective Payment System APM rate or 100% of the provider's Medicaid allowable cost. This amendment will allow reconciliation of interim payments received to the greater of the provider specific Prospective Payment System APM rate or 113% of the provider's Medicaid allowable cost. This temporary reimbursement revision is intended to support FQHC's financial viability in the face of increased costs not captured in standard costs reports and to strengthen North Carolina's array of safety net medical care providers.

This amendment is effective on July 1, 2022.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Cecilia Williams at (919) 270-2530.

Sincerely,

DocuSigned by:
Dave Richard
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Dave Richard
Deputy Secretary

Enclosures

(B) Interim payments to FQHCs are based on the Medicaid Fee Schedule which consists of their provider specific Core Service Rate (T1015) identified in subparagraph (10) and the NC FQHC Physician Service Fee Schedule for all other ambulatory services.

(C) For dates of services between July 1, 2022 and June 30, 2023, services furnished by a federally qualified health center (FQHC) are reimbursed at one hundred thirteen percent (113%) of reasonable allowable cost, as determined in an annual cost report, based on Medicare principles and methods. For all other dates of service, services furnished by a FQHC are reimbursed at one hundred percent (100%) of reasonable allowable cost.

(1) Nutrition services are provided by RHC's and FQHC's. Providers are reimbursed in accordance with reimbursement methodologies established for services provided by RHC's and FQHC's as based on Medicare principles.

(2) Effective October 1, 1993, physician-provided services at a hospital inpatient and an outpatient location are paid at the existing fee-for-service rate only to those clinics whose agreement with their physician states that the clinic does not compensate the physician for services in a location other than at the federally qualified health clinic location.

(D) FQHC Providers reimbursed under this methodology shall file annual Medicaid cost reports as directed by the Division of Health Benefits in accordance with 42 CFR 413, Subpart b and 42 CFR 447.202. The cost report is due five (5) months after the provider's fiscal year end. The Division of Health Benefits will have 120 days after the receipt of the cost report to issue a tentative settlement of 75% of the balance due to the FQHC provider with a final settlement to be issued within eighteen (18) months of the date the full cost report is received.

(E) Cost Report Settlement Process:

(1) The Division annually reconciles the interim payments made to FQHCs to the provider's allowable reimbursement which is the greater of the provider's applicable percentage of Medicaid allowable cost described in subparagraph (5)(C) or what the provider would have received under their APM PPS rate determined in subparagraph (5)(A).

(2) If the provider's allowable reimbursement exceeds interim payments received, the Division will pay the difference to the provider. If the interim payments received by the provider exceed the provider's allowable reimbursement the provider shall remit the difference and the federal share will be returned via the CMS-64 report.