HB475

190756-1

By Representative Mooney

RFD: Health

First Read: 01-MAR-18

190756-1:n:02/16/2018:PMG/bm LSA2018-538

SYNOPSIS: In 2013, a system for the provision of Medicaid services on a managed care basis throughout the state was established that authorized the creation of regional care organizations. The Medicaid Agency has not implemented the regional care organization program as a means of providing Medicaid services in the state. Currently, no beneficiaries are enrolled in regional care organizations.

This bill would repeal the law that authorized the establishment of regional care organizations and the regional care organization system for providing Medicaid services throughout the state.

A BILL

TO BE ENTITLED

AN ACT

Relating to Medicaid; to amend Sections 22-6-220, 22-6-221, and 27-1-17.1, Code of Alabama 1975; to amend Sections 40-26B-70, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, and 40-26B-82, Code of Alabama 1975, as last amended by Act 2017-382 of the 2017 Regular Session; and to repeal Article 9, commencing with Section 22-6-150, of Chapter 6 of Title 22, Code of Alabama 1975, which authorizes the establishment of regional care organizations for providing Medicaid services.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 22-6-220, 22-6-221, and 27-1-17.1, Code of Alabama 1975, and Sections 40-26B-70, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, and 40-26B-82, Code of Alabama 1975, as last amended by Act 2017-382 of the 2017 Regular Session, are amended to read as follows:

"§22-6-220.

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

"(1) CAPITATION PAYMENT. A payment the state Medicaid Agency makes periodically to the integrated care network on behalf of each recipient enrolled under a contract for the provision of medical services pursuant to this article.

"(2) COLLABORATOR. A private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals, and consumers who are

expecting to collectively cooperate, negotiate, or contract with another collaborator, or integrated care network in the health care system.

"(3) INTEGRATED CARE NETWORK. One or more statewide organizations of health care providers~~, with offices in each regional care organization region,~~ that contracts with the Medicaid Agency to provide Medicaid benefits to certain Medicaid beneficiaries as defined in subdivision (4) and that meets the requirements set forth in this article. The number of integrated care networks shall be based on actuarial soundness as determined by the Medicaid Agency.

"(4) MEDICAID BENEFICIARIES. As used in this article, those Medicaid beneficiaries who have been determined eligible for Medicaid benefits in a nursing facility or home and community based waiver programs covered by the Medicaid state plan, who have also been determined by a qualified provider to meet the level of care for skilled nursing facility services, and those Medicaid beneficiaries who are also eligible for Medicare coverage, under Title XVIII of the Social Security Act, and who are assigned by Medicaid to the integrated care network.

"(5) LONG-TERM CARE SERVICES. Medicaid-funded nursing facility services, home-based and community-based support services, or such other long-term care services as the Medicaid Agency may determine by rule provided to certain Medicaid beneficiaries defined in subdivision (4).

"(6) MEDICAID AGENCY. The Alabama Medicaid Agency or any successor agency of the state designated as the single state agency to administer the medical assistance program described in Title XIX of the Social Security Act.

"(7) QUALITY ASSURANCE PROVISIONS. Specifications for assessing and improving the quality of care provided by the integrated care networks.

"~~(8) 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.~~

"~~(9)~~ (8) RISK CONTRACT. A long-term care contract with a fully certified integrated care network under which the integrated care network assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract and which is competitively bid or competitively procured.

"§22-6-221.

"(a) An integrated care network shall serve only Medicaid beneficiaries in providing medical care and services. ~~For the purposes of this article, a beneficiary cannot be a member of both an integrated care network and a regional care organization.~~

"(b) An integrated care network shall provide required medical care and services to Medicaid beneficiaries and may coordinate care provided by or through an affiliation

of other health care providers or other programs as the Medicaid Agency shall determine.

"(c) Notwithstanding any other provision of law, the integrated care network shall not be deemed an insurance company under state law.

"(d)(1) An integrated care network shall have a governing board of directors composed of the following members:

"a. Twelve members shall be persons representing risk bearing participants. A participant bears risk by contributing cash, capital, or other assets to the integrated care network.

"b. Eight members shall be persons who do not represent a risk bearing participant in the integrated care network and are not employed by a risk bearing participant.

"c. A majority of the board may not represent a single provider. The Medicaid Agency may promulgate rules providing for the criteria and selection of risk bearing and non-risk bearing participants on the board of directors.

"(2) Any provider represented on the governing board shall meet licensing requirements set by law, shall have a valid Medicaid provider number, and shall not otherwise be disqualified from participating in Medicare or Medicaid.

"(3) The Medicaid Agency shall approve the members of the governing board and the board's structure, powers, bylaws, or other rules of procedure. No organization shall be

granted integrated care network certification without approval.

"(4) Any vacancy on the governing board of directors in connection with non-risk bearing directors shall be filled in accordance with rules promulgated by the Medicaid Agency. A vacancy in a board of directors' seat held by a representative of a risk bearing participant as defined herein, shall be filled by a majority vote of the remaining directors of the integrated care network. Notwithstanding other provisions of this subsection, the Medicaid Commissioner shall fill a board seat left vacant for more than three months.

"(5) All appointing authorities for the governing board shall coordinate their appointments so that diversity of gender, race, and geographical areas is reflective of the makeup of the population served.

"§27-1-17.1.

"(a) As used in this section, the following words shall have the following meanings:

"(1) ACH ELECTRONIC FUNDS TRANSFER. An electronic funds transfer through the Health Insurance Portability and Accountability Act (HIPPA) standard Automated Clearing House network.

"(2) COVERED HEALTH CARE PROVIDER. A physician as defined in Section 34-24-50.1; a dentist as defined in Section 34-9-1; a chiropractor as defined in Section 34-24-120; an individual engaged in the practice of optometry as defined in Section 34-22-1; other licensed health care professionals as

defined in Title 34; a hospital as defined in Section 22-21-20; and a health care facility, or other provider who or that is accredited, licensed, or certified and who or that is performing within the scope of that accreditation, license, or certification.

"(3) HEALTH INSURANCE PLAN. Any hospital and medical expense incurred policy, health maintenance organization subscriber contract, or any other health care plan, policy, coverage, or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise, offered in this state. ~~The term does not include a regional care organization.~~

"(4) HEALTH INSURER. An entity or person that offers or administers a health insurance plan in this state, or contracts with covered health care providers to furnish specified health care services to enrollees covered under a health insurance plan. The term includes corporations organized pursuant to Article 6 of Chapter 20 of Title 10A, commencing at Section 10A-20-6.01, and to policies, plans, or contracts entered into, issued by, or administered by such corporations.

"~~(5) REGIONAL CARE ORGANIZATION. An organization as defined in Section 22-6-150.~~

"(b) Contracts issued, amended, or renewed on or after January 1, 2017, between a health insurer or its contracted vendor ~~or a regional care organization~~ and a covered health care provider shall include the following

language, set off from other language in bold, 12-point type and in all capital letters: "If a covered health care provider requests payment under a health insurance plan from a health insurer or its contracted vendor ~~or a regional care organization~~ be made using ACH electronic funds transfer, that request must be honored. Furthermore, such a request may not be used to delay or reject a transaction, or attempt to adversely affect the covered health care provider."

"(c) Nothing in this section prohibits or adopts any standards for other methods of electronic funds transfers outside of the Automated Clearing House network. Alternative electronic funds transfer methods, including wire transfer and payment by card or otherwise through a private card network, are expressly permitted to pay a covered health care provider.

"§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.

"(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.

"(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.

"(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.

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

"(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.

"(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.

"(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.

"(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.

"~~(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.~~

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

"~~(18)~~ (16) 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.

"~~(19)~~ (17) STATE PLAN AMENDMENT. A change or update to the state Medicaid plan that is approved by the Centers for Medicare and Medicaid Services.

"~~(20)~~ (18) 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.

"~~(21)~~ (19) 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-77.1.

"(a) Beginning on October 1, 2016, and ending on September 30, 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 October 1, 2018, the amount of these intergovernmental transfers shall be calculated for each hospital using a pro-rata basis based on the hospitals IGT contribution for FY 2017 in relation to the total IGT for FY 2017. Total IGTs for any given fiscal year~~

~~shall not exceed $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 hospital payments. If Medicaid does not begin making payments pursuant to Title 22, Chapter 6, Article 9, on or before September 30, 2018, the~~ 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 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, 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 Section 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, 2018, Medicaid shall pay hospitals as a base amount for state fiscal year 2018, for inpatient services an APR-DRG payment that is equal to the total modeled UPL submitted and approved by CMS during fiscal year 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, 2018,~~ Medicaid shall pay hospitals as a base amount for fiscal year 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 2018. This payment to be paid using Medicaid's published check write table is in addition to any hospital access payments 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, 2018, Medicaid shall pay hospitals as a base amount for fiscal year 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, 2018,~~ Medicaid shall pay hospitals as a base amount for fiscal year 2018 for outpatient services, based upon an outpatient fee schedule in existence on September 30, 2015. Hospital 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, 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, 2018, the~~ (a) 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 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)~~ (b) 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)~~ (c) 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 2018 are less than the amount paid during fiscal year 2017. Reimbursement rates under this article for fiscal year 2018 are less than the rates approved by CMS in Sections 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 alternate care provider in a Medicaid region under any terms other than the following:~~

"a. If a regional care organization or an 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 Sections 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."

Section 2. Article 9, commencing with Section 22-6-150, of Chapter 6 of Title 22, Code of Alabama 1975, is repealed.

Section 3. This act shall become effective on the first day of the third month following its passage and approval by the Governor, or its otherwise becoming law.