GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

Legislative Fiscal Note

BILL NUMBER: Senate Bill 32 (First Edition)

SHORT TITLE: Hospital Medicaid Assessment/Payment Program.

SPONSOR(S): Senators Clodfelter and Brunstetter

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available ( )**

	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
REVENUES					
Assessments	**$215,615,530**		**See Assumptions and Methodology**		
Federal Medicaid Funds	**$413,347,075**		**See Assumptions and Methodology**		
EXPENDITURES					
Hospital Reimbursements	**$585,962,605**		**See Assumptions and Methodology**		
DHHS State Medicaid Program	**$43,000,000**	**$43,000,000**	**$43,000,000**	**$43,000,000**	**$43,000,000**
POSITIONS (cumulative):					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED: Department of Health & Human Service, Division of Medical Assistance

EFFECTIVE DATE: Upon enactment

BILL SUMMARY:

Senate Bill 32 proposes to establish assessments on hospitals and use the revenue derived from the assessments to obtain Federal Medicaid funds. The purpose of these funds would be to address the difference between hospitals' cost of treating Medicaid recipients and what hospitals are reimbursed.

ASSUMPTIONS AND METHODOLOGY:

Background

Healthcare Provider Assessments

Provider-specific assessments have been used by States since 1990 to help pay for the costs of States' Medicaid programs. The assessments, proposed by State policymakers and enacted by State legislatures, must meet the requirements of federal laws and regulations. In 2010 the number of states with some type of Medicaid-related provider assessment increased to 46 states.

States with Provider Assessments—2010	
Provider being Assessed	**States with Assessment**
Hospitals	34
ICF/MR-DD	34
Nursing Facility	38
Managed Care Facility	11
Other	15

Source: Kaiser Family Foundation, 2010

Currently, North Carolina utilizes provider assessments to enhance payment rates for 1) Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled and 2) Nursing Facilities by providing the state share of increases or offsets to recent year's rate decreases.

Example of a Provider Assessment Program

Federal regulations (42 CFR 433.56) allow for an assessment of up to 5.5% to be made against a healthcare provider's non-Medicare net revenue.

- *Initial assessment on health care services*. The first step in the process is to adopt an assessment on health care services.

- *Increased Medicaid payments*. The second step is to use the increased revenue to enhance the state's Medicaid program, e.g. through Medicaid reimbursements, generating additional Federal matching payments at the rate of nearly 2:1, in the case of North Carolina in SFY 2011-12.

- *Net impact on providers and the State.* The new Medicaid reimbursements can be split between providers who contributed to the assessment, other healthcare providers who were not assessed, and the state.

    - *Assessed providers.* Most providers end up net winners due to the increase in Medicaid reimbursement. The Federal government requires that the assessment result in some redistribution of funds on net, so that some providers will inevitably lose.

- *Non-assessed providers*. Non-assessed providers who benefit from the increase in Medicaid reimbursements are pure winners.

Hospital Medicaid Costs and Reimbursements

Medicaid's reimbursement of a hospital's inpatient treatment costs are based on Diagnostic Related Groups (DRGs). These DRG payment rates are based on the 1994 cost for each hospital, indexed forward based on General Assembly's approved changes in provider rates. Each year North Carolina's Medicaid program adjusts the Medicaid DRG reimbursement rate for any inflation or decrease approved by the General Assembly. However, during the past 15 years the North Carolina General Assembly has often foregone an inflationary increase in Medicaid provider rates.

According to the North Carolina Hospital Association (NCHA), which represents public and private hospitals in the state, the current North Carolina Medicaid DRG reimbursement rate for inpatient costs is 50% of the cost of delivering care to a Medicaid recipient. Medicaid's reimbursement of a hospital's outpatient and emergency treatment costs are at 80% of cost. In the aggregate, the NCHA asserts that its hospitals are reimbursed by Medicaid at 63% of their combined inpatient and outpatient costs. NCHA acknowledges that this percentage increases to 85% when the Disproportionate Share Hospital payment to North Carolina hospitals is factored in.

Analysis of Senate Bill 32

Under the applicable Federal regulations (42 CFR 433.56), SB 32 directs the Secretary of the Department of Health and Human Services (DHHS) to implement a hospital assessment program for eligible hospitals to improve funding for payments for hospital services provided to Medicaid and uninsured patients. The program proposed in SB 32 includes two different assessments on hospitals:

1. Equity Assessments
2. Upper Payment Limit Assessments

The assessments are to be levied as a percent of total hospital cost calculated using the most recent available Hospital Cost Report Information Systems cost report or comparable data. The receipts derived from these assessments would be used by the Department's Division of Medical Assistance to draw down Federal matching funds at an approximate rate of $2 Federal for every $1 State, beginning in July 2011. If the assessment is implemented prior to July 1, 2011, the federal match (FMAP) rate will be higher due to ARRA, requiring a lower assessment rate. The rate will have to be adjusted in July 2011 to compensate for the change in FMAP.

Equity Assessments/Medicaid Equity Payment

DHHS is to levy an Equity Assessment on the inpatient and outpatient Medicaid costs of each private hospital. The percentage of this assessment is to be calculated by DHHS so that the amount generated from assessment when matched with Federal funds in the Medicaid program is sufficient to reimburse the 67 private hospitals for their Medicaid costs consistent with the Medicaid reimbursements received by the 43 public hospitals and to fund an additional amount for the State's Medicaid program.

To fulfill the purpose of reimbursing the private hospitals, the rate must be set at 1.45% and would generate $118,317,394 for the first year, according to data from NCHA and DHHS.

As noted above, in order to maintain the payments at this level, the percentage would have to increase effective July 1, 2011, when the enhanced ARRA FMAP ends. At the end of each year, DHHS will be required to evaluate the amount of the Equity Assessment on Medicaid costs, to ensure that it does not exceed the Federal provider assessment guidelines, which permit an assessment on non-Medicare inpatient and outpatient revenue of up to 5.5%.

Upper Payment Limit Assessment/Upper Limit Payment

The bill also provides that DHHS levy an Upper Payment Limit (UPL) Assessment on the inpatient Medicaid costs of public and private hospitals, excluding:

- State-operated hospitals,
- Teaching Hospitals of the University of North Carolina Medical School,
- Critical Access Hospitals,
- Long-term Care Hospitals, and
- Free-standing Psychiatric and Rehabilitation Hospitals.

The percentage of this assessment is to be calculated by DHHS so that the amount generated from the assessment when matched with Federal funds in the Medicaid program is sufficient to reduce the losses that both public and private hospitals sustain when treating Medicaid and uninsured patients and to fund an additional amount for the State's Medicaid program.

To fulfill the purpose of reimbursing the public and private hospitals, the rate must be set at 0.76% and generate $ 97,298,136 for the first year, according to data from NCHA and DHHS.

Here again, in order to maintain the payments at this level, the percentage would have to increase effective July 1, 2011, due to the expiration of the enhanced FMAP. As with the Equity Assessment, DHHS will be required to evaluate the amount of the assessment on Medicaid costs, to ensure that it does not exceed the Federal provider assessment guidelines, which permit an assessment on non-Medicare inpatient and outpatient revenue.

Total Amount of Assessments

The combined Equity and UPL assessments in SB 32 will generate $215,615,530 in receipts the first year. This amount should be sufficient to cover the nonfederal share of the Equity and Upper Limit payments, as well as the $43 million payment for the State Medicaid program also provided for in the bill.

Payments to Hospitals

Of the nearly $216 million in receipts collected from the combined assessment, DHHS would use $173 million in the Medicaid program to draw down and an additional $413 million, for a total of $586 million Medicaid funds on an annual basis based on the current FMAP. DHHS would pay out this amount to the hospitals. The legislation calls for DHHS to disburse the Medicaid funds derived from these assessments on a quarterly basis.

In the aggregate, the public and private hospitals in North Carolina would net $370 million in payments over the assessments they paid ($586 million, less $216 million) for the first year. The total amount of the assessments and payments will more than likely change each year as hospital cost changes each year. However, because of the uncertainty of the changes in these costs, reasonable estimates of the assessments and payments to hospitals in future years cannot be determined.

SB32—Hospital Assessment Plan					
Assessments to Hospitals	**Amount to DHHS**	**State Share Medicaid**	**Federal Matching**	**Payments to Hospitals**	**Net Benefit to Hospitals**
$215,615,530	$43,000,000	$172,615,530	$413,347,075	$585,962,605	$370,347,074

Source: Department of Health and Human Services

With the proposed assessments, receipts, and resultant Medicaid funds, all North Carolina acute care hospitals included in SB 32 would be paid at the Medicare UPL for inpatient services for Medicaid patients, using hospital assessments to generate the additional needed federal matching funds. As a result, hospitals will have 86% of Medicaid allowable costs covered on an actual, net cash received basis and 27% of uninsured costs covered on the same basis, according to NCHA.

Payment to DHHS

SB 32 calls for $43 million of the amount collected from the Equity and UPL assessments each year to go to the State's Medicaid program. DHHS can use these funds as it chooses. If it were to use them for the Medicaid program, the $43 million would draw down an additional $86 million, approximately, in Federal matching funds for a total of $129 million in SFY 2011-12.

Each year the receipts derived from the two assessments in SB 32 will increase as hospital inpatient and outpatient costs increase. However, the amount DHHS is to receive will remain at $43 million.

Summary

SB 32 provides for the following:

1. An Equity Assessment and Payment to compensate private hospitals for their Medicaid costs and a level comparable to public hospitals. This assessment and payment would be adjusted each year.

2. An Upper Payment Limit Assessment and Payment to compensate public and private hospitals for treatment of the uninsured. This assessment and payment would be adjusted each year.

3. DHHS to receive $43 million from the Equity and Upper Payment Limit assessments. This amount would not be adjusted each year, but remain at $43 million.

SOURCES OF DATA: Kaiser Family Foundation; National Conference of State Legislatures; North Carolina Hospital Association; Department of Health and Human Services, Division of Medical Assistance

TECHNICAL CONSIDERATIONS: None

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