HB191

173849-1

By Representative Clouse

RFD: Ways and Means General Fund

First Read: 11-FEB-16

173849-1:n:02/10/2016:LFO-ML*/bdl

SYNOPSIS: This bill would extend the private hospital assessment and Medicaid funding program for fiscal years 2017, 2018, and 2019.

This bill would change the base year to fiscal year 2014 for purposes of calculating the assessment and would clarify the uses of certified public expenditures.

A BILL

TO BE ENTITLED

AN ACT

To amend Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, 40-26B-86, and 40-26B-88, Code of Alabama 1975, to extend the private hospital assessment and Medicaid funding program for fiscal years 2017, 2018 and 2019; to change the base year to fiscal year 2014 for purposes of calculating the assessment; and to clarify the uses of Certified Public

Expenditures by publically and state-owned hospitals; and to repeal Section 40-26B-77.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, 40-26B-86, and 40-26B-88, Code of Alabama 1975, are amended to read as follows:

"§40-26B-70.

"For purposes of this article, the following terms shall have the following meanings:

"~~(1) ACCESS PAYMENT. A payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient.~~

"~~(2)~~ (1) ALTERNATE CARE PROVIDER. A contractor, other than a regional care organization, that agrees to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state pursuant to a risk contract.

"~~(3)~~ (2) CERTIFIED PUBLIC EXPENDITURE. A certification in writing of the cost of providing medical care to Medicaid beneficiaries by publicly owned hospitals and hospitals owned by a state agency or a state university plus the amount of uncompensated care provided by publicly owned hospitals and hospitals owned by an agency of state government or a state university.

"~~(4)~~ (3) DEPARTMENT. The Department of Revenue of the State of Alabama.

"~~(5)~~ (4) HOSPITAL. A facility that is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

"~~(6)~~ (5) HOSPITAL SERVICES AND REIMBURSEMENT PANEL. A group of individuals appointed to review and approve any state plan amendments to be submitted to the Centers for Medicare and Medicaid Services which involve hospital services or reimbursement.

"~~(7)~~ (6) INTERGOVERNMENTAL TRANSFER. A transfer of funds made by a publicly or state-owned hospital to the Medicaid Agency, which will be used by the agency to obtain federal matching funds for all hospital payments to public and state-owned hospitals~~, other than disproportionate share payments~~.

"~~(8)~~ (7) MEDICAID PROGRAM. The medical assistance program as established in Title XIX of the Social Security Act and as administered in the State of Alabama by the Alabama Medicaid Agency pursuant to executive order, Chapter 6 of Title 22, commencing with Section 22-6-1, and Title 560 of the Alabama Administrative Code.

"~~(9)~~ (8) MEDICARE COST REPORT. ~~CMS-2552-96~~ CMS-2552-10, the Cost Report for Electronic Filing of Hospitals.

"~~(10)~~ (9) NET PATIENT REVENUE. The amount calculated in accordance with generally accepted accounting principles for privately operated hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the Medicare Cost Report, adjusted to exclude nonhospital revenue.

"~~(11)~~ (10) PRIVATELY OPERATED HOSPITAL. A hospital in Alabama other than:

"a. Any hospital that is owned and operated by the federal government;

"b. Any state-owned hospital;

"c. Any publicly owned hospital;

"d. A hospital that limits services to patients primarily to rehabilitation services; or

"e. A hospital granted a certificate of need as a long term acute care hospital.

"~~(12)~~ (11) PUBLICLY OWNED HOSPITAL. A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11 or Chapter 51 of Title 22, or a hospital otherwise owned and operated by a unit of local government.

"~~(13)~~ (12) REGIONAL CARE ORGANIZATION. An organization of health care providers that contracts with the Medicaid Agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state and that meets the requirements set forth by the Alabama Medicaid Agency.

"~~(14)~~ (13) STATE-OWNED HOSPITAL. A hospital that is a state agency or unit of government, including, without limitation, a hospital owned by a state agency or a state university.

"~~(15)~~ (14) STATE PLAN AMENDMENT. A change or update to the state Medicaid plan that is approved by the Centers for Medicare and Medicaid Services.

"~~(16)~~ (15) UPPER PAYMENT LIMIT. The maximum ceiling imposed by federal regulation on Medicaid reimbursement for inpatient hospital services under 42 C.F.R. §447.272 and outpatient hospital services under 42 C.F.R. §447.321.

"a. The upper payment limit shall be calculated separately for hospital inpatient and outpatient services.

"b. Medicaid disproportionate share payments shall be excluded from the calculation of the upper payment limit.

"~~(17)~~ (16) UNCOMPENSATED CARE SURVEY. A survey of hospitals conducted by the Medicaid program to determine the amount of uncompensated care provided by a particular hospital in a particular fiscal year.

"(17) OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS). An outpatient visit-based patient classification system used to organize and pay services with similar resource consumption across multiple settings.

"(18) DIAGNOSIS-RELATED GROUP (DRG). A statistical system of classifying any inpatient stay into groups for the purposes of payment.

"(19) ENCOUNTER RATE. A set fee for an outpatient encounter.

"(20) REGIONAL CARE ORGANIZATION CAPITATION PAYMENT. An actuarial sound payment made by Medicaid to the Regional Care Organizations.

"§40-26B-71.

"(a) For state fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019 an assessment is imposed on each privately operated hospital in the amount of 5.50 percent of net patient revenue in fiscal year ~~2011~~ 2014. The assessment is a cost of doing business as a privately operated hospital in the State of Alabama. ~~Prior to the legislative session preceding state fiscal year 2016~~ Annually, the Medicaid Agency shall make a determination of whether changes in federal law or regulation have adversely affected hospital Medicaid reimbursement since October 1, ~~2013~~ 2015 or a reduction in RCO capitation rates has occurred. If the agency determines that adverse impact to hospital Medicaid reimbursement has occurred, or will occur ~~during fiscal year 2016~~, the agency shall report its findings to the Chairman of the House Ways and Means General Fund Committee who shall propose an amendment to Act 2013-246 during any legislative session prior to ~~October 1, 2015~~ the start of the upcoming fiscal year from the year the report was made, to address the adverse impact.

"(b)(1) For state fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019, net patient revenue shall be determined using the data from each private hospital's fiscal year ending

~~2011~~ 2014 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services Healthcare Cost Information System.

"(2) The Medicare Cost Report for ~~2011~~ 2014 for each private hospital shall be used for fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019. If the Medicare Cost Report is not available in Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System, the hospital shall submit a copy to the department to determine the hospital's net patient revenue for fiscal year ~~2011~~ 2014.

"(3) If a privately operated hospital commenced operations after the due date for a ~~2011~~ 2014 Medicare Cost Report, the hospital shall submit its most recent Medicare Cost Report to the department in order to allow the department to determine the hospital's net patient revenue.

"(c) This article does not authorize a unit of county or local government to license for revenue or impose a tax or assessment upon hospitals or a tax or assessment measured by the income or earnings of a hospital.

"§40-26B-73.

"(a)(1) There is created within the Health Care Trust Fund referenced in Article 3, Chapter 6, Title 22, a designated account known as the Hospital Assessment Account.

"(2) The hospital assessments imposed under this article shall be deposited into the Hospital Assessment Account.

(3) The hospital intergovernmental transfers imposed under this article shall be deposited into the Hospital Assessment Account.

"(b) Moneys in the Hospital Assessment Account shall consist of:

"(1) All moneys collected or received by the department from privately operated hospital assessments imposed under this article;

"(2) Any interest or penalties levied in conjunction with the administration of this article; and

"(3) Any appropriations, transfers, donations, gifts, or moneys from other sources, as applicable~~.~~; and

(4) All moneys collected or received by the department from publicly and state operated hospital intergovernmental transfers imposed under this article.

"(c) The Hospital Assessment Account shall be separate and distinct from the State General Fund and shall be supplementary to the Health Care Trust Fund.

"(d) Moneys in the Hospital Assessment Account shall not be used to replace other general revenues appropriated and funded by the Legislature or other revenues used to support Medicaid.

"(e) The Hospital Assessment Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of State General Fund revenues to the extent permissible under Amendment 26 to the Constitution of Alabama of 1901, now appearing as Section 213 of the Official

Recompilation of the Constitution of Alabama of 1901, as amended.

"~~f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Assessment Account, the moneys in the Hospital Assessment Account shall be used only as follows:~~

"~~a. To make inpatient and outpatient private hospital access payments under this article; or~~

"~~b. To reimburse moneys collected by the department from hospitals through error or mistake or under this article.~~

"(2)a. The Hospital Assessment Account shall retain account balances remaining each fiscal year.

"b. ~~On September 30, 2014 and each year thereafter, any positive balance remaining in the Hospital Assessment Account which was not used by Alabama Medicaid to obtain federal matching funds shall be factored into the calculation of any new assessment rate by reducing the amount of hospital assessment funds that must be generated during the next fiscal year.~~ If there is no new assessment beginning October 1, ~~2016~~ 2019, the funds remaining shall be refunded to the hospital that paid the assessment in proportion to the amount remaining.

"(3) A privately operated hospital shall not be guaranteed that its inpatient and outpatient hospital payments will equal or exceed the amount of its hospital assessment.

"§40-26B-77.1.

"(a) Beginning on October 1, ~~2013~~ 2016, and ending on September 30, 2019, publicly owned and state-owned hospitals will begin making quarterly intergovernmental transfers to the Medicaid Agency. The amount of these intergovernmental transfers shall be calculated ~~by the Medicaid Agency to equal the amount of state funds necessary for the agency to obtain only those federal matching funds necessary to pay state-owned and public hospitals for direct inpatient and outpatient care and to pay state-owned and public hospital inpatient and outpatient access payments~~ for each hospital using a pro-rata basis based on the hospitals IGT and CPE contribution for FY 2016 in relation to the total IGT and CPE for FY 2016. The total IGT for any given fiscal year shall not exceed $324,858,765 with the exception of an adjustment as described in paragraph (d).

"(b) These intergovernmental transfers shall be made in compliance with 42 U.S.C. §1396b.(w).

"(c) If a publicly or state-owned hospital commences operations after October 1, 2013, the hospital shall commence making intergovernmental transfers to the Medicaid Agency in the first full month of operation of the hospital after October 1, 2013.

"(d) Notwithstanding any other provision of this article, a private hospital that is subject to payment of the assessment pursuant to this article at the beginning of a state fiscal year, but during the state fiscal year experiences a change in status so that it is subject to the

intergovernmental transfer computed under this article shall continue to pay the same amount as calculated in 40-26B-71, but in the form of an Intergovernmental Transfer.

"§40-26B-79.

"Medicaid shall pay hospitals as a base amount for state fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019, ~~the total inpatient payments made by Medicaid during state fiscal year 2007, divided by the total patient days paid in state fiscal year 2007, multiplied by patient days paid during fiscal years 2014, 2015, and 2016. This payment to be paid using Medicaid's published check write table is in addition to any access payments, disproportionate share payments, or other payments described in this article~~ for inpatient services a DRG payment that is equal to the total modeled UPL submitted and approved by CMS during fiscal year 2016. If approved by CMS, Medicaid shall publish the DRG rates for each hospital prior to October 1, 2016.

"§40-26B-80.

"Medicaid shall pay hospitals as a base amount for fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019 for outpatient services based upon ~~the~~ an outpatient ~~fee~~ encounter rate or OPPS schedule. ~~in existence on September 30, 2013, plus an additional six percent inflation factor over the amounts paid in 2012 and 2013. Outpatient base payments shall be paid using Medicaid's published check write table and shall be paid in addition to any access payments or other payments described in this article~~ Medicaid shall calculate a hospital

specific encounter rate based on the outpatient UPL submitted and approved by CMS for FY 2016 divided by the number of encounters a hospital had during FY 2015 times the outpatient utilization factor used in the FY 2016 UPL calculation. A hospital specific encounter rate schedule shall be published prior to October 1, 2016.

"Should Medicaid implement OPPS, the total amount budgeted (total base rate) for OPPS shall not be less than the total amount budgeted for encounter rates.

"§40-26B-81.

"~~(a)~~ To preserve and improve access to hospital services, for hospital inpatient and outpatient services rendered on or after October 1, ~~2009~~ 2016, Medicaid shall ~~make hospital access payments to publicly, state-owned, and privately operated hospitals as set forth in this section~~ consider the published inpatient and outpatient rates as defined in Sections 40-26B-79 and 40-26B-80 as the minimum payment allowed.

"~~(b) The aggregate hospital access payment amount is an amount equal to the upper payment limit, less total base payments determined under this article.~~

"~~(c) All publicly, state-owned, and privately operated hospitals shall be eligible for inpatient and outpatient hospital access payments for fiscal years 2014, 2015, and 2016 as set forth in this article.~~

"~~(1) In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid~~

~~patients, each eligible hospital shall receive inpatient hospital access payments each state fiscal year. Publicly and state-owned hospitals shall receive payments, including base payments, that, in the aggregate, equal the upper payment limit for publicly and state-owned hospitals. Privately operated hospitals shall receive payments, including base payments that, in the aggregate, equal the upper payment limit for privately operated hospitals.~~

"~~(2) Inpatient hospital access payments shall be made on a quarterly basis.~~

"~~(3) In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each state fiscal year. Publicly and state-owned hospitals shall receive payments, including base payments, that, in the aggregate, equal the upper payment limit for publicly and state-owned hospitals. Privately operated hospitals shall receive payments, including base payments that, in the aggregate, equal the upper payment limit for privately operated hospitals.~~

"~~(4) Outpatient hospital access payments shall be made on a quarterly basis.~~

"~~(d) A hospital access payment shall not be used to offset any other payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries, including, without limitation, any fee-for-service, per diem, private hospital inpatient adjustment, or cost settlement payment.~~

"~~(e) The specific hospital payments for publicly, state-owned, and privately operated hospitals shall be described in the state plan amendment to be submitted to and approved by the Centers for Medicare and Medicaid Services.~~

"§40-26B-82.

"(a) The assessment imposed under this article shall not take effect or shall cease to be imposed and any moneys remaining in the Hospital Assessment Account in the Alabama Medicaid Program Trust Fund shall be refunded to hospitals in proportion to the amounts paid by them if any of the following occur:

"(1) ~~Expenditures for hospital inpatient and outpatient services paid by the Alabama Medicaid Program for fiscal years 2014, 2015, and 2016 are less than the amount paid during fiscal year 2013.~~ Reimbursement rates under this article for fiscal years 2017, 2018, and 2019 are less than the rates approved by CMS in Section 40-26B-79 and 40-26B-80.

"(2) Medicaid makes changes in its rules that reduce hospital inpatient payment rates, outpatient payment rates, or adjustment payments, including any cost settlement protocol, that were in effect on September 30, ~~2013~~ 2016.

"(3) The inpatient or outpatient hospital access payments required under this article are changed or the assessments imposed or certified public expenditures, or intergovernmental transfers recognized under this article are not eligible for federal matching funds under Title XIX of the

Social Security Act, 42 U.S.C. §1396 et seq., or 42 U.S.C. §1397aa et seq.

"(4) The Medicaid Agency contracts with an alternate care provider in a Medicaid region under any terms other than the following:

"a. If a regional care organization failed to provide adequate service pursuant to its contract, or had its certification terminated, or if the Medicaid Agency could not award a contract to a regional care organization under its quality, efficiency, and cost conditions, or if no organization had been awarded a regional care organization certificate by October 1, 2016, then the Medicaid Agency shall first offer a contract, to resume interrupted service or to assume service in the region, under its quality, efficiency and cost conditions to any other regional care organization that Medicaid judged would meet its quality criteria.

"b. If by October 1, 2014, no organization had a probationary regional care organization certification in a region. However, the Medicaid Agency could extend the deadline until January 1, 2015, if it judged an organization was making reasonable progress toward getting probationary certification. If Medicaid judged that no organization in the region likely would achieve probationary certification by January 1, 2015, then the Medicaid Agency shall let any organization with probationary or full regional care organization certification apply to develop a regional care organization in the region. If at least one organization made such an application, the

agency no sooner than October 1, 2015, would decide whether any organization could reasonably be expected to become a fully certified regional care organization in the region and its initial region.

"c. If an organization lost its probationary certification before October 1, 2016, Medicaid shall offer any other organization with probationary or full regional care organization certification, which it judged could successfully provide service in the region and its initial region, the opportunity to serve Medicaid beneficiaries in both regions.

"d. Medicaid may contract with an alternate care provider only if no regional care organization accepted a contract under the terms of a., or no organization was granted the opportunity to develop a regional care organization in the affected region under the terms of b., or no organization was granted the opportunity to serve Medicaid beneficiaries under the terms of c.

"e. The Medicaid Agency may contract with an alternate care provider under the terms of paragraph d. only if, in the judgment of the Medicaid Agency, care of Medicaid enrollees would be better, more efficient, and less costly than under the then existing care delivery system. Medicaid may contract with more than one alternate care provider in a Medicaid region.

"f.1. If the Medicaid Agency were to contract with an alternate care provider under the terms of this section, that provider would have to pay reimbursements for hospital

inpatient or outpatient care at rates at least equal to those ~~most-recently paid directly by the state Medicaid Agency either through base payments or access payments~~ published as of October 1, 2016 pursuant to Section 40-26B-79 and 40-26B-80.

"2. If more than a year had elapsed since the Medicaid Agency directly paid reimbursements to hospitals, the minimum reimbursement rates paid by the alternate care provider would have to be changed to reflect any percentage increase in the national medical consumer price index minus 100 basis points. ~~The indexing requirement of this subdivision shall cease to be effective on October 1, 2016.~~

"(b)(1) The assessment imposed under this article shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

"(2) Moneys in the Hospital Assessment Account in the Alabama Medicaid Program Trust Fund derived from assessments imposed before the determination described in subdivision (1) shall be disbursed under this article to the extent federal matching is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospitals in proportion to the amounts paid by them.

"§40-26B-84.

"This article shall be of no effect if federal financial participation under Title XIX of the Social Security

Act is not available to Medicaid at the approved federal medical assistance percentage, established under Section 1905 of the Social Security Act, for the state fiscal years ~~2014, 2015, and 2016~~ 2017, 2018, and 2019.

"§40-26B-86.

"The Social Security Act provides for additional payments to hospitals qualifying as disproportionate share hospitals under Section 1923(d) of that act. Payments to disproportionate share hospitals shall be made to all hospitals qualifying for disproportionate share hospital payments under Section 1923(d) of that act, in addition to any other payments by Medicaid. Medicaid shall fully expend the allotment to hospitals under Section 1923(f)(3) of the Social Security Act. Medicaid shall not restrict the qualifications for disproportionate share hospital payments to anything less than what the act sets out as disproportionate share hospital qualifications. ~~State-owned institutions for mental disease shall receive no more than the same disproportionate share payments the hospitals received in state fiscal year 2009.~~ The ~~total~~ disproportionate share hospital payment to each hospital shall be made quarterly during the first month of each quarter for the state fiscal year. Medicaid shall mandate an uncompensated care survey be completed annually and returned to Medicaid by each hospital affected by this article beginning with the state fiscal year ending September 30, 2009, and thereafter for each state fiscal year. The survey shall be conducted in a manner that complies with federal

rules related to auditing and reporting of disproportionate share hospital payments, as described in 42 C.F.R. §§447 and 455.

"§40-26B-88.

"This article shall automatically terminate and become null and void by its own terms on September 30, ~~2013~~ 2019, unless a later bill is passed extending the article to future state fiscal years."

Section 2. Section 40-26B-77 is hereby repealed.

Section 3. This Act shall become effective on October 1, 2016.