§ 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.)