HB605

151840-2

By Representative Clouse

RFD: Ways and Means General Fund

First Read: 10-APR-13

ENGROSSED

A BILL

TO BE ENTITLED

AN ACT

To amend Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77, 40-26B-78, 40-26B-80, 40-26B-82, 40-26B-84, 40-26B-88, Code of Alabama 1975, to extend the private hospital assessment and Medicaid funding program for fiscal years 2014, 2015 and 2016; to change the base year to fiscal year 2011 for purposes of calculating the assessment; to change the assessment rate for fiscal years 2014, 2015 and 2016; to add Section 40-26B-77.1 to Article 5, Chapter 26B of the Code of Alabama 1975, to provide that state-owned and public hospitals shall make intergovernmental transfers to the Medicaid Agency to be used to fund payments for inpatient and outpatient care; and to provide that state-owned and public hospital certified public expenditures shall be for the hospital's uncompensated care and shall be used to pay the hospital its disproportionate share payments.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77, 40-26B-78, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, 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) 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.

~~(2)~~ (3) 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.

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

~~(4)~~ (5) 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.

~~(5)~~ (6) 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.

~~(6)~~ (7) 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.

~~(6) (7)~~ (8) 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.

~~(7) (8)~~ (9) MEDICARE COST REPORT. CMS-2552-96, the Cost Report for Electronic Filing of Hospitals.

~~(8) (9)~~ (10) 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.

~~(9) (10)~~ (11) 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.

~~(10) (11)~~ (12) 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 a hospital otherwise owned and operated by a unit of local government.

(13) 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.

~~(11) (12) (13)~~ (14) 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.

~~(12) (13)~~ (15) STATE PLAN AMENDMENT. A change or update to the state Medicaid plan that is approved by the Centers for Medicare and Medicaid Services.

~~(13) (14)~~ (16) 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.

~~(14) (15)~~ (17) 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.

"§40-26B-71.

(a) ~~An assessment is imposed on each privately operated hospital for the state fiscal year in the amount of 5.38 percent of each hospital's net patient revenue in fiscal year 2007 for the state fiscal years 2010 and 2011. For state fiscal years 2012 and 2013, an assessment is imposed on each privately operated hospital for the state fiscal year in the amount of 5.14 percent of net patient revenue in fiscal year 2009. If during fiscal year 2012 or 2013 there is an extraordinary change in a private hospital's cost due to an extraordinary known and measurable change that increases the hospital's upper payment limit and entitles that hospital to receive additional access payments, the assessment rate for all private hospitals shall be changed to reflect the~~

~~hospital's additional costs. An extraordinary known and measurable event is one that results in at least a 50 percent increase in capital costs, necessitates the calculation of the hospital's upper payment limit using a total cost to total charge ratio, and the hospital has at least a 15 percent annual Medicaid inpatient utilization rate. The private hospital must certify to the department the extraordinary costs by August 31, 2012, for the assessment to increase in 2013.~~ For state fiscal years 2014, 2015 and 2016 an assessment is imposed on each privately operated hospital in the amount of 5.50 percent of net patient revenue in fiscal year 2011. 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, the Medicaid Agency shall make a determination of whether changes in federal law or regulation have adversely affected hospital Medicaid reimbursement since the effective date of this act. 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 this act during any legislative session prior to October 1, 2015, to address the adverse impact.

(b)(1) ~~For state fiscal years 2010 and 2011, net patient revenue shall be determined using the data from each hospital's fiscal year ending in 2007 Medicare Cost Report~~

~~contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated December 31, 2008. For state fiscal years 2012 and 2013, net patient revenue shall be determined using the data from each hospital's fiscal year ending 2009 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System dated December 31, 2010.~~ For state fiscal years 2014, 2015 and 2016, net patient revenue shall be determined using the data from each private hospital's fiscal year ending 2011 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services Healthcare Cost Information System.

(2) ~~If a privately operated hospital's fiscal year ending in 2007 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated December 31, 2008, the hospital shall submit a copy of the hospital's 2007 Medicare Cost Report to the department in order to allow the department to determine the hospital's net patient revenue for 2010 and 2011. For fiscal years 2012 and 2013, the Medicare Cost Report for 2009 shall be used.~~ The Medicare Cost Report for 2011 for each private hospital shall be used for fiscal years 2014, 2015 and 2016. 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 ~~years 2012 and 2013.~~ year 2011.

(3) ~~If a privately operated hospital commenced operations after the due date for a 2007 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. If a privately operated hospital commenced operations after the due date for a 2009 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.~~ If a privately operated hospital commenced operations after the due date for a 2011 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.

(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.

(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, ~~2013~~ 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. ~~beginning on October 1, 2013, and if~~ If there is no new assessment beginning October 1, ~~2013~~ 2016, 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.

(a) A certification of public expenditures shall be completed and provided to Medicaid by each publicly and state-owned hospital for each state fiscal year beginning with fiscal year 2007. This written certification shall only include the ~~sum of the cost of providing care to Medicaid eligible beneficiaries for both inpatient and outpatient care plus the~~ amount of uncompensated care provided to hospital inpatients and outpatients during that same state fiscal year.

(b)(1) For state fiscal years ~~2010, 2011, 2012, and 2013~~ 2014, 2015 and 2016, Medicaid shall pay to each publicly or state-owned hospitals the disproportionate share moneys for that fiscal year during the first month of the state fiscal year.

(2) Certified public expenditures made by publicly and state-owned hospitals shall comply with the requirements of 42 U.S.C. §1396b(w).

(3) If a publicly or state-owned hospital commenced operations after the due date for the state fiscal year ~~2007~~ 2011, the hospital shall submit its certification upon completion of the first six months of operation of the hospital to Medicaid in order to allow Medicaid to add the certification amount to the total certified public expenditure amount. ~~If a publicly or state-owned hospital commenced operations after the due date for the state fiscal year 2009, the hospital shall submit its certification upon completion of the first six months of operation of the hospital to Medicaid in order to allow Medicaid to add the certification amount to the total certified public expenditure amount.~~

(4) If a hospital ceases to operate as a state-owned or public hospital it shall provide a certification to Medicaid which shall include all dates of inpatient and outpatient services until and including the hospital's last day of patient service as a publicly or state-owned hospital within 10 business days of the last day the hospital operated as a state-owned or public hospital.

"§40-26B-78.

(a) Medicaid shall account for those federal funds derived from certified public expenditures by publicly and state-owned hospitals as those funds are received by Medicaid from the federal government.

(b) The certified public expenditure accounting shall be separate and distinct from the State General Fund appropriation accounting.

(c) Federal moneys accounted for shall not be used to replace other State General Fund revenues appropriated and funded by the Legislature or other revenues used to support Medicaid.

(d) The moneys obtained by Medicaid from hospital certified public expenditure certifications shall be used only as follows:

(1) To make ~~inpatient, outpatient, and~~ disproportionate share hospital payments under this article;

(2) To reimburse moneys collected by the department through error or mistake under this article; or

(3) For any other permissible purpose allowed under Title XIX of the Social Security Act.

"§40-26B-79.

~~(a)~~ Medicaid shall pay hospitals as a base amount for state fiscal years ~~2010, 2011, 2012, and 2013~~ 2014, 2015 and 2016, 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 ~~2010, 2011, 2012, and 2013~~ 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.

~~(b) Any publicly owned or privately operated hospital that ceases to operate as a hospital that was in operation during the hospital's fiscal year ending in 2007 shall notify Medicaid at the time the facility ceases to operate. Base payments that would have been made to these facilities for these services will not be made beginning on the date that the facility ceased to operate as a hospital.~~

"§40-26B-80.

~~Medicaid shall pay hospitals as a base amount for state fiscal years 2010 and 2011 the total outpatient payments made by Medicaid during state fiscal year 2007, divided by the total Internal Control Number or ICN count incurred in state fiscal year 2007, multiplied by the Internal Control Number or ICN count incurred each month during fiscal years 2010 and 2011. Medicaid shall pay hospitals as a base amount for fiscal years 2012 and 2013 for outpatient services based upon the outpatient fee schedule in existence on September 30, 2009, plus an additional six percent inflation factor.~~ Medicaid shall pay hospitals as a base amount for fiscal years 2014, 2015 and 2016 for outpatient services based upon the outpatient fee 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.

"§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, Medicaid shall make hospital access payments to publicly, state-owned, and privately operated hospitals as set forth in this section.

(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 ~~2010, 2011, 2012, and 2013~~ 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 ~~2010, 2011, 2012, and 2013~~ 2014, 2015 and 2016 are less than the amount paid during fiscal year ~~2009~~ 2013.

(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 ~~October 1, 2009~~ September 30, 2013.

(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 ~~the terms of Section 4~~ 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 ~~the conditions of Section 4~~ 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 ~~alternative~~ 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 subsection (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.

(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 Oct. 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 ~~2010, 2011, 2012, and 2013~~ 2014, 2015 and 2016.

Section 2. The following code is added to Article 5, Chapter 26 of the Code of Alabama 1975, to read as follows:

§40-26B-77.1.

(a) Beginning on October 1, 2013, publicly owned and state-owned hospitals will begin making 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.(b) These intergovernmental transfers shall be made in compliance with 42 U.S.C. §1396(b)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.

Section 3. This act shall become effective on October 1, 2013.

House of Representatives

Read for the first time and referred to the House of Representatives committee on Ways and Means
General Fund..... ..... 10-APR-13

Read for the second time and placed on the calendar 1 amendment 18-APR-13

Read for the third time and passed as amended..... ..... 23-APR-13

Yeas 101, Nays 0, Abstains 0

Jeff Woodard
Clerk