Proposed Legislative Changes Related to the Hospital Provider Assessment Act

Session Law 2018-49, Section 9.(b)

Report to

The Joint Legislative Oversight Committee on Medicaid and NC Health Choice

By

North Carolina Department of Health and Human Services

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Contents

Introduction

Pursuant to Section 9.(b) of Session Law (S.L.) 2015-245, as amended,[1] the North Carolina Department of Health and Human Services (DHHS) is submitting this report on proposed legislative changes to the Hospital Provider Assessment Act in Article 7 of Chapter 108A of the General Statutes to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, North Carolina General Assembly.

On June 15, 2018, the North Carolina General Assembly passed S.L. 2018-49, amending S.L. 2015-245 "An Act to Transform and Reorganize North Carolina's Medicaid and NC Health Choice Programs." This new law establishes the intent of the General Assembly to enact legislation during the 2019 Regular Session that will replace the Hospital Provider Assessment Act in Article 7 of Chapter 108A of the General Statutes with a similar hospital provider assessment that will preserve existing levels of funding generated by the current assessment and will result in similar overall payment levels to hospitals.

Under section 9.(b) of S.L. 2015-245, as amended by S.L. 2018-49, DHHS is required to submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the North Carolina General Assembly a report "containing proposed legislative changes necessary to accomplish the intent set forth" above. This report must contain three components:

1. A description of the new assessment calculation methodology compared to the existing methodology and an estimate of the change in proceeds or revenue from the assessment compared to historical proceeds or revenue from the assessment.
2. A detailed description of the proposed uses for the proceeds of the tax or assessment.
3. Assurances that the proposed legislative changes do not violate federal Medicaid laws or regulations and are consistent with federal Medicaid managed care regulations.

This report addresses each component required by the legislation. The Department looks forward to continued collaboration with the General Assembly, the North Carolina Healthcare Association, and other stakeholders related to the development and passage of new provider assessment legislation (proposed legislative language included in Appendix).

[1] References to S.L. 2015-245 include subsequent amendments by S.L. 2016-121; Section 11H.17(a) of S.L. 2017-57; Section 4 of S.L. 2017-186; Section 11H.10.(d) of S.L. 2018-5; and S.L. 2018-49. This document is in response to reporting requirements defined in S.L 2018-49.

1. Comparison of Current and Proposed Assessment Calculation Methodology and Estimate of Revenue Change

Current Provider Assessment Methodology

NC G.S. 108A imposes two separate assessments on providers: (1) an equity assessment to fund equity payments made under the State's current supplemental payments plan (called the MRI/GAP plan), and (2) a UPL assessment to fund UPL payments made under the MRI/GAP plan in accordance with its approved State Plan Amendment. In addition to funding hospital payments, a portion of each assessment is retained by the State in accordance with G.S. 108A-123(d). Public hospitals are exempt from the equity assessment (G.S.108A-122(d)). Certain providers, specified in G.S.108A-122(c), are exempt from both assessments.[2] Providers exempt from one or both assessments may make contributions in other forms, such as intergovernmental transfers or certified public expenditures, that are outside the scope of this legislation.

North Carolina's Department of Health and Human Services (DHHS) determines the total equity and UPL payment amounts and the non-federal share needed to fund the hospital payments and state retention. DHHS then sets the assessment as a percentage of total hospital costs.

In SFY 2017, the total revenue generated from both assessments was approximately $485 million. Of that amount, the State retained approximately $140 million.

Future Provider Assessment Methodology

Background. The existing system of Medicaid supplemental payments is not permitted under federal rules in managed care; it also is not aligned with the State's goal of purchasing value. As a first step toward ensuring federal compliance and promoting value-based payments, most supplemental payments—including the equity and UPL payments currently funded by the hospital assessments—will be incorporated into base rates, directly tying most hospital payments to utilization of services. Specifically, inpatient base rates will be set to ensure each

[2] The following hospitals are exempt from both assessments: State-owned and State-operated hospitals; the primary affiliated teaching hospital for each University of North Carolina medical school; critical access hospitals; long-term care hospitals; freestanding psychiatric hospitals; freestanding rehabilitation hospitals.

hospital within a class[3] (public, non-public, and primary affiliated teaching hospitals for the University of North Carolina Medical Schools) receives the same percentage of Medicaid and uninsured costs covered on a per unit basis. Outpatient base rates will be set to approximate 100% of costs based on each hospital's cost to charge ratio.[4] The Department will continue to make DSH and GME payments directly to hospitals, and such payments will not be incorporated into base rates.

Prepaid Health Plans (PHPs) will be required to pay no less than these new, higher inpatient and outpatient base rates for at least the first three contract years (longer for critical access hospitals and hospitals in economically distressed counties), unless the PHP and hospital mutually agree to an alternative reimbursement amount or methodology.

The Governor's budget also proposes that hospitals receive an additional "glide path" or "access" payment to offset approximately 40% of projected revenue losses related to lower expected hospital utilization under managed care.[5] These additional payments will phase out over the first three PHP contract years.

The Department plans to release an additional policy paper in spring 2019 memorializing the specifics of the hospital payment methodology under managed care.

Since the equity and UPL payments will be incorporated into base rates, rather than paid separately, DHHS will need a new methodology for calculating hospital provider assessments. The new assessment calculation methodology is designed to preserve existing levels of funding generated by the assessment and similar overall net payment levels to hospitals, assuming that hospital utilization remains at the same levels.[6] Specifically, the methodology ensures hospitals continue to fund approximately the same proportion of their gross Medicaid payments after the managed care transition compared to the current state.

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[3] Inpatient payment methodology for critical access hospitals will differ from the above. Additional details will be included in forthcoming policy paper.

[4] UNC Health Care and Vidant Medical Center will receive additional inpatient and outpatient directed payments to approximate current per-unit payment levels.

[5] Payments will be made under 42 CFR § 438.6. The Department has included an appropriation request to fund the non-federal share of such payments in the Governor's budget, see https://files.nc.gov/ncosbm/documents/files/BudgetBook_web_2019.pdf, p. 130

[6] Current assessment revenue varies annually based on changes to Medicaid enrollment and utilization. Assessment revenue under managed care will vary based on the same factors.

The methodology will maintain two separate assessments and continue to exempt the same hospitals as defined in G.S. 108A-122(c) and 122(d). The UPL assessment will be re-named the "base assessment" and equity assessment will be renamed the "supplemental assessment" to align with the new hospital payment methodology. The Department will consult with [INSERT COMMITTEE SPECIFIED BY GENERAL ASSEMBLY] in setting and updating the assessment rates.

Base Assessment.

Initial Assessment. The initial base assessment ("target amount") will be set to approximate the amount paid under the UPL assessment in the FFY 2018 MRI/GAP plan year. The target amount will be increased to account for the non-federal share of increased gross payments to hospitals resulting from the new hospital payment methodology, including claims where Medicaid is the secondary payer to Medicare or third-party coverage, NC Health Choice payments, and any increased Medicaid GME payments.[7] *Hospitals will fund the full non-federal share amount of these increased gross payments, so there will be no increased cost to the State.* The target amount will then be divided by total hospital costs for all hospitals subject to the base assessment to arrive at an assessment rate.

***Annual Adjustment*.** DHHS will adjust the target amount annually to account for changes in gross GME payments, the State retention amount (see "state retention" section below), and Medicaid/CHIP federal matching rates. The target amount will also be adjusted by the percentage change in Medicaid payments to all hospitals subject to the base assessment plus critical access hospitals. The State expects that hospital utilization, and with it hospital payments, will decline under managed care, and thus the assessment revenue will also decline; however, the retention will remain at $110 million annually plus an annual trend factor (see "State retention" below).[8] Under this methodology, while total dollars collected under the base assessment will fluctuate annually, the base assessment will continue to finance roughly the same proportion of gross Medicaid hospital payments (for all hospitals subject to the base assessment plus critical access hospitals). *Because the assessment rate will change proportionately with hospital payments, there will be no increased cost to the*

[7] Additional details on hospital payment methodology are included in Medicaid Managed Care Draft Rate Book (p.195-197), available at: https://files.nc.gov/ncdhhs/30-19029-DHB-4.pdf.

State related to hospital payments. In sum, the approach for adjusting the base assessment maintains the current balance of financing for both the State and the hospitals.

Supplemental Assessment.

Initial Assessment. The initial supplemental assessment ("target amount") will be set to approximate the amount paid under the equity assessment in the FFY 2018 MRI/GAP plan year. The target amount will then be divided by total hospital costs for all hospitals subject to the supplemental assessment to arrive at an assessment rate.

***Annual Adjustment*.** DHHS will adjust the target amount annually to account for changes in Medicaid/CHIP federal matching rates. The target amount will also be adjusted by the percentage change in Medicaid payments to all hospitals subject to the supplemental assessment. Under this methodology, while total dollars collected under the supplemental assessment will fluctuate annually, the supplemental assessment will continue to finance the same proportion of gross Medicaid payments (for all hospitals subject to the supplemental assessment). *Because the assessment rate will change proportionately with hospital payments, there will be no increased cost to the State related to hospital payments.* Like with the base assessment, the approach for adjusting the supplemental assessment maintains the current balance of financing for both the State and the hospitals.

State Retention. The State will retain $110 million annually from revenue collected under the base assessment, trended annually based on the Medicare market basket index minus productivity adjustment. The retention amount represents the current approximate annual State retention, less $30 million to account for hospitals' parallel $30 million non-federal share **increase** to fully fund GME payments. Taken together, the changes have no net impact on hospitals' non-federal share contribution.

Expected Revenue. Based on initial estimates, in State Fiscal Year 2020 DHHS expects to generate approximately $475 million from both assessments.[9] The additional $34 million (from $441 million in SFY 2018) will fund the non-federal share of changes in

[9] Estimates are preliminary and subject to additional refinement.

reimbursement under the State Plan and the NC Health Choice Program. Examples include:

- Increased Medicaid FFS payments for cost-sharing for individuals with primary coverage from Medicare or commercial insurance—referred to as "crossover claims."
- Increased NC Health Choice payments (under the current payment methodology, there are no supplemental payments related to NC Health Choice claims. Under the new methodology, hospitals will receive the enhanced Medicaid FFS rate for NC Health Choice claims).

2. Description of Proposed Uses for the Proceeds of the Assessment

Proceeds from the assessments will be used to fund PHP capitation payments, Medicaid and CHIP FFS inpatient and outpatient hospital payments, GME payments, and the State retention (described above).

3. Assurances that the Proposed Legislative Changes Do Not Violate Federal Medicaid Laws or Regulations and are Consistent with Federal Medicaid Managed Care Regulations.

The proposed legislative changes do not violate federal laws or regulations. Under the proposed legislative changes, the provider assessments will apply to the same providers in roughly the same amount as they do today. Because certain hospitals (e.g., critical access hospitals) are exempted from the assessments both today and in the future, the State must demonstrate to the federal Centers for Medicare and Medicaid Services (CMS) that the State qualifies for a waiver of the requirement that provider taxes apply to all non-public hospitals equally—referred to as the "broad-based" requirement under CMS rules. The State has successfully made such demonstration repeatedly in the past, and the State fully expects that it will continue to be able to make this demonstration after these legislative changes are enacted.

Appendix

Article 7 of Chapter 108A - Hospital Provider Assessment Act
Proposed Revisions

SECTION 1. Article 7 of Chapter 108A of the General Statutes reads as rewritten:
"…

"§ 108A-121. Definitions.

The following definitions apply in this Article:

...

(4) ~~Equity~~ Supplemental assessment. - The assessment payable under G.S. 108A-123.

~~(5) Medicaid equity payment. - The amount required to be paid under G.S. 108A-124.~~

(5) Prepaid Health Plan. - As defined in Session Law 2015-245, s. 4(2), as amended.

...

(8) State's annual Medicaid payment. - ~~For an assessment collected under this Article, an amount equal to twenty-eight and eighty-five one hundredths percent (28.85%) of the total amount collected under the assessment.~~ An amount equal to one hundred ten million dollars ($110,000,000) for State fiscal year 2019, 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. The State's annual Medicaid payment will be made out of the base assessment.

...

~~(10) Upper pay limit (UPL). - The maximum ceiling imposed by federal regulation on hospital Medicaid payments under 42 C.F.R. § 447.272 for inpatient services.~~

(10) ~~UPL~~ Base assessment. - The assessment payable under G.S. 108A-123.

~~(12) UPL gap. - The difference between the UPL attributable to hospital inpatient services and the reasonable costs of inpatient hospital services as defined in Section (f)(2)(A) on page 11 of Attachment 4.19-A of the State Medicaid Plan as approved on December 15, 2005.~~

~~(13) UPL payment. - The amount required to be paid under G.S. 108A-124.~~"

(11) Base year. – Federal Fiscal Year 2018

"§ 108A-122. Assessment.

(a) Assessment Imposed. - Except as provided in this section, the assessments authorized under this Article are imposed as a percentage of total hospital costs on all licensed North Carolina hospitals. The assessments are due on the first business day of each quarter in the ~~quarterly in the time and~~ manner prescribed by the Secretary. Payment of an assessment is considered delinquent if not paid within seven days of the due date. With respect to any past-due assessment, the

Department may withhold the unpaid amount from Medicaid payments otherwise due or impose a late-payment penalty. The Secretary may waive a penalty for good cause shown.

…

(c) ~~Full~~ Exemption. - The following hospitals are exempt from both the ~~equity~~ supplemental assessment and the ~~UPL~~ base assessment:

(1) State-owned and State-operated hospitals.

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

(3) Critical access hospitals.

(4) Long-term care hospitals.

(5) Freestanding psychiatric hospitals.

(6) Freestanding rehabilitation hospitals.

(d) Partial Exemption. - A public hospital is exempt from the ~~equity~~ supplemental assessment."

"**§ 108A-123. Assessment amount.**

(a) Annual Calculation. - The Secretary must annually calculate the ~~equity~~ supplemental assessment amount and the ~~UPL~~ base assessment amount for each hospital subject to the respective assessment. Each assessment must comply with applicable federal regulations and may be prorated for any partial year. The Secretary must notify each hospital that is assessed the amount of its ~~UPL~~ base assessment and, if applicable, its ~~equity~~ supplemental assessment. The notice must include all of the following:

(1) The applicable assessment rates.

(2) The hospital costs on which the hospital's assessments are based.

(3) The quarterly amounts of the calculated annual amounts. ~~elements of the calculation of the hospital's UPL.~~

(b) ~~Equity~~ Supplemental Assessment. - The ~~equity~~ supplemental assessment shall be a percentage of total hospital costs for both inpatient and outpatient components. The rate of the supplemental assessment shall be published on the Department's website at least thirty (30) calendar days prior to its intended effective date. ~~consists of both inpatient and outpatient components. The equity assessment percentage rate must be calculated to produce an aggregate annual amount equal to the following:~~

(1) ~~The amount needed to make the Medicaid equity payments under G.S. 108-124.~~ Initial assessment. - For the first fiscal year, or remaining portion thereof, after the amendments to this Section become effective, the initial assessment shall be the percentage of total costs as calculated by the Department and approved by CMS for the base year's equity payments pursuant to the version of this Article in effect immediately prior to the effective date of the amendments to this Section.

(2) ~~The applicable portion of the State's annual Medicaid payment, as provided in subsection (d) of this section.~~ Future assessments. - For future fiscal years, the Department shall update the supplemental assessment rate no more than quarterly and no less than annually to take into account the following factors:

(i) The change in aggregate payments for Medicaid and NC Health Choice enrollees to hospitals subject to the supplemental assessment excluding hospital access payments made under 42 C.F.R. § 438.6,

as demonstrated in data from Prepaid Health Plans and the State; and

(ii) Any changes in the federal matching rate applicable to the Medicaid or NC Health Choice programs.

(c) ~~UPL~~ Base Assessment. - The~~ UPL~~ base assessment shall be a percentage of total hospital costs for both inpatient and outpatient components. The rate of the base assessment shall be published on the Department's website at least thirty (30) calendar days prior to its intended effective date. ~~consists of both inpatient and outpatient components. The UPL assessment percentage rate must be calculated to produce an aggregate annual amount equal to the following:~~

(1) ~~The amount needed to make the UPL payments under G.S. 108A-124.~~ Initial assessment. - For the first fiscal year, or remaining portion thereof, after the amendments to this Section become effective date, the initial assessment shall be the percentage of total costs as calculated by the Department and approved by CMS for the base year's UPL payments pursuant to the version of this Article in effect immediately prior to the effective date of the amendments to this Section. The assessment amount shall be adjusted to account for any changes in reimbursement under the State Plan, managed care payments authorized under 42 C.F.R. § 438.6 of which the non-federal share is not funded by General Fund appropriations, the NC Health Choice Program, and the annual State Medicaid payment.

(2) ~~The applicable portion of the State's annual Medicaid payment, as provided in subsection (d) of this section.~~ Future assessment. – Beginning the second fiscal year that Prepaid Health Plans provide coverage to Medicaid and NC Health Choice recipients and for all subsequent fiscal years, the base assessment rate will be updated no more than quarterly and no less than annually to take into account the following factors:

(i) The amount of the State Medicaid payment for the applicable year;

(ii) The change in aggregate payments for Medicaid and NC Health Choice enrollees to hospitals subject to the base assessment, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from Prepaid Health Plans and the State;

(iii) Any changes in the federal matching rate applicable to the Medicaid or NC Health Choice programs; and

(iv) Any changes in reimbursement under the State Plan, managed care payments authorized under 42 C.F.R. § 438.6 of which the non-federal share is not funded by General Fund appropriations, the NC Health Choice Program, and the annual State Medicaid payment.

..."

"§ 108A-124. Use of assessment proceeds.

(a) Use. - The proceeds of the assessments imposed under this Article and all corresponding matching federal funds must be used to make the State annual Medicaid payment to the State, to fund payments to hospitals made directly by the Department and to fund a portion of capitation payments to Prepaid Health Plans attributable to hospital care. ~~and the Medicaid equity payments and UPL payments to hospitals.~~

(b) ~~Quarterly Payments. - Within seven business days following the due date for each quarterly assessment imposed under G.S. 108A-123, the Secretary must do the following:~~

~~(1) Pay to each hospital that has paid its equity assessment for the respective quarter twenty-five percent (25%) of its Medicaid equity payment amount. A hospital's Medicaid equity payment amount is the sum of the hospital's Medicaid inpatient and outpatient deficits after calculating all other Medicaid payments, excluding disproportionate share hospital payments and the UPL payment remitted to the hospital under subdivision (2) of this subsection.~~

~~(2) Pay to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, to the critical access hospitals, and to each hospital that has paid its UPL assessment for the respective quarter twenty-five percent (25%) of its UPL payment amount, as determined under subsection (c) of this section.~~

~~(3) Pay to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, to the critical access hospitals, and to each hospital that has paid its UPL assessment for the respective quarter twenty-five percent (25%) of its UPL payment amount, as determined under subsection (c) of this section.~~

(c) ~~UPL Payment Amount. - The aggregate UPL payments made to eligible hospitals that are public hospitals is the sum of the UPL gaps for all public hospitals. The aggregate UPL payments made to eligible hospitals that are not public hospitals is the sum of the UPL gaps for these hospitals. UPL payments are payable to the individual hospitals in the ratio of each hospital's Medicaid inpatient costs to the total Medicaid inpatient costs for the respective group.~~

(d) ~~Refund of Assessment. - If all or any part of a payment required to be made under this section is not made to one or more hospitals when due, the Secretary must promptly refund to each such hospital the corresponding assessment proceeds collected in proportion to the amount of assessment paid by that hospital.~~"

"**§ 108A-126. Approval of assessment program.**

The Department must file a State plan amendment or other necessary documents with the CMS that incorporates the ~~assessment~~ payments and distributions consistent with the provisions of this Article. Upon CMS approval, the Secretary may impose the initial assessment retroactive to the effective date of the State plan amendment or waiver. ~~first day of the quarter in which the State Plan amended was filed, provided the Secretary remits the corresponding payments to hospitals required under G.S. 108A-124 for that quarter~~. If CMS approves only one component of the ~~equity~~ assessments imposed under this Article, the Secretary may adjust the percentage rate on the approved component to produce the required aggregate ~~Medicaid equity payment~~ amounts under G.S. 108A-124. ~~If CMS approves only one component of the UPL assessment, the Secretary may adjust the percentage rate on the approved component to produce the required aggregate UPL payment amounts under G.S. 108A-124.~~ The Secretary may adopt rules as necessary to implement the assessment program under this Article."

§ 108A-127. Repeal.

The authority to impose an assessment under this Article is repealed in the event that CMS determines that the assessment or payment methodologies described in this Article are

impermissible or CMS revokes approval of any portion of the State Plan amendment or waiver authorizing the payments required under G.S. 108A-124.

"§ 108A-128. Payment for providers formerly subject to this Article.

If a hospital provider (i) is exempt from both the ~~equity~~ base and ~~UPL~~ supplemental assessments under this Article, (ii) makes an intergovernmental transfer (IGT) to the Department of Health and Human Services to be used to draw down matching federal funds, and (iii) has acquired, merged, leased, or managed another provider on or after March 25, 2011, then the hospital provider shall transfer to the State an additional amount, which shall be retained by the State. The additional amount shall be a percentage of the amount of funds that (i) would be transferred to the State through such an IGT and (ii) are to be used to match additional federal funds that the hospital provider is able to receive because of the acquired, merged, leased, or managed provider. 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 program authorized by this Article. ~~the same percentage provided in the definition of "State's annual Medicaid payment" under G.S. 108A-121.~~"

SECTION 2. The amendments to Sections §§ 108A-121, 108A-122, 108A-123, 108A-124, 108A-126, 108A-127, and 108A-128 of Article 7 of the General Statutes are effective on October 1, 2019.

SECTION 3. The addition of Section § 108A-123(a) to Article 7 of the General Statutes is effective upon enactment.

SECTION 4. Section 12H.12(b) of S.L. 2014-100 is repealed for dates of service on or after October 1, 2019. This section is effective on October 1, 2019.