HOUSE BILL 383

Short Title:	Medicaid Modernized Hospital Assessments.	(Public)
Sponsors:	Representatives Lambeth, White, and Sasser (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Finance, if favorable, Rules, Calendar, and Operations of the House	

March 25, 2021

A BILL TO BE ENTITLED

AN ACT TO REVISE THE HOSPITAL ASSESSMENT ACT TO ACCOUNT FOR MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1. Effective July 1, 2020, the following portions of S.L. 2020-88 are repealed: subsections (b), (b1), (c), and (d) of Section 15.1, Section 15.2, and Section 15.3.

SECTION 2. Effective July 1, 2021, Chapter 108A of the General Statutes is amended by adding a new Article to read:

"Article 7B.

"Hospital Assessment Act.

"Part 1. General.

"**§ 108A-145.1. Short title and purpose.**

This Article shall be known as the "Hospital Assessment Act." This Article does not authorize a political subdivision of the State to license a hospital for revenue or impose a tax or assessment on a hospital.

"**§ 108A-145.3. Definitions.**

The following definitions apply in this Article:

(1) Acute care hospital. – A hospital licensed in North Carolina that is not a freestanding psychiatric hospital, a freestanding rehabilitation hospital, a long-term care hospital, or a State-owned and State-operated hospital.

(2) Base capitation rate. – A periodic per-enrollee or per-event amount paid by the Department to prepaid health plans for the delivery of Medicaid and NC Health Choice services in accordance with Article 4 of Chapter 108D of the General Statutes applicable to a particular rating group and appearing in a Medicaid managed care capitation rate certification, as adjusted by the Department and allowed by CMS in accordance with Part 438 of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations.

(3) Capitated contract plan type. – Any type of capitated prepaid health plan contract defined in G.S. 108D-1.

(4) CMS. – Centers for Medicare and Medicaid Services.

(5) Critical access hospital. – As defined in 42 C.F.R. § 400.202.

(6) Federal medical assistance percentage (FMAP). – The federal share of North Carolina Medicaid service costs as calculated by the federal Department of Health and Human Services in accordance with Section 1905(b) of the Social

Security Act, in effect at the start of the applicable assessment quarter, expressed as a decimal.

(7) Hospital costs. – A hospital's costs as calculated using the most recent available Hospital Cost Report Information System's cost report data available through CMS, including both inpatient and outpatient components.

(8) Inpatient hospital financing percentage. – For the 2021-2022 State fiscal year, the inpatient hospital financing percentage is sixty-six and one-tenth percent (66.1%), expressed as a decimal. For each subsequent State fiscal year, the inpatient hospital financing percentage is the sum of the inpatient hospital financing percentage for the previous State fiscal year plus the market basket percentage, divided by the sum of one plus the market basket percentage.

(9) Inpatient hospital services. – As defined in the Medicaid State Plan, excluding payments made under the graduate medical education methodology and the disproportionate share hospital methodology.

(10) Inpatient portion of the statewide capitation rate. – The amount of the statewide capitation rate applicable to a particular rating group that is attributed to inpatient hospital facility health services in the applicable Medicaid managed care rate certification, expressed as a statewide weighted average of all PHP regions.

(11) Market basket percentage. – The hospital inpatient prospective payment system market basket minus the multifactor productivity adjustment established in rule by CMS and in effect on March 1 of the previous State fiscal year, expressed as a decimal.

(12) Medicaid managed care capitation rate certification. – A rate certification for any capitated contract plan type that contains the rates paid to prepaid health plans and that has been submitted to CMS under 42 C.F.R. § 438.7 and, except as otherwise provided in this subdivision, (i) has been approved by CMS and (ii) is in effect during the applicable time period. If, on the first day of any assessment quarter, CMS has not approved a rate certification for a particular capitated contract plan type for that quarter, then the Medicaid managed care capitation rate certification for that capitated contract plan type is the rate certification submitted to CMS under 42 C.F.R. § 438.7 applicable to that quarter.

(13) Outpatient hospital financing percentage. – Twenty-eight percent (28%), expressed as a decimal.

(14) Outpatient hospital services. – As defined in the Medicaid State Plan.

(15) Outpatient portion of the statewide capitation rate. – The amount of the statewide capitation rate applicable to a particular rating group that is attributed to outpatient hospital facility services and emergency room facility services in the applicable Medicaid managed care capitation rate certifications, expressed as a statewide weighted average of all PHP regions.

(16) Paid capitation. – The total amount of the capitation payments made by the Department to all prepaid health plans for a particular rating group (i) attributable to the base capitation rate in the applicable Medicaid managed care capitation rate certification and (ii) adjusted by the Department as a result of retroactively implementing any base capitation rate adjustment that is approved by CMS or allowed under Part 438 of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations.

(17) Previous data collection period. – The period beginning on the eleventh day of the month that is four months prior to the start of the applicable assessment

quarter and ending on the tenth day of the month prior to the start of the applicable assessment quarter.

(18) Private acute care hospital. – An acute care hospital that (i) is not qualified to certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a critical access hospital, and (iii) is not part of the UNC Health Care System.

(19) Private hospital historical assessment share. – Seventy-nine percent (79%), expressed as a decimal.

(20) Public acute care hospital. – An acute care hospital that (i) is qualified to certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a critical access hospital, (iii) is not part of the UNC Health Care System, and (iv) is not the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine.

(21) Public hospital historical assessment share. – Twenty-one percent (21%), expressed as a decimal.

(22) Rating group. – A category of beneficiaries or maternity services for which a periodic per-enrollee or per-event amount appears in a Medicaid managed care capitation rate certification.

(23) State's annual Medicaid payment. – An annual amount equal to one hundred ten million dollars ($110,000,000) for the period July 1, 2021, through June 30, 2022, increased each year over the prior year's payment by the market basket percentage.

(24) Statewide capitation rate. – A periodic per-enrollee or per-event amount paid by the Department to prepaid health plans for the delivery of Medicaid and NC Health Choice services in accordance with Article 4 of Chapter 108D of the General Statutes applicable to a particular rating group, expressed as a statewide weighted average for the applicable capitated contract plan type for all PHP regions and appearing in a Medicaid managed care capitation rate certification, as adjusted by the Department and allowed by CMS in accordance with Part 438 of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations.

(25) Third-party coverage. – Liability by any individual, entity, or program for the payment of all or part of the expenditures for medical assistance under the Medicaid State Plan that has been identified by the Department before making the medical assistance expenditure.

(26) University of North Carolina Health Care System (UNC Health Care System). – As established in G.S. 116-37 and including the following hospitals:

a. The University of North Carolina Hospitals at Chapel Hill.
b. Rex Hospital, Inc.
c. Chatham Hospital, Incorporated.
d. UNC Rockingham Health Care, Inc.
e. Caldwell Memorial Hospital, Incorporated.

"**§ 108A-145.5. Due dates and collections.**

(a) Assessments under this Article are calculated, imposed, and due quarterly in the time and manner prescribed by the Secretary and shall be considered delinquent if not paid within seven calendar days of this due date.

(b) With respect to any hospital owing a past-due assessment amount under this Article, the Department may withhold the unpaid amount from Medicaid or NC Health Choice payments otherwise due or impose a late payment penalty. The Secretary may waive a penalty for good cause shown.

(c) In the event the data necessary to calculate an assessment under this Article is not available to the Secretary in time to impose the quarterly assessment, the Secretary may defer the due date for the assessment to a subsequent quarter.

"**§ 108A-145.7. Assessment appeals.**

A hospital may appeal a determination of the assessment amount owed through a reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation to pay an assessment amount when due.

"**§ 108A-145.9. Allowable costs; patient billing.**

(a) Assessments paid under this Article may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement formula, except that assessments paid under this Article shall be excluded from cost settlement.

(b) Assessments imposed under this Article may not be added as a surtax or assessment on a patient's bill.

"**§ 108A-145.11. Rulemaking authority.**

The Secretary may adopt rules to implement this Article.

"**§ 108A-145.13. Repeal.**

If CMS determines that an assessment under this Article is impermissible or revokes approval of an assessment under this Article, then that assessment shall not be imposed and the Department's authority to collect the assessment is repealed.

"Part 2. Modernized Hospital Assessments.

"**§ 108A-146.1. Public hospital assessment.**

(a) The public hospital assessment imposed under this Part shall apply to all public acute care hospitals.

(b) The public hospital assessment shall be assessed as a percentage of each public acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the aggregate assessment collection amount under G.S. 108A-146.5 multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

"**§ 108A-146.3. Private hospital assessment.**

(a) The private hospital assessment imposed under this Part shall apply to all private acute care hospitals.

(b) The private hospital assessment shall be assessed as a percentage of each private acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the aggregate assessment collection amount under G.S. 108A-146.5 multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals holding a license on the first day of the assessment quarter.

"**§ 108A-146.5. Aggregate assessment collection amount.**

The aggregate assessment collection amount is an amount of money that is calculated by adding (i) the managed care component under G.S. 108A-146.7, (ii) the fee-for-service component under G.S. 108A-146.9, (iii) the GME component under G.S. 108A-146.11, and (iv) one-fourth of the State's annual Medicaid payment, and then subtracting the intergovernmental transfer adjustment component under G.S. 108A-146.13.

"**§ 108A-146.7. Managed care component.**

(a) The managed care component is an amount of money that is a portion of the total paid capitation for all rating groups in all capitated contracted plan types for the previous data collection period and is calculated in accordance with this section. The managed care component consists of an inpatient subcomponent and an outpatient subcomponent.

(b) The inpatient subcomponent is an amount calculated for each rating group by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the inpatient portion of the statewide capitation rate for the applicable rating group by the inpatient hospital financing percentage, (ii) multiplying that product by the difference of one minus the FMAP, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(c) The outpatient subcomponent is an amount calculated for each rating group by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the outpatient portion of the statewide capitation rate for the applicable rating group by the outpatient hospital financing percentage, (ii) multiplying that product by the difference of one minus the FMAP, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(d) The managed care component is calculated by adding together the aggregate inpatient subcomponents for all rating groups and the aggregate outpatient subcomponents for all rating groups.

"**§ 108A-146.9. Fee-for-service component.**

(a) The fee-for-service component is an amount of money that is a portion of all the Medicaid fee-for-service payments made to acute care hospitals during the previous data collection period for claims with a date of service on or after July 1, 2021. The fee-for-service component consists of a subcomponent pertaining to claims for which there is no third-party coverage and a subcomponent pertaining to claims for which there is third-party coverage.

(b) The subcomponent pertaining to claims for which there is no third-party coverage is the sum of the inpatient amount and the outpatient amount described in this subsection:

(1) The inpatient amount is the product of the total fee-for-service payments for claims for which there is no third-party coverage made to all acute care hospitals for inpatient hospital services multiplied by the inpatient hospital financing percentage and multiplied by the difference of one minus the FMAP.

(2) The outpatient amount is the product of the total fee-for-service payments for claims for which there is no third-party coverage made to all acute care hospitals for outpatient hospital services multiplied by the outpatient hospital financing percentage and multiplied by the difference of one minus the FMAP.

(c) The subcomponent pertaining to claims for which there is third-party coverage is the product of the total fee-for-service payments for claims for which there is third-party coverage made for inpatient hospital services and outpatient hospital services to (i) public acute care hospitals, (ii) private acute care hospitals, and (iii) critical access hospitals multiplied by the difference of one minus the FMAP.

(d) The fee-for-service component is calculated by adding together the subcomponent pertaining to claims for which there is no third-party coverage and the subcomponent pertaining to claims for which there is third-party coverage.

"**§ 108A-146.11. Graduate medical education component.**

The graduate medical education component is an amount of money that is one-fourth (1/4) of the total amount of payments that will be made by the Department during the current State fiscal year to all public acute care hospitals and private acute care hospitals in accordance with the Medicaid graduate medical education methodology in the Medicaid State Plan multiplied by the difference of one minus the FMAP.

"**§ 108A-146.13. Intergovernmental transfer adjustment component.**

(a) The intergovernmental transfer adjustment component is forty-four million nine hundred twelve thousand five hundred seven dollars ($44,912,507) for each quarter of the 2021-2022 State fiscal year. For each subsequent State fiscal year, the intergovernmental transfer

adjustment component shall be increased over the prior year's quarterly payment by the market basket percentage.

(b) If a public acute care hospital closes or becomes a private acute care hospital, then, beginning in the first assessment quarter following the closure or change to a private acute care hospital and for each quarter thereafter, the intergovernmental transfer adjustment component described in subsection (a) of this section, as inflated in accordance with that section, shall be reduced by the amount of the public acute care hospital's intergovernmental transfer to the Department made during its last quarter of operation as a public acute care hospital.

"**§ 108A-146.15. Use of funds.**

The proceeds of the assessments imposed under this Part, and all corresponding matching federal funds, must be used to make the State's annual Medicaid payment to the State, to fund payments to hospitals made directly by the Department, to fund a portion of capitation payments to prepaid health plans attributable to hospital care, and to fund graduate medical education payments.

"**§ 108A-146.17. Changes of hospital status.**

(a) For purposes of this section, hospital status includes all of the following:

(1) A hospital's status as a public acute care hospital, a private acute care hospital, or a hospital owned or controlled by the UNC Health Care system.

(2) The operating status of an acute care hospital as open or closed, including new hospitals and hospital closures.

(b) The Department of Health and Human Services shall report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division whenever the Department is notified of a possible change of hospital status. The report shall be due 60 days after the Department is notified of the possible change. The report shall include all of the following:

(1) The anticipated change of hospital status and the anticipated time frame during which the change of hospital status may occur.

(2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes that would be needed if the change in hospital status occurs, including proposed changes to the public and private hospital historical assessment shares in G.S. 108A-145.3 and the intergovernmental transfer adjustment component in G.S. 108A-146.13, as well as the mathematical calculations supporting the proposed changes.

(c) The Department of Health and Human Services shall report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division whenever the Department is notified that a change in hospital status has occurred. The report shall be due 60 days after the Department is notified of the change. The report shall include all of the following:

(1) The change of hospital status and the date of the change.

(2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes that are needed as a result of the change in hospital status, including proposed changes to the public and private hospital historical assessment shares in G.S. 108A-145.3 and the intergovernmental transfer adjustment component in G.S. 108A-146.13, as well as the mathematical calculations supporting the proposed changes.

(3) If the change of hospital status occurred because a public acute care hospital closed or became a private acute care hospital, then the amount of the public acute care hospital's intergovernmental transfer to the Department made during its last quarter of operation."

SECTION 3.(a) Notwithstanding G.S. 108A-146.1, established in Section 2 of this act, for the assessment quarter beginning July 1, 2021, the public hospital assessment shall be thirty-eight hundredths percent (0.38%) of total hospital costs for all public acute care hospitals.

SECTION 3.(b) Notwithstanding G.S. 108A-146.3, established in Section 2 of this act, for the assessment quarter beginning July 1, 2021, the private hospital assessment shall be eighty-seven hundredths percent (0.87%) of total hospital costs for all private acute care hospitals.

SECTION 4.(a) Notwithstanding G.S. 108A-146.1, established in Section 2 of this act, for the assessment quarter beginning October 1, 2021, the Department of Health and Human Services shall determine the public hospital assessment percentage by, first, either increasing or reducing the aggregate assessment collection amount under G.S. 108A-146.5 by the reconciliation component under subsection (c) of this section, and then multiplying that amount by the public hospital historical assessment share, and lastly dividing by the total hospital costs of all public acute care hospitals.

SECTION 4.(b) Notwithstanding G.S. 108A-146.3, established in Section 2 of this act, for the assessment quarter beginning October 1, 2021, the Department of Health and Human Services shall determine the private hospital assessment percentage by, first, either increasing or reducing the aggregate assessment collection amount under G.S. 108A-146.5 by the reconciliation component under subsection (c) of this section, and then multiplying that amount by the private hospital historical assessment share, and lastly dividing by the total hospital costs of all private acute care hospitals.

SECTION 4.(c) The reconciliation component is a positive or a negative number that results from subtracting the actual amount of public hospital assessment and private hospital assessment collected for the assessment quarter beginning July 1, 2021, from the aggregate assessment collection amount calculated under G.S. 108A-146.5 for the assessment quarter beginning October 1, 2021, with the adjustment required in accordance with subsection (d) of this section. If the reconciliation component is a positive number, then the aggregate assessment collection amount shall be increased by the reconciliation component in accordance with this section. If the reconciliation component is a negative number, then the aggregate assessment collection amount shall be reduced by the reconciliation component in accordance with this section.

SECTION 4.(d) Notwithstanding the definition of federal medical assistance percentage (FMAP) in G.S. 108A-145.3, when calculating the aggregate assessment collection amount under G.S. 108A-146.5 for the reconciliation component in subsection (c) of this section, the FMAP used in the calculation shall be the federal share of North Carolina Medicaid service costs as calculated by the federal Department of Health and Human Services in accordance with Section 1905(b) of the Social Security Act that is in effect for the quarter beginning July 1, 2021.

SECTION 5. In response to changes in the Medicaid reimbursement environment that may occur as a result of the transition to managed care, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division by January 1, 2026, with a proposal to replace or adjust the market basket percentage as the inflation factor that is used in the modernized hospital assessments in Part 2 of Article 7B of Chapter 108A of the General Statutes, as well as in the hospital base rates for Medicaid fee-for-service reimbursements, beginning July 1, 2026.

SECTION 6. Except as otherwise provided, this act becomes effective July 1, 2021.