HOUSE BILL 555:
Medicaid Transformation Implementation.

2019-2020 General Assembly

Committee:		**Date:**	December 18, 2019
Introduced by:	Reps. Dobson, White, Saine, Lambeth	**Prepared by:**	Jennifer Hillman
Analysis of:	Ratified		Staff Attorney

OVERVIEW: House Bill 555 provides funding for the operation of the Medicaid program and the transition to managed care during the 2019-2021 fiscal biennium and makes other changes necessary for the transition of the Medicaid program to managed care as required by Medicaid Transformation legislation that was enacted in 2015.

This bill has various effective dates. Please see the full summary for more detail.

This bill was vetoed by the Governor on August 30, 2019, has not been overridden by the General Assembly, and has not become law.

CURRENT LAW: Medicaid Transformation legislation enacted in 2015 by the General Assembly required the current Medicaid and Health Choice fee-for-service programs to transition to a managed care model.[1] Under a waiver that was approved by the federal Centers for Medicare and Medicaid Services (CMS), the State will pay commercial and nonprofit prepaid health plans a monthly per-person capitated rate to cover Medicaid and Health Choice services for their enrollees.

BILL ANALYSIS:

Part I – Implementation in Conjunction with Statutory Procedures for Budget Continuation

Section 1.1 requires this act to be implemented in conjunction with the procedures for budget continuation outlined in the State Budget Act, and provides that the provisions of this act prevail in the event of any conflict. **Sections 1.2 and 1.3** provide for the repeal of duplicative provisions if House Bill 966, the 2019 Appropriations Act, becomes law.

Part II – Funds for Operation of the Medicaid Program

Sections 2.1 through 2.3 appropriate funds to the Division of Health Benefits for the Medicaid and NC Health Choice programs rebase and for the purpose of transitioning to Medicaid managed care.

Part III – Use of Medicaid Transformation Fund for Medicaid Transformation Needs

Section 3.1 transfers funds to the Medicaid Transformation Fund, and **Section 3.2** allows those funds to be used for claims run out as the Medicaid program transitions to managed care and for specified

[1] S.L. 2015-245, as amended.

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qualifying needs related to Medicaid Transformation, as verified by the Office of State Budget and Management.

Part V – Repeal of Past GME Directives to Align with Medicaid Transformation

Section 5.1 repeals past budget provisions directing the elimination of certain Medicaid graduate medical education reimbursement.

Part VI – Medicaid Transformation Hotline Option

Section 6.1 requires the Department of Health and Human Services (DHHS) to ensure that its Customer Service hotline is responsive to Medicaid Transformation questions from beneficiaries, providers, and the public.

Part VII – Tribal Option/Medicaid Transformation

Section 7.1 allows DHHS to contract with an Indian managed care entity or an Indian health care provider to assist with the provision of health-care related services to certain eligible Medicaid recipients and makes conforming changes to the legislation governing Medicaid Transformation.

Part VIII – Revise and Rename the Supplemental Payment Program for Eligible Medical Professional Providers

Section 8.1 requires DHHS to revise the current supplemental payment program for eligible medical professional providers to conform with managed care.

Part IX – Medicaid Contingency Reserve Codification

Section 9.1 codifies the establishment of the Medicaid Contingency Reserve and the use of funds in the reserve.

Part X – Revise and Update Hospital Assessments

Part X replaces the two existing hospital assessments with two revised hospital assessments, each of which utilizes a fixed percentage of hospital costs. The percentages provide funding for (1) the State share of Medicaid costs associated with the anticipated increase to the hospital claims payments and (2) the State retention amount. The percentage rates will be set each year by the General Assembly, and the Department of Health and Human Services (DHHS) will annually submit proposed adjustments to the rates.

- **Section 10.1(a)** repeals the current assessments, and **Section 10.1(b)** enacts the revised assessments. The supplemental assessment in new G.S. 108A-141 replaces the equity assessment currently in G.S. 108A-123(b), and the base assessment in new G.S. 108A-142 replaces the UPL assessment currently in G.S. 108A-123(c).
- **Sections 10.1(c) and (d)** set the rates for the revised assessments for the first taxable year, which is October 1, 2019, through September 30, 2020. The rate for the supplemental assessment is 2.26% of total hospital costs. The rate for the base assessment is 1.77% of total hospital costs.
- Because of the uncertainty involved in converting the assessments to prospective fixed rates, **Section 10.2** authorizes the State Controller to transfer funds from the Medicaid Contingency Reserve to cover

a shortfall in receipts in the Medicaid program during the 2019-2020 fiscal year. In the event that the actual receipts from the hospital assessments are higher than expected during the 2019-2020 fiscal year, **Section 10.3** directs that the amount of the over-realized receipts, up to $45 million, shall be transferred to a Hospital Assessment Fund to be used to support a decrease in the hospital assessment rates in the next fiscal year. Any over-realized receipts over $45 million will be transferred to the Medicaid Transformation Reserve. Before any transfer is executed under **Section 10.2 or 10.3**, the Office of State Budget and Management must verify the amount of the shortfall or over-realized receipts. **Section 10.4** makes a technical change to conform with House Bill 966, the 2019 Appropriations Act, if it becomes law.

Part XI – Gross Premiums Tax/Prepaid Health Plans

Section 11 amends Article 8B of Chapter 105 of the General Statutes, including G.S. 105-228.3 and G.S. 105-228.5, G.S. 105-259, and G.S. 58-6-25, as follows:

- Adds prepaid health plans to the types of organizations subject to the gross premiums tax and the insurance regulatory charge.
- Includes capitation payments for the Medicaid or Health Choice programs received by a prepaid health plan in the tax base on which the gross premiums tax is imposed.
- Establishes a tax rate of 1.9% for prepaid health plan gross premiums, which is the same rate applicable to other insurance contracts.
- Allows a deduction for capitation payments refunded by a prepaid health plan to the State, consistent with the deduction allowed for other gross premiums under the statute.

Part XII– Hospital Uncompensated Care Fund

Section 12.1 establishes the Hospital Uncompensated Care Fund as a nonreverting special fund to hold certain disproportionate share hospital adjustment (DSH) receipts to be used for payments related to uncompensated care in accordance with rules established by DHHS.

EFFECTIVE DATE: The repeal of the current hospital assessments, the enactment of the revised hospital assessments, and the assessment rates for the first taxable year are effective October 1, 2019. The changes related to the gross premiums tax in Section 11 are effective October 1, 2019, and apply to capitation payments received by prepaid health plans on or after that date. Sections 7.1(b), 7.1(c), and 8.1(e) are also effective October 1, 2019. The remainder of the bill is effective when it becomes law.

BACKGROUND:

Part X: Revise and Update Hospital Assessments

In 2011, the General Assembly put in place two hospital assessments, the "equity assessment" and the "UPL assessment," as a mechanism to draw down increased federal Medicaid dollars to enable the State to pay hospitals additional Medicaid amounts, called "***supplemental payments***," above the revenues earned by hospitals in the form of Medicaid claims payments. A portion of the receipts the State receives from these hospital assessments, called “State retention,” is also used to help fund the rest of the State Medicaid program. Each year, the State calculates how much is needed to pay the State share of the supplemental payments to hospitals. That total, combined with the State retention amount, is converted

to a percentage of hospital costs, and each hospital is assessed an amount equal to that percentage of the hospital's costs.

CMS does not allow the State to make the current Medicaid supplemental payments to hospitals in a managed care arrangement. DHHS plans to ***replace the current supplemental payments*** as follows:

- DHHS will set new hospital claims payments that are intended to be equivalent to the existing claims payments plus the existing supplemental payments.
- The capitated rates that will be set for managed care will be calculated using the new, higher hospital claims payments.

Because the current methodology for calculating the hospital assessments is based on supplemental payments, which are not allowed under managed care, there will be no money collected from the existing hospital assessments once DHHS begins the new payment approach.

Part XI: Gross Premiums Tax/Prepaid Health Plans

G.S. 105-228.5 requires insurers and health maintenance organizations to pay a 1.9% tax on gross premiums, due annually and collected in quarterly installments. G.S. 58-6-25 imposes a regulatory charge on the premiums tax liability of entities subject to the gross premiums tax. The regulatory charge established in Section 22.2 of S.L. 2018-5 is 6.5%.