HB348

183247-1

By Representative Clouse

RFD: Ways and Means General Fund

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SYNOPSIS: Currently, the private hospital assessment and Medicaid funding program will terminate at the end of fiscal year 2017.

This bill will extend the private hospital assessment and Medicaid funding program for fiscal year 2018 and clarify the use 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-75, 40-26B-76, 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 year 2018; and to clarify the uses of Certified Public Expenditures by publicly and state-owned hospitals;

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-75, 40-26B-76, 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 or outpatient hospital care, or both, provided to a Medicaid recipient.

"(2) ALL PATIENT REFINED DIAGNOSIS-RELATED GROUP (APR-DRG). A statistical system of classifying any non-Medicare inpatient stay into groups for the purposes of payment.

"(3) 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.

"(4) CERTIFIED PUBLIC EXPENDITURE (CPE). 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.

"(5) DEPARTMENT. The Department of Revenue of the State of Alabama.

"(6) 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.

"(7) HOSPITAL PAYMENT. Any payments received by a hospital for providing inpatient care or outpatient care to Medicaid patients or for uncompensated care, including, but not limited to, base payments, access payments, incentive payments, capitated payments, disproportionate share payments, etc. Excludes payments not directly related to patient care, such as Integrated Provider System Payments.

"(~~7~~ 8) 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.

"(~~8~~ 9) INTERGOVERNMENTAL TRANSFER (IGT). 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.

"(~~9~~ 10) 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.

"(~~10~~ 11) MEDICARE COST REPORT. CMS-2552-10, the Cost Report for Electronic Filing of Hospitals.

"(~~11~~ 12) 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.

"(~~12~~ 13) 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.

"(~~13~~ 14) 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.

"(~~14~~ 15) 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, Chapter 95 of Title 11, or Chapter 51 of Title 22, or a hospital otherwise owned and operated by a unit of local government.

"(~~15~~ 16) REGIONAL CARE ORGANIZATION (RCO). 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.

"(~~16~~ 17) REGIONAL CARE ORGANIZATION CAPITATION PAYMENT. An actuarially sound payment made by Medicaid to the Regional Care Organizations.

"(~~17~~ 18) STATE-OWNED HOSPITAL. A hospital that is a state agency or unit of government, including, without limitation, an authority or a hospital owned by a state agency or a state university or a hospital created pursuant to Chapter 17A of Title 16.

"(~~18~~ 19) STATE PLAN AMENDMENT. A change or update to the state Medicaid plan that is approved by the Centers for Medicare and Medicaid Services.

"(~~19~~ 20) 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.

"(~~20~~ 21) 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) For state fiscal year ~~2017~~ 2018, an assessment is imposed on each privately operated hospital in the amount of 5.50 percent of net patient revenue in fiscal year 2014. The assessment is a cost of doing business as a privately operated hospital in the State of Alabama. 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, 2015, or a reduction in capitation rates has occurred. If the agency determines that adverse impact to hospital Medicaid reimbursement has occurred, or will occur, 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 the start of the upcoming fiscal year from the year the report was made, to address the adverse impact. The assessment imposed on each private hospital under this Section shall be reduced pro rata, if the total disproportionate share allotment for all

hospitals is reduced before or during the 2018 fiscal year, as a result of any action by Alabama Medicaid Agency or the Centers for Medicare and Medicaid Services.

"(b)(1) For state fiscal year ~~2017~~ 2018, net patient revenue shall be determined using the data from each private hospital's fiscal year ending 2014 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services Healthcare Cost Information System.

(2) The Medicare Cost Report for 2014 for each private hospital shall be used for fiscal year ~~2017~~ 2018. 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 2014.

(3) If a privately operated hospital commenced operations after the due date for a 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) If the Medicaid Agency begins making payments under Title 22, Chapter 6, Article 9, while this Act is in force, the ~~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) If the Medicaid Agency begins making payments under Title 22, Chapter 6, Article 9, Code of Alabama 1975, while this Act is in force, all ~~All~~ moneys collected or received by the department from publicly owned and state-owned 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 public, private, and state inpatient and outpatient hospital base payments.~~, access payments, and disproportionate share hospital payments, or to draw down the hospital portion of a capitation rate necessary to make public, private, and state inpatient and outpatient base payments, access payments, and disproportionate share hospital payments under this article; or~~ 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 and paid out for hospital payments, 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, ~~2017~~ 2018, the funds remaining shall be refunded to the hospital that paid the assessment or made an intergovernmental transfer 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-75.

"(a)(1) The annual assessment imposed under this article shall be due and payable on a quarterly basis during the first ~~10~~ 15 business days of each quarter.

"(2) Notwithstanding subdivision (1), the ~~initial~~ installment payment of an assessment imposed by this article shall not be due and payable until:

"a. The department issues the written notice required by this article stating that the payment methodologies to privately operated hospitals required under this article have been approved by the Centers for Medicare

and Medicaid Services and the waiver under 42 C.F.R. §433.68 for the assessment imposed by this article, if necessary, has been granted by the Centers for Medicare and Medicaid Services, or if approval for the State Plan Amendment and the waiver under 42 CFR §433.68 for the assessment imposed by this article, if necessary, is delayed for any reason, the payment shall be recalulated by Medicaid upon actual approval; and

"b. The 30-day verification period required by this article has expired; and

"c. Medicaid has made all disproportionate share payments for the ~~fiscal year~~ quarter, consistent with the effective date of the approved state plan amendment and waiver.

"(3) After the initial installment has been paid under this section, each subsequent quarterly installment payment of an assessment imposed by this article shall be due and payable during the first ~~10~~ 15 business days of the quarter, or if approval for the State Plan Amendment and the waiver under 42 CFR §433.68 for the assessment imposed by this article, if necessary, is delayed for any reason, the payment shall be recalculated by Medicaid upon actual approval.

"(b) The payment by a privately operated hospital of the assessment created in this article shall be reported as an allowable cost for Medicaid reimbursement purposes.

"(c)(1) If a privately operated hospital fails to pay the full amount of a quarterly assessment by the ~~tenth~~

fifteenth business day of the quarter, the department shall add to the assessment:

"a. A penalty assessment equal to five percent of the quarterly amount not paid on or before the due date; and

"b. On the last day of each quarter after the due date until the assessed amount and the penalty imposed under this section are paid in full, an additional five percent penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

"(2) Payments shall be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

"§40-26B-76.

"(a)(1) The department shall send a notice of assessment to each privately operated hospital informing the hospital of the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount owed by the hospital for the applicable fiscal year.

"(2) ~~Except as set forth in subdivision (3), annual~~ Annual notices of assessment shall be sent at least 30 days before the due date for the first quarterly assessment payment of each fiscal year.

"~~(3) The first notice of assessment shall be sent within 30 days after receipt by the department of notification from the Centers for Medicare and Medicaid Services that the payments required under this article and, if necessary, the waiver granted under 42 C.F.R. §433.68, have been approved.~~

"(b)(1) The privately operated hospital shall have 30 days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount.

"(2) If a privately operated hospital disputes the hospital's net patient revenue calculation and the estimated assessment amount, the hospital shall notify the department of the disputed amounts within ~~10~~ 15 business days of notification of the assessment by the department. The hospital and the department shall attempt to resolve the dispute on an informal basis initially. If the hospital and department cannot informally resolve the dispute, the dispute resolution process described in Chapter 2A of this title, the Alabama Taxpayer's Bill of Rights and Uniform Revenue Procedures Act and any subsequent amendatory acts shall be followed to resolve the dispute.

"(c)(1) If a hospital provider operates, conducts, or maintains more than one privately operated hospital in the state, the hospital provider shall pay the assessment for each hospital separately.

"(2) However, if the hospital provider operates more than one privately operated hospital under one Medicaid provider number, the hospital provider may pay the assessment for the hospitals in the aggregate.

"(d) The total annual assessment amount for all private hospitals shall not exceed the amount of funds

necessary to obtain federal funds needed to pay private hospital payments.

"(e) ~~(d)~~ (1) For a privately operated hospital subject to the assessment imposed under this article that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a state fiscal year, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment computed under this article by a fraction, the numerator of which is the number of days during the year that the hospital operated and the denominator of which is 365.

"(2)a. Immediately prior to ceasing operations, the hospital shall pay the adjusted assessment for that state fiscal year to the extent not previously paid.

"b. The hospital also shall receive payments from Medicaid under this article, which shall be adjusted by the same fraction as its annual assessment.

"(e) A privately operated hospital subject to an assessment under this article that has not been previously licensed as a hospital in Alabama and that commences hospital operations during a state fiscal year shall pay the required assessment computed under this article and shall be eligible for hospital access payments under this article on the date specified in rules promulgated by Medicaid under the Alabama Administrative Procedure Act.

"(f) A hospital that is exempt from payment of the assessment under this article at the beginning of a state fiscal year, but during the state fiscal year experiences a change in status so that it becomes subject to the assessment shall pay the required assessment computed under this article and shall be eligible for hospital access payments under this article on the date specified in rules promulgated by Medicaid under the Alabama Administrative Procedure Act.

"(g) A privately operated hospital that is subject to payment of the assessment computed under this article at the beginning of a state fiscal year, but during the state fiscal year experiences a change in status so that it becomes exempted from payment under this article shall be relieved of its obligation to pay the hospital assessment on the date specified in rules promulgated by Medicaid under the Alabama Administrative Procedure Act."

"§40-26B-77.1.

"(a) Beginning on October 1, 2016, and ending on September 30, ~~2017~~ 2018, publicly owned and state-owned hospitals will begin making intergovernmental transfers to the Medicaid Agency. If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on or before ~~September 30~~ October 1, ~~2017~~ 2018, the amount of these intergovernmental transfers shall be calculated for each hospital using a pro-rata basis based on the hospitals IGT ~~and CPE~~ contribution for FY ~~2016~~ 2017 in relation to the total IGT ~~and CPE~~ for FY ~~2016~~ 2017. Total IGTs for any given fiscal year shall not

exceed ~~324,858,765~~ $333,434,048 with the exception of an adjustment as described in subsection (d) and to the extent adjustments are required to comply with federal regulations or terms of any waiver issued by the federal government relating to the state's Medicaid program. The total intergovernmental transfers shall equal and shall not exceed the amount of state funds necessary for the Medicaid Agency to obtain only those federal matching funds necessary to pay publicly owned and state-owned hospitals for payments. If Medicaid does not begin making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, the total intergovernmental transfers shall equal the amount of state funds necessary for the agency to obtain only those federal matching funds necessary to pay publicly owned and state-owned hospitals for ~~direct inpatient or outpatient care, or both, access payments, and disproportionate share~~ hospital payments.

"(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) If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, 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, it shall continue to pay the same amount as calculated in 40-26B-71, but in the form of an Intergovernmental Transfer."

"§40-26B-79.

"If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, Medicaid shall pay hospitals as a base amount for state fiscal year ~~2017~~ 2018, for inpatient services an APR-DRG payment that is equal to the total modeled UPL submitted and approved by CMS during fiscal year ~~2016~~ 2017. If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on a date other than the first day of fiscal year 2018, there shall be no retroactive adjustment to payments already made to hospitals in accordance with the approved State Plan. If approved by CMS, Medicaid shall publish the APR-DRG rates for each hospital prior to September 30, 2017. If Medicaid does not begin making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, Medicaid shall pay hospitals as a base amount for fiscal year ~~2017~~ 2018 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 year ~~2017~~ 2018. This payment to be paid using Medicaid's published check write table is in

addition to any hospital access payments, ~~disproportionate share payments, or other payments described in this article.~~ Medicaid may elect to pay hospitals inpatient payments other than per diems and access payments, if Medicaid does not make payments pursuant to Title 22, Chapter 6, Article 9 in fiscal year 2017 or fiscal year 2018, only if the Hospital Services and Reimbursement Panel approves the change in Hospital Payments."

"§40-26B-80.

"If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, Medicaid shall pay hospitals as a base amount for fiscal year ~~2017~~ 2018 for outpatient services based upon a fee for service and access payments or OPPS schedule. If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on a date other than the first day of fiscal year 2018, there shall be no retroactive adjustment to payments already made to hospitals in accordance with the approved State Plan.

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

"If Medicaid does not begin making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, Medicaid shall pay hospitals as a base amount for fiscal year ~~2017~~ 2018 for outpatient services, based upon an outpatient fee schedule in existence on September 30, 2015.

Hospital ~~Outpatient~~ outpatient base payments shall be in addition to any hospital access payments or other payments described in this article."

"§40-26B-81.

"(a) If Medicaid begins making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, to preserve and improve access to hospital services, for hospital inpatient and outpatient services rendered on or after October 1, 2016, Medicaid shall consider the published inpatient and outpatient rates as defined in Sections 40-26B-79 and 40-26B-80 as the minimum payment allowed.

"(b) If Medicaid does not begin making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, ~~2017~~ 2018, the aggregate hospital access payment amount is an amount equal to the upper payment limit, less total hospital base payments determined under this article. All publicly, state-owned, and privately operated hospitals shall be eligible for inpatient and outpatient hospital access payments for fiscal year ~~2017~~ 2018 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 hospital base payments, that, in the aggregate, equal the

upper payment limit for publicly and state-owned hospitals. Privately operated hospitals shall receive payments, including hospital 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 hospital base payments, that, in the aggregate, equal the upper payment limit for publicly and state-owned hospitals. Privately operated hospitals shall receive payments, including hospital 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.

"(c) 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 or public hospital inpatient adjustment, or hospital cost settlement payment.

"(d) 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 for by the Alabama Medicaid Program for fiscal year ~~2017~~ 2018 are less than the amount paid during fiscal year ~~2015~~ 2017. Reimbursement rates under this article for fiscal year ~~2017~~ 2018 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, 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 RCO or alternate care provider in a Medicaid region under any terms other than the following:

"a. If a regional care organization or alternate care provider 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, or the date of extension as set out in Act No. 2016-377, 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, or the date of the extension as set out in Act No. 2016-377, 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 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.

"(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 year ~~2017~~ 2018."

"§40-26B-88.

"This article shall automatically terminate and become null and void by its own terms on September 30, ~~2017~~ 2018, unless a later bill is passed extending the article to future state fiscal years."

Section 2. This Act shall become effective on October 1, 2017.