GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H **D**

HOUSE BILL 989
PROPOSED COMMITTEE SUBSTITUTE H989-PCS40506-MRxfa-8

Short Title: Required Components/Medicaid Transformation. (Public)

Sponsors:

Referred to:

April 26, 2019

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FUNDS FOR THE OPERATION OF THE MEDICAID AND NC HEALTH CHOICE PROGRAMS; TO AUTHORIZE THE USE OF THE MEDICAID TRANSFORMATION FUND FOR MEDICAID TRANSFORMATION NEEDS; TO REPEAL PAST DIRECTIVES TO ELIMINATE GRADUATE MEDICAL EDUCATION TO ALIGN WITH MEDICAID TRANSFORMATION; TO REVISE AND UPDATE HOSPITAL ASSESSMENTS IN A MANNER THAT WILL CONFORM WITH MEDICAID TRANSFORMATION; TO REVISE THE SUPPLEMENTAL PAYMENT PROGRAM FOR ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS AND TO ENACT THE MEDICARE RATE SUPPLEMENTAL AND DIRECTED PAYMENT PROGRAM; TO CREATE THE HOSPITAL UNCOMPENSATED CARE FUND; AND TO CODIFY THE MEDICAID CONTINGENCY RESERVE.

The General Assembly of North Carolina enacts:

PART I. IMPLEMENTATION IN CONJUNCTION WITH STATUTORY PROCEDURES FOR BUDGET CONTINUATION

SECTION 1.1. The provisions of this act shall be implemented in conjunction with the procedures for budget continuation specified in G.S. 143C-5-4(b). If the provisions of this act and G.S. 143C-5-4(b) are in conflict, the provisions of this act shall prevail.

PART II. FUNDS FOR OPERATION OF THE MEDICAID PROGRAM

SECTION 2.1.(a) There is appropriated from the General Fund the sum of thirty-three million seven hundred fifty-eight thousand one hundred thirty-six dollars ($33,758,136) in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice programs rebase.

SECTION 2.1.(b) There is appropriated from the General Fund the sum of twenty-eight million six hundred seventeen thousand six hundred fifty-five dollars ($28,617,655) in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services, Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

PART III. USE OF MEDICAID TRANSFORMATION FUND FOR MEDICAID TRANSFORMATION NEEDS

SECTION 3.1.(a) Funds Transfer. – The State Controller shall transfer the sum of one hundred ninety-three million dollars ($193,000,000) for the 2019-2020 fiscal year from funds

available in the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation Fund established under Section 12H.29 of S.L. 2015-241.

SECTION 3.1.(b) Claims Run Out. – Funds from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), as needed for the purpose of paying claims related to services billed under the fee-for-service payment model for recipients who are being, or have been, transitioned to managed care, otherwise known as "claims run out." Funds may be transferred to DHB as the need to pay claims run out arises and need not be transferred in one lump sum. To the extent that any funds are transferred under this subsection, the funds are appropriated for the purpose set forth in this subsection.

SECTION 3.1.(c) Non-Claims Run Out Medicaid Transformation Needs. – Subject to the fulfillment of conditions specified in subsection (d) of this section, the sum of twenty-seven million two hundred eighty thousand nine hundred forty-seven dollars ($27,280,947) in nonrecurring funds for the 2019-2020 fiscal year from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), for the sole purpose of providing the State share for nonrecurring qualifying needs directly related to Medicaid transformation, as required by S.L. 2015-241, as amended. Funds may be transferred to DHB as nonrecurring qualifying needs arise during the 2019-2021 fiscal biennium and need not be transferred in one lump sum.

For the purposes of this section, the term "qualifying need" shall be limited to information technology, time-limited staffing, and contracts related to the following Medicaid transformation needs:

(1) Program design.
(2) Beneficiary experience.
(3) NC FAST upgrades related to Medicaid transformation.
(4) Data management tools.
(5) Program integrity.
(6) Technical and operational integration.
(7) Other nonrecurring needs identified by DHB, as determined in consultation with the Office of State Budget and Management.

SECTION 3.1.(d) Requests for Transfer of Funds for Qualifying Need. – A request by the Department of Health and Human Services, Division of Health Benefits (DHB), for the transfer of funds pursuant to subsection (c) of this section shall be made to the Office of State Budget and Management (OSBM) and shall include the amount requested and the specific nonrecurring qualifying need for which the funds are to be used. None of the funds identified in subsection (c) of this section shall be transferred to DHB until OSBM verifies the following information:

(1) The amount requested is to be used for a nonrecurring qualifying need in the 2019-2021 fiscal biennium.
(2) The amount requested provides a State share that will not result in total requirements that exceed one hundred forty million dollars ($140,000,000) in nonrecurring funds for the 2019-2021 fiscal biennium.

SECTION 3.1.(e) Federal Fund Receipts. – Any federal funds received in any fiscal year by the Department of Health and Human Services, Division of Health Benefits (DHB), that represent a return of State share already expended on a qualifying need related to the funds received by the DHB under this section shall be deposited into the Medicaid Transformation Fund.

PART IV. REPEAL OF PAST DIRECTIVE TO ELIMINATE GME TO ALIGN WITH MEDICAID TRANSFORMATION

SECTION 4.1. Section 12H.12(b) of S.L. 2014-100 and Section 12H.23 of S.L. 2015-241, as amended by Section 88 of S.L. 2015-264, are repealed.

PART V. REVISE AND UPDATE HOSPITAL ASSESSMENTS

SECTION 5.1.(a) Effective October 1, 2019, Article 7 of Chapter 108A of the General Statutes is repealed.

SECTION 5.1.(b) Effective October 1, 2019, Chapter 108A of the General Statutes is amended by adding a new Article to read:

"Article 7A.

"Hospital Assessment Act.

"Part 1. General.

"**§ 108A-130. 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.

"**§ 108A-131. Definitions.**

The following definitions apply in this Article:

(1) Base assessment. – The assessment payable under G.S. 108A-142.

(2) CMS. – Centers for Medicare and Medicaid Services.

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

(4) Department. – The Department of Health and Human Services.

(5) Prepaid health plan. – As defined in G.S. 108D-1.

(6) Public hospital. – A hospital that certifies its public expenditures to the Department pursuant to 42 C.F.R. § 433.51(b) during the fiscal year for which the assessment applies.

(7) Secretary. – The Secretary of Health and Human Services.

(8) State's annual Medicaid payment. – An amount equal to one hundred ten million dollars ($110,000,000) for State fiscal year 2019-2020, increased each year over the prior year's payment by the percentage specified as the Medicare Market Basket Index less productivity most recently published in the Federal Register.

(9) Supplemental assessment. – The assessment payable under G.S. 108A-141.

(10) Total hospital costs. – The costs as calculated using the most recent available Hospital Cost Report Information System's cost report data available through CMS or other comparable data, including both inpatient and outpatient components, for all hospitals that are not exempt from the applicable assessment.

"**§ 108A-132. Due dates and collections.**

(a) Beginning October 1, 2019, assessments under this Article are 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 or NC Health Choice 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 assessments for a payment year, the Secretary may defer the due date for the assessment to a subsequent quarter.

"**§ 108A-133. 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.

"**§ 108A-134. 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.

"**§ 108A-135. Rule-making authority.**

The Secretary may adopt rules to implement this Article.

"**§ 108A-136. 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.

"Part 2. Supplemental and Base Assessments.

"**§ 108A-140. Applicability.**

(a) The assessments imposed under this Part apply to all licensed North Carolina hospitals, except as provided in this section.

(b) The following hospitals are exempt from both the supplemental assessment and the base assessment:

(1) Critical access hospitals.
(2) Freestanding psychiatric hospitals.
(3) Freestanding rehabilitation hospitals.
(4) Long-term care hospitals.
(5) State-owned and State-operated hospitals.
(6) The primary affiliated teaching hospital for each University of North Carolina medical school.

(c) Public hospitals are exempt from the supplemental assessment.

"**§ 108A-141. Supplemental assessment.**

(a) The supplemental assessment shall be a percentage, established by the General Assembly, of total hospital costs.

(b) The Department shall propose the rate of the supplemental assessment to be imposed under this section when the Department prepares its budget request for each upcoming fiscal year. The Governor shall submit the Department's proposed supplemental assessment rate to the General Assembly each fiscal year.

(c) The Department shall base the proposed supplemental assessment rate on all of the following factors:

(1) The percentage change in aggregate payments to hospitals subject to the supplemental assessment for Medicaid and NC Health Choice enrollees, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from prepaid health plans and the State, as determined by the Department.
(2) Any changes in the federal medical assistance percentage rate applicable to the Medicaid or NC Health Choice programs for the applicable year.

(d) The rate for the supplemental assessment for each taxable year shall be the percentage rate set by law by the General Assembly.

"**§ 108A-142. Base assessment.**

(a) The base assessment shall be a percentage, established by the General Assembly, of total hospital costs.

(b) The Department shall propose the rate of the base assessment to be imposed under this section when the Department prepares its budget request for each upcoming fiscal year. The Governor shall submit the Department's proposed base assessment rate to the General Assembly each fiscal year.

(c) The Department shall base the proposed base assessment rate on all of the following factors:

(1) The change in the State's annual Medicaid payment for the applicable year.

(2) The percentage change in aggregate payments to hospitals subject to the base assessment for Medicaid and NC Health Choice enrollees, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from prepaid health plans and the State, as determined by the Department.

(3) Any changes in the federal medical assistance percentage rate applicable to the Medicaid or NC Health Choice programs for the applicable year.

(4) Any changes as determined by the Department in (i) reimbursement under the Medicaid State Plan, (ii) managed care payments authorized under 42 C.F.R. § 438.6 for which the nonfederal share is not funded by General Fund appropriations, and (iii) reimbursement under the NC Health Choice program.

(d) The rate for the base assessment for each taxable year shall be the percentage rate set by law by the General Assembly.

"**§ 108A-143. Payment from other hospitals.**

If a hospital that is exempt from both the base and supplemental assessments under this Part (i) makes an intergovernmental transfer to the Department to be used to draw down matching federal funds and (ii) has acquired, merged, leased, or managed another hospital on or after March 25, 2011, then the exempt hospital shall transfer to the State an additional amount. The additional amount shall be a percentage of the amount of funds that (i) would be transferred to the State through such an intergovernmental transfer and (ii) are to be used to match additional federal funds that the exempt hospital is able to receive because of the acquired, merged, leased, or managed hospital. That percentage shall be calculated by dividing the amount of the State's annual Medicaid payment by the total amount collected under the base assessment under G.S. 108A-142.

"**§ 108A-144. 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, to fund payments to hospitals made directly by the Department, to fund a portion of capitation payments to prepaid health plans attributable to hospital care, and to fund the nonfederal share of graduate medical education payments."

SECTION 5.1.(c) The percentage rate to be used in calculating the supplemental assessment under G.S. 108A-141, as enacted in subsection (b) of this section, is two and twenty-six hundredths percent (2.26%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 5.1.(d) The percentage rate to be used in calculating the base assessment under G.S. 108A-142, as enacted in subsection (b) of this section, is one and seventy-seven hundredths percent (1.77%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 5.2. Notwithstanding G.S. 143C-4-11, as enacted by Section 7.1 of this act, the State Controller shall transfer funds from the Medicaid Contingency Reserve to the Department of Health and Human Services, Division of Health Benefits (DHB), only upon request by the DHB as needed to cover any shortfall in receipts from the supplemental or base assessments under G.S. 108A-141 and G.S. 108A-142, enacted by subsection (b) of Section 5.1 of this act, and only if the following two conditions are met:

(1) The Office of State Budget and Management (OSBM) has certified that there will be a shortfall in receipts from the supplemental or base assessments.

(2) OSBM has certified that the amount requested by DHB does not exceed the shortfall in receipts certified by OSBM under subdivision (1) of this subsection.

Upon making the request to the State Controller for the transfer of funds pursuant to this section, DHB shall notify the Fiscal Research Division and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the request and the amount of the request. To the extent any funds are transferred under this section, the funds are hereby appropriated for the purpose set forth in this section. The authority set forth in this section expires June 30, 2020.

SECTION 5.3.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), shall establish a new fund code entitled "Hospital Assessment Fund" in Budget Code 24445. When setting the supplemental assessment and base assessment rates in accordance with G.S. 108A-141(d) and G.S. 108A-142(d) for the 2020-2021 taxable year, funds in the Hospital Assessment Fund shall be used to support a decrease in the supplemental assessment or base assessment rates submitted by the Governor under G.S. 108A-141(b) and G.S. 108A-142(b) that corresponds with the amount in the Hospital Assessment Fund.

SECTION 5.3.(b) For the 2019-2020 fiscal year only, if the amount of receipts collected, in aggregate, from the supplemental and base assessments under G.S. 108A-141 and G.S. 108A-142 is more than the amount, in aggregate, anticipated in the Governor's proposed base budget for the 2019-2020 fiscal year for the Department of Health and Human Services, Division of Health Benefits, as adjusted by Section 2.1(a) of this act, from the supplemental and base assessments, then the amount of those over-realized receipts shall be transferred as follows:

(1) Forty-five million dollars ($45,000,000) shall be transferred to the Hospital Assessment Fund created under subsection (a) of this section. If the total amount of over-realized receipts is less than forty-five million dollars ($45,000,000), then the full amount of over-realized receipts shall be transferred to the Hospital Assessment Fund.

(2) The remaining amount of over-realized receipts not transferred under subdivision (1) of this subsection shall be transferred to the Medicaid Transformation Reserve.

(3) Prior to transferring any amount of over-realized receipts under this subsection, the Office of State Budget and Management shall certify that (i) there will be, in aggregate, over-realized receipts for the 2019-2020 fiscal year from the supplemental and base assessments and (ii) the amounts to be transferred are in compliance with this subsection.

PART VI. REVISE AND RENAME THE SUPPLEMENTAL PAYMENT PROGRAM FOR ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 6.1.(a) The Department of Health and Human Services shall revise the supplemental payment program for eligible medical professional providers described in the Medicaid State Plan, Attachment 4.19-B, Section 5, Pages 2 and 3, as required by this section. This payment program shall be called the Average Commercial Rate Supplemental and Directed Payment Program. Effective October 1, 2019, the following two changes to the program shall be implemented:

(1) The program shall no longer utilize a limit on the number of eligible medical professional providers that may be reimbursed through the program, and instead shall utilize a limit on the total payments made under the program.

(2) Payments under the program shall consist of two components: (i) supplemental payments that increase reimbursement to the average commercial rate under the State Plan and (ii) directed payments that increase reimbursement to the average commercial rate under the managed care system.

SECTION 6.1.(b) The limitation on total payments made under the Average Commercial Rate Supplemental and Directed Payment Program for eligible medical professional providers shall apply to the combined amount of payments made as supplemental payments under the State Plan and payments made as directed payments under the managed care system and shall be based on the amount of supplemental payments for services provided during the 2018-2019 fiscal year as follows:

(1) For services provided during the period October 1, 2019, through June 30, 2020, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed seventy-five percent (75%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year.

(2) For services provided on or after July 1, 2020, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed one hundred percent (100%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year, increased at the start of each State fiscal year by an inflation factor determined by the Department of Health and Human Services, Division of Health Benefits.

SECTION 6.1.(c) Consistent with the existing supplemental payment program for eligible medical professional providers, the Department of Health and Human Services shall limit the total amount of supplemental and directed payments that may be received by the eligible providers affiliated with East Carolina University Brody School of Medicine and University of North Carolina at Chapel Hill Health Care System. Average commercial rate supplemental payments and directed payments shall not be made for services provided in Wake County.

SECTION 6.1.(d) The Department of Health and Human Services is not authorized to make any modifications to the supplemental payment program for eligible medical professional providers, except as authorized by this section.

SECTION 6.1.(e) Effective October 1, 2019, Section 12H.13(e) of S.L. 2013-360 and Sections 12H.13(b) and 12H.13A of S.L. 2014-100 are repealed.

PART VII. MEDICAID CONTINGENCY RESERVE CODIFICATION

SECTION 7.1. Article 4 of Chapter 143C of the General Statutes is amended by adding a new section to read:

"**§ 143C-4-11. Medicaid Contingency Reserve.**

(a) Medicaid Contingency Reserve. – The Medicaid Contingency Reserve is established as a reserve to be used only for budget shortfalls in Medicaid or NC Health Choice programs.

(b) Funds from the Medicaid Contingency Reserve may be allocated or expended only if all of the following criteria are met:

(1) There is an act of appropriation by the General Assembly.

(2) After the State Controller has verified that receipts are being used appropriately, the Director of the Budget has found that additional funds are needed to cover a shortfall in the Medicaid or NC Health Choice budget for the State fiscal year.

(3) The Director of the Budget has reported immediately to the Fiscal Research Division on the amount of the shortfall found in accordance with subdivision (2) of this subsection. This report shall include an analysis of the causes of the shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii) unanticipated growth or utilization within particular service areas, (iii) errors in the data or analysis used to project the Medicaid or NC Health Choice budget, (iv) the failure of the program to achieve budgeted savings, (v) other

factors and market trends that have impacted the price of or spending for services, (vi) variations in receipts from prior years or from assumptions used to prepare the Medicaid and NC Health Choice budget for the current fiscal year, or (vii) other factors. The report shall also include data in an electronic format that is adequate for the Fiscal Research Division to confirm the amount of the shortfall and its causes.

(c) Nothing in this section shall be construed to limit the authority of the Governor to carry out the Governor's duties under the Constitution."

PART VIII. HOSPITAL UNCOMPENSATED CARE FUND

SECTION 8.1. Article 9 of Chapter 143 of the General Statutes is amended by adding a new section to read:

"**§ 143C-9-9. Hospital Uncompensated Care Fund.**

(a) Creation. – The Hospital Uncompensated Care Fund is established as a nonreverting special fund in the Department of Health and Human Services.

(b) Source of Funds. – The Fund shall consist of the federal disproportionate share adjustment receipts arising from certified public expenditures.

(c) Utilization of Funds. – The Department of Health and Human Services is authorized to utilize funds in the Hospital Uncompensated Care Fund to make the following payments, subject to any limitations under this section:

(1) Payments to institutions for mental diseases, as defined in 42 C.F.R. § 435.1010.

(2) Payments to eligible hospitals to reimburse inpatient services uncompensated care costs or outpatient services uncompensated care costs, or both.

(d) Eligibility and Fund Allocations. – The Department of Health and Human Services shall adopt rules for determining eligibility for, and allocations of, Hospital Uncompensated Care Fund payments."

PART IX. EFFECTIVE DATE

SECTION 9.1. Except as otherwise provided, this act is effective when it becomes law.