HB286

216950-4

By Representative Clouse

RFD: Ways and Means General Fund

First Read: 08-FEB-22

ENROLLED, An Act,

Relating to the Hospital Provider Privilege Tax; to amend Sections 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 2025.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 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-71.

"(a) For state fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, an assessment is imposed on each privately operated hospital in the amount of 6.00 percent of net patient revenue in fiscal year ~~2017~~ 2020, 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 ~~2022~~ 2025 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 ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, net patient revenue shall be determined using the data from each private hospital's fiscal year ending ~~2017~~ 2020, 2021, or 2022 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services Healthcare Cost 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 ~~2017~~ 2020, 2021, and

2022 for each private hospital, which shall be reviewed and updated annually, shall be used for fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, ~~and 2024~~ and 2025, 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 ~~fiscal year 2017~~ the most recent fiscal year.

"(2) If a privately operated hospital commenced operations after the due date for a ~~2017~~ 2020 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 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 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 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 payments.

"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 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 of the total current year's assessment, through fiscal year 2025 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, ~~2022~~ 2025, 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, ~~2022~~ 2025, 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, ~~2022~~ 2025, the agency shall pay hospitals as a base amount for fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, the ~~total~~ greater of a hospital's current per diem

as published for fiscal year 2022 or sixty-eight percent of total inpatient payments made by the agency during state fiscal year ~~2007~~ 2019, divided by the total patient days paid in state fiscal year ~~2007~~ 2019, multiplied by patient days paid during fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, and 2025. 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, 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 ~~2022~~ 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 agency shall pay hospitals as a base amount for fiscal ~~year 2019~~ years 2023, 2024, and 2025 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 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 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 ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, 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 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 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 ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, are less than the amount paid during fiscal year 2017~~.~~ ~~Reimbursement~~ or reimbursement rates under this article for fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, and 2025, 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, ~~2019~~ 2022.

"(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.

"e. 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. 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 published 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 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 the Medicaid Agency at the approved federal medical assistance percentage, established under Section 1905 of the Social Security Act, for the state fiscal years ~~2020, 2021, and 2022~~ 2023, 2024, and 2025.

"§40-26B-88.

"This article shall automatically terminate and become null and void by its own terms on September 30, ~~2022~~ 2025, unless a later act is enacted extending the article to future state fiscal years."

Section 2. This act shall become effective on October 1, 2022 following its passage and approval by the Governor, or its otherwise becoming law.

Speaker of the House of Representatives

President and Presiding Officer of the Senate

House of Representatives

I hereby certify that the within Act originated in and was passed by the House 17-FEB-22, as amended.

Jeff Woodard
Clerk

Senate 02-MAR-22 Passed