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Via email: rrc.comments@oah.nc.gov

North Carolina Rules Review Commission

RE: Comments in Support of Proposed/Temporary Subchapters and Rules 10A NCAC 22Q and 22R

To Whom It May Concern:

On behalf of our clients: Mission/ACA, Atrium Health Wake Forest Baptist, Cone Health, WakeMed Health and Hospitals, Duke Health, Novant New Hanover Regional Medical Center, Cape Fear Valley Health, Vidant Health and Atrium Health.

The undersigned desires to make an oral statement before the Commission concerning these rules.

Support for Temporary Rules Issuance

Session Law 2020-88 created the Hospital Uncompensated Care Fund to receive a portion of federal Disproportionate Share Hospital (DSH) funds for distribution to North Carolina hospitals. Session Law 2020-88 requires the Department to issue rules for implementation of the Hospital Uncompensated Care Fund. The Department moves to issue temporary rules for the prompt establishment of funding mechanisms for North Carolina hospitals. This written comment supports the Department's use of temporary rules.

N.C. Gen. Stat. 150B-21.1 lists the circumstances permitting agencies to issue temporary rules. In this instance, subsections 3 (a recent change of federal or state budgetary policy) or 4 (a recent federal regulation), both addressing changes in federal laws or fiscal policies are applicable. Additionally, subsection 17, the allowance for temporary rules to maximize federal receipts of the Medicaid program would also be relevant.

While Session Law 2020-88 was passed more than a year ago, the Department only recently received federal authority to move forward with a restructured DSH program. Adjustments to North Carolina's DSH program were necessitated by the state's recent (July 1, 2021) conversion of much of its Medicaid spending to managed care (as outlined below). The Department needed approval by the federal Centers for Medicare and Medicaid Services (CMS) to modify the existing DSH program within the North Carolina Medicaid State Plan. A CMS denial or significant reworking of the state's proposed DSH structures would have, in turn, necessitated revision of the proposed 10A NCAC 22Q and 22R.

CMS granted approval of the requested State Plan amendments on June 29, 2021 [as shown by the attached portion of the State Plan referencing "Disproportionate Share Hospital (DSH) Payment"]. The CMS approval fits the statutory requirement of "budgetary policy" as the CMS approval controls federal funding for the Medicaid program. The CMS approval fits the statutory intent of a

"recent federal regulation" as CMS approval is a legal requirement, just as much as a new regulatory requirement. As a result, the filing time for these temporary rules falls within the 210-day window for temporary issuance of rules as required by N.C. Gen. Stat. 150B-21.1.

Support of Issuance of Rules (22Q and 22R)

Disproportionate Share Hospital funds support hospitals with substantial levels of Medicaid and uninsured care. The Department, in partnership with North Carolina's hospitals, has long worked to support a broad array of hospitals with DSH funds. In contrast to other states, North Carolina distributes DSH funding across most hospitals rather than a small subset (such as public or children's hospitals). In North Carolina, most hospitals are safety net hospitals and thus receiving DSH funds. In State Fiscal Year 2020, the North Carolina DSH program distributed roughly $228 million to North Carolina hospitals.

Historically, North Carolina's public hospitals put forward the non-federal share for most federal DSH funds distributed to North Carolina's hospitals (both public and private hospitals). These public hospitals put up the nonfederal share through Certified Public Expenditures (CPE).

North Carolina's shift to Medicaid managed care required a reconfiguration and realignment of federal DSH dollars, predominantly to continue support of indigent care provided at nonpublic hospitals in North Carolina (such as Duke, WakeMed and Novant Hospitals).

The proposed rules of 22Q and 22R will permit nearly all North Carolina hospitals to continue to receive vital DSH funds. The proposed framework will permit many, if not most, North Carolina hospitals to receive their fair share of scarce DSH funds. This will permit North Carolina's hospitals to continue to serve underrepresented populations all across the State of North Carolina. Finally, the proposed rules allow for the accountability of the funds by way of audits of receiving hospitals to ensure their eligibility and proper documentation of costs.

North Carolina's hospitals appreciate the opportunity to comment on these much-needed rules. Further, North Carolina's hospitals appreciate the partnership extended by the Department so as to continue to permit all of North Carolina's populations to receive health care services.

Sincerely,

OTT CONE & REDPATH, P.A.

Curtis B. Venable

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CBV/caw
cc. Shazia A. Keller, DHB Rulemaking Coordinator (electronic delivery)

Enclosure: DSH State Plan page

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program

State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

With respect to hospitals that are licensed by the State of North Carolina, that are qualified to certify public expenditures (CPEs) and do certify in accordance with 42 CFR 433.51(b), that qualify for disproportionate share hospital status under Paragraph (c) of the "Disproportionate Share Hospital Payment" Section, the expenditures claimable for Federal Financial Participation (FFP) for the 12-month period ending September 30 each year will be the hospitals' uncompensated care expenditures for serving uninsured patients up to the State's available DSH allotment after allowing for DSH payments for the State-owned Institutes for Mental Diseases and Basic DSH. Each hospital's allowable uncompensated care costs for the rate year will be determined on an interim basis by calculating the hospital's inpatient and outpatient cost-to-charge ratios determined from the hospitals' most recent available as-filed CMS 2552 cost report and multiplying the ratios by the hospital's inpatient and outpatient charges, respectively, for uninsured patients as filed with and certified to the Division for the fiscal year. The Division will then subtract payments hospitals received from uninsured patients for services rendered during the fiscal period to which the gross charges referred to in the preceding sentence relate. The Division will bring the uncompensated care cost data forward to the end of the payment period by applying the applicable CMS PPS Hospital Input Price Indices. Hospitals' final allowable costs for services provided to uninsured patients will be determined based upon “Audit of Disproportionate Share Payments” section and requirements in 42 U.S.C. § 1396r-4(j).

(a) In accordance with 42 U.S.C. § 1396r-4 (g)(1) total disproportionate share payments to a hospital shall not exceed the percentage specified by 42 U.S.C. § 1396r-4 (g) of the total costs of providing inpatient and outpatient services to Medicaid and uninsured patients for the fiscal year in which such payments are made, less any Medicaid and uninsured payments received for services to Medicaid and uninsured patients. The total of all disproportionate share hospital payments shall not exceed the limits on disproportionate share hospital fundingas established for this State by CMS in accordance with 42 U.S.C. § 1396r-4 (f).

(b) The payments authorized by this section shall be effective in accordance with GS 108A-55(c).