HOUSE BILL 383:
Medicaid Modernized Hospital Assessments.

2021-2022 General Assembly

Committee:	House Rules, Calendar, and Operations of the House	**Date:**	May 6, 2021
Introduced by:	Reps. Lambeth, White, Sasser	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	First Edition		

OVERVIEW: HB 383 enacts two modernized hospital assessments that support continued funding for Medicaid payments to hospitals under the new Medicaid managed care system beginning July 1, 2021. The modernized assessments replace two hospital assessments that currently provide funding for Medicaid payments to hospitals but that will become obsolete upon the transition of the Medicaid program to managed care.

CURRENT LAW:

2011 Hospital Provider Assessment Act: The two hospital assessments in Article 7 of Chapter 108A of the General Statutes were enacted in 2011 (S.L. 2011-11) as a mechanism to draw down increased federal Medicaid dollars to enable the State to pay hospitals additional Medicaid amounts above the revenues earned by hospitals in the form of Medicaid claims payments. These additional amounts are referred to as "supplemental payments." A portion of the receipts the State receives from the hospital assessments, called "State retention," is also used to help fund the rest of the State Medicaid program. The amount collected from all hospitals under the hospital assessments is calculated to equal the amount of money needed for the State share of the supplemental payments plus the State retention amount.

2015 Medicaid Transformation Legislation: Medicaid transformation legislation enacted in 2015 (S.L. 2015-245, as amended) requires the current Medicaid and NC Health Choice fee-for-services programs to transition to a managed care model. Under a waiver that has been 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 July 1, 2021. CMS will not allow the State to continue making the current Medicaid supplemental payments to hospitals in a managed care arrangement. Therefore, the NC Department of Health and Human Services (DHHS) plans to replace the current supplemental payments as follows:

- DHHS will set new hospital-specific 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 methodology enacted in 2011 for calculating the hospital assessments is based on supplemental payments, which are not allowed under managed care, there would be no money collected from the original 2011 hospital assessments after July 1, 2021.

2020 Revised Hospital Assessments (effective July 1, 2021): To ensure continued assessment collections after July 1, 2021, the General Assembly enacted Section 15.1 of S.L. 2020-88, which repeals the 2011 hospital assessments and replaces them with two revised hospital assessments. The revised hospital assessments each utilize a fixed percentage of hospital costs to be set by the General Assembly annually. The rates to be used for the first quarter of the 2021-2022 fiscal year were set in S.L. 2020-88. Because of the uncertainty involved in converting the 2011 hospital assessments to prospective fixed rates during the first year of managed care operations, Section 15.2 of S.L. 2020-88 authorizes the use of funds from the Medicaid Contingency Reserve to cover any shortfall in receipts during the 2021-2022 fiscal year, and Section 15.3 creates the Hospital Assessment Fund to hold potential over-collections of receipts to be used to decrease the assessment rates in the 2021-2022 taxable year.

The revised hospital assessments in Section 15.1 of S.L. 2020-88 have two key differences from the 2011 hospital assessments:

- The revised hospital assessments require the General Assembly to enact legislation **every year** to establish the assessment rates. A failure to enact legislation before the start of a new taxable quarter on October 1 of each year will result in no collections from the assessment until the rates are enacted. Unlike the revised hospital assessments, the 2011 hospital assessments are calculated by DHHS according to a statutory formula that does not depend on future acts of the General Assembly.
- The revised hospital assessments use a prospective fixed rate that does not adjust to changing conditions, such as enrollments, federal match percentages, and capitation rates, during the course of the fiscal year. The 2011 hospital assessments are calculated according to a statutory formula based on data available during the applicable fiscal year, resulting in rates that are more adaptable to changing conditions.

BILL ANALYSIS:

Modernized Hospital Assessments: HB 383 repeals the revised hospital assessments enacted in S.L. 2020-88 and replaces them with two modernized hospital assessments. Like the 2011 hospital assessments, the modernized hospital assessments are calculated by DHHS based on a statutory formula and data available during the applicable fiscal year.

Section 1 repeals the revised hospital assessments that were enacted in S.L. 2020-88, retroactively effective July 1, 2020.

Section 2 enacts modernized hospital assessments in Article 7B of Chapter 108A of the General Statutes, effective July 1, 2021, consisting of a public hospital assessment and a private hospital assessment, with the following features:

- The public hospital assessment applies to hospitals that are qualified to certify public expenditures under federal Medicaid regulations, and the private hospital assessment applies to hospitals that are not qualified to certify public expenditures. The following hospitals are exempt from both assessments: critical access hospitals, specified hospitals within the UNC Healthcare System, the primary hospital affiliated with East Carolina University Brody School of Medicine, freestanding psychiatric hospitals, freestanding rehabilitation hospitals, long term care hospitals, and State-owned and State-operated hospitals. The hospitals that are subject to the hospital assessments have remained the same in all versions of the hospital assessments.
- Each assessment is assessed as a percentage of total hospital costs. Each quarter, DHHS determines the assessment percentages according to a statutory formula and determines the amount of the

assessment owed by each subject hospital based on the assessment percentages. This approach takes into account changing conditions, such as enrollments, federal match percentages, and capitation rates, during the fiscal year. It is similar to the 2011 hospital assessments and differs from the revised hospital assessments.

- The total amount to be collected from both assessments represents a portion of the State share of Medicaid expenses for hospital services (paid through managed care capitation rates, fee-for-service claims, and Graduate Medical Education) plus the State retention and minus certain intergovernmental transfers from hospitals that offset State Medicaid costs. The CMS market basket percentage is used as the annual inflation factor for the components of the total amount to be collected in future years. This is a modified approach to the formula used in the 2011 hospital assessments.
- Of the total amount to be collected from both assessments, the statutory formula allocates a percentage to be collected through the public hospital assessment and a percentage to be collected through the private hospital assessment, based on the percentage of assessment collections that historically have been paid by each hospital type under the 2011 hospital assessments. This is a modified approach to determining the share of the assessments paid by public and private hospitals, which has been a feature of all versions of the hospital assessments.
- Whenever certain changes in hospital status have occurred (*e.g.*, a change of ownership from public to private or private to public, a hospital closure, etc.), or DHHS has been notified of a possible change, a report is due to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice proposing any needed adjustments to the formula. This feature was not included in the previous assessments.

During the first quarter of managed care operations, some of the data necessary to calculate the modernized hospital assessment rates will not exist. Accordingly, **Section 3** sets the percentage rates for the modernized hospital assessments for the first quarter.

Once the data for the first quarter is available, **Section 4** requires DHHS to calculate a reconciliation component by comparing the amount of the assessments collected during the first quarter under the rates set in Section 3 to the amount of the assessments that would have been collected for the first quarter under the statutory formula with the data from the first quarter. The reconciliation component will increase or decrease the assessment rates in the second quarter of managed care operations to account for any over- or under-collection during the first quarter, and the reconciliation process does not continue in subsequent quarters.

Because the Medicaid reimbursement environment may change after the transition to managed care, **Section 5** requires DHHS to submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 1, 2026, on a proposal to adjust the annual inflation factor used in the modernized hospital assessments beginning July 1, 2026.

EFFECTIVE DATE: The repeal of the 2020 Revised Hospital Assessments is effective July 1, 2020. The remainder of the bill is effective July 1, 2021.