Amendment No. 1 to SB1740

Crowe
Signature of Sponsor

AMEND Senate Bill No. 1740 House Bill No. 1723*

by deleting all language after the enacting clause and substituting:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 20, is amended by deleting the part and substituting:

71-5-2001. Short title.

This part is known and may be cited as the "Annual Coverage Assessment Act of 2024."

71-5-2002. Part definitions.

As used in this part:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" means the total net patient revenue minus the medicare net revenue, for all hospitals as shown in the hospital's medicare cost report for the fiscal year that ended during calendar year 2021, on file with CMS as of September 30, 2023, subject to the following qualifications:

(A) If a hospital does not have a full twelve-month medicare cost report for 2021 on file with CMS but has a full twelve-month cost report for a subsequent year, then the first full twelve-month medicare cost report for a year following 2021 on file with CMS is the hospital's portion of the annual coverage assessment base;

(B) If a hospital does not have a full twelve-month medicare cost report for 2021 on file with CMS and does not have a full twelve-month cost report for a subsequent year, but has a cost report for 2021 that covers at least nine (9) months of 2021, then the hospital's portion of the assessment base is calculated by annualizing the 2021 cost report data;

(C) If a hospital was first licensed in 2021 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, then the hospital's initial cost report on file with CMS is the hospital's portion of the annual coverage assessment base for the hospital assessment. If the hospital does not have an initial cost report on file with CMS but does have a complete twelve-month joint annual report (JAR) filed with the department of health, then the net patient revenue from the first twelve-month JAR is the hospital's portion of the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month JAR filed with the department of health, then the hospital's portion of the annual coverage assessment base is the hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health facilities commission;

(D) If a hospital was first licensed in 2021 or later and replaced an existing hospital, then the hospital's portion of the annual coverage assessment base is the replacement hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, then the hospital's portion of the annual coverage assessment base is either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2021, or, if the predecessor hospital does not have a 2021

medicare cost report, then the cost report for the first fiscal year following 2021 on file with CMS;

(E) If a hospital is not required to file an annual medicare cost report with CMS, then the hospital's portion of the annual coverage assessment base is its net patient revenue for the fiscal year ending during calendar year 2021 or the first fiscal year that the hospital was in operation after 2021 as shown in the covered hospital's JAR filed with the department of health; and

(F) If a hospital's fiscal year 2021 medicare cost report is not contained in a CMS healthcare cost report information system file, and if the hospital does not meet another qualification listed in subdivisions (2)(A)-(E), then the hospital must submit a copy of the hospital's 2021 medicare cost report to the division in order to allow for the determination of the hospital's net patient revenue as its portion of the annual coverage assessment base;

(3) ''CMS'' means the federal centers for medicare and medicaid services;

(4) ''Controlling person'' means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. As used in this subdivision (4), ''control'' means indirect or direct ownership of ten percent (10%) or more of a covered hospital;

(5) ''Covered hospital'' means a hospital licensed under title 33 or title 68, as of July 1, 2024, but does not include an excluded hospital;

(6) ''Division'' means the division of TennCare;

(7) ''Excluded hospital'' means:

(A) A hospital that has been designated by CMS as a critical access hospital as of July 1, 2024;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers;

(E) A hospital that is determined by the division as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments; and

(F) A hospital that has been designated by CMS as a rural emergency hospital as of July 1, 2024;

(8) ''Hospital'' means a facility licensed under title 33 or title 68 to provide inpatient hospital care;

(9) ''Medicare cost report'' means CMS-2552-10 or a subsequent form adopted by CMS for medicare cost reporting, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(10) ''Net patient revenue minus medicare net revenue'' means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the 2021 medicare cost report, excluding net medicare revenue, long-term care inpatient ancillary and other nonhospital revenues, or, in the case of a hospital that did not file a 2021 medicare cost report, comparable data from the first complete cost report filed after 2021 by the hospital.

71-5-2003. Annual coverage assessment on covered hospitals.

(a) There is imposed on covered hospitals an annual coverage assessment for fiscal year (FY) 2024-2025 as set forth in this part, such that the total assessment on all covered hospitals in the aggregate will be equal to six percent (6%) of the federally recognized annual coverage assessment base.

(b) The annual coverage assessment imposed by this part is not effective and validly imposed until the division has provided the Tennessee Hospital Association with written notice that includes:

(1)

(A) A determination from CMS that the annual coverage assessment is a permissible source of revenue that does not adversely affect the amount of federal financial participation in the division; and

(B) Approval from CMS of an adjustment to the budget neutrality agreement with CMS, pursuant to the process set forth in the special terms and conditions in the division's 1115 demonstration project;

(2)

(A) Approval from CMS for the distribution of the full amount of directed payments to hospitals for TennCare services as described in § 71-5-2005(d)(2) as long as an assessment installment is not collected prior to the distribution of the installment of the directed payments; or

(B) The rules promulgated by the division pursuant to § 71-5-2004(j)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital payment rate variation corridors set forth in § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment are not to be used as a justification to reduce or eliminate state funding to the division. The annual coverage assessment is not effective and validly imposed if the coverage or the amount of revenue available for expenditure by the division in FY 2024-2025 is less than:

(1) The governor's FY 2024-2025 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the division for FY 2024-2025, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment are not to be used as justification for a division managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2024. For those rates in effect on July 1, 2024, the division shall include provisions in the managed care organizations' contractor risk agreements that prohibit the managed care organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians by specific service, category, or type of provider. The requirements of the preceding sentence also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but do not apply to reductions in benefits or reimbursement for the ancillary services if the reductions:

(i) Are different from those items being funded in § 71-5-2005(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B) As used in this subsection (d):

(i) ''Physician'' includes a physician licensed under title 63, chapter 6 or 9, and a group practice of physicians that holds a contract with a managed care organization;

(ii) ''Services or settings of care that are ancillary'' includes ambulatory surgical facilities, free standing emergency departments, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services; and

(iii) ''Services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician'' include services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in the ancillary services or settings of care, but does not include other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the division shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and between managed care organizations and physicians on an individualized, case-by-case basis. This subsection (d) does not serve as justification for managed care organizations, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny a party the ability to enter into individualized, case-by-case good faith negotiations. Good faith negotiation

necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements; the ability to modify negotiated rates, pricing, or units of service; the ability to alter payment methodologies; and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) does not preclude the full implementation of § 71-5-161.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage assessment becomes invalid, then this part does not prohibit the managed care organizations from implementing a rate change as may be mandated by the division or by state or federal law.

71-5-2004. Amount of annual coverage assessment — Payment — Penalty — Suspension of payments — Civil action.

(a) Each covered hospital's annual assessment is a weighted portion of the annual coverage assessment base as determined under § 71-5-2002. The weight for each covered hospital must be determined in accordance with the hospital's classification for children's, tier 1, tier 2, tier 3, psychiatric, and safety net hospitals in the division DSH program. The weights determined pursuant to this subsection (a) are not a rule as defined in § 4-5-102 and are not subject to rulemaking under title 4, chapter 5, part 2. The division shall implement this section in a manner that complies with federal requirements necessary to ensure that the assessment qualifies for federal matching funds. The weights for:

(1) Children's hospitals are an inpatient weight of eight-tenths (0.8) and an outpatient weight of three-tenths (0.3);

(2) Tier 1 hospitals are an inpatient weight of one (1.0) and an outpatient weight of fifty-five hundredths (0.55);

(3) Tier 2 hospitals are an inpatient weight of seventy-five hundredths (0.75) and an outpatient weight of three-tenths (0.3);

(4) Tier 3 hospitals are an inpatient weight of fifteen hundredths (0.15) and an outpatient weight of one hundred seventy-five thousandths (0.175);

(5) Psychiatric hospitals are an inpatient weight of eleven hundredths (0.11) and an outpatient weight of one (1.0);

(6) Safety net hospitals are an inpatient weight of one hundred thirty-three thousandths (0.133) and an outpatient weight of one hundred fifty-seven thousandths (0.157); and

(7) Any other hospitals eligible for the assessment have a weight of six percent (6%).

(b) The division may, in consultation with the Tennessee Hospital Association, modify the amount of the individual percentages set forth in this section if necessary to comply with 42 CFR 433.68 or to address additional state appropriations.

(c) The annual coverage assessment must be paid in installments pursuant to this subsection (c) if the requirements of § 71-5-2003(b) have been satisfied. The division shall establish a schedule of four (4) equal installment payments spread as evenly as possible throughout FY 2024-2025 with each installment payment due fifteen (15) days after the FY 2024-2025 directed payments approved by CMS to offset unreimbursed division costs have been made to hospitals.

(d) To facilitate collection of the annual coverage assessment, the division shall send each covered hospital, at least thirty (30) days in advance of each installment payment due date, a notice of payment along with a return form developed by the division. Failure of a covered hospital to receive a notice and return form, however,

does not relieve a covered hospital from the obligation of timely payment. The division shall also post the return form on its website.

(e) Failure of a covered hospital to pay an installment of the annual coverage assessment, when due, results in an imposition of a penalty of five hundred dollars ($500) per day until the installment is paid in full. The division at its discretion may waive the penalty if the hospital establishes that it attempted to mail or electronically transfer payment to the state on or before the date the payment was due.

(f) If a covered hospital ceases to operate or changes status to be an excluded hospital between July 1, 2024, and June 30, 2025, then the hospital's total annual coverage assessment is equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2024, until July 1, 2025, and the numerator of which is the number of days from July 1, 2024, until the date the health facilities commission has recorded as the date that the hospital changed status or ceased operation.

(g) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person controlling the hospital as of the date the hospital ceased operation is jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(h) If a covered hospital is sold after July 1, 2024, and before July 1, 2025, then the seller is responsible for annual coverage assessment payments due for the period up to and including the date the sale is final. If the hospital continues to operate in this state and continues to meet the definition of a covered hospital in § 71-5-2002, then the new owner is responsible for paying all coverage assessment amounts due for the period beginning on the day after the date of the sale until July 1, 2025.

(i) If a covered hospital fails to pay an installment of the annual coverage assessment within thirty (30) days of its due date, then the division must suspend the payments to the hospital required by § 71-5-2005(d)(2) until the installment is paid and

report the failure to the department that licenses the covered hospital. Notwithstanding another law, failure of a covered hospital to pay an installment of the annual coverage assessment or a refund required by this part is considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(j) In addition to the action required by subsection (h), the division is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (j) is in the chancery court for Davidson County.

(k)

(1) If a federal agency with jurisdiction over the annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue or if there is a reduction of the coverage and funding of the division's program contrary to § 71-5-2003(c), or if the requirements of §§ 71-5-161 and 71-5-2003(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-2003(d), then:

(A) Subsequent installments of the annual coverage assessment are not due and payable; and

(B) Further payments must not be paid to hospitals pursuant to § 71-5-2005(d)(2) after the date of the event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of directed payments to hospitals for providing services to division enrollees as authorized under § 71-5-2005(d), then the division must suspend payments from or to

covered hospitals otherwise required by this part and must promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-2005(d)(2) if approved by CMS;

(ii) Prioritize payments to hospitals as set forth in § 71-5-2005(d)(2);

(iii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that otherwise would be imposed in the absence of the coverage assessment;

(iv) Determine the amount and timing of payments for benefits and services identified under subdivisions (k)(2)(A)(ii) and (iii), as appropriate;

(v) Reinstitute payments from or to covered hospitals as appropriate; and

(vi) Otherwise achieve the goals of this subdivision (k)(2).

(B) The rules adopted under this subdivision (k)(2) must, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the division's program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-2005(d).

(C) Notwithstanding another law, the division is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (k)(2).

(3) Upon occurrence of an event set forth in subdivision (k)(1) or (k)(2), the division then has authority to make necessary changes to the division's budget to account for the loss of annual coverage assessment revenue.

(l) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, has the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to meet the requirements of this part. A covered hospital shall not increase charges or add a surcharge based on, or as a result of, the annual coverage assessment.

71-5-2005. Deposits in maintenance of coverage trust fund — Expenditures — Quarterly reports.

(a) The funds generated as a result of this part must be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund must not be used to replace monies otherwise appropriated to the division's program by the general assembly or to replace monies appropriated outside of the division's program.

(b) The maintenance of coverage trust fund must continue without interruption and must be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund consists of:

(1) The balance of the trust fund remaining as of June 30, 2024;

(2) All annual coverage assessments received by the division;

(3) Investment earnings credited to the assets of the maintenance of coverage trust fund;

(4) Penalties paid by covered hospitals for late payment of assessment installments imposed by this part or a prior statute authorizing an annual coverage assessment; and

(5) Intergovernmental transfer of funds from hospitals determined by the division as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments up to three hundred million dollars ($300,000,000).

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, must be available to and used by the division only for expenditures in the division's program and include the following purposes:

(1) Expenditures for benefits and services under the division's program, including those that would have been subject to reduction or elimination from the division's funding for FY 2024-2025, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011, except for reductions that were included on a list for a given year but then funded in a subsequent year with recurring state dollars;

(B) Funding virtual DSH payments, funding payments to hospitals for uncompensated care to charity patients, and funding payments to hospitals for quality incentive arrangements, with all of those payments being made in accordance with, and as those categories of payments are defined in, the division's 1115 demonstration waiver from the federal centers for medicare and medicaid services to the maximum amount permitted for each category under that waiver;

(C) Maintenance of payments for graduate medical education of at least forty-eight million dollars ($48,000,000);

(D) Unless otherwise addressed in a separate appropriation for FY 2024-2025, maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(E) Avoidance of coverage limitations relative to the number of hospital inpatient days per year or the annual cost of hospital services for a division enrollee;

(F) Avoidance of coverage limitations relative to the number of nonemergency outpatient visits per year for a division enrollee;

(G) Avoidance of coverage limitations relative to the number of physician office visits per year for a division enrollee;

(H) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a division enrollee;

(I) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services;

(J) In the total amount of five hundred ninety thousand seven hundred seventy dollars ($590,770) to maintain reimbursement at the same emergency care rate as in FY 2023-2024 for nonemergent care to children twelve (12) to twenty-four (24) months of age;

(K) In the total amount of two million one hundred eleven thousand four hundred dollars ($2,111,400) to the division to offset the elimination of the provision in the division's managed care contractor risk agreements for hospitals as follows: CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B

program give the division MCOs the benefit of 340B pricing; provided, however, if the division obtains approval from CMS for the adjustment to the budget neutrality agreement, as set forth in § 71-5-2003(b)(1)(B), the expenditure authorized by this subdivision (d)(1)(K) is twenty million, five hundred seventy-nine thousand nine hundred dollars ($20,579,900);

(L) In the total amount of one hundred seventy-five thousand dollars ($175,000) to offset a portion of the hospital cost of providing admissions, discharge, and transfer (ADT) messages to the division to support the division's Patient Centered Medical Home initiative;

(M) In the total amount of one million four hundred twenty-six thousand seven hundred dollars ($1,426,700) to provide funding for stipends for physicians and other healthcare providers who commit to work in designated medically underserved areas in this state; and

(N) In the amount of three million dollars ($3,000,000) to offset the unreimbursed cost of charity care for critical access hospitals to be funded from funds remaining in the trust fund as of June 30, 2024;

(2) Directed payments to hospitals for providing services to division patients and the uninsured, as approved by CMS and as set forth in this subdivision (d)(2):

(A) Directed payments to hospitals will be made based on claims paid with the division's utilization and encounter data from the managed care organizations during each quarter of FY 2024-2025. A directed payment must be in an amount set by the division in consultation with the Tennessee Hospital Association and dependent on funding available through this section. The directed payment must include a quality program designed and implemented with the partnership and cooperation of the division and the Tennessee Hospital Association;

(B) If CMS does not approve either the structure of directed payments set forth in subdivision (d)(2)(A) or provide a budget neutrality adjustment, then payments required by this subdivision (d)(2) must be in accordance with this subdivision (d)(2)(B). Directed payments to hospitals must be based on the claims paid to covered hospitals from the managed care organizations during each quarter of FY 2024-2025. Each covered hospital is entitled to payments for FY 2024-2025 for providing services to division enrollees. The amount of payment to covered hospitals must be no less than thirty-seven percent (37%) of unreimbursed division costs for all hospitals licensed by the state that reported division charges, revenue, and total expenses on the 2022 JAR, excluding state-owned hospitals. As used in this subdivision (d)(2)(B), ''unreimbursed division costs'' means the excess of the division costs over the division's net revenue. The division's charges and net revenue are calculated using data from Schedule E, items (A)(l)(e) and (A)(l)(f), from the hospital's 2022 JAR filed with the department of health. As used in this subdivision (d)(2)(B), ''division costs'' means the quotient of a facility's cost-to-charge ratio, calculated as B(3) (total expenses) divided by A(3)(e) (total gross patient charges) from Schedule E of the 2022 JAR, multiplied by the division's charges;

(C) If CMS does not approve directed payments to hospitals set forth in either subdivision (d)(2)(A) or (d)(2)(B), but instead approves hospital supplemental pools in the division waiver, then payments must be made from the allocated pools to covered hospitals to offset losses incurred in providing services to division enrollees as first priority before any other supplemental payments authorized in the division waiver are distributed;

(D) The payments required by this subdivision (d)(2) must be made in four (4) equal installments. The division shall provide to the Tennessee Hospital Association a schedule showing the payments to each hospital at least seven (7) days in advance of the payments;

(E) Payments required by this subdivision (d)(2) may be made by the division directly or by the division managed care organizations with the direction to make payments to hospitals, or by a designee approved by the division, as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(2) are not part of the reimbursement a hospital is entitled to under its contract with a division managed care organization;

(F) In addition to the items and expenditures set forth in subdivisions (d)(1) and (2), other programs and initiatives developed by the division, in consultation with the Tennessee Hospital Association, to offset the unreimbursed costs of providing services to division enrollees and the financial consequences of the public health emergency. The state portion of the funding for programs and initiatives developed under this subdivision (d)(2)(F) must be used to obtain federal matching funds to raise funds up to three hundred fifty million dollars ($350,000,000);

(G) Refunds, in proportion to the amount paid in, to covered hospitals based on:

(i) The payment of annual coverage assessments or penalties to the division through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; or

(ii) Circumstances where the division, in consultation with the Tennessee Hospital Association, has determined a lower

coverage assessment would have been required to carry out the purposes of subdivisions (d)(1) and (2); and

(H) Payments authorized under rules promulgated by the division pursuant to § 71-5-2004(j)(2);

(3) Administrative funding to the division for six (6) full-time state employees to assist with implementation, operationalization, and ongoing management of hospital payment programs in the amount of three hundred eighty-two thousand four hundred dollars ($382,400); and

(4) Funding from the trust fund or assessment to offset any public hospital funding shortfalls for state directed payments.

(e) The division shall modify the contracts with the division managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(f) The division shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, and an applicable Section 1115 demonstration project, as necessary, to implement this part.

(g) At quarterly intervals beginning September 1, 2024, the division shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, to the health committee of the house of representatives, and to the legislative librarian. The report must include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-2003(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(h) Notwithstanding another law, no part of the maintenance of coverage trust fund must be diverted to the general fund or used for a purpose other than as set forth in this part.

71-5-2006. Expiration of part — Survival of certain rights and obligations.

This part expires on July 1, 2025. However, the following rights and obligations survive the expiration:

(1) The authority of the division to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for a declaratory order to determine compliance with this part;

(3) The existence of the maintenance of coverage trust fund and the obligation of the division to use and apply the assets of the maintenance of coverage trust fund; and

(4) The obligation of the division to implement and maintain the requirements of § 71-5-161.

71-5-2007. Audit of expenditure of funds from maintenance of coverage trust fund.

The comptroller of the treasury may audit the expenditure of funds pursuant to this part from the maintenance of coverage trust fund. At the discretion of the comptroller of the treasury, the audit may be prepared by a certified public accountant, a public accountant, or the department of audit. Notwithstanding § 71-5-2005, the division and the maintenance of coverage trust fund must bear the full costs of the audit.

SECTION 2. Tennessee Code Annotated, Section 71-5-161, is amended by adding the following as a new subsection:

(g) The requirements of this section are not applicable in any state fiscal year or portion thereof that is subject to an adjustment to the state's budget neutrality agreement and in which CMS has approved the hospital coverage assessment base.

SECTION 3. Tennessee Code Annotated, Section 71-5-2005(d), is amended by adding the following as new subdivisions:

(8) In addition to expenditures otherwise authorized by this subsection (d), payments to hospitals for uncompensated care in providing services to division enrollees, the state portion of which will be up to seven million five hundred ninety-three thousand three hundred dollars ($7,593,300); and

(9) Administrative funding to the division for six (6) full-time state employees to assist with implementation, operationalization, and ongoing management of hospital payment programs in the amount of three hundred eighty-two thousand four hundred dollars ($382,400).

SECTION 4. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 5. SECTIONS 2 and 3 of this act take effect upon becoming a law, the public welfare requiring it. SECTION 1 and SECTION 4 of this act take effect June 30, 2024, at 11:59 p.m., the public welfare requiring it.