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. (2021-61, s. 2.)

§ 108A-145.3. Definitions.

The following definitions apply in this Article:

(1a) Actual nonfederal expenditures. – The nonfederal share for newly eligible individuals multiplied by the amount of the Medicaid assistance payment expenditures attributable to newly eligible individuals, inclusive of any adjustments, reported by the Department to CMS on the Form CMS-64.

(1b) 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 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.

(4a) Consumer Price Index: All Urban Consumers. – The Consumer Price Index for All Urban Consumers for the South Region published by the Bureau of Labor Statistics of the United States Department of Labor.

(4b) Consumer Price Index: Medical Care. – The Consumer Price Index for All Urban Consumers for Medical Care, U.S. city average, seasonally adjusted, published by the Bureau of Labor Statistics of the United States Department of Labor.

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

(5a) Current quarter. – The State fiscal quarter for which the assessment is being calculated.

(6) FMAP. – Federal medical assistance percentage.

(6a) FMAP for newly eligible individuals. – The FMAP specified in 42 U.S.C. § 1396d(y)(1), expressed as a decimal.

(6b) FMAP for not newly eligible individuals. – 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.

(6c) HASP directed payments. – Payments made by the Department to prepaid health plans to be used for (i) increased reimbursements to hospitals under the

HASP program and (ii) the costs to prepaid health plans from the gross premiums tax under G.S. 105-228.5 and the insurance regulatory charge under G.S. 58-6-25 associated with those hospital reimbursements.

(6d) Healthcare access and stabilization program (HASP). – The directed payment program providing increased reimbursements to acute care hospitals approved by CMS and authorized by G.S. 108A-148.1.

(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.

(7a) IGT. – Intergovernmental transfer.

(8) Inpatient hospital financing percentage. – For the 2021-2022 State fiscal year, the inpatient hospital financing percentage is sixty-five and seventy-four hundredths percent (65.74%), 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.

(12a) Medicare Economic Index. – The percent change in the Medicare Economic Index established in rule by CMS and in effect on March 1 of the previous State fiscal year.

(12b) Newly eligible individual. – As defined in 42 C.F.R. § 433.204.

(12c) Nonfederal share for newly eligible individuals. – One minus the FMAP for newly eligible individuals.

(12d) Nonfederal share for not newly eligible individuals. – One minus the FMAP for not newly eligible individuals.

(13) Outpatient hospital financing percentage. – Twenty-seven and sixty-nine hundredths percent (27.69%), 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, (iii) is not a rural emergency hospital, and (iv) is not part of the UNC Health Care System.

(19) Private hospital historical assessment share. – Eighty and seventeen hundredths percent (80.17%), 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 a rural emergency hospital, (iv) is not part of the UNC Health Care System, and (v) is not the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine.

(21) Public hospital historical assessment share. – Nineteen and eighty-three hundredths percent (19.83%), 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.

(22a) Rural emergency hospital. – As defined in 42 C.F.R. § 485.502.

(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 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. 116-350.5 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. (2021-61, s. 2; 2021-180, s. 9D.13A(a), (g), (h); 2022-74, s. 9D.15(z); 2023-7, s. 1.6(a); 2023-134, s. 9E.23(f1), (f2); 2024-28, ss. 5.1(a)-(c), 5.2(a), (b), 5.3(a)-(c), 5.3A.)

§ 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 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. (2021-61, s. 2; 2022-74, s. 9D.15(z).)

§ 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. (2021-61, s. 2.)

§ 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. (2021-61, s. 2.)

§ 108A-145.11. Rulemaking authority.

The Secretary may adopt rules to implement this Article. (2021-61, s. 2.)

§ 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. (2021-61, s. 2.)

Part 2. Modernized Hospital Assessments.

§ 108A-146.1. Public hospital modernized assessment.

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

(b) The public hospital modernized 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 modernized 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. (2021-61, s. 2; 2023-7, s. 1.7(a).)

§ 108A-146.3. Private hospital modernized assessment.

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

(b) The private hospital modernized 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 modernized 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. (2021-61, s. 2; 2023-7, s. 1.7(b).)

§ 108A-146.5. Aggregate modernized assessment collection amount.

(a) The aggregate modernized assessment collection amount is an amount of money that is calculated by subtracting the modernized intergovernmental transfer adjustment component under G.S. 108A-146.13 from the total modernized nonfederal receipts under subsection (b) of this section and then adding the positive or negative amount of the modernized IGT actual receipts adjustment component under G.S. 108A-146.14.

(b) The total modernized nonfederal receipts is the sum of all of the following:

(1) One-fourth of the State's annual Medicaid payment.

(2) The managed care component under G.S. 108A-146.7.

(3) The fee-for-service component under G.S. 108A-146.9.

(3a) The modernized HASP component under G.S. 108A-146.10.

(4) The GME component under G.S. 108A-146.11.

(5) Beginning April 1, 2022, and ending March 31, 2027, the postpartum coverage component under G.S. 108A-146.12.

(6) Beginning April 1, 2024, the home and community-based services component under G.S. 108A-146.12A. (2021-61, s. 2; 2021-180, s. 9D.13A(b); 2023-7, s. 1.7(c).)

§ 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 not associated with newly eligible individuals in all capitated contracted plan types for the previous data collection period. The managed care component is calculated by adding the aggregate inpatient subcomponents for all the rating groups calculated under subsection (b) of this section and the aggregate outpatient subcomponents for all the rating groups calculated under subsection (c) of this section.

(b) The inpatient subcomponent is an amount calculated for each rating group not associated with newly eligible individuals 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 nonfederal share for not newly eligible individuals, 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 not associated with newly eligible individuals 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 nonfederal share for not newly eligible individuals, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(d) Repealed by Session Laws 2023-7, s. 1.7(d), effective April 1, 2023, and applicable to assessments imposed on or after that date. (2021-61, s. 2; 2023-7, s. 1.7(d).)

§ 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, excluding claims attributable to newly eligible individuals. The fee-for-service component is calculated by adding the subcomponent pertaining to claims for which there is no third-party coverage under subsection (b) of this section and the subcomponent pertaining to claims for which there is third-party coverage under subsection (c) of this section.

(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 not attributable to newly eligible individuals 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 nonfederal share for not newly eligible individuals.

(2) The outpatient amount is the product of the total fee-for-service payments for claims not attributable to newly eligible individuals 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 nonfederal share for not newly eligible individuals.

(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 not attributable to newly eligible individuals 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, (iii) critical access hospitals, and (iv) rural emergency hospitals multiplied by the nonfederal share for not newly eligible individuals.

(d) Repealed by Session Laws 2023-7, s. 1.7(e), effective April 1, 2023, and applicable to assessments imposed on or after that date. (2021-61, s. 2; 2023-7, s. 1.7(e); 2024-28, s. 5.3(d).)

§ 108A-146.10. Modernized HASP component.

The modernized HASP component is an amount of money that is calculated each quarter by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements that are not attributable to newly eligible individuals by the nonfederal share for not newly eligible individuals. (2023-7, s. 1.7(f).)

§ 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 nonfederal share for not newly eligible individuals. (2021-61, s. 2; 2023-7, s. 1.7(g).)

§ 108A-146.12. Postpartum coverage component.

(a) The postpartum coverage component is twelve million five hundred thousand dollars ($12,500,000) for each quarter of the 2021-2022 State fiscal year.

(b) For each quarter of the 2022-2023 State fiscal year prior to the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424). For any quarter of the 2022-2023 State fiscal year in which G.S. 108A-54.3A(a)(24) becomes or is effective, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000).

(c) For each quarter of the 2023-2024 State fiscal year prior to the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the postpartum coverage component is eleven million four thousand four hundred twenty-four dollars ($11,004,424) increased by the Medicare Economic Index. For any quarter of the 2023-2024 State fiscal year in which G.S. 108A-54.3A(a)(24) becomes or is effective, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000).

(d) For each quarter of the 2024-2025 State fiscal year, the postpartum coverage component is four million five hundred thousand dollars ($4,500,000) increased by the Medicare Economic Index.

(e) Reserved for future codification purposes.

(f) Reserved for future codification purposes.

(g) Reserved for future codification purposes.

(h) Reserved for future codification purposes.

(i) For each State fiscal year after the 2025-2026 fiscal year, the postpartum coverage component shall be increased over the prior year's quarterly amount by the Medicare Economic Index. (2021-180, s. 9D.13A(c); 2022-74, s. 9D.10(a); 2023-7, s. 1.7(k); 2023-134, s. 9E.23(c2).)

§ 108A-146.12A. Home and community-based services component.

The home and community-based services component is thirty-five million five hundred thousand dollars ($35,500,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the home and community-based services component shall be increased over the prior year's quarterly amount by the Medicare Economic Index. (2021-180, s 9D.13A(c); 2022-74, s. 9D.14(b).)

§ 108A-146.13. Modernized presumptive IGT adjustment component.

(a) Repealed by Session Laws 2023-7, s. 1.7(h), effective April 1, 2023, and applicable to assessments imposed on or after that date.

(b) Repealed by Session Laws 2023-7, s. 1.7(h), effective April 1, 2023, and applicable to assessments imposed on or after that date.

(c) The modernized presumptive IGT adjustment component is an amount of money equal to the sum of all of the following subcomponents:

(1) The public hospital IGT subcomponent is the total of the following amounts:

a. Sixteen and forty-three hundredths percent (16.43%) of the amount of money that is equal to the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. Sixty percent (60%) of the nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to public acute care hospitals and that are not attributable to newly eligible individuals.

(2) The UNC Health Care System IGT subcomponent is the total of the following amounts:

a. Four and sixty-two hundredths percent (4.62%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to UNC Health Care System hospitals that are not attributable to newly eligible individuals.

(3) The East Carolina University IGT subcomponent is the total of the following amounts:

a. One and four hundredths percent (1.04%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized HASP component under G.S. 108A-146.10 for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine that are not attributable to newly eligible individuals. (2021-61, s. 2; 2021-180, s. 9D.13A(d); 2022-74, s. 9D.10(b); 2023-7, s. 1.7(h).)

§ 108A-146.14. Modernized IGT actual receipts adjustment component.

The modernized IGT actual receipts adjustment component is a positive or negative dollar amount equal to the modernized presumptive IGT adjustment component under G.S. 108A-146.13 for the previous quarter minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt related to the modernized assessments. (2023-7, s. 1.7(i).)

§ 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 and to fund all of the following:

(1) Payments to hospitals made directly by the Department.

(2) A portion of capitation payments to prepaid health plans attributable to hospital care.

(3) HASP directed payments attributable to hospital reimbursements for not newly eligible individuals.

(4) Graduate medical education payments. (2021-61, s. 2; 2023-7, s. 1.7(j).)

§ 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. (2021-61, s. 2.)

§ 108A-147: Reserved for future codification purposes.

Part 3. Health Advancement Assessments.

§ 108A-147.1. Public hospital health advancement assessment.

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

(b) The public hospital health advancement 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 in accordance with this Part. The percentage for each quarter shall equal the aggregate health advancement assessment collection amount calculated under G.S. 108A-147.3 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. (2023-7, s. 1.6(b).)

§ 108A-147.2. Private hospital health advancement assessment.

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

(b) The private hospital health advancement 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 in accordance with this Part. The percentage for each quarter shall equal the aggregate health advancement assessment collection amount calculated under G.S. 108A-147.3 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. (2023-7, s. 1.6(b).)

§ 108A-147.3. Aggregate health advancement assessment collection amount.

(a) The aggregate health advancement assessment collection amount is an amount of money that is calculated quarterly by adjusting the total nonfederal receipts for health advancement calculated under subsection (b) of this section by (i) subtracting the health advancement presumptive IGT adjustment component calculated under G.S. 108A-147.9, (ii) adding the positive or negative health advancement IGT actual receipts adjustment component calculated under G.S. 108A-147.10, and (iii) subtracting the positive or negative IGT share of the reconciliation adjustment component calculated under G.S. 108A-147.11(b).

(b) The total nonfederal receipts for health advancement is an amount of money that is calculated quarterly by adding all of the following:

(1) The presumptive service cost component calculated under G.S. 108A-147.5.

(2) The HASP health advancement component calculated under G.S. 108A-147.6.

(3) The administration component calculated under G.S. 108A-147.7.
(4) The State retention component under G.S. 108A-147.9.
(5) The positive or negative health advancement reconciliation adjustment component calculated under G.S. 108A-147.11(a). (2023-7, s. 1.6(b).)

§ 108A-147.4. (Reserved)

Reserved for future codification purposes.

§ 108A-147.5. Presumptive service cost component.

(a) For every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is the product of forty-eight million seven hundred fifty thousand dollars ($48,750,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(a)(24) is effective during any part of the month.

(c) For the first State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is one hundred forty-six million two hundred fifty thousand dollars ($146,250,000).

(d) For the second State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, and for each State fiscal quarter thereafter, the presumptive service cost component is an amount of money that is the greatest of the following:

(1) The prior quarter's presumptive service cost component amount.
(2) The prior quarter's presumptive service cost component amount increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: Medical Care for the most recent three months available on the first day of the current quarter.
(3) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for standard benefit plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for standard benefit plans.
(4) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for BH IDD tailored plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for BH IDD tailored plans.
(5) The amount produced from multiplying 1.15 by the highest amount produced when calculating, for each quarter that is at least two and not more than five quarters prior to the current quarter, the actual nonfederal expenditures for the applicable quarter minus the HASP health advancement component calculated under G.S. 108A-147.6 for the applicable quarter. (2023-7, s. 1.6(b); 2023-134, s. 9E.23(c2).)

§ 108A-147.6. HASP health advancement component.

The HASP health advancement component is an amount of money that is calculated by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements attributable to newly eligible individuals by the nonfederal share for newly eligible individuals. (2023-7, s. 1.6(b).)

§ 108A-147.7. Administration component.

(a) The administration component is an amount of money that is calculated by adding the State administration subcomponent calculated under subsection (b) of this section and the county administration subcomponent calculated under subsection (c) of this section.

(b) For each quarter of the 2023-2024 State fiscal year, the State administration subcomponent is the product of one million three hundred fifty thousand dollars ($1,350,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month. For each quarter of the 2024-2025 State fiscal year, the State administration subcomponent is four million one hundred eighty-seven thousand seven hundred dollars ($4,187,700). For each subsequent State fiscal year, the State administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year.

(c) For each quarter of the 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the county administration subcomponent is the product of one million six hundred sixty-seven thousand dollars ($1,667,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month. The county administration subcomponent is seven million four hundred thousand dollars ($7,400,000) for each quarter of the 2024-2025 State fiscal year and seven million eight hundred thousand dollars ($7,800,000) for each quarter of the 2025-2026 State fiscal year. For each State fiscal year after the 2025-2026 State fiscal year, the county administration subcomponent shall be increased over the prior year's quarterly amount by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: All Urban Consumers for the most recent 12 months available on March 1 of the previous State fiscal year. (2023-7, s. 1.6(b), (e); 2023-134, s. 9E.23(c2); 2024-28, s. 5.1(d).)

§ 108A-147.8. State retention component.

(a) For every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the State retention component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, and each State fiscal quarter thereafter, the State retention component is ten million seven hundred fifty thousand dollars ($10,750,000) for each assessment quarter. (2023-7, s. 1.6(b); 2023-134, s. 9E.23(c2).)

§ 108A-147.9. Health advancement presumptive IGT adjustment component.

(a) The health advancement presumptive IGT adjustment component is an amount of money calculated by adding the public hospital health advancement IGT adjustment subcomponent calculated under subsection (b) of this section, the UNC Health Care System health advancement IGT adjustment subcomponent calculated under subsection (c) of this section, and the East Carolina University health advancement IGT adjustment subcomponent calculated under subsection (d) of this section.

(b) The public hospital health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) Sixty percent (60%) of the public hospital share of the sum of the presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter, the administration component calculated under G.S. 108A-147.7 for the current quarter, and the State retention component under G.S. 108A-147.8 for the current quarter. The public hospital share is the total hospital costs for all public acute care hospitals divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

(2) Sixty percent (60%) of the nonfederal share for newly eligible individuals of the aggregate amount of the HASP directed payments due to PHPs in the current quarter for reimbursements to public acute care hospitals that are attributable to newly eligible individuals.

(c) The UNC Health Care System health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) The UNC Health Care System share of the presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter and the administration component calculated under G.S. 108A-147.7 for the current quarter. The UNC Health Care System share is the total hospital costs for the UNC Health Care System hospitals divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

(2) The nonfederal share for newly eligible individuals of the aggregate amount of the HASP directed payments due to PHPs in the current quarter for reimbursements to UNC Health Care System hospitals that are attributable to newly eligible individuals.

(d) The East Carolina University health advancement IGT adjustment subcomponent is the total of the following amounts:

(1) The East Carolina University share of the presumptive service cost component calculated under G.S. 108A-147.5 for the current quarter and the administration component calculated under G.S. 108A-147.7 for the current quarter. The East Carolina University share is the total hospital costs for the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine divided by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals for the current quarter.

(2) The nonfederal share for newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine that are attributable to newly eligible individuals. (2023-7, s. 1.6(b); 2024-28, s. 5.3(e)-(g).)

§ 108A-147.10. Health advancement IGT actual receipts adjustment component.

The health advancement IGT actual receipts adjustment component is a positive or negative dollar amount equal to the health advancement presumptive IGT adjustment component calculated under G.S. 108A-147.9 for the previous quarter, plus the positive or negative IGT share of the

reconciliation adjustment component calculated under G.S. 108A-147.11(b) for the previous quarter, and minus the amount of money received during the previous quarter by the Department through intergovernmental transfer and designated in the Department's accounting system as a receipt for health advancement. (2023-7, s. 1.6(b).)

§ 108A-147.11. Health advancement reconciliation adjustment component.

(a) The health advancement reconciliation adjustment component is a positive or negative dollar amount equal to the actual nonfederal expenditures for the quarter that is two quarters prior to the current quarter minus the sum of the following specified amounts:

(1) The presumptive service cost component calculated under G.S. 108A-147.5 for the quarter that is two quarters prior to the current quarter.

(2) The positive or negative gross premiums tax offset amount calculated under G.S. 108A-147.12(b).

(3) The HASP health advancement component calculated under G.S. 108A-147.6 for the quarter that is two quarters prior to the current quarter.

(b) The IGT share of the reconciliation adjustment component is a positive or negative dollar amount that is calculated by multiplying the health advancement reconciliation adjustment component calculated under subsection (a) of this section by the share of public hospital costs calculated under subsection (c) of this section.

(c) The share of public hospital costs is calculated by adding total hospital costs for the UNC Health Care System, total hospital costs for the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, and sixty percent (60%) of the total hospital costs for all public acute care hospitals and dividing that sum by the total hospital costs for all acute care hospitals except for critical access hospitals and rural emergency hospitals. (2023-7, s. 1.6(b); 2024-28, s. 5.3(h).)

§ 108A-147.12. Gross premiums tax offset amount.

(a) For the purposes of this section, the term "annualized offset" means the total paid capitation for all rating groups associated with newly eligible individuals in all capitated contract plan types for the calendar year that was completed immediately prior to the start of the applicable State fiscal year multiplied by one and nine-tenths percent (1.9%) and then multiplied by sixty percent (60%).

(b) The gross premiums tax offset amount is as follows:

(1) For each quarter of the 2022-2023 State fiscal year and the 2023-2024 State fiscal year, the gross premiums tax offset amount is zero.

(2) For the 2024-2025 State fiscal year, and each fiscal year thereafter, the gross premiums tax offset amount is the following:

a. For the first quarter of the applicable State fiscal year, the gross premiums tax offset amount is a positive or negative number equal to the annualized offset minus the sum of the gross premiums tax offset amounts for the second, third, and fourth quarters of the previous State fiscal year.

b. For the second, third, and fourth quarters of the applicable State fiscal year, the gross premiums tax offset amount is the annualized offset multiplied by one–third. (2023-7, s. 1.6(b).)

§ 108A-147.13. Use of funds.

(a) Except as provided in subsection (d) of this section, the proceeds of the health advancement assessments imposed under this Part, and all corresponding matching federal funds, shall only be used to fund the following:

(1) Medicaid actual nonfederal expenditures for newly eligible individuals, including HASP directed payments.

(2) Administrative expenditures for newly eligible individuals.

(3) Administrative expenditures related to the HASP program.

(b) The Department shall use an amount of the proceeds of the health advancement assessments that is equal to the county administration subcomponent of the administration component in G.S. 108A-147.7 to provide funding to county departments of social services to support the counties in determining eligibility for newly eligible individuals.

(c) The amount of the proceeds of the health advancement assessments that may be used for administrative expenses attributable to providing Medicaid coverage to newly eligible individuals and administrative expenditures associated with the HASP program shall not exceed, for any State fiscal year, an amount equal to the sum of the State administration subcomponent of the administration component in G.S. 108A-147.7 for each quarter of the State fiscal year, and all corresponding matching federal funds.

(d) The Department shall use an amount from the proceeds of the health advancement assessments equal to the State retention component in G.S. 108A-147.8, and all corresponding matching federal funds, for Medicaid program costs. (2023-7, s. 1.6(b).)

§ 108A-148: Reserved for future codification purposes.

Part 4. Healthcare Access and Stabilization Program.

§ 108A-148.1. Healthcare access and stabilization program.

(a) The healthcare access and stabilization program is a directed payment program that provides acute care hospitals with increased reimbursements funded through hospital assessments in accordance with this section.

(b) The Department shall submit a 42 C.F.R. § 438.6(c) preprint requesting approval for the HASP program that includes any required demonstration for the financing of the nonfederal share of the HASP program costs. The Department shall not make any HASP directed payments prior to CMS approval of the initial preprint. The Department may not request any date of service for claims eligible for reimbursement through the HASP program earlier than July 1, 2022. The Department shall continue to submit any necessary documentation requesting continued approval for the HASP program as described in this section in the time and manner as required by CMS.

(c) All State funds required to make HASP directed payments shall be derived from HASP components of the hospital assessments under this Article, subject to all of the following limitations:

(1) If the Department determines that the HASP components under this Article will not generate funds in an amount equal to or greater than the total State funds required to make all HASP directed payments in any given quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that the HASP components under this Article will generate enough funds to equal the total State funds required to make all the HASP directed payments in that quarter.

(2) If the aggregate amount of all assessments due from hospitals under this Article are determined by the Department to exceed the permissible limit established under 42 C.F.R. § 433.68(f) in any quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that these hospital assessments in aggregate do not exceed the permissible limit.

(d) As part of the preprint submission required under this section, for the 2022-2023 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is greater than the maximum amount allowable under 42 C.F.R. § 438.6(c). Beginning with the 2023-2024 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is (i) greater than the maximum amount allowable under 42 C.F.R. § 438.6(c) or (ii) less than an annual estimated total dollar amount of three billion two hundred million dollars ($3,200,000,000) for services provided to not newly eligible individuals. (2023-7, s. 1.4.)

§ 108A-149: Reserved for future codification purposes.