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HOUSE PRINCIPAL CLERK

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HOUSE BILL DRH40238-MRxf-1C

Short Title: Medicaid Modernized Hospital Assessments. (Public)

Sponsors: Representative Lambeth.

Referred to:

1 A BILL TO BE ENTITLED  
2 AN ACT TO REVISE THE HOSPITAL ASSESSMENT ACT TO ACCOUNT FOR  
3 MEDICAID TRANSFORMATION.

4 The General Assembly of North Carolina enacts:

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6 repealed: subsections (b), (b1), (c), and (d) of Section 15.1, Section 15.2, and Section 15.3.

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

9 "Article 7B.

10 "Hospital Assessment Act.

11 "Part 1. General.

12 "**§ 108A-145.1. Short title and purpose.**

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

16 "**§ 108A-145.3. Definitions.**

17 The following definitions apply in this Article:

- 18 (1) Acute care hospital. – A hospital licensed in North Carolina that is not a  
19 freestanding psychiatric hospital, a freestanding rehabilitation hospital, a  
20 long-term care hospital, or a State-owned and State-operated hospital.
- 21 (2) Base capitation rate. – A periodic per-enrollee or per-event amount paid by  
22 the Department to prepaid health plans for the delivery of Medicaid and NC  
23 Health Choice services in accordance with Article 4 of Chapter 108D of the  
24 General Statutes applicable to a particular rating group and appearing in a  
25 Medicaid managed care capitation rate certification, as adjusted by the  
26 Department and allowed by CMS in accordance with Part 438 of Subchapter  
27 C of Chapter IV of Title 42 of the Code of Federal Regulations.
- 28 (3) Capitated contract plan type. – Any type of capitated prepaid health plan  
29 contract defined in G.S. 108D-1.
- 30 (4) CMS. – Centers for Medicare and Medicaid Services.
- 31 (5) Critical access hospital. – As defined in 42 C.F.R. § 400.202.
- 32 (6) Federal medical assistance percentage (FMAP). – The federal share of North  
33 Carolina Medicaid service costs as calculated by the federal Department of  
34 Health and Human Services in accordance with Section 1905(b) of the Social  
35 Security Act, in effect at the start of the applicable assessment quarter,  
36 expressed as a decimal.



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- 1           (7)   Hospital costs. – A hospital's costs as calculated using the most recent  
2           available Hospital Cost Report Information System's cost report data available  
3           through CMS, including both inpatient and outpatient components.
- 4           (8)   Inpatient hospital financing percentage. – For the 2021-2022 State fiscal year,  
5           the inpatient hospital financing percentage is sixty-six and one-tenth percent  
6           (66.1%), expressed as a decimal. For each subsequent State fiscal year, the  
7           inpatient hospital financing percentage is the sum of the inpatient hospital  
8           financing percentage for the previous State fiscal year plus the market basket  
9           percentage, divided by the sum of one plus the market basket percentage.
- 10          (9)   Inpatient hospital services. – As defined in the Medicaid State Plan, excluding  
11          payments made under the graduate medical education methodology and the  
12          disproportionate share hospital methodology.
- 13          (10) Inpatient portion of the statewide capitation rate. – The amount of the  
14          statewide capitation rate applicable to a particular rating group that is  
15          attributed to inpatient hospital facility health services in the applicable  
16          Medicaid managed care rate certification, expressed as a statewide weighted  
17          average of all PHP regions.
- 18          (11) Market basket percentage. – The hospital inpatient prospective payment  
19          system market basket minus the multifactor productivity adjustment  
20          established in rule by CMS and in effect on March 1 of the previous State  
21          fiscal year, expressed as a decimal.
- 22          (12) Medicaid managed care capitation rate certification. – A rate certification for  
23          any capitated contract plan type that contains the rates paid to prepaid health  
24          plans and that has been submitted to CMS under 42 C.F.R. § 438.7 and, except  
25          as otherwise provided in this subdivision, (i) has been approved by CMS and  
26          (ii) is in effect during the applicable time period. If, on the first day of any  
27          assessment quarter, CMS has not approved a rate certification for a particular  
28          capitated contract plan type for that quarter, then the Medicaid managed care  
29          capitation rate certification for that capitated contract plan type is the rate  
30          certification submitted to CMS under 42 C.F.R. § 438.7 applicable to that  
31          quarter.
- 32          (13) Outpatient hospital financing percentage. – Twenty-eight percent (28%),  
33          expressed as a decimal.
- 34          (14) Outpatient hospital services. – As defined in the Medicaid State Plan.
- 35          (15) Outpatient portion of the statewide capitation rate. – The amount of the  
36          statewide capitation rate applicable to a particular rating group that is  
37          attributed to outpatient hospital facility services and emergency room facility  
38          services in the applicable Medicaid managed care capitation rate  
39          certifications, expressed as a statewide weighted average of all PHP regions.
- 40          (16) Paid capitation. – The total amount of the capitation payments made by the  
41          Department to all prepaid health plans for a particular rating group (i)  
42          attributable to the base capitation rate in the applicable Medicaid managed  
43          care capitation rate certification and (ii) adjusted by the Department as a result  
44          of retroactively implementing any base capitation rate adjustment that is  
45          approved by CMS or allowed under Part 438 of Subchapter C of Chapter IV  
46          of Title 42 of the Code of Federal Regulations.
- 47          (17) Previous data collection period. – The period beginning on the eleventh day  
48          of the month that is four months prior to the start of the applicable assessment  
49          quarter and ending on the tenth day of the month prior to the start of the  
50          applicable assessment quarter.

- 1           (18) Private acute care hospital. – An acute care hospital that (i) is not qualified to  
2 certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a  
3 critical access hospital, and (iii) is not part of the UNC Health Care System.  
4           (19) Private hospital historical assessment share. – Seventy-nine percent (79%),  
5 expressed as a decimal.  
6           (20) Public acute care hospital. – An acute care hospital that (i) is qualified to  
7 certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a  
8 critical access hospital, (iii) is not part of the UNC Health Care System, and  
9 (iv) is not the primary affiliated teaching hospital for the East Carolina  
10 University Brody School of Medicine.  
11           (21) Public hospital historical assessment share. – Twenty-one percent (21%),  
12 expressed as a decimal.  
13           (22) Rating group. – A category of beneficiaries or maternity services for which a  
14 periodic per-enrollee or per-event amount appears in a Medicaid managed  
15 care capitation rate certification.  
16           (23) State's annual Medicaid payment. – An annual amount equal to one hundred  
17 ten million dollars (\$110,000,000) for the period July 1, 2021, through June  
18 30, 2022, increased each year over the prior year's payment by the market  
19 basket percentage.  
20           (24) Statewide capitation rate. – A periodic per-enrollee or per-event amount paid  
21 by the Department to prepaid health plans for the delivery of Medicaid and  
22 NC Health Choice services in accordance with Article 4 of Chapter 108D of  
23 the General Statutes applicable to a particular rating group, expressed as a  
24 statewide weighted average for the applicable capitated contract plan type for  
25 all PHP regions and appearing in a Medicaid managed care capitation rate  
26 certification, as adjusted by the Department and allowed by CMS in  
27 accordance with Part 438 of Subchapter C of Chapter IV of Title 42 of the  
28 Code of Federal Regulations.  
29           (25) Third-party coverage. – Liability by any individual, entity, or program for the  
30 payment of all or part of the expenditures for medical assistance under the  
31 Medicaid State Plan that has been identified by the Department before making  
32 the medical assistance expenditure.  
33           (26) University of North Carolina Health Care System (UNC Health Care System).  
34 – As established in G.S. 116-37 and including the following hospitals:  
35           a. The University of North Carolina Hospitals at Chapel Hill.  
36           b. Rex Hospital, Inc.  
37           c. Chatham Hospital, Incorporated.  
38           d. UNC Rockingham Health Care, Inc.  
39           e. Caldwell Memorial Hospital, Incorporated.

40 **"§ 108A-145.5. Due dates and collections.**

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

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

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

51 **"§ 108A-145.7. Assessment appeals.**

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

4 **"§ 108A-145.9. Allowable costs; patient billing.**

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

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

10 **"§ 108A-145.11. Rulemaking authority.**

11 The Secretary may adopt rules to implement this Article.

12 **"§ 108A-145.13. Repeal.**

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

16 "Part 2. Modernized Hospital Assessments.

17 **"§ 108A-146.1. Public hospital assessment.**

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

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

26 **"§ 108A-146.3. Private hospital assessment.**

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

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

36 **"§ 108A-146.5. Aggregate assessment collection amount.**

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

42 **"§ 108A-146.7. Managed care component.**

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

47 (b) The inpatient subcomponent is an amount calculated for each rating group by  
48 multiplying the paid capitation for the applicable rating group in the previous data collection  
49 period by the percentage that is calculated by (i) multiplying the inpatient portion of the statewide  
50 capitation rate for the applicable rating group by the inpatient hospital financing percentage, (ii)

1 multiplying that product by the difference of one minus the FMAP, and (iii) dividing that product  
2 by the statewide capitation rate for the applicable rating group.

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

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

12 **"§ 108A-146.9. Fee-for-service component.**

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

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

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

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

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

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

38 **"§ 108A-146.11. Graduate medical education component.**

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

44 **"§ 108A-146.13. Intergovernmental transfer adjustment component.**

45 (a) The intergovernmental transfer adjustment component is forty-four million nine  
46 hundred twelve thousand five hundred seven dollars (\$44,912,507) for each quarter of the  
47 2021-2022 State fiscal year. For each subsequent State fiscal year, the intergovernmental transfer  
48 adjustment component shall be increased over the prior year's quarterly payment by the market  
49 basket percentage.

50 (b) If a public acute care hospital closes or becomes a private acute care hospital, then,  
51 beginning in the first assessment quarter following the closure or change to a private acute care

1 hospital and for each quarter thereafter, the intergovernmental transfer adjustment component  
2 described in subsection (a) of this section, as inflated in accordance with that section, shall be  
3 reduced by the amount of the public acute care hospital's intergovernmental transfer to the  
4 Department made during its last quarter of operation as a public acute care hospital.

5 **"§ 108A-146.15. Use of funds.**

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

11 **"§ 108A-146.17. Changes of hospital status.**

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

- 13 (1) A hospital's status as a public acute care hospital, a private acute care hospital,  
14 or a hospital owned or controlled by the UNC Health Care system.  
15 (2) The operating status of an acute care hospital as open or closed, including new  
16 hospitals and hospital closures.

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

- 23 (1) The anticipated change of hospital status and the anticipated time frame during  
24 which the change of hospital status may occur.  
25 (2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes  
26 that would be needed if the change in hospital status occurs, including  
27 proposed changes to the public and private hospital historical assessment  
28 shares in G.S. 108A-145.3 and the intergovernmental transfer adjustment  
29 component in G.S. 108A-146.13, as well as the mathematical calculations  
30 supporting the proposed changes.

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

- 37 (1) The change of hospital status and the date of the change.  
38 (2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes  
39 that are needed as a result of the change in hospital status, including proposed  
40 changes to the public and private hospital historical assessment shares in  
41 G.S. 108A-145.3 and the intergovernmental transfer adjustment component in  
42 G.S. 108A-146.13, as well as the mathematical calculations supporting the  
43 proposed changes.  
44 (3) If the change of hospital status occurred because a public acute care hospital  
45 closed or became a private acute care hospital, then the amount of the public  
46 acute care hospital's intergovernmental transfer to the Department made  
47 during its last quarter of operation."

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

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

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

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

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

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

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

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