HOUSE BILL 941

By Alexander

AN ACT to amend Tennessee Code Annotated, Title 71, Chapter 5 and Chapter 877 of the Public Acts of 2014, relative to the annual coverage assessment.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part to be appropriately designated:

71-5-701. This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2015."

71-5-702. As used in this part, unless the context otherwise requires:

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

(2) "Annual coverage assessment base" is a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008 on file with the centers for medicare and medicaid services (CMS) as of September 30, 2009, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2008 on file with CMS as of September 30, 2009, but does have a full twelve-month medicare cost report for 2008 on file as of September 30, 2010, the twelve-month medicare cost report for 2008 on file with CMS as of September 30, 2010, will be the annual coverage assessment base;

(B) If a covered hospital does not have a full twelve-month medicare cost report on file with CMS for 2008, but does have a medicare cost report on file with CMS for 2009, that medicare cost report will be the annual coverage assessment base. If the covered hospital's 2009 medicare cost report is for a

partial year only, the net patient revenue in such medicare cost report shall be annualized to determine the hospital's annual coverage assessment base;

(C) If a covered hospital was first licensed in 2010 or later and did not replace an existing hospital, the annual coverage assessment base is the covered 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 services and development agency;

(D) If a covered hospital was first licensed in 2010 or later and replaced an existing hospital, the annual coverage assessment base shall be the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008 on file with CMS as of September 30, 2009, subject to the qualifications of subdivisions (2)(A) and (2)(B);

(E) If a covered hospital is not required to file an annual medicare cost report with CMS, then its annual coverage assessment base shall be its net patient revenue for the fiscal year ending during calendar year 2008 or the first fiscal year that the hospital was in operation, if after 2008, as shown in the covered hospital's joint annual report filed with the department of health; and

(F) If a covered hospital's fiscal year 2008 medicare cost report is not contained in the centers for medicare and medicaid services' healthcare cost report information system file dated September 30, 2009, and does not meet any of the other qualifications listed in subdivisions (2)(A)–(E), then the hospital shall submit a copy of the hospital's 2008 medicare cost report to the bureau of TennCare in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2014-2015 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) “Controlling person” means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. Indirect or direct ownership of ten percent (10%) or more of a covered hospital shall constitute control;

(6) “Covered hospital” means a hospital licensed under title 33 or title 68, as of the effective date of this part, except an excluded hospital;

(7) “Excluded hospital” means:

(A) A hospital that has been designated by CMS as a critical access hospital;

(B) A mental health hospital owned by the state of Tennessee;

(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 payors; and

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

(8) “Medicare cost report” means CMS-2552-96, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) “Net patient 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 medicare cost report, excluding long-term care inpatient ancillary revenues.

71-5-703.

(a) There is imposed on each covered hospital licensed as of July 1, 2015, an annual coverage assessment for fiscal year (FY) 2015-2016 as set forth in this part.

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

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation in the TennCare program;

(2) Approval from CMS for the distribution of additional payments to hospitals to offset unreimbursed TennCare costs as set forth in § 71-5-705(d)(2); and

(3) Evidence that the bureau is working to implement the remaining rate changes that will be retroactively effective to July 1, 2014, that establish a floor and ceiling for hospital reimbursement that reduce the amount of variation in reimbursement rates to hospitals for the same or similar services.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate the state funding to the TennCare program. To this end, the annual coverage assessment shall not be effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2015-2016 is less than:

(1) The governor's FY 2015-2016 recommended budget level; plus

(2) All annual appropriations made by the general assembly to the TennCare program for FY 2015-2016, 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 not be used as justification for any TennCare managed care organization (MCO) to implement across the board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2015. To this end, for those rates in effect on July 1, 2015, the bureau 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 either by category or type of provider. The requirements of the preceding sentence shall also apply to services or settings of care that are ancillary to a covered or excluded hospital or physician's primary license, but shall not apply to reductions in benefits or reimbursement for those ancillary services if:

(i) The reductions are different from those items being restored in § 71-5-705(d); and

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

(B) For purposes of this subsection (d), services or settings of care that are ancillary to a covered or excluded hospital or physician's primary license shall include all 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 shall not include any other ancillary services or settings of care. For across the board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements. For purposes of this subsection (d), services or settings of care that are "ancillary" shall mean, but not be limited to, ambulatory surgical facilities, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, and outpatient rehabilitation or skilled nursing services. For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 or 9 and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for Tennessee managed care organizations, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into such individualized, case-by-case good faith negotiations. A 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 implement new managed care techniques.

(3) Notwithstanding the other provisions of this subsection (d), if CMS mandates a TennCare program change or a change is required by federal law that impacts rates and that is required to be implemented by the MCOs in accordance with their contracts, or the annual coverage assessment becomes invalid, then nothing in this part shall prohibit the managed care organizations from implementing any rate changes as may be mandated by TennCare or federal law.

71-5-704.

(a) The annual coverage assessment established for this part shall be four and a quarter percent (4.25%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment shall be paid in equal quarterly installments, with the first quarterly payment due on the fifteenth day of the first month of the first quarter of the state fiscal year after the bureau has obtained the determination and approval from CMS described in § 71-5-703(b). Subsequent installments shall be due on the fifteenth day of the first month of the three (3) successive calendar quarters following the calendar quarter in which the first installment is due.

(c) To facilitate collection of the annual coverage assessment, the bureau shall send to each covered hospital, at least thirty (30) days in advance of each quarterly payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, shall not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its web site.

(d) Failure of a covered hospital to pay a quarterly installment of the annual coverage assessment when due shall result in an imposition of a penalty of five hundred dollars ($500) per day until the installment is paid in full.

(e) If a covered hospital ceases to operate after July 1, 2015, and before July 1, 2016, its total annual coverage assessment shall be equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2015, until July 1, 2016, and the numerator of which is the number of days from July 1, 2015, until the date the Tennessee division of health care facilities has recorded as the date that the hospital ceased operation.

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

(g) If a covered hospital fails to pay a quarterly installment of the annual coverage assessment within thirty (30) days of its due date, the bureau shall report that failure to the department which licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay a quarterly installment of the annual coverage assessment or any refund required by this part shall be considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(h) In addition to the action required by subsection (g), the bureau 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 (h) shall be in the chancery court for Davidson County.

(i)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid source of revenue, or that the methodology for distribution of the additional payments to hospitals from the annual coverage assessment is not valid after an installment has been collected, or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-703(c), or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-703(d), then:

(A) The bureau shall refund to covered hospitals all installment payments previously collected within forty-five (45) days of that event;

(B) No subsequent installments of the annual coverage assessment shall be due and payable; and

(C) Covered hospitals that received payments pursuant to § 71-5-705(d)(2) shall refund to the bureau all of those payments within forty-five (45) days of that event, or shall establish a payment plan that has been approved by the bureau within forty-five (45) days of the event.

(2) The bureau will then have authority to make necessary changes to the TennCare budget to account for the loss of the annual coverage assessment revenue.

(j) A covered hospital or an association, the membership of which includes thirty (30) or more covered hospitals, shall have the right to file a petition for a declaratory

order pursuant to § 4-5-223 to determine if there has been a failure to satisfy one (1) of the conditions precedent to the valid imposition of the annual coverage assessment.

(k) A covered hospital may not increase charges or add a surcharge based on or as a result of the annual coverage assessment.

(l) Notwithstanding any other provision of this part, if the bureau receives from CMS notification of the determination and approval set forth in § 71-5-703(b), and if the determination and approval have retroactive effective dates, then:

(1) Quarterly annual coverage assessment payments that become due by application of the retroactive determination date from CMS shall be paid to the bureau within thirty (30) days of the bureau notifying the Tennessee Hospital Association that CMS has issued the determination; and

(2) Quarterly payments to covered hospitals required by § 71-5-705(d)(2) that become due by application of the retroactive approval date from CMS shall be paid within fifteen (15) days of the bureau notifying the Tennessee Hospital Association that CMS has issued the approval.

71-5-705.

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

(b) The maintenance of coverage trust fund shall continue without interruption and shall be operated in accordance with this section.

(c) The maintenance of coverage trust fund shall consist of:

(1) All annual coverage assessments received by the bureau; and

(2) Investment earnings credited to the assets of the maintenance of coverage trust fund.

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

(1) Expenditure for benefits and services under the TennCare program that would have been subject to reduction or elimination from TennCare funding for FY 2014-2015, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of seven percent (7%) reduction in covered and excluded hospital and professional reimbursement rates described in the governor's FY 2015-2016 recommended budget;

(B) Maintenance of essential access hospital payments to the maximum allowed by CMS under the TennCare waiver of at least one hundred million dollars ($100,000,000);

(C) Maintenance of payments to critical access hospitals to achieve reimbursement of full cost of benefits provided to TennCare enrollees up to sixteen million dollars ($16,000,000);

(D) Maintenance of payments for graduate medical education of at least fifty million dollars ($50,000,000);

(E) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(F) Funding to increase the rates for the lowest paid hospitals to reduce the amount of variation in TennCare hospital rates for the same or similar services;

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

(H) Avoidance of any coverage limitations relative to the number of non-emergency outpatient visits per year for a TennCare enrollee;

(I) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

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

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

(L) Making medicaid disproportionate share hospital payments at the maximum amount authorized by the federal Social Security Act for FY 2015-2016;

(2)

(A) Solely from the annual coverage assessment payments received by the bureau, payments to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(2);

(B) Each covered hospital shall be entitled to payments for FY 2015-2016 of a portion of its unreimbursed cost of providing services to

TennCare enrollees. Unreimbursed TennCare costs are defined as the excess of TennCare cost over TennCare net revenue as reported on Schedule E, items (A)(1)(c) and (A)(1)(d) from the hospital's 2013 joint annual report filed with the department of health. TennCare costs are defined as the product of a facility's cost-to-charge ratio times TennCare charges. The amount of the payment to covered hospitals shall be no less than forty-eight and forty-four hundredths percent (48.44%) of unreimbursed TennCare cost for all hospitals licensed by this state excluding state-owned hospitals;

(C) The payments required by this subdivision (d)(2) shall be made in four (4) equal installments. Each installment payment shall be made by the third business day of four (4) successive calendar quarters, with the first calendar quarter to be the calendar quarter in which the annual coverage assessment is first levied in accordance with § 71-5-704. The bureau shall provide to the Tennessee Hospital Association a schedule showing the quarterly payments to each hospital at least seven (7) days in advance of such payments;

(D) The payments required by this subdivision (d)(2) may be made by the bureau directly to the hospitals or the bureau may transfer the funds to one (1) or more managed care organizations with the direction to make payments to hospitals as required by this subsection. The payments to a hospital pursuant to this subdivision (d)(2) shall not be considered as part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(3) Refunds to covered hospitals on the basis of payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; and

(4)

(A) Solely from funds remaining in the trust fund as of June 30, 2015, payments and expenditures in the TennCare program as follows:

(i) In the total amount of three million dollars ($3,000,000) to critical access hospitals to offset their cost of charity care incurred in FY 2014-2015;

(ii) In the total amount of three million dollars ($3,000,000) to critical access hospitals to offset their cost of charity care incurred in FY 2015-2016;

(iii) In the total amount of seven million five hundred sixty-seven thousand four hundred dollars ($7,567,400) to replace the one percent (1%) reduction in covered and excluded hospital and professional reimbursement rates described in the governor's FY 2015-2016 recommended budget;

(iv) In the total amount of eight million one hundred ninety-nine thousand dollars ($8,199,000) to increase the reimbursement of covered and excluded hospitals and of professionals for services provided in FY 2015-2016 to enrollees covered by TennCare Select;

(v) In the total amount of five hundred eighty-six thousand five hundred dollars ($586,500) to maintain reimbursement at the emergency care rate for nonemergent care to children twelve (12)

to twenty-four (24) months of age to avoid the reduction described in the governor's FY 2015-2016 recommended budget; and

(vi) In the total amount of two million ninety-six thousand one hundred dollars ($2,096,100) to the bureau to offset the elimination of the provision in the 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 TennCare MCOs the benefit of 340B pricing."

(B) Expenditures authorized under this subdivision (d)(4) shall be in addition to expenditures otherwise authorized under subdivisions (d)(1)–(3). The payments to critical access hospitals authorized under subdivisions (d)(4)(A)(i) and (ii) shall be made by the bureau to reimburse a portion of the charity care costs incurred by critical access hospitals.

(e) If a hospital closes or changes status from a covered hospital to an excluded hospital and consequently reduces the amount of the annual coverage assessment such that the amount is no longer sufficient to cover the total cost of the items included in subsection (d), the payments for these items may be adjusted by an amount equal to the shortfall including the federal financial participation. The items to be adjusted and the amounts of the adjustments shall be determined by the bureau in consultation with the hospitals.

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

(g) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, or the TennCare II Section 1115 demonstration project as necessary to implement the requirements of this part.

(h) At quarterly intervals beginning September 1, 2015, the bureau shall submit a report to the finance, ways and means committees of the senate and house of representatives, to the health and welfare committee of the senate and to the health committee of the house of representatives, which report shall include:

(1) The status if applicable of the determination and approval by CMS set forth in § 71-5-703(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.

(i) No part of the maintenance of coverage trust fund shall be diverted to the general fund or used for any purpose other than set forth in this part.

71-5-706. This part shall expire on June 30, 2016; provided, however, that the following rights and obligations shall survive the expiration:

(1) The authority of the bureau 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 declaratory order to determine whether the annual coverage assessment has been validly imposed; and

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

SECTION 2. This act shall take effect July 1, 2015, the public welfare requiring it.