GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL DRH40406-MRxf-116

Short Title:	Hospital Assessment Revision/Prof. Payments.	(Public)
Sponsors:	Representatives Dobson and Lambeth (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO REVISE AND UPDATE HOSPITAL ASSESSMENTS IN A MANNER THAT WILL CONFORM WITH MEDICAID TRANSFORMATION, TO REPEAL PAST DIRECTIVES TO ELIMINATE GRADUATE MEDICAL EDUCATION TO ALIGN 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.

The General Assembly of North Carolina enacts:

PART I. REVISE AND UPDATE HOSPITAL ASSESSMENTS

SECTION 1.(a) Effective October 1, 2019, Article 7 of Chapter 108A of the General Statutes is repealed.

SECTION 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. – Defined in 42 C.F.R. § 400.202.

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

(5) Prepaid Health Plan. – As defined in Section 4 of S.L. 2015-245, as amended.

(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 Systems 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 Medical 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 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 three percent (3%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 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 three percent (3%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 1.(e) The Department of Health and Human Services shall submit any State Plan amendment or other documents necessary to the Center for Medicare and Medicaid Services to implement this section.

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

SECTION 2. 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 III. REVISE AND RENAME THE SUPPLEMENTAL PAYMENT PROGRAM FOR ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 3.(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 3.(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 made 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 made to 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 made to 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 3.(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 3.(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 3.(e) Effective October 1, 2019, Section 12H.13(b) of S.L. 2014-100 is repealed.

PART IV. ENACT THE MEDICARE RATE SUPPLEMENTAL AND DIRECTED PAYMENT PROGRAM

SECTION 4.(a) The Department of Health and Human Services shall create the Medicare Rate Supplemental and Directed Payment Program. Payments under the program shall consist of two components: (i) supplemental payments made to eligible professionals that increase reimbursement to the Medicare rate under the State Plan and (ii) directed payments made to eligible professionals that increase reimbursement to the Medicare rate under the managed care system. No Medicare rate supplemental or directed payment shall be made for any service for which an average commercial rate supplemental or directed payment is made. Professionals eligible to receive payments under this program shall include Medicaid-enrolled North Carolina physicians, advance care practitioners, and other related professionals, who are employed or contracted by any of the following:

(1) State-operated schools of medicine.
(2) The University of North Carolina Health Care System.
(3) University Health Systems of Eastern Carolina, doing business as Vidant Health.
(4) Any entity controlled by or under common control with a hospital that qualifies to certify expenditures or a public hospital. For the purposes of this subdivision, common control includes common operational control.
(5) Any entity controlled by or under common control with a hospital that is not exempt from the supplemental assessment under G.S. 108A-140. For the purposes of this subdivision, common control includes common operational control.
(6) The faculty practice plan associated with Duke University.

The Department shall further condition eligibility for contracted eligible professionals upon a demonstration that the contracts account for at least eighty percent (80%) of net professional fees from commercial payers or that the contracts address the overall financial risk of the professional's practice or group.

SECTION 4.(b) Article 7A of Chapter 108A of the General Statutes, as enacted by Section 1(b) of this act, is amended by adding a new Part to read:

"Part 3. Professional Assessment.

"**§ 108A-150. Applicability.**

The professional assessment imposed under this Part applies to all licensed North Carolina hospitals, except for the following hospitals:

(1) Critical access hospitals.
(2) Freestanding psychiatric hospitals.

(3) Freestanding rehabilitation hospitals.
(4) Hospitals owned by the University Health Systems of Eastern Carolina, doing business as Vidant Health.
(5) Hospitals owned by the University of North Carolina Health Care System.
(6) Long-term care hospitals.
(7) Public hospitals.
(8) State-owned and State-operated hospitals.

"**§ 108A-151. Professional assessment.**

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

(b) The Department shall propose the rate of the professional 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 professional assessment rate to the General Assembly each fiscal year.

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

(1) The percentage change in aggregate payments to hospitals subject to the professional 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 required increases or decreases in the Medicare rate supplemental or directed payments.
(3) 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 professional assessment for each taxable year shall be the percentage rate set by law by the General Assembly.

"**§ 108A-152. Use of funds.**

The proceeds of the assessment imposed under this Part, and all corresponding matching federal funds, must be used to fund a portion of fee-for-service Medicare rate supplemental payments to professionals made directly by the Department and to fund a portion of capitation Medicare rate directed payments to prepaid health plans."

SECTION 4.(c) The percentage rate to be used in calculating the professional assessment under G.S. 108A-151, as enacted in subsection (b) of this section, is three percent (3%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 4.(d) The Department of Health and Human Services shall submit a State Plan amendment, or other necessary documents, to the Centers for Medicare and Medicaid (CMS) to implement the Medicare Rate Supplemental and Directed Payment Program and the Professional Assessment, required under subsections (a) and (b) of this section. Upon approval by CMS, the Office of State Budget and Management (OSBM) shall certify whether the implementation of the Medicare Rate Supplemental and Directed Payment Program and the Professional Assessment is expected to result in total spending under the 1115 waiver that exceeds the budget neutrality limit during the demonstration period. The Department shall not make any Medicare rate supplemental or directed payments or collect any professional assessments unless and until OSBM certifies that the budget neutrality limit is not expected to be exceeded.

SECTION 4.(e) Subsections (b) and (c) of this section are effective upon certification by the Office of State Budget and Management (OSBM) that the implementation of the Medicare Rate Supplemental and Directed Payment Program and the Professional Assessment is not expected to result in total spending under the 1115 waiver that exceeds the budget neutrality limit during the demonstration period. If OSBM certifies that the budget

neutrality limit is not expected to be exceeded, then the Department of Health and Human Services shall notify the Revisor of Statutes of the certification and shall post the certification on its Web site.

SECTION 4.(f) If at any point during the operation of the 1115 waiver, CMS determines that the budget neutrality limit in the waiver has been reached, then (i) the Department of Health and Human Services shall immediately discontinue the Medicare Rate Supplemental and Directed Payment Program, (ii) Part 3 of Article 7A of Chapter 108A of the General Statutes is repealed, and (iii) the Department shall notify the Revisor of Statutes of CMS's determination.

SECTION 5. Except as otherwise provided, this act is effective July 1, 2019.