House Ways and Means General Fund Reported Substitute for HB312

A BILL

TO BE ENTITLED

AN ACT

Relating to the Hospital Provider Privilege Tax; to amend Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, and 40-26B-88 of the Code of Alabama 1975, to extend the tax until fiscal year 2028.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 40-26B-70, 40-26B-71, 40-26B-73, 40-26B-77.1, 40-26B-79, 40-26B-80, 40-26B-81, 40-26B-82, 40-26B-84, and 40-26B-88 of the Code of Alabama 1975, are amended 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)~~ (2) ALTERNATE CARE PROVIDER. A contractor, other than a regional care organization, that agrees to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state pursuant to a risk contract.

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

~~(6)~~ (5) HOSPITAL. A facility that is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

~~(7)~~ (6) 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)~~ (7) 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)~~ (8) 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)~~ (9) 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)~~ (10) MEDICARE COST REPORT. CMS-2552-10, the Cost 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 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)~~ (15) 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)~~(16) STATE PLAN AMENDMENT. A change or update to the state Medicaid plan that is approved by the Centers for Medicare and Medicaid Services.

~~(20)~~(17) 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)~~(18) 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 years ~~2023, 2024, and 2025~~2026, 2027, and 2028, an assessment is imposed on each privately operated hospital in the amount of 6.00 percent of net patient revenue in fiscal year ~~2020~~2023, which shall be reviewed and hospital cost reports updated annually, subject to limitations in this article on the use of funds in the Hospital Assessment Account. 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 during the most recently

completed fiscal year, or a reduction in payment 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 Chair of the House Ways and Means General Fund Committee who shall propose an amendment to this article 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 ~~2025~~2028 fiscal year, as a result of any action by the Medicaid Agency or the Centers for Medicare and Medicaid Services, and only to the extent that the Hospital Assessment Account is more than necessary to fund some or all hospital payments under this article.

(b)(1) For state fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028, net patient revenue shall be determined using the data from each private hospital's fiscal year ending ~~2020, 2021, or 2022~~2023, 2024, or 2025 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System, which shall be reviewed and the hospital cost reports updated annually subject to limitations in this article on the use of funds in the Hospital Assessment Account. The Medicare Cost Report for ~~2020, 2021, and 2022~~2023, 2024, and 2025 for each private hospital, which shall be reviewed and updated annually, shall be used for fiscal years ~~2023, 2024, and 2025~~2026, 2027, and

2028, respectively. If the Medicare Cost Report is not available in the 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 the most recent fiscal year.

(2) If a privately operated hospital commenced operations after the due date for a ~~2020~~2023 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 of Chapter 6 of Title 22 of 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 Article 9 of Chapter 6 of Title 22, while Act 2017-382 is in force, the hospital intergovernmental transfers imposed under this article shall be deposited into the Hospital Assessment Account.~~

(b) ~~Moneys~~Monies in the Hospital Assessment Account shall consist of:

(1) All ~~moneys~~monies 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~~moneies from other sources, as applicable.~~; and~~

~~(4) If the Medicaid Agency begins making payments under Article 9 of Chapter 6 of Title 22, while Act 2017-382 is in force, 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~~Monies 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~~Section 213 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~~2022.

(f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Assessment Account, the ~~moneys~~monies in the Hospital Assessment Account

shall be used only as follows:

a. To make public, private, and state inpatient and outpatient hospital payments.

b. To reimburse ~~moneys~~monies 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 the Medicaid Agency 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. The Medicaid Agency may carry over a balance of unspent assessment funds not considered in the previous sentence and not to exceed ~~one third~~one-third of the total current year's assessment, through fiscal year ~~2025~~2028 to account for future variations in hospital expenses and federal match rates in the upcoming fiscal year. If there is no new assessment beginning October 1, ~~2025~~2028, 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-77.1

(a) Beginning on October 1, 2016, and ending on September 30, ~~2025~~2028, publicly owned and state-owned hospitals shall begin making intergovernmental transfers to the Medicaid Agency. ~~If the agency begins making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2019, the amount of the intergovernmental transfers shall be calculated for each hospital using a pro-rata basis based on the hospital's IGT contribution for FY 2018 in relation to the total IGT for FY 2018.~~ Total IGTs for ~~any given fiscal year shall not exceed three hundred thirty-three million, four hundred thirty-four thousand, and forty-eight dollars ($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 agency to obtain only those federal matching funds necessary to pay publicly owned and state-owned hospitals for hospital payments. If the agency does not begin making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2022,~~ 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 the Medicaid Agency begins making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2019, 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 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 state fiscal year 2019, for inpatient services an APR-DRG payment that is equal to the total modeled UPL submitted and approved by CMS during fiscal year 2019. 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 2019, there shall be no retroactive adjustment to payments already made to hospitals in accordance with the approved state plan. If approved by CMS, the agency shall publish the APR-DRG rates for each hospital prior to September 30, 2018. If the agency~~

~~does not begin making payments pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2025, the~~The agency shall pay hospitals, as a base amount for fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028, the greater of a hospital's current per diem as published for fiscal year 2022 or 68 percent of total inpatient payments made by the agency during state fiscal year 2019, divided by the total patient days paid in state fiscal year 2019, multiplied by patient days paid during fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028. A hospital may request to have their per diem reviewed and revised at the sole discretion of the Medicaid Agency. This payment to be paid using the agency's published check write table is in addition to any hospital access payments the agency may elect to pay hospitals as inpatient payments other than per diems and access payments, if the agency does not make payments pursuant to Article 9 of Chapter 6 of Title 22 in fiscal year 2019, or fiscal years ~~2023, 2024, 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 pursuant to Article 9 of Chapter 6 of Title 22, on or before September 30, 2019, to preserve and improve access to hospital services, for hospital inpatient and outpatient services rendered on or after October 1, 2018, the~~The agency 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 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 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 years ~~2023, 2024, and 2025~~2026, 2027, and 2028, 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 total payments, including hospital base payments, that, in the aggregate, equal the upper payment limit for publicly and state-owned hospitals, until the Hospital Assessment Account is exhausted. Privately operated hospitals shall receive total payments, including hospital base payments that, in the aggregate, equal the upper payment limit for privately operated hospitals, until the Hospital Assessment Account is exhausted. Any intergovernmental transfers and hospital provider taxes shall be used only as ~~moneys~~monies paid to 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, until the Hospital Assessment Account is exhausted. Privately operated hospitals shall receive payments, including hospital base payments, that, in the aggregate, equal the upper payment limit for privately operated hospitals, until the Hospital Assessment Account is exhausted.

(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 the Medicaid Agency 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~~monies 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 years ~~2023, 2024, and 2025~~2026, 2027, and 2028~~,~~ are less than

the amount paid during fiscal year 2017 or reimbursement rates under this article for fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028~~,~~ are less than the rates approved by CMS in Sections 40-26B-79 and 40-26B-80.

(2) The Medicaid Agency 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, ~~2022~~2025.

(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 alternate care provider failed to provide adequate service pursuant to its contract, or had its certification terminated, or if the 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 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 the agency 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 agency could extend the deadline until January 1, 2015, if it judged an organization was making reasonable progress toward getting probationary certification. If the agency judged that no organization in the region likely would achieve probationary certification by January 1, 2015, then the 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, the agency 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. The agency may contract with an alternate care provider only if no regional care organization accepted a~~

~~contract under the terms of paragraph a., or no organization was granted the opportunity to develop a regional care organization in the affected region under the terms of paragraph b., or no organization was granted the opportunity to serve Medicaid beneficiaries under the terms of paragraph c.~~

~~c.~~a. The agency may contract with an alternate care provider ~~under the terms of paragraph d.~~ only if, in the judgment of the agency, care of Medicaid enrollees would be better, more efficient, and less costly than under the then existing care delivery system. The agency may contract with more than one alternate care provider in a Medicaid region.

~~f.1.~~b.1. If the 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~~the most recent published rates ~~as of October 1, 2017,~~ pursuant to Sections 40-26B-79 and 40-26B-80.

2. If more than a year had elapsed since the 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~~Monies 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~~monies 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 the Medicaid Agency at the approved federal medical assistance percentage, established under Section 1905 of the Social Security Act, for the state fiscal years ~~2023, 2024, and 2025~~2026, 2027, and 2028.~~-~~"

"§40-26B-88

This article shall automatically terminate and become ~~null and~~ void by its own terms on September 30, ~~2025~~2028, unless a later act is enacted extending the article to future state fiscal years. "

Section 2. This act shall become effective on October 1, 2025.