

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2019

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HOUSE BILL 555  
Committee Substitute Favorable 5/2/19  
Senate Health Care Committee Substitute Adopted 8/21/19  
PROPOSED SENATE COMMITTEE SUBSTITUTE H555-PCS50096-MRxfa-13

Short Title: Medicaid Transformation Implementation. (Public)

Sponsors:

Referred to:

April 3, 2019

1 A BILL TO BE ENTITLED  
2 AN ACT TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF MEDICAID  
3 TRANSFORMATION AND TO MAKE OTHER MEDICAID  
4 TRANSFORMATION-RELATED CHANGES.

5 The General Assembly of North Carolina enacts:

6  
7 **PART I. IMPLEMENTATION IN CONJUNCTION WITH STATUTORY**  
8 **PROCEDURES FOR BUDGET CONTINUATION**

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

12 **SECTION 1.2.** If House Bill 966, 2019 Regular Session, becomes law, then Section  
13 9D.14, Section 9D.15, Section 9D.15A, Section 9D.15B, Section 9D.16, Section 9D.17, Section  
14 9D.18, and Section 9D.19 of House Bill 966, 2019 Regular Session, are repealed.

15 **SECTION 1.3.** If House Bill 966, 2019 Regular Session, becomes law, then Part II  
16 of this act is repealed.

17  
18 **PART II. FUNDS FOR OPERATION OF THE MEDICAID PROGRAM**

19 **SECTION 2.1.(a)** There is appropriated from the General Fund the sum of  
20 thirty-three million seven hundred fifty-eight thousand one hundred thirty-six dollars  
21 (\$33,758,136) in recurring funds for the 2019-2020 fiscal year to the Department of Health and  
22 Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice  
23 programs rebase.

24 **SECTION 2.1.(b)** There is appropriated from the General Fund the sum of one  
25 hundred ninety-nine million seven hundred eighty-four thousand two hundred thirty-eight dollars  
26 (\$199,784,238) in recurring funds for the 2020-2021 fiscal year to the Department of Health and  
27 Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice  
28 programs rebase.

29 **SECTION 2.2.(a)** There is appropriated from the General Fund the sum of  
30 twenty-eight million six hundred seventeen thousand six hundred fifty-five dollars (\$28,617,655)  
31 in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services,  
32 Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

33 **SECTION 2.2.(b)** There is appropriated from the General Fund the sum of forty  
34 million one hundred sixty-seven thousand six hundred fifty-five dollars (\$40,167,655) in



1 recurring funds for the 2020-2021 fiscal year to the Department of Health and Human Services,  
2 Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

3 **SECTION 2.3.** Departmental receipts received as a result of this act are appropriated  
4 in each year of the 2019-2021 biennium for the purposes specified in this act.

5  
6 **PART III. USE OF MEDICAID TRANSFORMATION FUND FOR MEDICAID**  
7 **TRANSFORMATION NEEDS**

8 **SECTION 3.1.(a)** The State Controller shall transfer the sum of two hundred  
9 twenty-four million dollars (\$224,000,000) for the 2019-2020 fiscal year from funds available in  
10 the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation Fund  
11 established under Section 12H.29 of S.L. 2015-241.

12 **SECTION 3.1.(b)** The State Controller shall transfer the sum of forty-five million  
13 dollars (\$45,000,000) for the 2020-2021 fiscal year from funds available in the Medicaid  
14 Transformation Reserve in the General Fund to the Medicaid Transformation Fund established  
15 under Section 12H.29 of S.L. 2015-241.

16 **SECTION 3.2.(a)** Claims Run Out. – Funds from the Medicaid Transformation Fund  
17 may be transferred to the Department of Health and Human Services, Division of Health Benefits  
18 (DHB), as needed for the purpose of paying claims related to services billed under the  
19 fee-for-service payment model for recipients who are being, or have been, transitioned to  
20 managed care, otherwise known as "claims run out." Funds may be transferred to DHB as the  
21 need to pay claims run out arises and need not be transferred in one lump sum. To the extent that  
22 any funds are transferred under this subsection, the funds are appropriated for the purpose set  
23 forth in this subsection.

24 **SECTION 3.2.(b)** Non-Claims Run Out Medicaid Transformation Needs. – Subject  
25 to the fulfillment of conditions specified in subsection (c) of this section, the sum of twenty-seven  
26 million two hundred eighty thousand nine hundred forty-seven dollars (\$27,280,947) in  
27 nonrecurring funds for the 2019-2020 fiscal year and the sum of ten million nine hundred  
28 eighty-three thousand five hundred forty-eight dollars (\$10,983,548) for the 2020-2021 fiscal  
29 year from the Medicaid Transformation Fund may be transferred to the Department of Health  
30 and Human Services, Division of Health Benefits (DHB), for the sole purpose of providing the  
31 State share for nonrecurring qualifying needs directly related to Medicaid transformation, as  
32 required by S.L. 2015-241, as amended. Funds may be transferred to DHB as nonrecurring  
33 qualifying needs arise during the 2019-2021 fiscal biennium and need not be transferred in one  
34 lump sum. To the extent that any funds are transferred under this subsection, the funds are  
35 appropriated for the purpose set forth in this subsection.

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

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

47 **SECTION 3.2.(c)** Requests for Transfer of Funds for Qualifying Need. – A request  
48 by the Department of Health and Human Services, Division of Health Benefits (DHB), for the  
49 transfer of funds pursuant to subsection (b) of this section shall be made to the Office of State  
50 Budget and Management (OSBM) and shall include the amount requested and the specific  
51 nonrecurring qualifying need for which the funds are to be used. None of the funds identified in

1 subsection (b) of this section shall be transferred to DHB until OSBM verifies the following  
2 information:

- 3 (1) The amount requested is to be used for a nonrecurring qualifying need in the  
4 2019-2021 fiscal biennium.
- 5 (2) The amount requested provides a State share that will not result in total  
6 requirements that exceed one hundred ninety million dollars (\$190,000,000)  
7 in nonrecurring funds for the 2019-2021 fiscal biennium.

8 **SECTION 3.2.(d) Federal Fund Receipts.** – Any federal funds received in any fiscal  
9 year by the Department of Health and Human Services, Division of Health Benefits (DHB), that  
10 represent a return of State share already expended on a qualifying need related to the funds  
11 received by DHB under this section shall be deposited into the Medicaid Transformation Fund.

12 **SECTION 3.2.(e) Administrative Bridge Funding.** – Notwithstanding the stated  
13 purpose of the Medicaid Transformation Fund established under Section 12H.29 of S.L.  
14 2015-241, the sum of thirty million six hundred fifty-eight thousand eight hundred eighty-five  
15 dollars (\$30,658,885) in nonrecurring funds for the 2019-2020 fiscal year and the sum of  
16 twenty-one million three hundred forty-five thousand eight hundred eight dollars (\$21,345,808)  
17 in nonrecurring funds for the 2020-2021 fiscal year from the Medicaid Transformation Fund may  
18 be transferred to the Department of Health and Human Services for the purpose of providing  
19 nonrecurring funding for administrative expenses during the transition to Medicaid-managed  
20 care. To the extent that any funds are transferred under this subsection, the funds are appropriated  
21 for the purpose set forth in this subsection.  
22

#### 23 **PART IV. MEDICAID TRANSFORMATION ADMINISTRATIVE REDUCTION** 24 **FLEXIBILITY AND REPORT**

25 **SECTION 4.1.** The General Fund budget for the Division of Health Benefits is  
26 reduced by the sum of thirty million six hundred fifty-eight thousand eight hundred eighty-five  
27 dollars (\$30,658,885) in recurring funds for the 2019-2020 fiscal year and in the amount of  
28 forty-two million six hundred ninety-one thousand six hundred fifteen dollars (\$42,691,615) in  
29 recurring funds for the 2020-2021 fiscal year due to reduced administrative costs resulting from  
30 the implementation of Medicaid transformation. In order to achieve this reduction, the Secretary  
31 of the Department of Health and Human Services (Secretary) may reduce administrative costs  
32 across all Divisions within the Department of Health and Human Services. In achieving these  
33 budgeted reduction amounts, the Secretary shall not reduce any funds that (i) impact direct  
34 services or (ii) are used to support the 2012 settlement agreement entered into between the United  
35 States Department of Justice and the State of North Carolina to ensure that the State will willingly  
36 meet the requirements of the Americans with Disabilities Act of 1990, Section 504 of the  
37 Rehabilitation Act of 1973, and the United States Supreme Court decision in *Olmstead v. L.C.*,  
38 527 U.S. 581 (1999). The prohibition on reducing funds that impact direct services shall not be  
39 construed to prohibit a reduction in administrative costs associated with contracts for the  
40 provision of direct services.

41 **SECTION 4.2.** By January 15, 2020, and January 15, 2021, the Secretary of the  
42 Department of Health and Human Services (Secretary) shall submit a report to the Joint  
43 Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight  
44 Committee on Medicaid and North Carolina Health Choice, the House of Representatives  
45 Appropriations Committee on Health and Human Services, the Senate Appropriations  
46 Committee on Health and Human Services, and the Fiscal Research Division on the actions taken  
47 during that fiscal year to achieve the reduction in administrative costs attributable to the  
48 implementation of Medicaid transformation required by Section 4.1 of this act. If the Secretary  
49 elects to eliminate positions, the report shall include a list of each position eliminated, along with  
50 its position number, title, and the amount of salary and fringe benefits associated with each  
51 position.

1  
2 **PART V. REPEAL OF PAST DIRECTIVE TO ELIMINATE GME TO ALIGN WITH**  
3 **MEDICAID TRANSFORMATION**

4 **SECTION 5.1.** Section 12H.12(b) of S.L. 2014-100 and Section 12H.23 of S.L.  
5 2015-241, as amended by Section 88 of S.L. 2015-264, are repealed.  
6

7 **PART VI. MEDICAID TRANSFORMATION HOTLINE OPTION**

8 **SECTION 6.1.** The Department of Health and Human Services shall ensure that the  
9 existing DHHS Customer Service hotline is responsive to questions posed by a Medicaid  
10 beneficiary or provider or by the general public that are related to the rollout of Medicaid  
11 Transformation during the 2019-2020 fiscal year.  
12

13 **PART VII. TRIBAL OPTION/MEDICAID TRANSFORMATION**

14 **SECTION 7.1.(a)** The Department of Health and Human Services may contract with  
15 an Indian managed care entity (IMCE) or an Indian health care provider (IHCP), as defined under  
16 42 C.F.R. § 438.14(a), to assist in the provision of health care or health care–related services to  
17 Medicaid and NC Health Choice beneficiaries who are members of federally recognized tribes  
18 or who are eligible to enroll in an IMCE. Contracts may include health care or health care–related  
19 services as agreed upon with the IMCE or IHCP, as approved by the Secretary of the Department  
20 of Health and Human Services and as allowed by the Centers for Medicare and Medicaid Services  
21 (CMS), including, but not limited to, the following services:

- 22 (1) Primary care case management as a primary care case managed system or  
23 entity, as described in 42 C.F.R. § 438.2.  
24 (2) Utilization management and referrals.  
25 (3) The management or provision of home- and community-based services under  
26 a 1915(c) waiver.  
27 (4) The management or provision of specialized services covered by a BH IDD  
28 Tailored Plan in accordance with subdivision (10) of Section 4 of S.L.  
29 2015-245, as amended by S.L. 2018-48.

30 Coverage provided by the IMCE or IHCP may be more permissive, but no more  
31 restrictive, than Medicaid or NC Health Choice medical coverage policy adopted or amended by  
32 the Department of Health and Human Services; however, the coverage shall be in compliance  
33 with federal regulations and policies related to the receipt of federal funding for these health care  
34 or health care–related services.

35 **SECTION 7.1.(b)** Subdivision (5) of Section 4 of S.L. 2015-245, as amended by  
36 subsection 2(b) of S.L. 2016-121, S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of  
37 S.L. 2019-81, reads as rewritten:

38 "(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all  
39 Medicaid and NC Health Choice program aid categories except for the  
40 following categories:

41 ...

42 e. Members of federally recognized tribes. Members of federally  
43 recognized tribes shall have the option to enroll voluntarily in PHPs.

44 e1. Eligible recipients who are enrolled in a DHHS-contracted Indian  
45 managed care entity, as defined in 42 C.F.R. § 438.14(a).

46 ...."

47 **SECTION 7.1.(c)** Subdivision (9) of Section 4 of S.L. 2015-245, as amended by  
48 S.L. 2018-48 and Section 12 of S.L. 2019-81, reads as rewritten:

49 "(9) LME/MCOs. – Beginning on the date that capitated contracts begin,  
50 LME/MCOs shall cease managing Medicaid services for all Medicaid  
51 recipients other than recipients described in sub-subdivisions a., d., e., e1., f.,

- g., j., k., l., and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:
- a. LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., e1., f., g., j., k., l., and m. of subdivision (5) of this section.
  - b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.
  - c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

**SECTION 7.1.(d)** The Department of Health and Human Services is authorized to seek approval from CMS and submit any necessary State Plan Amendments and waivers, or any amendments thereto, to implement the provisions of this section.

**SECTION 7.1.(e)** Subsections (b) and (c) of this section become effective October 1, 2019.

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

**SECTION 8.1.(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 8.1.(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

1 eligible medical providers during the 2018-2019 fiscal year, increased at the  
2 start of each State fiscal year by an inflation factor determined by the  
3 Department of Health and Human Services, Division of Health Benefits.

4 **SECTION 8.1.(c)** Consistent with the existing supplemental payment program for  
5 eligible medical professional providers, the Department of Health and Human Services shall limit  
6 the total amount of supplemental and directed payments that may be received by the eligible  
7 providers affiliated with East Carolina University Brody School of Medicine and University of  
8 North Carolina at Chapel Hill Health Care System. Average commercial rate supplemental  
9 payments and directed payments shall not be made for services provided in Wake County.

10 **SECTION 8.1.(d)** The Department of Health and Human Services is not authorized  
11 to make any modifications to the supplemental payment program for eligible medical  
12 professional providers, except as authorized by this section.

13 **SECTION 8.1.(e)** Effective October 1, 2019, Section 12H.13(e) of S.L. 2013-360  
14 and Sections 12H.13(b) and 12H.13A of S.L. 2014-100 are repealed.

## 15 16 **PART IX. MEDICAID CONTINGENCY RESERVE CODIFICATION**

17 **SECTION 9.1.** Article 4 of Chapter 143C of the General Statutes is amended by  
18 adding a new section to read:

### 19 **"§ 143C-4-11. Medicaid Contingency Reserve.**

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

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

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

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

29 (3) The Director of the Budget has reported immediately to the Fiscal Research  
30 Division on the amount of the shortfall found in accordance with subdivision  
31 (2) of this subsection. This report shall include an analysis of the causes of the  
32 shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii)  
33 unanticipated growth or utilization within particular service areas, (iii) errors  
34 in the data or analysis used to project the Medicaid or NC Health Choice  
35 budget, (iv) the failure of the program to achieve budgeted savings, (v) other  
36 factors and market trends that have impacted the price of or spending for  
37 services, (vi) variations in receipts from prior years or from assumptions used  
38 to prepare the Medicaid and NC Health Choice budget for the current fiscal  
39 year, or (vii) other factors. The report shall also include data in an electronic  
40 format that is adequate for the Fiscal Research Division to confirm the amount  
41 of the shortfall and its causes.

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

## 44 45 **PART X. REVISE AND UPDATE HOSPITAL ASSESSMENTS**

46 **SECTION 10.1.(a)** Effective October 1, 2019, Article 7 of Chapter 108A of the  
47 General Statutes is repealed.

48 **SECTION 10.1.(b)** Effective October 1, 2019, Chapter 108A of the General Statutes  
49 is amended by adding a new Article to read:

50 "Article 7A.

51 "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.**

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

4 "Part 2. Supplemental and Base Assessments.

5 **"§ 108A-140. Applicability.**

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

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

10 (1) Critical access hospitals.

11 (2) Freestanding psychiatric hospitals.

12 (3) Freestanding rehabilitation hospitals.

13 (4) Long-term care hospitals.

14 (5) State-owned and State-operated hospitals.

15 (6) The primary affiliated teaching hospital for each University of North Carolina  
16 medical school.

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

18 **"§ 108A-141. Supplemental assessment.**

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

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

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

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

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

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

36 **"§ 108A-142. Base assessment.**

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

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

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

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

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

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



1           (4)    Any changes as determined by the Department in (i) reimbursement under the  
2                Medicaid State Plan, (ii) managed care payments authorized under 42 C.F.R.  
3                § 438.6 for which the nonfederal share is not funded by General Fund  
4                appropriations, and (iii) reimbursement under the NC Health Choice program.

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

7 **"§ 108A-143. Payment from other hospitals.**

8           If a hospital that is exempt from both the base and supplemental assessments under this Part  
9 (i) makes an intergovernmental transfer to the Department to be used to draw down matching  
10 federal funds and (ii) has acquired, merged, leased, or managed another hospital on or after March  
11 25, 2011, then the exempt hospital shall transfer to the State an additional amount. The additional  
12 amount shall be a percentage of the amount of funds that (i) would be transferred to the State  
13 through such an intergovernmental transfer and (ii) are to be used to match additional federal  
14 funds that the exempt hospital is able to receive because of the acquired, merged, leased, or  
15 managed hospital. That percentage shall be calculated by dividing the amount of the State's  
16 annual Medicaid payment by the total amount collected under the base assessment under  
17 G.S. 108A-142.

18 **"§ 108A-144. Use of funds.**

19           The proceeds of the assessments imposed under this Part, and all corresponding matching  
20 federal funds, must be used to make the State's annual Medicaid payment to the State, to fund  
21 payments to hospitals made directly by the Department, to fund a portion of capitation payments  
22 to prepaid health plans attributable to hospital care, and to fund the nonfederal share of graduate  
23 medical education payments."

24           **SECTION 10.1.(c)** The percentage rate to be used in calculating the supplemental  
25 assessment under G.S. 108A-141, as enacted in subsection (b) of this section, is two and  
26 twenty-six hundredths percent (2.26%) for the taxable year October 1, 2019, through September  
27 30, 2020.

28           **SECTION 10.1.(d)** The percentage rate to be used in calculating the base assessment  
29 under G.S. 108A-142, as enacted in subsection (b) of this section, is one and seventy-seven  
30 hundredths percent (1.77%) for the taxable year October 1, 2019, through September 30, 2020.

31           **SECTION 10.2.** Notwithstanding G.S. 143C-4-11, as enacted by Section 9.1 of this  
32 act, the State Controller shall transfer funds from the Medicaid Contingency Reserve to the  
33 Department of Health and Human Services, Division of Health Benefits (DHB), only upon  
34 request by DHB as needed to cover any shortfall in receipts from the supplemental or base  
35 assessments under G.S. 108A-141 and G.S. 108A-142, enacted by subsection (b) of Section 10.1  
36 of this act, and only if the following two conditions are met:

- 37           (1)    The Office of State Budget and Management (OSBM) has certified that there  
38                will be a shortfall in receipts from the supplemental or base assessments.  
39           (2)    OSBM has certified that the amount requested by DHB does not exceed the  
40                shortfall in receipts certified by OSBM under subdivision (1) of this  
41                subsection.

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

47           **SECTION 10.3.(a)** The Department of Health and Human Services, Division of  
48 Health Benefits (DHB), shall establish a new fund code entitled "Hospital Assessment Fund" in  
49 Budget Code 24445. When setting the supplemental assessment and base assessment rates in  
50 accordance with G.S. 108A-141(d) and G.S. 108A-142(d) for the 2020-2021 taxable year, funds  
51 in the Hospital Assessment Fund shall be used to support a decrease in the supplemental

1 assessment or base assessment rates submitted by the Governor under G.S. 108A-141(b) and  
2 G.S. 108A-142(b) that corresponds with the amount in the Hospital Assessment Fund.

3 **SECTION 10.3.(b)** For the 2019-2020 fiscal year only, if the amount of receipts  
4 collected, in aggregate, from the supplemental and base assessments under G.S. 108A-141 and  
5 G.S. 108A-142 is more than the amount, in aggregate, anticipated in the Governor's proposed  
6 base budget for the 2019-2020 fiscal year for the Department of Health and Human Services,  
7 Division of Health Benefits, as adjusted by Section 2.1 of this act, from the supplemental and  
8 base assessments, then the amount of those over-realized receipts shall be transferred as follows:

- 9 (1) Forty-five million dollars (\$45,000,000) shall be transferred to the Hospital  
10 Assessment Fund created under subsection (a) of this section. If the total  
11 amount of over-realized receipts is less than forty-five million dollars  
12 (\$45,000,000), then the full amount of over-realized receipts shall be  
13 transferred to the Hospital Assessment Fund.
- 14 (2) The remaining amount of over-realized receipts not transferred under  
15 subdivision (1) of this subsection shall be transferred to the Medicaid  
16 Transformation Reserve.
- 17 (3) Prior to transferring any amount of over-realized receipts under this  
18 subsection, the Office of State Budget and Management shall certify that (i)  
19 there will be, in aggregate, over-realized receipts for the 2019-2020 fiscal year  
20 from the supplemental and base assessments and (ii) the amounts to be  
21 transferred are in compliance with this subsection.  
22

## 23 **PART XI. GROSS PREMIUMS TAX/PREPAID HEALTH PLANS**

24 **SECTION 11.(a)** The title of Article 8B of Chapter 105 of the General Statutes reads  
25 as rewritten:

26 "Article 8B.

27 "Taxes Upon Insurance ~~Companies~~ Companies and Prepaid Health Plans."

28 **SECTION 11.(b)** G.S. 105-228.3 reads as rewritten:

### 29 **"§ 105-228.3. Definitions.**

30 The following definitions apply in this Article:

- 31 (1) Article 65 corporation. – A corporation subject to Article 65 of Chapter 58 of  
32 the General Statutes, regulating hospital, medical, and dental service  
33 corporations.
- 34 (2) Capitation payment. – Amounts paid by the Department of Health and Human  
35 Services to prepaid health plans under capitated contracts for the delivery of  
36 Medicaid and NC Health Choice services in accordance with Article 4 of  
37 Chapter 108D of the General Statutes.
- 38 ~~(1a)~~(3) Captive insurance company. – Defined in G.S. 58-10-340.
- 39 ~~(1b)~~(4) Foreign captive insurance company. – A captive insurance company as  
40 defined in G.S. 58-10-340(9), except that such company is not formed or  
41 licensed under the laws of this State but is formed and licensed under the laws  
42 of any jurisdiction within the United States other than this State.
- 43 ~~(2)~~(5) Insurer. – An insurer as defined in G.S. 58-1-5 or a group of employers who  
44 have pooled their liabilities pursuant to G.S. 97-93 of the Workers'  
45 Compensation Act.
- 46 (6) Prepaid health plan. – As defined in G.S. 108D-1.
- 47 ~~(3)~~(7) Self-insurer. – An employer that carries its own risk pursuant to G.S. 97-93 of  
48 the Workers' Compensation Act."

49 **SECTION 11.(c)** G.S. 105-228.5 reads as rewritten:

50 **"§ 105-228.5. Taxes measured by gross premiums.**

1 (a) Tax Levied. – A tax is levied in this section on insurers, Article 65 corporations, health  
2 maintenance organizations, prepaid health plans, and self-insurers. An insurer, health  
3 maintenance organization, prepaid health plan, or Article 65 corporation that is subject to the tax  
4 levied by this section is not subject to franchise or income taxes imposed by Articles 3 and 4,  
5 respectively, of this Chapter.

6 (b) Tax Base. –

7 (1) Insurers. – The tax imposed by this section on an insurer or a health  
8 maintenance organization shall be measured by gross premiums from business  
9 done in this State during the preceding calendar year.

10 (2) Repealed by Session Laws 2006-196, effective for taxable years beginning on  
11 or after January 1, 2008.

12 (3) Article 65 Corporations. – The tax imposed by this section on an Article 65  
13 corporation shall be measured by gross collections from membership dues,  
14 exclusive of receipts from cost plus plans, received by the corporation during  
15 the preceding calendar year.

16 (4) Self-insurers. – The tax imposed by this section on a self-insurer shall be  
17 measured by the gross premiums that would be charged against the same or  
18 most similar industry or business, taken from the manual insurance rate then  
19 in force in this State, applied to the self-insurer's payroll for the previous  
20 calendar year as determined under Article 36 of Chapter 58 of the General  
21 Statutes modified by the self-insurer's approved experience modifier.

22 (5) Prepaid health plans. – The tax imposed by this section on a prepaid health  
23 plan shall be measured by gross capitation payments received by the prepaid  
24 health plan from the Department of Health and Human Services for services  
25 provided to enrollees in the State Medicaid program or NC Health Choice  
26 program in the preceding calendar year.

27 (b1) Calculation of Tax Base. – In determining the amount of gross premiums from  
28 business in this State, all gross premiums received in this State, credited to policies written or  
29 procured in this State, or derived from business written in this State shall be deemed to be for  
30 contracts covering persons, property, or risks resident or located in this State unless one of the  
31 following applies:

32 (1) The premiums are properly reported and properly allocated as being received  
33 from business done in some other nation, territory, state, or states.

34 (2) The premiums are from policies written in federal areas for persons in military  
35 service who pay premiums by assignment of service pay.

36 Gross premiums from business done in this State in the case of life insurance contracts,  
37 including supplemental contracts providing for disability benefits, accidental death benefits, or  
38 other special benefits that are not annuities, means all premiums collected in the calendar year,  
39 other than for contracts of reinsurance, for policies the premiums on which are paid by or credited  
40 to persons, firms, or corporations resident in this State, or in the case of group policies, for  
41 contracts of insurance covering persons resident within this State. The only deductions allowed  
42 shall be for premiums refunded on policies rescinded for fraud or other breach of contract and  
43 premiums that were paid in advance on life insurance contracts and subsequently refunded to the  
44 insured, premium payer, beneficiary or estate. Gross premiums shall be deemed to have been  
45 collected for the amounts as provided in the policy contracts for the time in force during the year,  
46 whether satisfied by cash payment, notes, loans, automatic premium loans, applied dividend, or  
47 by any other means except waiver of premiums by companies under a contract for waiver of  
48 premium in case of disability.

49 Gross premiums from business done in this State in the case of prepaid health plans means  
50 all capitation payments received by a prepaid health plan from the Department of Health and  
51 Human Services for the delivery of services to enrollees in the State Medicaid program or NC

1 Health Choice program in the calendar year. Capitation payments refunded by a prepaid health  
2 plan to the State are the only allowable deductions.

3 Gross premiums from business done in this State for all other health care plans and contracts  
4 of insurance, including contracts of insurance required to be carried by the Workers'  
5 Compensation Act, means all premiums written during the calendar year, or the equivalent  
6 thereof in the case of self-insurers under the Workers' Compensation Act, for contracts covering  
7 property or risks in this State, other than for contracts of reinsurance, whether the premiums are  
8 designated as premiums, deposits, premium deposits, policy fees, membership fees, or  
9 assessments. Gross premiums shall be deemed to have been written for the amounts as provided  
10 in the policy contracts, new and renewal, becoming effective during the year irrespective of the  
11 time or method of making payment or settlement for the premiums, and with no deduction for  
12 dividends whether returned in cash or allowed in payment or reduction of premiums or for  
13 additional insurance, and without any other deduction except for return of premiums, deposits,  
14 fees, or assessments for adjustment of policy rates or for cancellation or surrender of policies.

15 (c) Exclusions. – Every insurer, in computing the premium tax, shall exclude all of the  
16 following from the gross amount of premiums, and the gross amount of excluded premiums is  
17 exempt from the tax imposed by this section:

18 (1) All premiums received on or after July 1, 1973, from policies or contracts  
19 issued in connection with the funding of a pension, annuity, or profit-sharing  
20 plan qualified or exempt under section 401, 403, 404, 408, 457 or 501 of the  
21 Code as defined in G.S. 105-228.90.

22 (2) Premiums or considerations received from annuities, as defined in  
23 G.S. 58-7-15.

24 (3) Funds or considerations received in connection with funding agreements, as  
25 defined in G.S. 58-7-16.

26 (4) The following premiums, to the extent federal law prohibits their taxation  
27 under this Article:

28 a. Federal Employees Health Benefits Plan premiums.

29 b. ~~Medicaid or Medicare~~ premiums.

30 c. Medicaid or NC Health Choice premiums, other than capitation  
31 payments, paid by or on behalf of a Medicaid or NC Health Choice  
32 beneficiary.

33 (d) Tax Rates; Disposition. –

34 (1) Workers' Compensation. – The tax rate to be applied to gross premiums, or  
35 the equivalent thereof in the case of self-insurers, on contracts applicable to  
36 liabilities under the Workers' Compensation Act is two and five-tenths percent  
37 (2.5%). The net proceeds shall be credited to the General Fund.

38 (2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on  
39 all other taxable contracts issued by insurers or health maintenance  
40 organizations and to be applied to gross premiums and gross collections from  
41 membership dues, exclusive of receipts from cost plus plans, received by  
42 Article 65 corporations is one and nine-tenths percent (1.9%). The net  
43 proceeds shall be credited to the General Fund.

44 (2a) Prepaid Health Plans. – The tax rate to be applied to gross premiums from  
45 capitation payments received by prepaid health plans is one and nine-tenths  
46 percent (1.9%). The net proceeds shall be credited to the General Fund.

47 (3) Additional Rate on Property Coverage Contracts. – An additional tax at the  
48 rate of seventy-four hundredths percent (0.74%) applies to gross premiums on  
49 insurance contracts for property coverage. The tax is imposed on ten percent  
50 (10%) of the gross premiums from insurance contracts for automobile  
51 physical damage coverage and on one hundred percent (100%) of the gross

1 premiums from all other contracts for property coverage. Twenty percent  
2 (20%) of the net proceeds of this additional tax must be credited to the  
3 Volunteer Fire Department Fund established in Article 87 of Chapter 58 of  
4 the General Statutes. Twenty percent (20%) of the net proceeds must be  
5 credited to the Department of Insurance for disbursement pursuant to  
6 G.S. 58-84-25. Up to twenty percent (20%), as determined in accordance with  
7 G.S. 58-87-10(f), must be credited to the Workers' Compensation Fund. The  
8 remaining net proceeds must be credited to the General Fund. The additional  
9 tax imposed on property coverage contracts under this subdivision is a special  
10 purpose assessment based on gross premiums and not a gross premiums tax.  
11 The following definitions apply in this subdivision:

- 12 a. Automobile physical damage. – The following lines of business  
13 identified by the NAIC: private passenger automobile physical  
14 damage and commercial automobile physical damage.  
15 b. Property coverage. – The following lines of business identified by the  
16 NAIC: fire, farm owners multiple peril, homeowners multiple peril,  
17 nonliability portion of commercial multiple peril, ocean marine, inland  
18 marine, earthquake, private passenger automobile physical damage,  
19 commercial automobile physical damage, aircraft, and boiler and  
20 machinery. The term also includes insurance contracts for wind  
21 damage.  
22 c. NAIC. – National Association of Insurance Commissioners.

23 (4) Repealed by Session Laws 2006-196, effective for taxable years beginning on  
24 or after January 1, 2008.

25 (5) Repealed by Session Laws 2003-284, s. 43.1, effective for taxable years  
26 beginning on or after January 1, 2004.

27 (6) Repealed by Session Laws 2005-276, s. 38.4(a), effective for taxable years  
28 beginning on or after January 1, 2007.

29 (e) Report and Payment. – Each taxpayer doing business in this State shall, within the  
30 first 15 days of March, file with the Secretary of Revenue a full and accurate report of the total  
31 gross premiums as defined in this section, the payroll and other information required by the  
32 Secretary in the case of a self-insurer, or the total gross collections from membership dues  
33 exclusive of receipts from cost plus plans collected in this State during the preceding calendar  
34 year. The taxes imposed by this section shall be remitted to the Secretary with the report.

35 (f) Installment Payments Required. – Taxpayers that are subject to the tax imposed by  
36 this section and have a premium tax liability of ten thousand dollars (\$10,000) or more for  
37 business done in North Carolina during the immediately preceding year shall remit three equal  
38 quarterly installments with each installment equal to at least thirty-three and one-third percent  
39 (33 1/3%) of the premium tax liability incurred in the immediately preceding taxable year. The  
40 quarterly installment payments shall be made on or before April 15, June 15, and October 15 of  
41 each taxable year. The ~~company taxpayer~~ shall remit the balance by the following March 15 in  
42 the same manner provided in this section for annual returns.

43 The Secretary may permit an insurance company or prepaid health plan to pay less than the  
44 required estimated payment when the insurer or prepaid health plan reasonably believes that the  
45 total estimated payments made for the current year will exceed the total anticipated tax liability  
46 for the year.

47 An underpayment or an overpayment of an installment payment required by this subsection  
48 accrues interest in accordance with G.S. 105-241.21. An overpayment of tax shall be credited to  
49 the ~~company taxpayer~~ and applied against the taxes imposed upon the ~~company taxpayer~~  
50 under this Article.

1 (g) Exemptions. – This section does not apply to farmers' mutual assessment fire  
2 insurance companies or to fraternal orders or societies that do not operate for a profit and do not  
3 issue policies on any person except members. This section does not apply to a captive insurance  
4 company taxed under G.S. 105-228.4A."

5 **SECTION 11.(d)** G.S. 58-6-25 reads as rewritten:

6 "**§ 58-6-25. Insurance regulatory charge.**

7 ...

8 (e) Definitions. – The following definitions apply in this section:

9 ...

10 (2) Insurance company. – A company or prepaid health plan, as defined in  
11 G.S. 58-93-5, that pays the gross premiums tax levied in G.S. 105-228.5 and  
12 G.S. 105-228.8.

13 ...."

14 **SECTION 11.(e)** G.S. 105-259 reads as rewritten:

15 "**§ 105-259. Secrecy required of officials; penalty for violation.**

16 ...

17 (b) Disclosure Prohibited. – An officer, an employee, or an agent of the State who has  
18 access to tax information in the course of service to or employment by the State may not disclose  
19 the information to any other person except as provided in this subsection. Standards used or to  
20 be used for the selection of returns for examination and data used or to be used for determining  
21 the standards may not be disclosed for any purpose. All other tax information may be disclosed  
22 only if the disclosure is made for one of the following purposes:

23 ...

24 (49) To exchange information concerning a tax imposed by Article 8B of this  
25 Chapter with the North Carolina Department of Insurance or the North  
26 Carolina Department of Health and Human Services when the information is  
27 needed to fulfill a duty imposed on the ~~Department.~~Department of Revenue.

28 ...."

29 **SECTION 11.(f)** This section is effective October 1, 2019, and applies to capitation  
30 payments received by prepaid health plans on or after that date.

## 31 **PART XII. HOSPITAL UNCOMPENSATED CARE FUND**

32 **SECTION 12.1.** Article 9 of Chapter 143 of the General Statutes is amended by  
33 adding a new section to read:

34 "**§ 143C-9-9. Hospital Uncompensated Care Fund.**

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

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

39 (c) Utilization of Funds. – The Department of Health and Human Services is authorized  
40 to utilize funds in the Hospital Uncompensated Care Fund to make the following payments,  
41 provided the entity receiving the payment has been determined to be an eligible entity in  
42 accordance with subsection (d) of this section:

43 (1) Payments to institutions for mental diseases, as defined in 42 C.F.R. §  
44 435.1010.

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

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

1 **PART XIII. EFFECTIVE DATE**

2           **SECTION 13.1.** Except as otherwise provided, this act is effective when it becomes  
3 law.