1 HB312

2 TB2P619-1

3 By Representatives Lee, Reynolds

4 RFD: Ways and Means General Fund

5 First Read: 20-Feb-25

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4 SYNOPSIS:
5 Currently, hospitals in this state provide
6 funding for the Medicaid Agency through a provider tax.
7 This tax will end on September 30, 2025, unless new
8 amendments are passed by the Legislature and approved
9 by the Governor.
10 This bill would extend the Hospital Provider Tax
11 through fiscal year 2028 and establish an effective
12 date.
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14
15 A BILL
16 TO BE ENTITLED
17 AN ACT
18
19 Relating to the Hospital Provider Privilege Tax; to
20 amend Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77.1,
21 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, and
22 40-26B-88 of the Code of Alabama 1975, to extend the tax until
23 fiscal year 2028.
24 BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:
25 Section 1. Sections 40-26B-70, 40-26B-71, 40-26B-73,
26 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82,
27 40-26B-84, and 40-26B-88 of the Code of Alabama 1975, are
28 amended as follows:

29 "§40-26B-70

30 For purposes of this article, the following terms~~ shall~~

31 have the following meanings:

32 (1) ACCESS PAYMENT. A payment by the Medicaid program

33 to an eligible hospital for inpatient or outpatient hospital

34 care, or both, provided to a Medicaid recipient.

35 ~~(2) ALL PATIENT REFINED DIAGNOSIS-RELATED GROUP~~

36 ~~(APR-DRG). A statistical system of classifying any~~

37 ~~non-Medicare inpatient stay into groups for the purposes of~~

38 ~~payment.~~

39 ~~(3)~~(2) ALTERNATE CARE PROVIDER. A contractor, other

40 than a regional care organization, that agrees to provide a

41 comprehensive package of Medicaid benefits to Medicaid

42 beneficiaries in a defined region of the state pursuant to a

43 risk contract.

44 ~~(4)~~(3) CERTIFIED PUBLIC EXPENDITURE (CPE). A

45 certification in writing of the cost of providing medical care

46 to Medicaid beneficiaries by publicly owned hospitals and

47 hospitals owned by a state agency or a state university plus

48 the amount of uncompensated care provided by publicly owned

49 hospitals and hospitals owned by an agency of state government

50 or a state university.

51 ~~(5)~~(4) DEPARTMENT. The Department of Revenue of the

52 State of Alabama.

53 ~~(6)~~(5) HOSPITAL. A facility that is licensed as a

54 hospital under the laws of the State of Alabama, provides

55 24-hour nursing services, and is primarily engaged in

56 providing, by or under the supervision of doctors of medicine

57 or osteopathy, inpatient services for the diagnosis,
58 treatment, and care or rehabilitation of persons who are sick,
59 injured, or disabled.
60 ~~(7)~~(6) HOSPITAL PAYMENT. Any payments received by a
61 hospital for providing inpatient care or outpatient care to
62 Medicaid patients or for uncompensated care, including, but
63 not limited to, base payments, access payments, incentive
64 payments, capitated payments, disproportionate share payments,
65 etc. Excludes payments not directly related to patient care,
66 such as Integrated Provider System Payments.
67 ~~(8)~~(7) HOSPITAL SERVICES AND REIMBURSEMENT PANEL. A
68 group of individuals appointed to review and approve any state
69 plan amendments to be submitted to the Centers for Medicare
70 and Medicaid Services which involve hospital services or
71 reimbursement.
72 ~~(9)~~(8) INTERGOVERNMENTAL TRANSFER (IGT). A transfer of
73 funds made by a publicly or state-owned hospital to the
74 Medicaid Agency, which will be used by the agency to obtain
75 federal matching funds for all hospital payments to public and
76 state-owned hospitals.
77 ~~(10)~~(9) MEDICAID PROGRAM. The medical assistance
78 program as established in Title XIX of the Social Security Act
79 and as administered in the State of Alabama by the Alabama
80 Medicaid Agency pursuant to executive order, Chapter 6 of
81 Title 22, commencing with Section 22-6-1, and Title 560 of the
82 Alabama Administrative Code.
83 ~~(11)~~(10) MEDICARE COST REPORT. CMS-2552-10, the Cost
84 Report for Electronic Filing of Hospitals.

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

113 ~~to Medicaid beneficiaries in a defined region of the state and~~
114 ~~that meets the requirements set forth by the Alabama Medicaid~~
115 ~~Agency.~~
116 ~~(17) REGIONAL CARE ORGANIZATION CAPITATION PAYMENT. An~~
117 ~~actuarially sound payment made by Medicaid to the Regional~~
118 ~~Care Organizations.~~
119 ~~(18)~~(15) STATE-OWNED HOSPITAL. A hospital that is a
120 state agency or unit of government, including, without
121 limitation, an authority or a hospital owned by a state agency
122 or a state university or a hospital created pursuant to
123 Chapter 17A of Title 16.
124 ~~(19)~~(16) STATE PLAN AMENDMENT. A change or update to
125 the state Medicaid plan that is approved by the Centers for
126 Medicare and Medicaid Services.
127 ~~(20)~~(17) UPPER PAYMENT LIMIT. The maximum ceiling
128 imposed by federal regulation on Medicaid reimbursement for
129 inpatient hospital services under 42 C.F.R. § 447.272 and
130 outpatient hospital services under 42 C.F.R. § 447.321.
131 a. The upper payment limit shall be calculated
132 separately for hospital inpatient and outpatient services.
133 b. Medicaid disproportionate share payments shall be
134 excluded from the calculation of the upper payment limit.
135 ~~(21)~~(18) UNCOMPENSATED CARE SURVEY. A survey of
136 hospitals conducted by the Medicaid program to determine the
137 amount of uncompensated care provided by a particular hospital
138 in a particular fiscal year."
139 "§40-26B-71
140 (a) For state fiscal years ~~2023, 2024, and 2025~~2026,

141 2027, and 2028, an assessment is imposed on each privately
142 operated hospital in the amount of 6.00 percent of net patient
143 revenue in fiscal year ~~2020~~2023, which shall be reviewed and
144 hospital cost reports updated annually, subject to limitations
145 in this article on the use of funds in the Hospital Assessment
146 Account. The assessment is a cost of doing business as a
147 privately operated hospital in the State of Alabama. Annually,
148 the Medicaid Agency shall make a determination of whether
149 changes in federal law or regulation have adversely affected
150 hospital Medicaid reimbursement during the most recently
151 completed fiscal year, or a reduction in payment rates has
152 occurred. If the agency determines that adverse impact to
153 hospital Medicaid reimbursement has occurred, or will occur,
154 the agency shall report its findings to the Chair of the House
155 Ways and Means General Fund Committee who shall propose an
156 amendment to this article during any legislative session prior
157 to the start of the upcoming fiscal year from the year the
158 report was made, to address the adverse impact. The assessment
159 imposed on each private hospital under this section shall be
160 reduced pro rata, if the total disproportionate share
161 allotment for all hospitals is reduced before or during the
162 ~~2025~~2028 fiscal year, as a result of any action by the
163 Medicaid Agency or the Centers for Medicare and Medicaid
164 Services, and only to the extent that the Hospital Assessment
165 Account is more than necessary to fund some or all hospital
166 payments under this article.
167 (b)(1) For state fiscal years ~~2023, 2024, and 2025~~2026,
168 2027, and 2028, net patient revenue shall be determined using

169 the data from each private hospital's fiscal year ending ~~2020,~~
170 ~~2021, or 2022~~2023, 2024, or 2025 Medicare Cost Report
171 contained in the Centers for Medicare and Medicaid Services'
172 Healthcare Cost Report Information System, which shall be
173 reviewed and the hospital cost reports updated annually
174 subject to limitations in this article on the use of funds in
175 the Hospital Assessment Account. The Medicare Cost Report for
176 ~~2020, 2021, and 2022~~2023, 2024, and 2025 for each private
177 hospital, which shall be reviewed and updated annually, shall
178 be used for fiscal years ~~2023, 2024, and 2025~~2026, 2027, and
179 2028, respectively. If the Medicare Cost Report is not
180 available in the Centers for Medicare and Medicaid Services'
181 Healthcare Cost Report Information System, the hospital shall
182 submit a copy to the department to determine the hospital's
183 net patient revenue for the most recent fiscal year.
184 (2) If a privately operated hospital commenced
185 operations after the due date for a ~~2020~~2023 Medicare Cost
186 Report, the hospital shall submit its most recent Medicare
187 Cost Report to the department in order to allow the department
188 to determine the hospital's net patient revenue.
189 (c) This article does not authorize a unit of county or
190 local government to license for revenue or impose a tax or
191 assessment upon hospitals or a tax or assessment measured by
192 the income or earnings of a hospital."
193 "§40-26B-73
194 (a)(1) There is created within the Health Care Trust
195 Fund referenced in Article 3 of Chapter 6 of Title 22 of a
196 designated account known as the Hospital Assessment Account.

197 (2) The hospital assessments imposed under this article
198 shall be deposited into the Hospital Assessment Account.
199 ~~(3) If the Medicaid Agency begins making payments under~~
200 ~~Article 9 of Chapter 6 of Title 22, while Act 2017-382 is in~~
201 ~~force, the hospital intergovernmental transfers imposed under~~
202 ~~this article shall be deposited into the Hospital Assessment~~
203 ~~Account.~~
204 (b) ~~Moneys~~Monies in the Hospital Assessment Account
205 shall consist of:
206 (1) All ~~moneys~~monies collected or received by the
207 department from privately operated hospital assessments
208 imposed under this article;
209 (2) Any interest or penalties levied in conjunction
210 with the administration of this article; and
211 (3) Any appropriations, transfers, donations, gifts, or
212 ~~moneys~~moneies from other sources, as applicable.~~; and~~
213 ~~(4) If the Medicaid Agency begins making payments under~~
214 ~~Article 9 of Chapter 6 of Title 22, while Act 2017-382 is in~~
215 ~~force, all moneys collected or received by the department from~~
216 ~~publicly owned and state-owned hospital intergovernmental~~
217 ~~transfers imposed under this article.~~
218 (c) The Hospital Assessment Account shall be separate
219 and distinct from the State General Fund and shall be
220 supplementary to the Health Care Trust Fund.
221 (d) ~~Moneys~~Monies in the Hospital Assessment Account
222 shall not be used to replace other general revenues
223 appropriated and funded by the Legislature or other revenues
224 used to support Medicaid.

225 (e) The Hospital Assessment Account shall be exempt
226 from budgetary cuts, reductions, or eliminations caused by a
227 deficiency of State General Fund revenues to the extent
228 permissible under ~~Amendment 26~~Section 213 to the Constitution
229 of Alabama of ~~1901, now appearing as Section 213 of the~~
230 ~~Official Recompilation of the Constitution of Alabama of 1901,~~
231 ~~as amended~~2022.
232 (f)(1) Except as necessary to reimburse any funds
233 borrowed to supplement funds in the Hospital Assessment
234 Account, the ~~moneys~~monies in the Hospital Assessment Account
235 shall be used only as follows:
236 a. To make public, private, and state inpatient and
237 outpatient hospital payments.
238 b. To reimburse ~~moneys~~monies collected by the
239 department from hospitals through error or mistake or under
240 this article.
241 (2)a. The Hospital Assessment Account shall retain
242 account balances remaining each fiscal year.
243 b. On September 30, 2014, and each year thereafter, any
244 positive balance remaining in the Hospital Assessment Account
245 which was not used by the Medicaid Agency to obtain federal
246 matching funds and paid out for hospital payments, shall be
247 factored into the calculation of any new assessment rate by
248 reducing the amount of hospital assessment funds that must be
249 generated during the next fiscal year. The Medicaid Agency may
250 carry over a balance of unspent assessment funds not
251 considered in the previous sentence and not to exceed ~~one~~
252 ~~third~~one-third of the total current year's assessment, through

253 fiscal year ~~2025~~2028 to account for future variations in
254 hospital expenses and federal match rates in the upcoming
255 fiscal year. If there is no new assessment beginning October
256 1, ~~2025~~2028, the funds remaining shall be refunded to the
257 hospital that paid the assessment or made an intergovernmental
258 transfer in proportion to the amount remaining.
259 (3) A privately operated hospital shall not be
260 guaranteed that its inpatient and outpatient hospital payments
261 will equal or exceed the amount of its hospital assessment."
262 "§40-26B-77.1
263 (a) Beginning on October 1, 2016, and ending on
264 September 30, ~~2025~~2028, publicly owned and state-owned
265 hospitals shall begin making intergovernmental transfers to
266 the Medicaid Agency. ~~If the agency begins making payments~~
267 ~~pursuant to Article 9 of Chapter 6 of Title 22, on or before~~
268 ~~September 30, 2019, the amount of the intergovernmental~~
269 ~~transfers shall be calculated for each hospital using a~~
270 ~~pro-rata basis based on the hospital's IGT contribution for FY~~
271 ~~2018 in relation to the total IGT for FY 2018.~~ Total IGTs for
272 ~~any given fiscal year shall not exceed three hundred~~
273 ~~thirty-three million, four hundred thirty-four thousand, and~~
274 ~~forty-eight dollars ($333,434,048) with the exception of an~~
275 ~~adjustment as described in subsection (d) and to the extent~~
276 ~~adjustments are required to comply with federal regulations or~~
277 ~~terms of any waiver issued by the federal government relating~~
278 ~~to the state's Medicaid program. The total intergovernmental~~
279 ~~transfers shall equal and shall not exceed the amount of state~~
280 ~~funds necessary for the agency to obtain only those federal~~

281 ~~matching funds necessary to pay publicly owned and state-owned~~
282 ~~hospitals for hospital payments. If the agency does not begin~~
283 ~~making payments pursuant to Article 9 of Chapter 6 of Title~~
284 ~~22, on or before September 30, 2022,~~ the total
285 intergovernmental transfers shall equal the amount of state
286 funds necessary for the agency to obtain only those federal
287 matching funds necessary to pay publicly owned and state-owned
288 hospitals for hospital payments.
289 (b) These intergovernmental transfers shall be made in
290 compliance with 42 U.S.C. § 1396b.(w).
291 (c) If a publicly or state-owned hospital commences
292 operations after October 1, 2013, the hospital shall commence
293 making intergovernmental transfers to the Medicaid Agency in
294 the first full month of operation of the hospital after
295 October 1, 2013.
296 ~~(d) If the Medicaid Agency begins making payments~~
297 ~~pursuant to Article 9 of Chapter 6 of Title 22, on or before~~
298 ~~September 30, 2019, notwithstanding any other provision of~~
299 ~~this article, a private hospital that is subject to payment of~~
300 ~~the assessment pursuant to this article at the beginning of a~~
301 ~~state fiscal year, but during the state fiscal year~~
302 ~~experiences a change in status so that it is subject to the~~
303 ~~intergovernmental transfer computed under this article, it~~
304 ~~shall continue to pay the same amount as calculated in Section~~
305 ~~40-26B-71, but in the form of an intergovernmental transfer.~~"
306 "§40-26B-79
307 ~~If the Medicaid Agency begins making payments pursuant~~
308 ~~to Article 9 of Chapter 6 of Title 22, on or before September~~

309 ~~30, 2019, the agency shall pay hospitals as a base amount for~~
310 ~~state fiscal year 2019, for inpatient services an APR-DRG~~
311 ~~payment that is equal to the total modeled UPL submitted and~~
312 ~~approved by CMS during fiscal year 2019. If the agency begins~~
313 ~~making payments pursuant to Article 9 of Chapter 6 of Title~~
314 ~~22, on a date other than the first day of fiscal year 2019,~~
315 ~~there shall be no retroactive adjustment to payments already~~
316 ~~made to hospitals in accordance with the approved state plan.~~
317 ~~If approved by CMS, the agency shall publish the APR-DRG rates~~
318 ~~for each hospital prior to September 30, 2018. If the agency~~
319 ~~does not begin making payments pursuant to Article 9 of~~
320 ~~Chapter 6 of Title 22, on or before September 30, 2025, the~~The
321 agency shall pay hospitals, as a base amount for fiscal years
322 ~~2023, 2024, and 2025~~2026, 2027, and 2028, the greater of a
323 hospital's current per diem as published for fiscal year 2022
324 or 68 percent of total inpatient payments made by the agency
325 during state fiscal year 2019, divided by the total patient
326 days paid in state fiscal year 2019, multiplied by patient
327 days paid during fiscal years ~~2023, 2024, and 2025~~2026, 2027,
328 and 2028. A hospital may request to have their per diem
329 reviewed and revised at the sole discretion of the Medicaid
330 Agency. This payment to be paid using the agency's published
331 check write table is in addition to any hospital access
332 payments the agency may elect to pay hospitals as inpatient
333 payments other than per diems and access payments, if the
334 agency does not make payments pursuant to Article 9 of Chapter
335 6 of Title 22 in fiscal year 2019, or fiscal years ~~2023, 2024,~~
336 ~~and 2025~~2026, 2027, and 2028, only if the Hospital Services

and Reimbursement Panel approves the change in hospital payments.~~—~~"

"§40-26B-80

~~If the Medicaid Agency begins making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2019, the agency shall pay hospitals as a base amount for fiscal year 2019 for outpatient services based upon a fee for service and access payments or OPPS schedule. If the agency begins making payments pursuant to Article 9 of Chapter 6 of Title 22, on a date other than the first day of fiscal year 2023, there shall be no retroactive adjustment to payments already made to hospitals in accordance with the approved state plan.~~

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

~~If the Medicaid Agency does not begin making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2019, the~~ The agency shall pay hospitals as a base amount for fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028 for outpatient services, based upon an outpatient fee schedule in existence on September 30, 2018. Medicaid may update the outpatient fee schedule with approval of the Hospital Services and Reimbursement Panel. 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 the Medicaid Agency begins making payments~~

365 ~~pursuant to Article 9 of Chapter 6 of Title 22, on or before~~
366 ~~September 30, 2019, to preserve and improve access to hospital~~
367 ~~services, for hospital inpatient and outpatient services~~
368 ~~rendered on or after October 1, 2018, the~~The agency shall
369 consider the published inpatient and outpatient rates as
370 defined in Sections 40-26B-79 and 40-26B-80 as the minimum
371 payment allowed.
372 (b) ~~If the Medicaid Agency does not begin making~~
373 ~~payments pursuant to Article 9 of Chapter 6 of Title 22, on or~~
374 ~~before September 30, 2019, the~~The aggregate hospital access
375 payment amount is an amount equal to the upper payment limit,
376 less total hospital base payments determined under this
377 article. All publicly, state-owned, and privately operated
378 hospitals shall be eligible for inpatient and outpatient
379 hospital access payments for fiscal years ~~2023, 2024, and~~
380 ~~2025~~2026, 2027, and 2028, as set forth in this article.
381 (1) In addition to any other funds paid to hospitals
382 for inpatient hospital services to Medicaid patients, each
383 eligible hospital shall receive inpatient hospital access
384 payments each state fiscal year. Publicly and state-owned
385 hospitals shall receive total payments, including hospital
386 base payments, that, in the aggregate, equal the upper payment
387 limit for publicly and state-owned hospitals, until the
388 Hospital Assessment Account is exhausted. Privately operated
389 hospitals shall receive total payments, including hospital
390 base payments that, in the aggregate, equal the upper payment
391 limit for privately operated hospitals, until the Hospital
392 Assessment Account is exhausted. Any intergovernmental

393 transfers and hospital provider taxes shall be used only as
394 ~~moneys~~monies paid to hospitals.
395 (2) Inpatient hospital access payments shall be made on
396 a quarterly basis.
397 (3) In addition to any other funds paid to hospitals
398 for outpatient hospital services to Medicaid patients, each
399 eligible hospital shall receive outpatient hospital access
400 payments each state fiscal year. Publicly and state-owned
401 hospitals shall receive payments, including hospital base
402 payments, that, in the aggregate, equal the upper payment
403 limit for publicly and state-owned hospitals, until the
404 Hospital Assessment Account is exhausted. Privately operated
405 hospitals shall receive payments, including hospital base
406 payments, that, in the aggregate, equal the upper payment
407 limit for privately operated hospitals, until the Hospital
408 Assessment Account is exhausted.
409 (4) Outpatient hospital access payments shall be made
410 on a quarterly basis.
411 (c) A hospital access payment shall not be used to
412 offset any other payment by the Medicaid Agency for hospital
413 inpatient or outpatient services to Medicaid beneficiaries,
414 including, without limitation, any fee-for-service, per diem,
415 private or public hospital inpatient adjustment, or hospital
416 cost settlement payment.
417 (d) The specific hospital payments for publicly,
418 state-owned, and privately operated hospitals shall be
419 described in the state plan amendment to be submitted to and
420 approved by the Centers for Medicare and Medicaid Services."

421 "§40-26B-82

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

428 (1) Expenditures for hospital inpatient and outpatient
429 services paid for by the Alabama Medicaid Program for fiscal
430 years ~~2023, 2024, and 2025~~2026, 2027, and 2028~~,~~ are less than
431 the amount paid during fiscal year 2017 or reimbursement rates
432 under this article for fiscal years ~~2023, 2024, and 2025~~2026,
433 2027, and 2028~~,~~ are less than the rates approved by CMS in
434 Sections 40-26B-79 and 40-26B-80.

435 (2) The Medicaid Agency makes changes in~~ its~~ rules that
436 reduce hospital inpatient payment rates, outpatient payment
437 rates, or adjustment payments, including any cost settlement
438 protocol, that were in effect on September 30, ~~2022~~2025.

439 (3) The inpatient or outpatient hospital access
440 payments required under this article are changed or the
441 assessments imposed or certified public expenditures, or
442 intergovernmental transfers recognized under this article are
443 not eligible for federal matching funds under Title XIX of the
444 Social Security Act, 42 U.S.C. § 1396 et seq., or 42 U.S.C. §
445 1397aa et seq.

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

449 ~~a. If a regional care organization or alternate care~~
450 ~~provider failed to provide adequate service pursuant to its~~
451 ~~contract, or had its certification terminated, or if the~~
452 ~~agency could not award a contract to a regional care~~
453 ~~organization under its quality, efficiency, and cost~~
454 ~~conditions, or if no organization had been awarded a regional~~
455 ~~care organization certificate by October 1, 2016, or the date~~
456 ~~of extension as set out in Act No. 2016-377, then the agency~~
457 ~~shall first offer a contract, to resume interrupted service or~~
458 ~~to assume service in the region, under its quality,~~
459 ~~efficiency, and cost conditions to any other regional care~~
460 ~~organization that the agency judged would meet its quality~~
461 ~~criteria.~~
462 ~~b. If by October 1, 2014, no organization had a~~
463 ~~probationary regional care organization certification in a~~
464 ~~region. However, the agency could extend the deadline until~~
465 ~~January 1, 2015, if it judged an organization was making~~
466 ~~reasonable progress toward getting probationary certification.~~
467 ~~If the agency judged that no organization in the region likely~~
468 ~~would achieve probationary certification by January 1, 2015,~~
469 ~~then the agency shall let any organization with probationary~~
470 ~~or full regional care organization certification apply to~~
471 ~~develop a regional care organization in the region. If at~~
472 ~~least one organization made such an application, the agency no~~
473 ~~sooner than October 1, 2015, would decide whether any~~
474 ~~organization could reasonably be expected to become a fully~~
475 ~~certified regional care organization in the region and its~~
476 ~~initial region.~~

477 ~~c. If an organization lost its probationary~~
478 ~~certification before October 1, 2016, or the date of the~~
479 ~~extension as set out in Act No. 2016-377, the agency shall~~
480 ~~offer any other organization with probationary or full~~
481 ~~regional care organization certification, which it judged~~
482 ~~could successfully provide service in the region and its~~
483 ~~initial region, the opportunity to serve Medicaid~~
484 ~~beneficiaries in both regions.~~
485 ~~d. The agency may contract with an alternate care~~
486 ~~provider only if no regional care organization accepted a~~
487 ~~contract under the terms of paragraph a., or no organization~~
488 ~~was granted the opportunity to develop a regional care~~
489 ~~organization in the affected region under the terms of~~
490 ~~paragraph b., or no organization was granted the opportunity~~
491 ~~to serve Medicaid beneficiaries under the terms of paragraph~~
492 ~~c.~~
493 ~~e.~~a. The agency may contract with an alternate care
494 provider ~~under the terms of paragraph d.~~ only if, in the
495 judgment of the agency, care of Medicaid enrollees would be
496 better, more efficient, and less costly than under the then
497 existing care delivery system. The agency may contract with
498 more than one alternate care provider in a Medicaid region.
499 ~~f.1.~~b.1. If the agency were to contract with an
500 alternate care provider under the terms of this section, that
501 provider would have to pay reimbursements for hospital
502 inpatient or outpatient care at rates at least equal to
503 ~~those~~the most recent published ~~as of October 1, 2017,~~ pursuant
504 to Sections 40-26B-79 and 40-26B-80.

505 2. If more than a year had elapsed since the agency
506 directly paid reimbursements to hospitals, the minimum
507 reimbursement rates paid by the alternate care provider would
508 have to be changed to reflect any percentage increase in the
509 national medical consumer price index minus 100 basis points.
510 (b)(1) The assessment imposed under this article shall
511 not take effect or shall cease to be imposed if the assessment
512 is determined to be an impermissible tax under Title XIX of
513 the Social Security Act, 42 U.S.C. § 1396 et seq.
514 (2) ~~Moneys~~Monies in the Hospital Assessment Account in
515 the Alabama Medicaid Program Trust Fund derived from
516 assessments imposed before the determination described in
517 subdivision (1) shall be disbursed under this article to the
518 extent federal matching is not reduced due to the
519 impermissibility of the assessments, and any remaining
520 ~~moneys~~monies shall be refunded to hospitals in proportion to
521 the amounts paid by them."
522 "§40-26B-84
523 This article shall be of no effect if federal financial
524 participation under Title XIX of the Social Security Act is
525 not available to the Medicaid Agency at the approved federal
526 medical assistance percentage, established under Section 1905
527 of the Social Security Act, for the state fiscal years ~~2023,~~
528 ~~2024, and 2025~~2026, 2027, and 2028.~~ ~~"
529 "§40-26B-88
530 This article shall automatically terminate and become
531 ~~null and~~ void by its own terms on September 30, ~~2025~~2028,
532 unless a later act is enacted extending the article to future

533 state fiscal years. "

534 Section 2. This act shall become effective on October

535 1, 2025.