This Bill Analysis reflects the contents of the bill as it was presented in committee.

HOUSE BILL 989: Required Components/Medicaid Transformation.

2019-2020 General Assembly

Committee:	House Health. If favorable, re-refer to Finance. If favorable, re-refer to Rules, Calendar, and Operations of the House	**Date:**	July 11, 2019
Introduced by:	Reps. Dobson, Lambeth	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to First Edition H989-CSMRxfa-8		

OVERVIEW: The PCS to House Bill 989 provides funding for the operation of the Medicaid program and the transition to managed care during the 2019-2020 fiscal year, and makes other changes necessary for the transition to managed care to begin as scheduled on November 1, 2019.

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 recently 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 beginning November 1, 2019.

BILL ANALYSIS:

Section 1.1 – Implementation in Conjunction with Statutory Procedures for Budget Continuation: 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.

Section 2.1 – Funds for Operation of the Medicaid Program: Appropriates 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.

Section 3.1 – Use of Medicaid Transformation Fund for Medicaid Transformation Needs: Allows funds in the Medicaid Transformation fund to be used for (i) claims run out as the Medicaid program transitions to managed care and (ii) specified qualifying needs related to Medicaid Transformation. The Office of State Budget and Management (OSBM) may transfer funds from the Medicaid Transformation Fund to the Division of Health Benefits provided that OSBM is able to verify the funds are to be used for a qualifying need.

Section 4.1 – Repeal of Past GME Directives to Align with Medicaid Transformation: Repeals past budget provisions directing the elimination of certain Medicaid graduate medical education reimbursement.

Sections 5.1, 5.2, and 5.3 – Revise and Update Hospital Assessments: 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

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

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 5.1(a) repeals the current assessments, and Section 5.1(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 5.1(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 5.2 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 5.3 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 5.3, the Office of State Budget and Management must verify the amount of the shortfall or over-realized receipts.

Section 6.1 – Revise and Rename the Supplemental Payment Program for Eligible Medical Professional Providers: Requires DHHS to revise the current supplemental payment program for eligible medical professional providers to conform with managed care.

Section 7.1 – Medicaid Contingency Reserve Codification: Codifies the establishment of the Medicaid Contingency Reserve and the use of funds in the reserve.

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 remainder of the act is effective when it becomes law.

BACKGROUND: 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. On October 1, 2019, the NC Department of Health and Human Services (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.