Proposal for Incorporating Freestanding Psychiatric Hospitals into the Healthcare Access and Stabilization Program (HASP)

Session Law 2023-134, Section 9E.27.(b)

Report to

Joint Legislative Oversight Committee on Medicaid
By

North Carolina Department of Health and Human Services

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Contents

Introduction

Pursuant to Section 9E.27 of Session Law (S.L.) 2023-134, the North Carolina Department of Health and Human Services (DHHS), Division of Health Benefits (DHB) is submitting this report describing a proposal for incorporating freestanding psychiatric hospitals in the Healthcare Access and Stabilization Program (HASP) to the Joint Legislative Oversight Committee on Medicaid. The text of the legislation is provided in Appendix B.

The Healthcare Access and Stabilization Program (HASP), authorized under G.S. 108A-148.1 and enacted by Section 1.4 of S.L. 2023-7, is a Medicaid state directed payment program that will allow the North Carolina Division of Health Benefits (DHB) to require Prepaid Health Plans (PHPs) to make additional payments to acute care hospitals in North Carolina for inpatient and outpatient hospital services, contingent on approval by the Centers for Medicare and Medicaid Services (CMS). In September 2023, CMS authorized the first year of the HASP program retroactive to State Fiscal Year (SFY) 2023. DHB is currently working to develop policy around HASP payments for SFY 2024.

CMS has historically viewed the average commercial rate (ACR) as the maximum payment level for Medicaid state directed payments. As part of recent rulemaking, CMS is proposing to codify the ACR as the maximum payment level for state directed payments.[1] In accordance with these limitations, SFY 2023 HASP payments were within the estimated ACR.

Under current state law, freestanding psychiatric hospitals are excluded from the statutory definition of acute care hospitals, and therefore are not eligible to receive HASP payments.[2] Pursuant to requirements set forth in S.L. 2023-134, Section 9E.27(b), this report includes the following:

1. A detailed description of a proposal for allowing freestanding psychiatric hospitals to receive HASP payments and for financing these payments through changes to North Carolina's hospital assessment programs.[3,4]
2. A description of documents required to request federal approval needed to implement the proposal.[5]
3. Proposed legislative changes that would be needed to implement the proposal (see Appendix A).[6]
4. An analysis of any impact to the HASP reimbursements to hospitals other than freestanding psychiatric hospitals that might occur due to the limit on provider assessments established under 42 C.F.R. § 433.68(f).[7]

[1] 88 FR 28092
[2] North Carolina G.S. 108A-145.3(1b); § 108A-145.3(6d)
[3] S.L. 2023-134, Section 9E.27(b)(1)
[4] Given that S.L. 2023-134, Section 9E.27 contemplates financing the non-federal share of HASP payments to freestanding psychiatric hospitals via an assessment, DHB assumed that this proposal was intended to exclude state-owned and state-operated IMDs (which are excluded from the existing assessments). DHB agrees with this approach given that state IMDs receive cost-based reimbursement. DHB has proposed a definition to this effect in the Appendix of this report for legislative language.
[5] S.L. 2023-134, Section 9E.27(b)(2)
[6] S.L. 2023-134, Section 9E.27(b)(3)
[7] S.L. 2023-134, Section 9E.27(b)(4)

Background on HASP Payments and Financing Approach

Existing HASP Payment Approach

For SFY 2023, DHB worked with the North Carolina Healthcare Association (NCHA) to develop an approach for calculating HASP payments. Under this approach, DHB estimated the difference between a percentage of commercial-equivalent payments for inpatient and outpatient hospital services and Medicaid managed care base payments for those same services. This approach relied on a combination of historical data sources on Medicaid payments and costs, including Medicare Cost Report data from the Healthcare Provider Cost Reporting Information System (HCRIS), Disproportionate Share Hospital (DSH) Audits, and Medicaid managed care encounter data.

Existing HASP Financing Approach

A significant component of the non-federal share of hospital Medicaid payments in North Carolina is financed by hospital assessments and intergovernmental transfers (IGTs). North Carolina's two hospital assessment programs include the Modernized Hospital Assessment, which finances certain non-expansion Medicaid costs, and the Health Advancement Assessment, which was newly established in 2023 and finances the non-federal share costs associated with Medicaid expansion not otherwise covered by PHP premium tax collections. All non-state owned public and private acute care hospitals are subject to both the Modernized and Health Advancement Assessments, and non-state owned public hospitals additionally contribute IGTs (though they generally pay lower tax rates).[8] State-owned and operated hospitals, which include hospitals in the UNC Health Care System and the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, are excluded from the assessments and instead contribute non-federal share funds entirely through IGTs.[9] Freestanding psychiatric hospitals (and certain other facility types) are excluded from the assessments and do not make IGTs.[10,11]

The non-federal share of HASP payments is financed entirely by eligible hospitals through the Modernized and Health Advancement Assessments (and associated IGTs). Both the Modernized and Health Advancement Assessments are calculated each quarter based on statutorily defined formulas that account for various Medicaid program costs, including portions of managed care base capitation, fee-for-service claims, program administration, graduate medical education, HASP, and certain other components. Under this structure, HASP payments associated with non-expansion population utilization are financed through the Modernized Hospital Assessment, while expansion-related HASP costs are financed through the Health Advancement Assessment.[12]

[8] § 108A-145.3(1b), § 108A-146.1., § 108A-146.3., § 108A-147.1., § 108A-147.2.
[9] § 108A-145.3(1b)
[10] § 108A-145.3(1b), § 108A-145.3(18), § 108A-145.3(20)
[11] Critical access hospitals, freestanding rehabilitation hospitals, and long-term care hospitals are also excluded from the assessments and do not make IGTs.
[12] § 108A-146.5

Description of Proposal

Payment Approach

If the General Assembly decides to allow freestanding psychiatric hospitals to receive HASP payments, these hospitals would need to be added to the group of hospitals eligible for the existing HASP program (currently limited to public and private acute care hospitals). Like with acute care hospitals, DHB would calculate uniform percentage increases needed to bring Medicaid hospital payments to freestanding psychiatric hospitals up to a percentage of the ACR. These payment increases would account for rate increases for inpatient behavioral health services previously authorized through S.L. 2023-134 and would apply to all inpatient and outpatient hospital services delivered by freestanding psychiatric hospitals to Medicaid enrollees.[13]

The approach should be approvable under federal rules, as CMS provides considerable flexibility for states to calculate the ACR and to determine which providers are eligible for payments. The approach would also be administratively feasible to implement. In order to estimate the size of potential payments, DHB will need to collect additional data from freestanding psychiatric hospitals to identify the amount ACR "room" available. See the appendix for legislative changes required to authorize this change.

We note that this proposal would have a greater impact on freestanding psychiatric hospitals if North Carolina were to seek a waiver of the "institutions of mental disease (IMD) exclusion" for mental health treatment. The IMD exclusion is a longstanding federal policy that generally prohibits states from using federal Medicaid dollars to reimburse IMDs for delivering inpatient behavioral health care.[14] In recent years, CMS has approved waivers of the IMD exclusion for substance use disorder (SUD) and mental health treatment across a number of states, allowing those states to reimburse for these services using Medicaid dollars. North Carolina currently has an approved IMD waiver for SUD treatment and is considering applying for a waiver for mental health treatment.[15] If approved, this waiver would increase Medicaid base payments to North Carolina's IMDs and proportionately increase any HASP payments (which are tied to Medicaid base payments).

Financing Approaches

S.L. 2023-134, Section 9E.27.(a) requires that DHB's proposal to include freestanding psychiatric hospitals in HASP be "contingent upon the receipt of the nonfederal share of the reimbursements through hospital assessments in which those hospitals participate". It also notes that "DHB shall consider whether to assess freestanding psychiatric hospitals under the existing hospital assessment structures in Article 7B of Chapter 108A of the General Statutes or whether to develop another assessment structure". In the below, DHB describes two potential approaches for collecting non-federal

[13] The ACR calculation—that is, the gap between Medicaid and commercial-equivalent payment levels—would account for Medicaid rate increases for inpatient behavioral health services authorized under S.L. 2023-134
[14] § 1905(a)(30)(B) of the Social Security Act
[15] North Carolina Medicaid Reform Demonstration

share funds associated with HASP payments to freestanding psychiatric hospitals should the General Assembly move forward with this policy.

Option 1: Include Freestanding Psychiatric Hospitals in Assessments

Currently, the Modernized Hospital Assessment and Health Advancement Assessment apply separate tax rates for public and private acute care hospitals; freestanding psychiatric hospitals are excluded from both assessments.[16] Under option 1, the General Assembly would amend the current structure of the Modernized and Health Advancement Assessments to include freestanding psychiatric hospitals (see Appendix A for draft legislative language).

Under this option, the General Assembly could modify the existing tax calculations for both the Modernized and Health Advancement Assessments to allow for distinct tax rates for freestanding psychiatric hospitals. This would involve establishing separate tax calculations for freestanding psychiatric hospitals that would only account for the non-federal share of HASP payments to these hospitals (i.e., freestanding psychiatric hospitals would not be responsible for financing other costs included in the existing tax structures, such as managed care base capitation, Medicaid fee-for-service claims payments, graduate medical education, and program administration). Tax rates for freestanding psychiatric hospitals would be calculated based on the following steps for both the Modernized and Health Advancement Assessments:

1. Sum applicable inpatient and outpatient non-federal share HASP payments to freestanding psychiatric hospitals, based on the methodology approved by CMS.
2. Divide total amount by total hospital costs for freestanding psychiatric hospitals to arrive at tax rates.

In order to pursue this approach whereby freestanding psychiatric hospitals are subject to distinct tax rates, the Modernized and Health Advancement Assessments would need to qualify for waivers of federal broad-based and uniformity requirements. Federal law requires that health care-related taxes be broad-based and uniform and not hold taxpayers harmless.[17,18] However, CMS will approve waivers of the broad-based and uniformity requirements if a state can demonstrate through a specific mathematical calculation that the net impact of the tax program is "generally redistributive" (referred to as a "B1/B2 test").[19] The Modernized and Health Advancement Assessments currently meet these criteria and operate under federal broad-based and uniformity tax waivers. DHB would need to conduct new B1/B2 tests and submit amended tax waiver requests to CMS to gain approval for the updated tax programs. Preliminary modeling by DHB suggests that incorporating freestanding psychiatric hospitals into the Modernized and Health Advancement Assessments would not have a significant impact on the results of the B1/B2 test and both would likely still pass (though DHB will need to confirm this using actual tax amounts once available).

[16] § 108A-145.3(1b), § 108A-146.1, § 108A-146.3
[17] 42 CFR 433.68(b)
[18] A tax is "broad-based" if it applies to all items and services within a class. A tax is "uniform" if the rate does not vary within the class. A tax is considered to "hold taxpayers harmless" if there is a direct or indirect guarantee that providers will receive all of their tax costs back in Medicaid payments.
[19] 42 CFR 433.68(e)

Under this approach, licensed freestanding psychiatric hospitals that are not enrolled in Medicaid would pay the assessments based on a percentage of their total hospital costs (like all other hospitals subject to the tax) but would not receive HASP payments. This approach is consistent with the application of the existing assessments to acute care hospitals and aligns with the principles governing federal healthcare-related tax requirements described above. As of January 2024, 4 out of 13 licensed freestanding psychiatric hospitals in North Carolina were not enrolled in the Medicaid program.[20]

Option 2: Continue to Exclude Freestanding Psychiatric Hospitals from Assessments

A second potential financing option would involve adding the non-federal share of HASP payments to freestanding psychiatric hospitals to the calculation of the Modernized and Health Advancement Assessments but continuing to exempt freestanding psychiatric hospitals from these assessments (in other words, acute care hospitals would finance the non-federal share of HASP payments to freestanding psychiatric hospitals). This approach would likely have a minimal impact on acute care hospitals given the expected size of payments to freestanding psychiatric hospitals in the context of the broader HASP program (HASP payments to freestanding psychiatric hospitals would likely be less than one percent of total HASP payments). Additionally, acute care hospitals currently finance a number of program costs through the assessments that are not directly related to hospital care (e.g., program administration).

Draft Federal Approval Documents

S.L. 2023-134, Section 9E.27(b)(2) requires that the DHB provide "copies of the draft documents required to request the federal approval needed to implement the developed proposal". If this proposal is adopted, DHB would incorporate freestanding psychiatric hospitals into the broader state directed payment "preprint" submitted to CMS to authorize the HASP program.[21] (The SFY2023 preprint approved by CMS is provided in Appendix C.) Changes to the preprint would include the following:

- Question 19(d): revising the description of the methodology for calculating payment increases and estimates of payment increase percentages/amounts to incorporate freestanding psychiatric hospitals.
- Question 20(b): adding freestanding psychiatric hospitals as an eligible provider class.
- Question 20(c): adding a reference to the section of the Medicaid State Plan defining freestanding psychiatric hospitals.

DHB has not yet developed the HASP directed payment preprint for SFY 2024 (or subsequent years). Once developed, DHB will submit draft versions (inclusive of the changes described above) to the Joint Legislative Oversight Committee on Medicaid for review, upon request.

[20] https://info.ncdhhs.gov/dhsr/data/Psyclist.pdf?ver=1.3

[21] For most state directed payment programs, CMS requires states to annually submit a preprint describing the type of payment, methodology for calculating payments, estimated payment amounts, quality monitoring approach, and other relevant details.

Impact on HASP Reimbursements to Acute Care Hospitals

S.L. 2023-134, Section 9E.27(b)(4) requires that DHB provide "an analysis of any impact to the HASP reimbursements to hospitals other than freestanding psychiatric hospitals that might occur due to the limit on provider assessments established under 42 C.F.R. § 433.68(f)". As described above, 42 C.F.R. § 433.68(f) requires that health care-related taxes (like the Modernized and Health Advancement Assessments) not hold taxpayers harmless by providing a direct or indirect guarantee that a taxpayer will receive all or part of their tax payments back as Medicaid payments. 42 C.F.R. § 433.68(f)(3)(i)(A) further specifies that health care-related taxes that produce revenues less than or equal to 6 percent of net patient services revenues received by the taxpayer are not considered to indirectly hold providers harmless and are therefore considered permissible. In order to ensure compliance with this requirement and that sufficient non-federal share funds will be available to finance the full amount of HASP payments, S.L. 2023-7, Section 1.4 (§ 108A-148.1(c)(2)) requires that, should the assessment amounts due from hospitals exceed the federal 6 percent limit, DHB must reduce the amount of HASP payments such that aggregate hospital assessments do not exceed the 6 percent limit.

For SFY 2024, DHB expects that total Modernized and Health Advancement Assessments will fall well below the 6 percent limit. While final tax amounts for the state fiscal year will not be known until April 2024, current projections suggest that total taxes will be less than 5 percent of net patient services revenues. At these tax levels, DHB would not need to reduce HASP payments to acute care hospitals in order to accommodate payments to freestanding psychiatric hospitals.

Current DHB projections suggest that the state will continue to have enough tax "room" to fully finance HASP beyond SFY 2024. However, this is dependent on a number of factors, including actual utilization and the approach for calculating the ACR (this is still under development for SFY 2024 and could change in subsequent years). Both Medicaid expansion and the launch of BH I/DD Tailored Plans will increase Medicaid managed care base payments subject to HASP payment increases; this will increase the amount of tax needed to generate sufficient non-federal share. While current estimates suggest that there will be enough tax room, it is possible that the increase in the assessments could "crowd out" the ability to include freestanding psychiatric hospitals in HASP without offsetting reductions in HASP payments to acute care hospitals.

Conclusion

If the General Assembly chooses to adopt this policy, DHB recommends adding freestanding psychiatric hospitals to the HASP program as an eligible hospital type. This would allow freestanding psychiatric hospitals to receive a uniform percentage increase on all Medicaid inpatient and outpatient hospital services (like acute care hospitals do today). DHB has also presented two options for financing the non-federal share of HASP payments to freestanding psychiatric hospitals for consideration by the Joint Legislative Oversight Committee for Medicaid. These options include:

- Adding freestanding psychiatric hospitals to the Modernized and Health Advancement Assessments and calculating separate, HASP-specific tax rates for those hospitals.
- Continuing to exempt freestanding psychiatric hospitals from the assessments and instead building their associated non-federal share HASP costs into the existing assessments on acute care hospitals.

DHB believes that these proposals will comply with all relevant federal requirements, including "hold harmless" requirements set forth at 42 C.F.R. § 433.68(f). Currently, the state has sufficient tax "room" under the 6 percent federal limit to finance additional payments to freestanding psychiatric hospitals. However, it is possible that adding freestanding psychiatric hospitals to HASP would require offsetting reductions in payments to acute care hospitals in future years, given expected increases in Medicaid managed care base payments.

Appendix A: Proposal to Amend Legislative Language

Background

North Carolina Session Law (S.L.) 2023-134, Section 9E.27(b) requires that the Department of Health and Human Services, Division of Health Benefits (DHB) develop a proposal to allow freestanding psychiatric hospitals to receive reimbursements through the Healthcare Access and Stabilization Program (HASP) that are contingent upon the receipt of the nonfederal share of those reimbursements. Furthermore, S.L. 2023-134, Section 9E.27(b)(3) requires that DHB develop proposed legislative changes that would be needed to implement the proposal. In this appendix, we provide draft legislative changes needed to implement the proposals described in previous sections.

As described above, the Department has proposed two possible approaches for financing non-federal share costs associated with HASP payments to freestanding psychiatric hospitals. Option 1 would involve adding freestanding psychiatric hospitals to the Modernized and Health Advancement assessments and calculating unique tax rates for those hospitals covering only the non-federal share of their HASP payments (i.e., they would not be responsible for covering other Medicaid program costs). Option 2 would continue to exclude freestanding psychiatric hospitals from the assessments and would finance non-federal share HASP costs for these hospitals through the existing assessments (i.e., costs would be spread across acute care hospitals currently subject to the assessments). Both options would involve amendments to North Carolina General Statutes § 108A-145.3 (Definitions) and § 108A, Article 7B, Part 4 (HASP). Only Option 1 would involve amendments to § 108A, Article 7B, Part 2 (Modernized Hospital Assessments) and § 108A, Article 7B, Part 3 (Health Advancement Assessments). Option 2 would not involve any changes to the assessments; accordingly, only changes to § 108A-145.3 and § 108A, Article 7B, Part 4 apply to Option 2. Proposed changes are described below.

Legislative Changes Applicable to Both Financing Options 1 and 2

Definitions (§ 108A-145.3)

New Definitions

(XX) Freestanding psychiatric hospital. A hospital licensed in North Carolina as a freestanding psychiatric hospital that is not state-owned and state-operated.

Amendments to Existing Definitions

(6d) Healthcare access and stabilization program (HASP). – The directed payment program providing increased reimbursements to acute care hospitals and freestanding psychiatric hospitals approved by CMS and authorized by G.S. 108A-148.1.

Healthcare Access and Stabilization Program (§ 108A, Article 7B, Part 4)

Amendments to Existing Subsections

§ 108A-148.1. Healthcare access and stabilization program.

(a) The healthcare access and stabilization program is a directed payment program that provides acute care hospitals and freestanding psychiatric hospitals with increased reimbursements funded through hospital assessments in accordance with this section.

(b) The Department shall submit a 42 C.F.R. § 438.6(c) preprint requesting approval for the HASP program that includes any required demonstration for the financing of the nonfederal share of the HASP program costs. The Department shall not make any HASP directed payments prior to CMS approval of the initial preprint. The Department may not request any date of service for claims eligible for reimbursement through the HASP program earlier than July 1, 2022. The Department shall continue to submit any necessary documentation requesting continued approval for the HASP program as described in this section in the time and manner as required by CMS.

(c) All State funds required to make HASP directed payments shall be derived from HASP components of the hospital assessments under this Article, subject to all of the following limitations:

(1) If the Department determines that the HASP components under this Article will not generate funds in an amount equal to or greater than the total State funds required to make all HASP directed payments in any given quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that the HASP components under this Article will generate enough funds to equal the total State funds required to make all the HASP directed payments in that quarter.

(2) If the aggregate amount of all assessments due from hospitals under this Article are determined by the Department to exceed the permissible limit established under 42 C.F.R. § 433.68(f) in any quarter of the State fiscal year, then the Department shall reduce the amount of the HASP directed payments in the lowest amount necessary to ensure that these hospital assessments in aggregate do not exceed the permissible limit.

(d) As part of the preprint submission required under this section, for the 2022-2023 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is greater than the maximum amount allowable under 42 C.F.R. § 438.6(c). Beginning with the 2023-2024 State fiscal year, the Department shall not request any amount of HASP hospital reimbursements that is (i) greater than the maximum amount allowable under 42 C.F.R. § 438.6(c) or (ii) less than an annual estimated total dollar amount of three billion two hundred million dollars ($3,200,000,000) for services provided to not newly eligible individuals.

Legislative Changes Applicable to Financing Option 1 Only

Modernized Hospital Assessments (§ 108A, Article 7B, Part 2)

New Subsections

§ 108A-146.XX. Freestanding psychiatric hospital modernized assessment.

(a) The freestanding psychiatric hospital modernized assessment imposed under this Part shall apply to all freestanding psychiatric hospitals.

(b) The freestanding psychiatric hospital modernized assessment shall be assessed as a percentage of each freestanding psychiatric hospital's hospital costs. The assessment percentage shall

be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the modernized freestanding psychiatric hospital HASP component under G.S. 108A-146.XX divided by the total hospital costs for all freestanding psychiatric hospitals holding a license on the first day of the assessment quarter.

§ 108A-146.XX. Modernized freestanding psychiatric hospital HASP component.

The modernized freestanding psychiatric hospital HASP component is an amount of money that is calculated each quarter by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements to freestanding psychiatric hospital that are not attributable to newly eligible individuals by the nonfederal share for not newly eligible individuals.

Amendments to Existing Subsections

§ 108A-146.1. Public hospital modernized assessment.

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

(b) The public hospital modernized assessment shall be assessed as a percentage of each public acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the difference of the aggregate modernized assessment collection amount under G.S. 108A-146.5 minus the modernized freestanding psychiatric HASP component under G.S. 108A-146.XX multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

§ 108A-146.3. Private hospital modernized assessment.

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

(b) The private hospital modernized assessment shall be assessed as a percentage of each private acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the difference of the aggregate modernized assessment collection amount under G.S. 108A-146.5 minus the modernized freestanding psychiatric HASP component under G.S. 108A-146.XX multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals holding a license on the first day of the assessment quarter.

§ 108A-146.5. Aggregate modernized assessment collection amount.

(a) The aggregate modernized assessment collection amount is an amount of money that is calculated by subtracting the modernized intergovernmental transfer adjustment component under G.S. 108A-146.13 from the total modernized nonfederal receipts under subsection (b) of this section and then adding the positive or negative amount of the modernized IGT actual receipts adjustment component under G.S. 108A-146.14.

(b) The total modernized nonfederal receipts is the sum of all of the following:

(1) One-fourth of the State's annual Medicaid payment.

(2) The managed care component under G.S. 108A-146.7.

(3) The fee-for-service component under G.S. 108A-146.9.

(3a) The modernized acute care hospital HASP component under G.S. 108A-146.10.

(3b) The modernized freestanding psychiatric HASP component under G.S. 108A-146.XX.

(4) The GME component under G.S. 108A-146.11.

(5) Beginning April 1, 2022, and ending March 31, 2027, the postpartum coverage component under G.S. 108A-146.12.

(6) Beginning April 1, 2024, the home and community-based services component under G.S. 108A-146.12A. (2021-61, s. 2; 2021-180, s. 9D.13A(b).)

§ 108A-146.10. Modernized acute care hospital HASP component.

The modernized acute care hospital HASP component is an amount of money that is calculated each quarter by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements to acute care hospitals that are not attributable to newly eligible individuals by the nonfederal share for not newly eligible individuals.

§ 108A-146.13. Modernized presumptive IGT adjustment component.

(c) The modernized presumptive IGT adjustment component is an amount of money equal to the sum of all of the following subcomponents:

(1) The public hospital IGT subcomponent is the total of the following amounts:

a. Sixteen and forty-three hundredths percent (16.43%) of the amount of money that is equal to the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized acute care hospital HASP component under G.S. 108A-146.10 for the current quarter minus the modernized freestanding psychiatric HASP component under G.S. 108A-146.XX for the current quarter.

b. Sixty percent (60%) of the nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to public acute care hospitals and that are not attributable to newly eligible individuals.

(2) The UNC Health Care System IGT subcomponent is the total of the following amounts:

a. Four and sixty-two hundredths percent (4.62%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current quarter minus the modernized acute care hospital HASP component under G.S. 108A-146.10 for the current quarter minus the modernized freestanding psychiatric HASP component under G.S. 108A-146.XX for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to UNC Health Care System hospitals that are not attributable to newly eligible individuals.

(3) The East Carolina University IGT subcomponent is the total of the following amounts:

a. One and four hundredths percent (1.04%) of the difference of the total modernized nonfederal receipts under G.S. 108A-146.5(b) for the current

quarter minus the modernized acute care hospital HASP component under G.S. 108A-146.10 for the current quarter minus the modernized freestanding psychiatric hospital HASP component under G.S. 108A-146.XX for the current quarter.

b. The nonfederal share for not newly eligible individuals of the aggregate amount of HASP directed payments due to PHPs in the current quarter for reimbursements to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine that are not attributable to newly eligible individuals.

Health Advancement Assessments (§ 108A, Article 7B, Part 3)

New Subsections

§ 108A-147.XX. Freestanding psychiatric hospital health advancement assessment.

(a) The freestanding psychiatric hospital health advancement assessment imposed under this Part shall apply to all freestanding psychiatric hospitals.

(b) The freestanding psychiatric hospital health advancement assessment shall be assessed as a percentage of each freestanding psychiatric hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department in accordance with this Part. The percentage for each quarter shall equal the HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX divided by the total hospital costs for all freestanding psychiatric hospitals holding a license on the first day of the assessment quarter.

§ 108A-147.XX. HASP freestanding psychiatric hospital health advancement component.

The HASP freestanding psychiatric hospital health advancement component is an amount of money that is calculated by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements to freestanding psychiatric hospitals for newly eligible individuals by the nonfederal share for newly eligible individuals.

Amendments to Existing Subsections

§ 108A-147.1. Public hospital health advancement assessment.

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

(b) The public hospital health advancement assessment shall be assessed as a percentage of each public acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department in accordance with this Part. The percentage for each quarter shall equal the difference of the aggregate health advancement assessment collection amount calculated under G.S. 108A-147.3 minus the HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX multiplied by the public hospital historical assessment share and divided by the total hospital costs for all public acute care hospitals holding a license on the first day of the assessment quarter.

§ 108A-147.2. Private hospital health advancement assessment.

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

(b) The private hospital health advancement assessment shall be assessed as a percentage of each private acute care hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department in accordance with this Part. The percentage for each quarter shall equal the difference of the aggregate health advancement assessment collection amount calculated under G.S. 108A-147.3 minus the HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX multiplied by the private hospital historical assessment share and divided by the total hospital costs for all private acute care hospitals holding a license on the first day of the assessment quarter.

§ 108A-147.3. Aggregate health advancement assessment collection amount.

(a) The aggregate health advancement assessment collection amount is an amount of money that is calculated quarterly by adjusting the total nonfederal receipts for health advancement calculated under subsection (b) of this section by (i) subtracting the health advancement presumptive IGT adjustment component calculated under G.S. 108A-147.9, (ii) adding the positive or negative health advancement IGT actual receipts adjustment component calculated under G.S. 108A-147.10, and (iii) subtracting the positive or negative IGT share of the reconciliation adjustment component calculated under G.S. 108A-147.11(b).

(b) The total nonfederal receipts for health advancement is an amount of money that is calculated quarterly by adding all of the following:

(1) The presumptive service cost component calculated under G.S. 108A-147.5.

(2) The HASP acute care hospital health advancement component calculated under G.S. 108A-147.6.

(2a) The HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX.

(3) The administration component calculated under G.S. 108A-147.7.

(4) The State retention component under G.S. 108A-147.9.

(5) The positive or negative health advancement reconciliation adjustment component calculated under G.S. 108A-147.11(a).

§ 108A-147.5. Presumptive service cost component.

(a) For every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is the product of forty-eight million seven hundred fifty thousand dollars ($48,750,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(24) is effective during any part of the month.

(c) For the first State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, the presumptive service cost component is one hundred forty-six million two hundred fifty thousand dollars ($146,250,000).

(d) For the second State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(24) becomes effective, and for each State fiscal quarter thereafter, the presumptive service cost component is an amount of money that is the greatest of the following:

(1) The prior quarter's presumptive service cost component amount.

(2) The prior quarter's presumptive service cost component amount increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: Medical Care for the most recent three months available on the first day of the current quarter.

(3) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for standard benefit plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for standard benefit plans.

(4) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for BH IDD tailored plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for BH IDD tailored plans.

(5) The amount produced from multiplying 1.15 by the highest amount produced when calculating, for each quarter that is at least two and not more than five quarters prior to the current quarter, the actual nonfederal expenditures for the applicable quarter minus the HASP acute care hospital health advancement component calculated under G.S. 108A-147.6 for the applicable quarter minus the HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX for the applicable quarter.

§ 108A-147.6. HASP acute care hospital health advancement component.

The HASP acute care hospital health advancement component is an amount of money that is calculated by multiplying the aggregate amount of HASP directed payments due to PHPs in the current quarter for hospital reimbursements to acute care hospitals for newly eligible individuals by the nonfederal share for newly eligible individuals.

§ 108A-147.11. Health advancement reconciliation adjustment component.

(a) The health advancement reconciliation adjustment component is a positive or negative dollar amount equal to the actual nonfederal expenditures for the quarter that is two quarters prior to the current quarter minus the sum of the following specified amounts:

(1) The presumptive service cost component calculated under G.S. 108A-147.5 for the quarter that is two quarters prior to the current quarter.

(2) The positive or negative gross premiums tax offset amount calculated under G.S. 108A-147.12(b).

(3) The HASP acute care hospital health advancement component calculated under G.S. 108A-147.6 for the quarter that is two quarters prior to the current quarter.

(4) The HASP freestanding psychiatric hospital health advancement component calculated under G.S. 108A-147.XX for the quarter that is two quarters prior to the current quarter.

(b) The IGT share of the reconciliation adjustment component is a positive or negative dollar amount that is calculated by multiplying the health advancement reconciliation adjustment component calculated under subsection (a) of this section by the share of public hospital costs calculated under subsection (c) of this section.

(c) The share of public hospital costs is calculated by adding total hospital costs for the UNC Health Care System, total hospital costs for the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, and sixty percent (60%) of the total hospital costs for all public acute care hospitals and dividing that sum by the total hospital costs for all acute care hospitals except for critical access hospitals.

Appendix B: Legislative Requirements – HASP/Freestanding Psychiatric Hospitals Proposal Report

HASP/FREESTANDING PSYCHIATRIC HOSPITALS

SECTION 9E.27.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), shall develop a proposal to allow freestanding psychiatric hospitals to receive reimbursements through the healthcare access and stabilization program (HASP) authorized under G.S. 108A-148.1, enacted by Section 1.4 of S.L. 2023-7, that are contingent upon the receipt of the nonfederal share of the reimbursements through hospital assessments in which those hospitals participate. In developing the proposal, DHB shall consider whether to assess freestanding psychiatric hospitals under the existing hospital assessment structures in Article 7B of Chapter 108A of the General Statutes or whether to develop another assessment structure. The proposal shall ensure that the entire nonfederal share of the HASP reimbursements to freestanding psychiatric hospitals is funded by increased receipts from hospital assessments. DHB shall create all draft documents required to request federal approval of the developed proposal. No documents shall be submitted requesting federal approval of the developed proposal without further authorization from the General Assembly. DHB shall consult with staff from the Fiscal Research Division, the Legislative Drafting Division, and the Legislative Analysis Division to develop the proposed legislative changes necessary to impose the requisite hospital assessments.

SECTION 9E.27.(b) By March 1, 2024, DHB shall submit a report to the Joint Legislative Oversight Committee on Medicaid with all of the following information related to the proposal developed under subsection (a) of this section:

(1) A detailed description of the proposal.

(2) Copies of the draft documents required to request the federal approval needed to implement the developed proposal.

(3) Proposed legislative changes that would be needed to implement the proposal.

(4) An analysis of any impact to the HASP reimbursements to hospitals other than freestanding psychiatric hospitals that might occur due to the limit on provider assessments established under 42 C.F.R. § 433.68(f).

SECTION 9E.27.(c) This section is effective the date this act becomes law.

Appendix C: Copy of Section 42 C.F.R § 438.6(c) Preprint for SFY2023 HASP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

September 28, 2023

Jay Ludlam
Deputy Secretary, North Carolina Medicaid
North Carolina Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699

Dear Jay Ludlam:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving North Carolina's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. CMS received a draft version of the proposal on February 28, 2023, and it was circulated for formal federal review on May 15, 2023. A revised, final version of the proposal was received on September 8, 2023. The proposal has a control name of NC_Fee_IPH.OPH.BHI.BHO_New_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform percentage increase established by the state for inpatient and outpatient hospital services and behavioral health inpatient and outpatient hospital services at eligible acute care and critical access hospitals for the rating period covering July 1, 2022 through June 30, 2023, incorporated in the capitation rates through a separate payment term of up to $2,596,485,198.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period(s), or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. CMS continues to work with the State of North Carolina to ensure that its Modernized Hospital Assessment and Health Advancement Assessment meet federal requirements. CMS reserves its authority to enforce requirements in the Social Security Act and implementing regulations, including by initiating separate deferrals and/or disallowances of federal financial participation. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Therefore, CMS strongly recommends that states share this approval letter and the final approved preprint with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must

ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

The total dollar amount approved for the separate payment term for this state directed payment is $2,596,485,198 within the Standard Plan Services managed care program. If the total amount of the separate payment term is exceeded from what was approved under this preprint or, the payment methodology is changed from the approved preprint, CMS requires the state to submit a state directed payment preprint amendment. Please note that if the separate payment term amount documented within the rate certification exceeds the separate payment term amount approved under the preprint, then the state will be required to submit a rate certification amendment to address the inconsistencies between the rate certification and the approved preprint.

If you have questions concerning this approval or state directed payments in general, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

Laura M. Snyder -S

Digitally signed by Laura M. Snyder -S
Date: 2023.09.28 15:11:30 -04'00'

Laura Snyder
Acting Deputy Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2022 - June 30, 2023
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2022
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Standard Plan Services
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $2,596,485,198
   a. Identify the estimated federal share of this state directed payment: $1,880,114,932
   b. Identify the estimated non-federal share of this state directed payment: $716,370,266

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☐ Quality Metric(s) / Benchmark(s) Change
      ☐ Other; please describe:

      ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

   Each in-network hospital's final payment amount under the directed payment will be based on the hospital's actual paid Medicaid managed care claims for utilization for the contract rate period, multiplied by the uniform rate increase percentage applicable to that hospital's class.

   a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

      State Plan Excerpt on Inpatient and Outpatient Hospital Services

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

   a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

   If checked, please answer all questions in Subsection IIA.

   b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

   If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	Measure Steward/ Developer[1]	Baseline[2] Year	Baseline[2] Statistic	Performance Measurement Period[3]	Performance Target	Notes[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Percentages for each class are identified in response to Question 19(d).

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

See Attachment

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

See Attachment

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☒ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☒ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Class 1: All acute care hospitals and critical access hospitals not included in Class 2
Class 2: Hospitals owned or controlled by the University of North Carolina Health Care System (UNCHS) and Vidant Medical Center (d/b/a ECU Health Medical Center).

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The classes of hospitals that are eligible for the directed payment are based on the classes identified in 4.19-A Section (d)(5) of the State Plan. All acute care hospitals, including critical access hospitals, identified in this section of the State Plan are eligible for the directed payment. A copy of 4.19-A Section (d)(5) of the State Plan is attached.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The directed payment is a uniform percentage increase for every in-network hospital within each hospital class, which applies to all inpatient and outpatient hospital services that each in-network hospital provides under the contract. The increase is the same regardless of which PHP the patient is enrolled in.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Class 1 Inpatient Services	100.00%	87.00%	0.00%		187.00%
b. Class 2 Inpatient Services	100.00%	77.00%	49.00%		226.00%
c. Class 1 Outpatient Services	100.00%	122.00%	0.00%		222.00%
d. Class 2 Outpatient Services	100.00%	39.00%	69.00%		208.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☒ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Please see response to question 19(d) in the Attachment.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

DHB determined that the percent payment increases for each class are appropriate and reasonable because they bring the reimbursement to each class of hospitals, for the in-network Medicaid managed care services they provide, closer to non-governmental managed care rates in support of DHB policies and Medicaid managed care access goals.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

DHB will submit the contract action upon CMS approval of the preprint.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

The state plans to submit amended certification concurrent with or following the contract action.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

See Attachment.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☒ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. See Attachment					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☑ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Modernized Hospital Assessment	Inpatient and Outpatient Hospital Services	No	No	Yes		No
ii.						
iii.						
iv.						
v.						

15

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. See attachment			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☑ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://medicaid.ncdhhs.gov/2021-quality-strategy-june-21-2021-final/download?inline=true
- **b.** The effective date of quality strategy. June 16, 2021

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal 1: Ensure appropriate access to care	Objective 1.1: Ensure equitable, timely access to care Objective 1.2: Maintain Medicaid provider engagement	9
b.		
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement is expected to advance these goals and objectives, this year and in future years, primarily by maintaining and enhancing access to care for Medicaid managed care enrollees, which will improve health outcomes and quality of care for Medicaid managed care enrollees. We anticipate the payment arrangement will support the financial sustainability of hospitals that serve large proportions of Medicaid-covered individuals. This will in turn ensure a sufficient number of hospitals engage in each managed care plan's network to provide timely access to services. Over the longer term, it is also anticipated that these payments will support provider efforts to improve performance, resulting in higher quality services provided to Medicaid managed care enrollees.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Getting Care Quickly Measure Steward: AHRQ CAHPS Survey Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version NQF #: 0006	CY 2020	Adult 80.8% Child 93.9% CY2019	Increase the percentage of adults and children getting care quickly by 1% total from the baseline year to CY 2023 (i.e., adult target: 81.6%; child target: 94.8%).	
ii. Getting Needed Care Measure Steward: AHRQ CAHPS Survey Health Plan Survey 5.0, Adult Version, and CAHPS Health Plan Survey 5.0, Child Version NQF#: 0006	CY 2020	Adult 82.0% Child 89.0% CY2019	Increase the percentage of adults and children getting needed care by 1% total from the baseline year to CY 2023 (i.e., adult target: 82.8%; child target: 89.9%).	
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.