HB568

167521-2

By Representatives Weaver, Beech, Morrow, Collins, Henry, Shedd, Martin, Buskey, Bracy, Clarke, McClammy, Drummond, Hubbard, Clouse, Robinson, Scott, South, Williams (JD), Treadaway, Hall, Pettus, Whorton (R), Hanes, Patterson, Harper and Hill (M)

RFD: Ways and Means General Fund

First Read: 28-APR-15

167521-2:n:04/16/2015:PMG*/agb LRS2015-1536R1

SYNOPSIS: This bill would provide for the establishment, operations, and funding of the Health Center Access and Quality Improvement Program.

This bill would provide for an assessment on qualified health centers in Alabama to be administered by the Department of Revenue.

This bill would create a Health Center Assessment Account and require health center assessments be deposited in that account for use by the Alabama Medicaid Agency to obtain matching federal funds.

This bill would provide that the program shall terminate on September 30, 2018.

This bill would provide that the federal Centers for Medicare and Medicaid Services (CMS) must approve changes to the Medicaid State Plan associated with the creation, operation, and funding of the Health Center Access and Quality

Improvement Program before the assessment program is put into place.

This bill would also establish and set out responsibilities of the Health Center Services and Reimbursement Panel.

A BILL

TO BE ENTITLED

AN ACT

To provide for the establishment, operations, and funding of the Health Center Access and Quality Improvement Program; to provide for an assessment on qualified health centers in Alabama to be administered by the Department of Revenue; to create a Health Center Assessment Account and require health center assessments be deposited in that account for use by the Alabama Medicaid Agency to obtain matching federal funds; to provide the program terminate on September 30, 2018; to provide that the Centers for Medicare and Medicaid Services (CMS) must approve changes to the Medicaid State Plan associated with the creation, operation, and funding of the Health Center Access and Quality Improvement Program before the assessment program is put into place; and to establish and set out responsibilities of the Health Center Services and Reimbursement Panel.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. The Alabama Medicaid Program was created pursuant to Title XIX of the federal Social Security Act which has specific requirements for each state's program. The Alabama Medicaid Program enrolls qualified health centers as primary care providers. The Alabama Medicaid Program and qualified health centers are committed to improve care coordination, clinical outcomes, patient engagement and access while ensuring support for advanced quality improvement activities and programs through patient centered medical home models of care. The State of Alabama, the Alabama Medicaid Agency, and qualified health centers desire to create, operate, and fund the Health Center Access and Quality Improvement Program as a supporting component of Medicaid's Transformation Plan. The State of Alabama has had difficulty for many years in appropriating sufficient money in the State General Fund to establish programs designed to enhance access to coordinated care and advance quality systems and performance improvement. The Alabama Medicaid Agency, Alabama health centers, and the Alabama Primary Health Care Association have worked to develop a state funding methodology that will establish and operate the Health Center Access and Quality Improvement Program to foster continued and expanded access to primary care, foster quality systems, and advance quality improvement activities and programs within health centers, subject to approval by the Centers for Medicare and Medicaid Services prior to the methodology being put into place.

The Legislature finds that the Health Center Access and Quality Improvement Program created in this act will assure payments for access to care and advanced quality improvement activities and performance through qualified health centers and assist Medicaid in its statewide system transformation efforts by developing new federally approved resources in addition to the annual General Fund appropriation for the fiscal years ending September 30, 2016, 2017, and 2018, unless the Legislature approves subsequent legislation extending this act into future fiscal years.

Section 2. As used in this act, the following terms shall have the following meanings:

(1) ACCESS PAYMENT. An enhanced payment made to qualified health centers to ensure access to primary care and preventive services for medically underserved or medically vulnerable individuals.

(2) AGENCY. The Alabama Medicaid Agency.

(3) ALTERNATIVE PAYMENT METHODOLOGY. A payment methodology established in accordance with Section 1902(a)(10)(A), Section 1905(a)(2)(C), and 1902(bb) of the Social Security Act, as of March 1, 2015.

(4) ASSESSMENT. A license fee imposed on qualified health centers by the state for the purpose of creating, funding, and operating the Health Center Access and Quality Improvement Program.

(5) CARE COORDINATION AND MANAGEMENT PAYMENTS. A payment made to primary medical providers including qualified

health centers as part of Medicaid's Health Home Program and in accordance with the Medicaid State Plan.

(6) CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS). The federal agency responsible for the administration and oversight of the state Medicaid program.

(7) DEPARTMENT. The State Department of Revenue.

(8) FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP). That portion of funds paid by the federal government to the state for its federal share of expenditures for providing and administering the state's Medicaid Program.

(9) HEALTH CENTER ACCESS AND QUALITY IMPROVEMENT PROGRAM. Alabama's program for qualified health centers designed to support access to primary care and preventive services for Medicaid, enhanced care coordination through a patient centered medical home, and advanced quality systems and performance through an alternative payment methodology to foster improved health outcomes for Medicaid recipients.

(10) HEALTH CENTER ASSESSMENT ACCOUNT. An account created within the Health Care Trust Fund for the purpose of operating the Alabama Health Center Access and Quality Improvement Program.

(11) TOTAL FUNDED EXPENDITURES. The combined total of federal matching funds and state revenue dollars generated from the assessment imposed under this act.

(12) HEALTH CENTER MEDICAID REIMBURSEMENT. Methodology for Medicaid reimbursement to health centers for services provided to Medicaid recipients in accordance with

Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act as of March 1, 2015.

(13) HEALTH CENTER SERVICES AND REIMBURSEMENT PANEL. A group of individuals appointed to review and approve any policy, Medicaid State Plan amendments, or waivers which involve health center services or reimbursement prior to implementation or submission to the Centers for Medicare and Medicaid Services or the Legislature, if applicable.

(14) HEALTH HOME PROGRAM. A program which provides care coordination and management services through a team of health care professionals and primary medical providers in a health home model for eligible Medicaid recipients in accordance with the Medicaid State Plan.

(15) HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA). An office within the U.S. Department of Health and Human Services that is primarily responsible for improving access to health care services for people who are uninsured, isolated, or medically vulnerable and serves as the federal oversight entity for qualified health centers.

(16) MEDICAID. The medical assistance program as established in Title XIX of the Social Security Act and as administered in the state by the Alabama Medicaid Agency pursuant to executive order, Chapter 6 (commencing with Section 22-6-1) of Title 22, Code of Alabama 1975, and Title 560 of the Alabama Administrative Code.

(17) MEDICAID APPROPRIATION. That amount appropriated by the Legislature for Medicaid that includes

both state and federal funds representing total Medicaid expenditure.

(18) MEDICAID STATE PLAN. The document describing the nature and scope of the Alabama Medicaid Agency as required under Section 1902 of the Social Security Act and approved by the U.S. Department of Health and Human Services.

(19) MEDICAID STATE PLAN AMENDMENT. A change or update to the Medicaid State Plan that is approved by the Centers for Medicare and Medicaid Services.

(20) NET PATIENT REVENUE. The amount calculated in accordance with generally accepted accounting principles for qualified health centers reported through the Uniform Data System.

(21) OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY. A position within the U.S. Department of Health and Human Services to promote a national health information technology infrastructure and oversee its development.

(22) PERFORMANCE ENHANCEMENT. A type of Medicaid quality improvement payment to qualified health centers for engaging in advanced quality improvement activities and for demonstrated performance in meeting or exceeding outcome measures approved by the Health Center Services and Reimbursement Panel.

(23) QUALIFIED HEALTH CENTER. A facility recognized as a Federally Qualified Health Center (FQHC) under Section

1905(l)(2)(B) of the Social Security Act operating health centers within the state.

(24) QUALITY IMPROVEMENT PAYMENT. Medicaid payment to qualified health centers to include quality system payments and performance enhancements for advanced quality systems, activities, programs, and demonstrated outcomes.

(25) QUALITY SYSTEM PAYMENT. A type of Medicaid quality improvement payment to qualified health centers for certified engagement in advanced quality system activities.

(26) UNIFORM DATA SYSTEM. A core set of information and data for each qualified health center submitted to, and maintained by the Health Resources and Services Administration within the U.S. Department of Health and Human Services.

Section 3. (a) Beginning in the quarter starting with October 1, 2015, an assessment shall be imposed on each qualified health center in the state for the fiscal years ending September 30, 2016, 2017, and 2018, in an amount not to exceed the percentage limitation of net patient revenue for each qualified health center established pursuant to 42 C.F.R. §§ 433.66-433.72. The assessment shall be considered a licensing fee and cost of doing business as a qualified health center in the state.

(b) The assessment shall be imposed on the class of services provided by qualified health centers for the purpose of creating, operating, and funding the Health Center Access and Quality Improvement Program, including access, quality improvement, and related program activities.

(c) This act does not authorize a unit of a county or local government to license for revenue or impose a tax or assessment upon qualified health centers or a tax or assessment measured by the income or earnings of a qualified health center.

(d) Any assessment imposed under this act for qualified health centers, operating both within and outside the state, is only to be calculated on net patient revenues generated within the state.

(e) The payment by a qualified health center of the assessment created in this act shall be reported as an allowable cost for Medicaid reimbursement purposes.

Section 4. (a) There is hereby established the Alabama Primary Health Care Association, a 501(c)(3) nonprofit organization, as the certifying entity for the Alabama Health Center Access and Quality Improvement Program. The certifying entity is exempt from paying or collecting any state, county, or municipal sales and use taxes.

(b) Certifications by the Alabama Primary Health Care Association of qualified health centers shall be made on an annual basis.

(1) The certifying entity shall review the Uniform Data System reports of each qualified health center and shall make a certification to the Alabama Medicaid Agency regarding the qualified health center's eligibility for access payments and quality improvement payments. The initial eligibility

certification shall be made 90 days prior to the first access payment and quality improvement payment.

(2) The certifying entity shall review the Uniform Data System reports of each qualified health center and shall make certifications to the Alabama Medicaid Agency and the Department of Revenue of each qualified health center's net patient revenue for purposes of assessment.

a. The initial patient revenue certification shall be made 90 days prior to the collection of the first assessment.

b. Net patient revenue shall be determined using data from the Uniform Data System. If net patient revenue data is not available through the Uniform Data System for a qualified health center as of September 1, 2015, the qualified health center shall submit a copy of associated revenue data to the Alabama Primary Health Care Association in order to allow for the certification of net patient revenue and the submission of revenue data to the Alabama Medicaid Agency and the Department of Revenue for determining the corresponding assessment.

c. Net patient revenue shall be determined for the fiscal year ending September 30, 2016, based on 2013 data from the Uniform Data System. Subsequent net patient revenue shall be determined and certified based on the most recent, complete calendar year reporting through the Uniform Data System.

(c)(1) The agency shall verify the annual certifications from the Alabama Primary Health Care

Association. Upon acceptable verifications of the net patient review certification, the agency shall deliver its own certification of the net patient review data to the department within 30 days of receipt of the certifications from the Alabama Primary Health Care Association.

(2) Upon acceptable verification of the eligibility certification, the agency shall pay each qualified health center all of its eligible access payment, quality improvement payments, and health home payment in accordance with this act.

(d)(1) The department shall administer the assessment program created by this act. The department shall adopt rules pursuant to the Administrative Procedure Act to implement this act. Unless otherwise provided in this act, the rules may not grant any exceptions to or exemptions from the qualified health center assessment imposed. The rules shall include all of the following:

a. The proper imposition and collection of the assessment imposed.

b. Procedures for the enforcement of this act, including without limitation, preliminary and final tax assessments.

c. Procedures for reporting net patient revenue.

(2) To the extent practicable, the department shall administer and enforce this act and collect the assessments using procedures generally employed in the administration of the department's other powers, duties, and functions, including without limitation, those procedures enumerated in

the Taxpayer's Bill of Rights and Uniform Revenue Procedures Act, as well as the Tax Enforcement and Compliance Act, as codified in Chapters 2A and 29 of Title 40, Code of Alabama 1975.

Section 5. (a) There is created within the Alabama Health Care Trust Fund a designated account known as the Health Center Assessment Account. The health care assessments imposed under this act shall be deposited into the Health Center Assessment Account by the department upon receipt for the purpose of operating the Alabama Health Care Access and Quality Improvement Program.

(b) Moneys in the Health Center Assessment Account shall consist of the following:

a. All moneys received by the department from qualified health center assessments collected pursuant to this act.

b. Any appropriations, transfers, donations, gifts, or moneys from other sources, as applicable.

(c) Moneys in the Health Center Assessment Account may not be used to replace other general revenues funded and appropriated by the Legislature or other revenues used to support Medicaid and qualified health centers.

(d) The Health Center 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 of the Constitution of Alabama of 1901, now appearing as Section 213 of the Official

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

(e) Except as necessary to reimburse any funds borrowed to supplement funds in the Health Center Assessment Account, the moneys in the account shall be used only to support the operations of the Alabama Health Center Access and Quality Improvement Program as follows:

(1) To make care coordination and management payments to qualified health centers under this act.

(2) To make access payments to qualified health centers under this act. Access payments shall be paid based on access criteria met by qualified health centers.

(3) To make quality improvement payment to qualified health centers. Quality improvement payments shall be paid based on certified participation and performance in designated areas and shall be consistent with performance measures and priorities established by the HRSA and as set forth in Section 12 of this act.

(4) To reimburse moneys collected by the department from qualified health centers through error, mistake, as a result of cessation of the assessment, or as otherwise permissible under this act.

(f) Provided that the payments set forth in subsection (e) are fully funded, the balance of funds remaining in the Health Center Assessment Account included in the Medicaid appropriation that are the subject of this act may be used by the agency for eligible expenditures.

(g) Any reimbursement or payment to qualified health centers under Medicaid shall be paid in a timely fashion. If the amount payable is not in dispute and is not paid by the Alabama Medicaid Agency within 30 days of the due date, interest on the amount due shall be charged. The interest rate shall be the legal amount currently charged by the state.

(h) Any funds remaining in the account at the end of the fiscal year shall remain in the account and not revert to the General Fund or other fund.

(i) On September 30, 2018, any unspent, unencumbered balance remaining in the account which was not used by Medicaid to obtain federal matching funds shall be factored into the calculation of the new assessment rate by reducing the amount of qualified health center assessment funds that must be generated during the fiscal year beginning October 1, 2018. If there is no new assessment beginning October 1, 2018, the funds remaining shall be refunded to the qualified health center that paid the assessment in proportion to the remaining amount.

Section 6. (a) The assessment imposed under subsection (a) of Section 3 of this act shall be due and payable by the qualified health center on a quarterly basis, provided all of the following has occurred:

(1) The department issues the written notice required by this act stating that the payment methodologies to qualified health centers required under this act have been approved by the CMS and the waiver under 42 C.F.R. §433.72 for

the assessment imposed by this article, if necessary, has been granted by the CMS.

(2) The 30-day verification period required by this act has expired.

(3) The department and the certifying entity have been notified by the agency that the agency has made all health home payments, access payments, and quality improvement payments that are due for the fiscal year consistent with the effective date of the approved Medicaid State Plan amendment and waiver, if applicable.

(4) The department and the certifying entity have been notified by Medicaid that the CMS has determined revenue generated from the licensing assessment is eligible for Federal Medicaid Assistance Percentage (FMAP).

(b) The quarterly assessment shall be paid during the first 10 business days of each quarter beginning with the quarter starting January 1, 2016.

Section 7. (a)(1) The department shall send a notice of assessment to each qualified health center upon which an assessment is imposed informing it of the assessment rate, the net patient revenue calculation, and the resulting assessment amount owed by the qualified health center for the applicable fiscal year.

(2) Except as set forth in subsection (c), annual notices of assessment shall be sent at least 60 days before the due date for the first quarterly assessment payment of each fiscal quarter.

(3) The first notice of assessment shall be sent within 30 days after receipt by the department of notification from the CMS that the payments required under this act and, if necessary, the waiver granted under 42 C.F.R. §433.72, have been approved and eligible for Federal Medicaid Assistance Percentage (FMAP). The assessment provided for in this act is not intended to be retroactively applied and will only be assessed for the quarter following the effective date of the CMS approval.

(b)(1) Qualified health centers shall have 30 days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the net patient revenue calculation, and the resulting assessment amount.

(2) If a qualified health center disputes the department's net patient revenue calculation and the resulting assessment amount, the qualified health center shall notify the department of the disputed amounts within 10 business days of notification of the assessments by the department. The department shall regard the notice as equivalent to a Petition for Review of a Preliminary Assessment in the Taxpayer's Bill of Rights and Uniform Revenue Procedures Act, and the qualified health center and the department shall attempt to resolve the dispute on an informal basis initially. If they cannot informally resolve the dispute, then the process described for appeal from a disputed final assessment in Chapter 2A of Title 40, the Alabama Taxpayer's Bill of Rights and Uniform Revenue Procedures Act shall be followed.

(c)(1) For a qualified health center subject to the assessment imposed by this act that ceases to conduct health center operations or experiences a change in its federal designation as a qualified health center, or did not conduct operations throughout a fiscal year, the assessment for the fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment computed under this act by a fraction, the numerator of which is the number of days during the year that the qualified health center operated and the denominator of which is 365.

(2) Immediately prior to ceasing operations, the qualified health center shall pay the adjusted assessment for that fiscal year to the extent not previously paid.

(3) The qualified health center shall also receive Access and Quality Improvement Payments from Medicaid under this act, which shall be adjusted by the same fraction as its quarterly assessment.

(d) Qualified health centers subject to an assessment under this act that have not previously been federally designated as a qualified health center operating in the state and that commences health center operations during a fiscal year shall pay the required assessment computed under this act and shall be eligible for care coordination and management payment and health home, access, and quality improvement payments under this act.

(e) An organization that is exempt from payment of the assessment under this act at the beginning of a fiscal

year, but during the fiscal year experiences a change in status so that it becomes subject to the assessment shall pay the required assessment computed under this act, and shall be eligible for qualified health center payments to include health home, access, and quality improvement payments under this act.

(f) A qualified health center that is subject to payment of the assessment computed under this act at the beginning of a fiscal year, but during the fiscal year experiences a change in status so that it becomes exempted from payment under this act shall be relieved of its obligations to pay the health center assessment.

(g) Medicaid shall review any change in status and shall notify the department when an organization should begin to be treated as a qualified health center under this act, or should no longer be treated as such. If an organization disputes the determination by Medicaid, the organization and Medicaid shall resolve the dispute and Medicaid shall notify the department if the determination is not changed.

Section 8. Medicaid or its designee shall directly reimburse qualified health centers for health center services provided to Medicaid recipients in accordance with Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act as of March 1, 2015. This payment shall be made using Medicaid or its designee's published check write table and is in addition to any care coordination and management payments and access or quality improvement payments described

in the act or allowed by the Medicaid State Plan. Medicaid reimbursement to qualified health centers shall be funded from any available state revenue appropriated to Medicaid and not from revenues generated under this act.

Section 9. (a) Medicaid shall pay qualified health centers for care coordination and management through the Health Home Program as established within the Medicaid State Plan and as reimbursed to non-health center primary medical providers. This payment shall be paid using Medicaid or its designee's published check write table and is in addition to any Medicaid reimbursement for medical services, access, quality improvement, or other payments described in this act or allowed by the Medicaid State Plan. Care coordination and management payments to qualified health centers shall be funded from the Health Center Assessment Account or other funds appropriated by the Legislature.

(b) There is hereby annually allocated from the Health Center Assessment Account an amount necessary as determined by the agency and the Health Center Services and Reimbursement Panel to make care coordination and management payments to qualified health centers at the same level care coordination and management payments are available to non-health center primary medical providers.

(c) An alternative payment methodology for health center payments as allowed under Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act as of March 1, 2015, and including care coordination and management

payments to qualified health centers shall be described in the Medicaid State Plan through an amendment to be submitted to and approved by the CMS. The assessment created by this act shall not become effective until and unless the alternative payment methodology is approved by the CMS and federal financial participation is made available.

Section 10. (a) As part of the Alabama Access and Quality Improvement Program, Medicaid shall pay access payments to qualified health centers as set forth in this section to preserve and improve access to primary and preventive health care services for medically underserved individuals including those who are uninsured or medically vulnerable or otherwise disenfranchised for services provided by a qualified health center on or after October 1, 2015.

(b) All qualified health centers shall be eligible for access payments to be paid by Medicaid for the fiscal years ending September 30, 2016, 2017, and 2018 as set forth in this act, provided the qualified health center meets at least one of the following access criteria:

(1) Greater than or equal to 30 percent of patients served by the qualified health center lack health coverage, or;

(2) Greater than or equal to 30 percent of patients served by the qualified health center have health coverage through a public program including, but not limited to, Medicaid, Medicare, Children's Health Insurance Program, or

health plans available through federal or state health insurance marketplace exchanges.

(3) Greater than or equal to 50 percent of patients served by the qualified health center have incomes at or below 200 percent of the federal poverty limit.

(4) Greater than or equal to 40 percent of patients served by the qualified health center have either a chronic disease, are at risk for chronic disease, or have a mental health diagnosis.

(5) Greater than or equal to 75 percent of patients served by the qualified health center fall within designated medically underserved populations or areas.

(c) Subsequent criteria may be considered and adopted by the Health Center Services and Reimbursement Panel in accordance with this act.

(d) There is hereby annually allocated the amount of 22.4 percent of total funded expenditures designated for access payments by Medicaid to qualified health centers. This percentage shall be adjusted as necessary to maintain an equivalent percentage, based on any change in the state's FMAP, established under Section 1905 of the Social Security Act, for the fiscal years ending September 30, 2016, 2017, and 2018.

(e) Access payments to eligible qualified health centers shall be paid by the agency on a quarterly basis no later than within the last 10 business days of each quarter beginning with the quarter starting October 1, 2015.

(f) An access payment shall not be used to offset any other Medicaid payment for health center reimbursement, care coordination and management payment, quality improvement payments, or any other payment allowed under this act or the Medicaid State Plan.

(g) An alternative payment methodology for health centers payments as allowed under Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act as of March 1, 2015, including access payments to qualified health centers shall be described in the Medicaid State Plan through an amendment to be submitted to and approved by the CMS. The assessment created by this act shall not become effective until and unless the alternative payment methodology is approved by CMS and federal financial participation is made available.

Section 11. (a) As part of the Health Center Access and Quality Improvement Program, Medicaid shall pay quality improvement payments to eligible qualified health centers. Quality improvement payments include quality system payments and performance enhancements as set forth in this section to support advanced quality improvement activities and support performance and outcome improvement in designated areas.

(b) Quality improvement payments to qualified health centers shall be payable on a quarterly basis no later than within the last 10 business days of each quarter beginning with the quarter starting October 1, 2015. Quality improvement payments may not be used to offset any other payments made to

eligible qualified health centers including health center Medicaid reimbursement, care coordination and management payments, access payments and any other allowable payments under the Medicaid State Plan.

(c)(1) As part of quality improvement payments, qualified health centers are eligible for quality system payments provided that the qualified health center is certified by the Alabama Primary Health Care Association for the following:

a. Adopting an electronic medical record system certified by the Office of the National Coordinator for Health Information Technology.

b. Tracking and reporting clinical data related to patient health outcomes consistent with reporting priorities defined by the HRSA.

c. Developing and maintaining an integrated continuous quality improvement plan supported by operational and clinical data.

(2) There is hereby annually allocated the amount of 9.6 percent of total funded expenditures designated for quality system payments by Medicaid to qualified health centers. This percentage shall be adjusted as necessary to maintain an equivalent percentage, based on any change in the state's FMAP, established under Section 1905 of the Social Security Act, for the fiscal years ending September 30, 2016, 2017, and 2018.

(d)(1) Medicaid shall make payments to qualified health centers for demonstrated engagement and performance in priority measures through performance enhancements. Enhancements shall be paid to eligible qualified health centers for the following advanced quality improvement activities and programs:

a. Patient Centered Medical Home (PCMH) accreditation, recognition, or certification through either the National Council on Quality Assurance, the Joint Commission, or other accrediting body approved by the Health Center Services and Reimbursement Panel.

b. Connection into and participation in a statewide quality information system to support continuous quality improvement and clinical performance tracking.

c. Participation in a statewide quality and clinical improvement program designed to improve patient outcomes within relevant chronic disease states including, but not limited to, diabetes, hypertension, and cardiovascular diseases. Specific clinical measures shall be consistent with reporting priorities established by the HRSA and reviewed and approved by the Health Center Services and Reimbursement Panel.

d. Clinical outcomes performance.

(2) Performance enhancements shall be paid quarterly based on certification by the certifying entity to the agency of engagement by qualified health centers in a Patient Centered Medical Home, connection to and participation in a

statewide quality information system, and participation in a statewide quality and clinical improvement program. Additionally, qualified health centers shall be paid quarterly for meeting or exceeding clinical performance measures established and approved by the Health Center Services and Reimbursement Panel. Clinical performance measures shall be consistent with priorities areas established by the HRSA and the agency.

(3) There is hereby annually allocated an amount not less than 15 percent of total funded expenditures designated for performance enhancements by Medicaid to qualified health centers. This percentage shall be adjusted as necessary to maintain an equivalent percentage, based on any change in the state's FMAP, established under Section 1905 of the Social Security Act, for the fiscal years ending September 30, 2016, 2017, and 2018.

(e) An alternative payment methodology for health centers payments as allowed under Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act as of March 1, 2015, and including quality improvement payments to qualified health centers shall be described in the Medicaid State Plan through an amendment to be submitted to and approved by the Centers for Medicare and Medicaid Services. The assessment created by this act shall not become effective until and unless the alternative payment methodology is approved by the Centers for Medicare and Medicaid Services and federal financial participation is made available.

Section 12. (a) The assessment imposed under this act shall not take effect or shall immediately cease to be imposed if any of the following occur:

(1) Changes within the Medicaid program that violate the reimbursement provisions within Sections 1902(a)(10)(A), 1905(a)(2)(C), and 1902(bb) of the Social Security Act.

(2) The assessment is determined to be an impermissible tax under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and if so, shall be disbursed to the extent federal matching is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to qualified health centers in proportion to the amounts paid by them.

(3) The Centers for Medicare and Medicaid Services determine that Medicaid is not eligible for FMAP on the assessment referenced in this act.

(4) The FMAP under Title XIX of the Social Security Act is not available to Medicaid at the approved FMAP, established under Section 1905 of the Social Security Act, for the fiscal years ending September 30, 2016, 2017, and 2018.

(5) CMS fails to approve any Medicaid State Plan amendments or alternative payment methodology submitted by Medicaid related to the implementation of this act.

(6) CMS fails to approve any necessary waivers requested by Medicaid under 42 C.F.R. § 433.72, if applicable.

(7) CMS or the United States Congress implements statutory or regulatory provisions inconsistent with the requirements set forth in this act.

(8) Any portion of this act is adjudged to be unconstitutional or otherwise invalid.

(b) In the event of cessation as described in subsection (a), any moneys remaining in the Health Center Assessment Account shall be refunded to qualified health centers in proportion to the amounts paid by them, unless otherwise stated.

Section 13. (a) There is established the Health Center Services and Reimbursement Panel to advise in the development of and approval of any Medicaid State Plan amendment, waiver, or policy which involves health center services or reimbursement before submission to CMS or the Legislature, if applicable.

(b) The panel shall consist of six members and be constituted in the following manner:

(1) The Commissioner of the Alabama Medicaid Agency.

(2) Three members to be appointed by the Governor from a list of six names submitted by the Alabama Primary Health Care Association. The health center members appointed shall represent the diversity of health centers within the state.

(3) One member to be appointed by the Speaker of the House of Representatives.

(4) One member to be appointed by the President Pro Tempore of the Senate.

(c) All members shall be residents of Alabama, and the composition of the panel shall reflect the racial, gender, geographic, urban/rural, and economic diversity of the state. The panel shall meet no more than 30 days after the effective date of this act to elect a chair and establish procedures necessary to carry out the business of the panel. A quorum shall be a majority of the members appointed to the panel.

(d) The sole purpose of the panel is to review and approve any amendments to the Medicaid State Plan, waivers, or policies prior to consideration by and submission to CMS or the Legislature, if applicable, which involve health center services or reimbursement. Amendments to the Medicaid State Plan, waivers, or policies must be approved by a majority of the members on the panel prior to consideration by or submission to the Centers for Medicare and Medicaid Services or the Legislature or otherwise implemented.

(e) Each member of the panel shall serve for three years or until his or her successor is appointed.

Section 14. (a) Medicaid shall file with CMS a Medicaid State Plan amendment approved by the Health Center Services and Reimbursement Panel to implement the requirements of this act, including the establishment of an alternative payment methodology and payment of health center access payments and quality improvement payments no later than 45 days after the effective date of this act.

(b) Medicaid shall file a Medicaid State Plan amendment approved by the Health Center Services and Reimbursement Panel with CMS to implement payment for care coordination and management services through the Health Home Program to health centers no later than 45 days after the effective date of this act. The Health Home Program shall include qualified health centers as participating providers reimbursed at the same level as non-health center primary medical providers.

Section 15. The provisions of this act are expressly declared not to be severable. If any part or provision of this act is declared or adjudged to be invalid under the Alabama Constitution or laws of this state, or if Medicaid is ineligible for FMAP, then this entire act shall be invalid and the Health Center Access and Quality Improvement Program shall cease immediately upon such determination.

Section 16. This act shall become effective immediately following its passage and approval by the Governor, or its otherwise becoming law. This act shall automatically terminate and become null and void by its own terms on September 30, 2018, unless a later bill is passed extending the act to future fiscal years.