

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

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SENATE BILL 391

Short Title: Medicaid Modernized Hospital Assessments. (Public)

Sponsors: Senators Krawiec, Burgin, and Perry (Primary Sponsors).

Referred to: Rules and Operations of the Senate

March 31, 2021

1 A BILL TO BE ENTITLED
2 AN ACT TO REVISE THE HOSPITAL ASSESSMENT ACT TO ACCOUNT FOR
3 MEDICAID TRANSFORMATION.

4 The General Assembly of North Carolina enacts:

5 **SECTION 1.** Effective July 1, 2020, the following portions of S.L. 2020-88 are
6 repealed: subsections (b), (b1), (c), and (d) of Section 15.1, Section 15.2, and Section 15.3.

7 **SECTION 2.** Effective July 1, 2021, Chapter 108A of the General Statutes is
8 amended by adding a new Article to read:

9 "Article 7B.

10 "Hospital Assessment Act.

11 "Part 1. General.

12 "**§ 108A-145.1. Short title and purpose.**

13 This Article shall be known as the "Hospital Assessment Act." This Article does not authorize
14 a political subdivision of the State to license a hospital for revenue or impose a tax or assessment
15 on a hospital.

16 "**§ 108A-145.3. Definitions.**

17 The following definitions apply in this Article:

18 (1) Acute care hospital. – A hospital licensed in North Carolina that is not a
19 freestanding psychiatric hospital, a freestanding rehabilitation hospital, a
20 long-term care hospital, or a State-owned and State-operated hospital.

21 (2) Base capitation rate. – A periodic per-enrollee or per-event amount paid by
22 the Department to prepaid health plans for the delivery of Medicaid and NC
23 Health Choice services in accordance with Article 4 of Chapter 108D of the
24 General Statutes applicable to a particular rating group and appearing in a
25 Medicaid managed care capitation rate certification, as adjusted by the
26 Department and allowed by CMS in accordance with Part 438 of Subchapter
27 C of Chapter IV of Title 42 of the Code of Federal Regulations.

28 (3) Capitated contract plan type. – Any type of capitated prepaid health plan
29 contract defined in G.S. 108D-1.

30 (4) CMS. – Centers for Medicare and Medicaid Services.

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

32 (6) Federal medical assistance percentage (FMAP). – The federal share of North
33 Carolina Medicaid service costs as calculated by the federal Department of
34 Health and Human Services in accordance with Section 1905(b) of the Social
35 Security Act, in effect at the start of the applicable assessment quarter,
36 expressed as a decimal.



- 1 (7) Hospital costs. – A hospital's costs as calculated using the most recent
2 available Hospital Cost Report Information System's cost report data available
3 through CMS, including both inpatient and outpatient components.
- 4 (8) Inpatient hospital financing percentage. – For the 2021-2022 State fiscal year,
5 the inpatient hospital financing percentage is sixty-six and one-tenth percent
6 (66.1%), expressed as a decimal. For each subsequent State fiscal year, the
7 inpatient hospital financing percentage is the sum of the inpatient hospital
8 financing percentage for the previous State fiscal year plus the market basket
9 percentage, divided by the sum of one plus the market basket percentage.
- 10 (9) Inpatient hospital services. – As defined in the Medicaid State Plan, excluding
11 payments made under the graduate medical education methodology and the
12 disproportionate share hospital methodology.
- 13 (10) Inpatient portion of the statewide capitation rate. – The amount of the
14 statewide capitation rate applicable to a particular rating group that is
15 attributed to inpatient hospital facility health services in the applicable
16 Medicaid managed care rate certification, expressed as a statewide weighted
17 average of all PHP regions.
- 18 (11) Market basket percentage. – The hospital inpatient prospective payment
19 system market basket minus the multifactor productivity adjustment
20 established in rule by CMS and in effect on March 1 of the previous State
21 fiscal year, expressed as a decimal.
- 22 (12) Medicaid managed care capitation rate certification. – A rate certification for
23 any capitated contract plan type that contains the rates paid to prepaid health
24 plans and that has been submitted to CMS under 42 C.F.R. § 438.7 and, except
25 as otherwise provided in this subdivision, (i) has been approved by CMS and
26 (ii) is in effect during the applicable time period. If, on the first day of any
27 assessment quarter, CMS has not approved a rate certification for a particular
28 capitated contract plan type for that quarter, then the Medicaid managed care
29 capitation rate certification for that capitated contract plan type is the rate
30 certification submitted to CMS under 42 C.F.R. § 438.7 applicable to that
31 quarter.
- 32 (13) Outpatient hospital financing percentage. – Twenty-eight percent (28%),
33 expressed as a decimal.
- 34 (14) Outpatient hospital services. – As defined in the Medicaid State Plan.
- 35 (15) Outpatient portion of the statewide capitation rate. – The amount of the
36 statewide capitation rate applicable to a particular rating group that is
37 attributed to outpatient hospital facility services and emergency room facility
38 services in the applicable Medicaid managed care capitation rate
39 certifications, expressed as a statewide weighted average of all PHP regions.
- 40 (16) Paid capitation. – The total amount of the capitation payments made by the
41 Department to all prepaid health plans for a particular rating group (i)
42 attributable to the base capitation rate in the applicable Medicaid managed
43 care capitation rate certification and (ii) adjusted by the Department as a result
44 of retroactively implementing any base capitation rate adjustment that is
45 approved by CMS or allowed under Part 438 of Subchapter C of Chapter IV
46 of Title 42 of the Code of Federal Regulations.
- 47 (17) Previous data collection period. – The period beginning on the eleventh day
48 of the month that is four months prior to the start of the applicable assessment
49 quarter and ending on the tenth day of the month prior to the start of the
50 applicable assessment quarter.

- 1 (18) Private acute care hospital. – An acute care hospital that (i) is not qualified to
2 certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a
3 critical access hospital, and (iii) is not part of the UNC Health Care System.
4 (19) Private hospital historical assessment share. – Seventy-nine percent (79%),
5 expressed as a decimal.
6 (20) Public acute care hospital. – An acute care hospital that (i) is qualified to
7 certify public expenditures as described in 42 C.F.R. § 433.51(b), (ii) is not a
8 critical access hospital, (iii) is not part of the UNC Health Care System, and
9 (iv) is not the primary affiliated teaching hospital for the East Carolina
10 University Brody School of Medicine.
11 (21) Public hospital historical assessment share. – Twenty-one percent (21%),
12 expressed as a decimal.
13 (22) Rating group. – A category of beneficiaries or maternity services for which a
14 periodic per-enrollee or per-event amount appears in a Medicaid managed
15 care capitation rate certification.
16 (23) State's annual Medicaid payment. – An annual amount equal to one hundred
17 ten million dollars (\$110,000,000) for the period July 1, 2021, through June
18 30, 2022, increased each year over the prior year's payment by the market
19 basket percentage.
20 (24) Statewide capitation rate. – A periodic per-enrollee or per-event amount paid
21 by the Department to prepaid health plans for the delivery of Medicaid and
22 NC Health Choice services in accordance with Article 4 of Chapter 108D of
23 the General Statutes applicable to a particular rating group, expressed as a
24 statewide weighted average for the applicable capitated contract plan type for
25 all PHP regions and appearing in a Medicaid managed care capitation rate
26 certification, as adjusted by the Department and allowed by CMS in
27 accordance with Part 438 of Subchapter C of Chapter IV of Title 42 of the
28 Code of Federal Regulations.
29 (25) Third-party coverage. – Liability by any individual, entity, or program for the
30 payment of all or part of the expenditures for medical assistance under the
31 Medicaid State Plan that has been identified by the Department before making
32 the medical assistance expenditure.
33 (26) University of North Carolina Health Care System (UNC Health Care System).
34 – As established in G.S. 116-37 and including the following hospitals:
35 a. The University of North Carolina Hospitals at Chapel Hill.
36 b. Rex Hospital, Inc.
37 c. Chatham Hospital, Incorporated.
38 d. UNC Rockingham Health Care, Inc.
39 e. Caldwell Memorial Hospital, Incorporated.

40 **§ 108A-145.5. Due dates and collections.**

41 (a) Assessments under this Article are calculated, imposed, and due quarterly in the time
42 and manner prescribed by the Secretary and shall be considered delinquent if not paid within
43 seven calendar days of this due date.

44 (b) With respect to any hospital owing a past-due assessment amount under this Article,
45 the Department may withhold the unpaid amount from Medicaid or NC Health Choice payments
46 otherwise due or impose a late payment penalty. The Secretary may waive a penalty for good
47 cause shown.

48 (c) In the event the data necessary to calculate an assessment under this Article is not
49 available to the Secretary in time to impose the quarterly assessment, the Secretary may defer the
50 due date for the assessment to a subsequent quarter.

51 **§ 108A-145.7. Assessment appeals.**

1 A hospital may appeal a determination of the assessment amount owed through a
2 reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation
3 to pay an assessment amount when due.

4 **"§ 108A-145.9. Allowable costs; patient billing.**

5 (a) Assessments paid under this Article may be included as allowable costs of a hospital
6 for purposes of any applicable Medicaid reimbursement formula, except that assessments paid
7 under this Article shall be excluded from cost settlement.

8 (b) Assessments imposed under this Article may not be added as a surtax or assessment
9 on a patient's bill.

10 **"§ 108A-145.11. Rulemaking authority.**

11 The Secretary may adopt rules to implement this Article.

12 **"§ 108A-145.13. Repeal.**

13 If CMS determines that an assessment under this Article is impermissible or revokes approval
14 of an assessment under this Article, then that assessment shall not be imposed and the
15 Department's authority to collect the assessment is repealed.

16 "Part 2. Modernized Hospital Assessments.

17 **"§ 108A-146.1. Public hospital assessment.**

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

20 (b) The public hospital assessment shall be assessed as a percentage of each public acute
21 care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the
22 Department of Health and Human Services in accordance with this Part. The percentage for each
23 quarter shall equal the aggregate assessment collection amount under G.S. 108A-146.5
24 multiplied by the public hospital historical assessment share and divided by the total hospital
25 costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

26 **"§ 108A-146.3. Private hospital assessment.**

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

29 (b) The private hospital assessment shall be assessed as a percentage of each private acute
30 care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the
31 Department of Health and Human Services in accordance with this Part. The percentage for each
32 quarter shall equal the aggregate assessment collection amount under G.S. 108A-146.5
33 multiplied by the private hospital historical assessment share and divided by the total hospital
34 costs for all private acute care hospitals holding a license on the first day of the assessment
35 quarter.

36 **"§ 108A-146.5. Aggregate assessment collection amount.**

37 The aggregate assessment collection amount is an amount of money that is calculated by
38 adding (i) the managed care component under G.S. 108A-146.7, (ii) the fee-for-service
39 component under G.S. 108A-146.9, (iii) the GME component under G.S. 108A-146.11, and (iv)
40 one-fourth of the State's annual Medicaid payment, and then subtracting the intergovernmental
41 transfer adjustment component under G.S. 108A-146.13.

42 **"§ 108A-146.7. Managed care component.**

43 (a) The managed care component is an amount of money that is a portion of the total paid
44 capitation for all rating groups in all capitated contracted plan types for the previous data
45 collection period and is calculated in accordance with this section. The managed care component
46 consists of an inpatient subcomponent and an outpatient subcomponent.

47 (b) The inpatient subcomponent is an amount calculated for each rating group by
48 multiplying the paid capitation for the applicable rating group in the previous data collection
49 period by the percentage that is calculated by (i) multiplying the inpatient portion of the statewide
50 capitation rate for the applicable rating group by the inpatient hospital financing percentage, (ii)

1 multiplying that product by the difference of one minus the FMAP, and (iii) dividing that product
2 by the statewide capitation rate for the applicable rating group.

3 (c) The outpatient subcomponent is an amount calculated for each rating group by
4 multiplying the paid capitation for the applicable rating group in the previous data collection
5 period by the percentage that is calculated by (i) multiplying the outpatient portion of the
6 statewide capitation rate for the applicable rating group by the outpatient hospital financing
7 percentage, (ii) multiplying that product by the difference of one minus the FMAP, and (iii)
8 dividing that product by the statewide capitation rate for the applicable rating group.

9 (d) The managed care component is calculated by adding together the aggregate inpatient
10 subcomponents for all rating groups and the aggregate outpatient subcomponents for all rating
11 groups.

12 **"§ 108A-146.9. Fee-for-service component.**

13 (a) The fee-for-service component is an amount of money that is a portion of all the
14 Medicaid fee-for-service payments made to acute care hospitals during the previous data
15 collection period for claims with a date of service on or after July 1, 2021. The fee-for-service
16 component consists of a subcomponent pertaining to claims for which there is no third-party
17 coverage and a subcomponent pertaining to claims for which there is third-party coverage.

18 (b) The subcomponent pertaining to claims for which there is no third-party coverage is
19 the sum of the inpatient amount and the outpatient amount described in this subsection:

20 (1) The inpatient amount is the product of the total fee-for-service payments for
21 claims for which there is no third-party coverage made to all acute care
22 hospitals for inpatient hospital services multiplied by the inpatient hospital
23 financing percentage and multiplied by the difference of one minus the
24 FMAP.

25 (2) The outpatient amount is the product of the total fee-for-service payments for
26 claims for which there is no third-party coverage made to all acute care
27 hospitals for outpatient hospital services multiplied by the outpatient hospital
28 financing percentage and multiplied by the difference of one minus the
29 FMAP.

30 (c) The subcomponent pertaining to claims for which there is third-party coverage is the
31 product of the total fee-for-service payments for claims for which there is third-party coverage
32 made for inpatient hospital services and outpatient hospital services to (i) public acute care
33 hospitals, (ii) private acute care hospitals, and (iii) critical access hospitals multiplied by the
34 difference of one minus the FMAP.

35 (d) The fee-for-service component is calculated by adding together the subcomponent
36 pertaining to claims for which there is no third-party coverage and the subcomponent pertaining
37 to claims for which there is third-party coverage.

38 **"§ 108A-146.11. Graduate medical education component.**

39 The graduate medical education component is an amount of money that is one-fourth (1/4)
40 of the total amount of payments that will be made by the Department during the current State
41 fiscal year to all public acute care hospitals and private acute care hospitals in accordance with
42 the Medicaid graduate medical education methodology in the Medicaid State Plan multiplied by
43 the difference of one minus the FMAP.

44 **"§ 108A-146.13. Intergovernmental transfer adjustment component.**

45 (a) The intergovernmental transfer adjustment component is forty-four million nine
46 hundred twelve thousand five hundred seven dollars (\$44,912,507) for each quarter of the
47 2021-2022 State fiscal year. For each subsequent State fiscal year, the intergovernmental transfer
48 adjustment component shall be increased over the prior year's quarterly payment by the market
49 basket percentage.

50 (b) If a public acute care hospital closes or becomes a private acute care hospital, then,
51 beginning in the first assessment quarter following the closure or change to a private acute care

1 hospital and for each quarter thereafter, the intergovernmental transfer adjustment component
2 described in subsection (a) of this section, as inflated in accordance with that section, shall be
3 reduced by the amount of the public acute care hospital's intergovernmental transfer to the
4 Department made during its last quarter of operation as a public acute care hospital.

5 **"§ 108A-146.15. Use of funds.**

6 The proceeds of the assessments imposed under this Part, and all corresponding matching
7 federal funds, must be used to make the State's annual Medicaid payment to the State, to fund
8 payments to hospitals made directly by the Department, to fund a portion of capitation payments
9 to prepaid health plans attributable to hospital care, and to fund graduate medical education
10 payments.

11 **"§ 108A-146.17. Changes of hospital status.**

12 (a) For purposes of this section, hospital status includes all of the following:

- 13 (1) A hospital's status as a public acute care hospital, a private acute care hospital,
14 or a hospital owned or controlled by the UNC Health Care system.
15 (2) The operating status of an acute care hospital as open or closed, including new
16 hospitals and hospital closures.

17 (b) The Department of Health and Human Services shall report to the House of
18 Representatives Appropriations Committee on Health and Human Services, the Senate
19 Appropriations Committee on Health and Human Services, and the Fiscal Research Division
20 whenever the Department is notified of a possible change of hospital status. The report shall be
21 due 60 days after the Department is notified of the possible change. The report shall include all
22 of the following:

- 23 (1) The anticipated change of hospital status and the anticipated time frame during
24 which the change of hospital status may occur.
25 (2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes
26 that would be needed if the change in hospital status occurs, including
27 proposed changes to the public and private hospital historical assessment
28 shares in G.S. 108A-145.3 and the intergovernmental transfer adjustment
29 component in G.S. 108A-146.13, as well as the mathematical calculations
30 supporting the proposed changes.

31 (c) The Department of Health and Human Services shall report to the House of
32 Representatives Appropriations Committee on Health and Human Services, the Senate
33 Appropriations Committee on Health and Human Services, and the Fiscal Research Division
34 whenever the Department is notified that a change in hospital status has occurred. The report
35 shall be due 60 days after the Department is notified of the change. The report shall include all
36 of the following:

- 37 (1) The change of hospital status and the date of the change.
38 (2) Any proposed revisions to Article 7B of Chapter 108A of the General Statutes
39 that are needed as a result of the change in hospital status, including proposed
40 changes to the public and private hospital historical assessment shares in
41 G.S. 108A-145.3 and the intergovernmental transfer adjustment component in
42 G.S. 108A-146.13, as well as the mathematical calculations supporting the
43 proposed changes.
44 (3) If the change of hospital status occurred because a public acute care hospital
45 closed or became a private acute care hospital, then the amount of the public
46 acute care hospital's intergovernmental transfer to the Department made
47 during its last quarter of operation."

48 **SECTION 3.(a)** Notwithstanding G.S. 108A-146.1, established in Section 2 of this
49 act, for the assessment quarter beginning July 1, 2021, the public hospital assessment shall be
50 thirty-eight hundredths percent (0.38%) of total hospital costs for all public acute care hospitals.

1 **SECTION 3.(b)** Notwithstanding G.S. 108A-146.3, established in Section 2 of this
2 act, for the assessment quarter beginning July 1, 2021, the private hospital assessment shall be
3 eighty-seven hundredths percent (0.87%) of total hospital costs for all private acute care
4 hospitals.

5 **SECTION 4.(a)** Notwithstanding G.S. 108A-146.1, established in Section 2 of this
6 act, for the assessment quarter beginning October 1, 2021, the Department of Health and Human
7 Services shall determine the public hospital assessment percentage by, first, either increasing or
8 reducing the aggregate assessment collection amount under G.S. 108A-146.5 by the
9 reconciliation component under subsection (c) of this section, and then multiplying that amount
10 by the public hospital historical assessment share, and lastly dividing by the total hospital costs
11 of all public acute care hospitals.

12 **SECTION 4.(b)** Notwithstanding G.S. 108A-146.3, established in Section 2 of this
13 act, for the assessment quarter beginning October 1, 2021, the Department of Health and Human
14 Services shall determine the private hospital assessment percentage by, first, either increasing or
15 reducing the aggregate assessment collection amount under G.S. 108A-146.5 by the
16 reconciliation component under subsection (c) of this section, and then multiplying that amount
17 by the private hospital historical assessment share, and lastly dividing by the total hospital costs
18 of all private acute care hospitals.

19 **SECTION 4.(c)** The reconciliation component is a positive or a negative number
20 that results from subtracting the actual amount of public hospital assessment and private hospital
21 assessment collected for the assessment quarter beginning July 1, 2021, from the aggregate
22 assessment collection amount calculated under G.S. 108A-146.5 for the assessment quarter
23 beginning October 1, 2021, with the adjustment required in accordance with subsection (d) of
24 this section. If the reconciliation component is a positive number, then the aggregate assessment
25 collection amount shall be increased by the reconciliation component in accordance with this
26 section. If the reconciliation component is a negative number, then the aggregate assessment
27 collection amount shall be reduced by the reconciliation component in accordance with this
28 section.

29 **SECTION 4.(d)** Notwithstanding the definition of federal medical assistance
30 percentage (FMAP) in G.S. 108A-145.3, when calculating the aggregate assessment collection
31 amount under G.S. 108A-146.5 for the reconciliation component in subsection (c) of this section,
32 the FMAP used in the calculation shall be the federal share of North Carolina Medicaid service
33 costs as calculated by the federal Department of Health and Human Services in accordance with
34 Section 1905(b) of the Social Security Act that is in effect for the quarter beginning July 1, 2021.

35 **SECTION 5.** In response to changes in the Medicaid reimbursement environment
36 that may occur as a result of the transition to managed care, the Department of Health and Human
37 Services shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health
38 Choice and the Fiscal Research Division by January 1, 2026, with a proposal to replace or adjust
39 the market basket percentage as the inflation factor that is used in the modernized hospital
40 assessments in Part 2 of Article 7B of Chapter 108A of the General Statutes, as well as in the
41 hospital base rates for Medicaid fee-for-service reimbursements, beginning July 1, 2026.

42 **SECTION 6.** Except as otherwise provided, this act becomes effective July 1, 2021.