HOSPITAL ASSESSMENTS

2010 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Lyle W. Hillyard

House Sponsor: Kevin S. Garn

LONG TITLE

General Description:

This bill enacts the Hospital Provider Assessment Act in the health code.

Highlighted Provisions:

This bill:

- makes legislative findings;
- defines terms;
- clarifies the application of the chapter;
- establishes the assessment and payment of the hospital provider assessment;
- establishes the calculation of the assessment;
- provides for quarterly assessment and payment;
- establishes a Medicaid inpatient hospital access payment from the division to a hospital;
- provides for penalties if the hospital provider assessment is not paid;
- creates a restricted special revenue fund;
- repeals the assessment if certain events occur;
- creates a Hospital Policy Review Board to review Medicaid state plan amendments that effect hospital reimbursements;
- requires the division to seek approval from the Center for Medicare and Medicaid Services for federal matching based on the hospital provider assessment; and
- repeals the hospital provider assessment on July 1, 2013.

Monies Appropriated in this Bill:

None

Other Special Clauses:

This bill has retrospective operation for taxable years beginning on or after January 1, 2010.

Utah Code Sections Affected:

AMENDS:

63I-1-226, as last amended by Laws of Utah 2009, Chapter 334

ENACTS:

26-36a-101, Utah Code Annotated 1953

26-36a-102, Utah Code Annotated 1953

26-36a-103, Utah Code Annotated 1953

26-36a-201, Utah Code Annotated 1953

26-36a-202, Utah Code Annotated 1953

26-36a-203, Utah Code Annotated 1953

26-36a-204, Utah Code Annotated 1953

26-36a-205, Utah Code Annotated 1953

26-36a-206, Utah Code Annotated 1953

26-36a-207, Utah Code Annotated 1953

26-36a-208, Utah Code Annotated 1953

26-36a-209, Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **26-36a-101** is enacted to read:

CHAPTER 36a. HOSPITAL PROVIDER ASSESSMENT ACT

Part 1. General Provisions

26-36a-101. Title.

This chapter is known as the "Hospital Provider Assessment Act."

Section 2. Section **26-36a-102** is enacted to read:

26-36a-102. Legislative findings.

(1) The Legislature finds that there is an important state purpose to improve the access of Medicaid patients to quality care in Utah hospitals because of continuous decreases in state revenues and increases in enrollment under the Utah Medicaid program.

(2) The Legislature finds that in order to improve this access to those persons described in Subsection (1):

(a) the rates paid to Utah hospitals must be adequate to encourage and support improved access; and

(b) adequate funding must be provided to increase the rates paid to Utah hospitals providing services pursuant to the Utah Medicaid program.

Section 3. Section **26-36a-103** is enacted to read:

26-36a-103. Definitions.

As used in this chapter:

(1) "Assessment" means the Medicaid hospital provider assessment established by this chapter.

(2) "Discharges" means the number of total hospital discharges reported on worksheet S-3, column 15, lines 12, 14, and 14.01 of the Medicare Cost Report for the applicable assessment year.

(3) "Division" means the Division of Health Care Financing of the department.

(4) "Hospital":

(a) means a privately owned:

(i) general acute hospital operating in the state as defined in Section 26-21-2; and

(ii) specialty hospital operating in the state, which shall include a privately owned hospital whose inpatient admissions are predominantly:

(A) rehabilitation;

(B) psychiatric;

(C) chemical dependency; or

(D) long-term acute care services; and

(b) does not include:

(i) a residential care or treatment facility as defined in Section 62A-2-101;

(ii) a hospital owned by the federal government, including the Veterans Administration Hospital;

(iii) a Shriners hospital that does not charge for its services; or

(iv) a hospital that is owned by the state government, a state agency, or a political subdivision of the state, including:

(A) a state-owned teaching hospital; and

(B) the Utah State Hospital.

(5) "Low volume select access hospital" means a hospital that furnished inpatient hospital services during fiscal year 2008 to less than 300 Medicaid cases under the select access program.

(6) "Medicare cost report" means CMS-2552-96, the cost report for electronic filing of hospitals.

(7) "Select access cases" means the number of hospital inpatient cases related to individuals enrolled in the state's select access program for 2008.

(8) "State plan amendment" means a change or update to the state Medicaid plan.

(9) "Upper payment limit" means the maximum ceiling imposed by federal regulation on a hospital Medicaid reimbursement for inpatient services under 42 C.F.R. Sec. 447.272.

(10) "Upper payment limit gap":

(a) means the difference between:

(i) the inpatient hospital upper payment limit for hospitals; and

(ii) Medicaid payments for inpatient hospital services not financed using hospital assessments paid by all hospitals;

(b) shall be calculated separately for hospital inpatient services; and

(c) does not include Medicaid disproportionate share payments as part of the calculation for the upper payment limit gap.

Section 4. Section **26-36a-201** is enacted to read:

Part 2. Application of Chapter

26-36a-201. Application of chapter.

(1) Other than for the imposition of the assessment described in this chapter, nothing in this chapter shall affect the nonprofit or tax exempt status of any nonprofit charitable, religious, or educational health care provider under:

(a) Section 501(c), as amended, of the Internal Revenue Code;

(b) other applicable federal law;

(c) any state law;

(d) any ad valorem property taxes;

(e) any sales or use taxes; or

(f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by the state or any political subdivision, county, municipality, district, authority, or any agency or department thereof.

(2) All assessments paid under this chapter may be included as an allowable cost of a hospital for purposes of any applicable Medicaid reimbursement formula.

(3) This chapter does not authorize a political subdivision of the state to:

(a) license a hospital for revenue;

(b) impose a tax or assessment upon hospitals; or

(c) impose a tax or assessment measured by the income or earnings of a hospital.

Section 5. Section **26-36a-202** is enacted to read:

26-36a-202. Assessment, collection, and payment of hospital provider assessment.

(1) A uniform, broad based, assessment is imposed on each hospital as defined in Subsection 26-36a-103(4)(a):

(a) in the amount designated in Section 26-36a-203; and

(b) in accordance with Section 26-36a-204, beginning when the division has obtained approval from the Center for Medicare and Medicaid Services and provided notice of the assessment to the hospital.

(2) (a) The assessment imposed by this chapter is due and payable on a quarterly basis in accordance with Section 26-36a-204.

(b) The collecting agent for this assessment is the department which is vested with the administration and enforcement of this chapter, including the right to adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(i) implement and enforce the provisions of this act; and

(ii) audit records of a facility:

(A) that is subject to the assessment imposed by this chapter; and

(B) does not file a Medicare cost report.

(c) The department shall forward proceeds from the assessment imposed by this chapter to the state treasurer for deposit in the restricted special revenue fund as specified in Section 26-36a-207.

(3) The department may, by rule, extend the time for paying the assessment.

Section 6. Section **26-36a-203** is enacted to read:

26-36a-203. Calculation of assessment.

(1) The division shall calculate the inpatient upper payment limit gap for hospitals for each state fiscal year.

(2) (a) An annual assessment is payable on a quarterly basis for each hospital in an amount calculated at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed hospitals divided into the total non-federal portion of the upper payment limit gap.

(c) Any quarterly changes to the uniform assessment rate must be applied uniformly to all assessed hospitals.

(d) (i) Except as provided in Subsection (2)(d)(ii), the annual uniform assessment rate may not generate more than the non-federal share of the annual upper payment limit gap for the fiscal year.

(ii) (A) For fiscal year 2010 the assessment may not generate more than the

non-federal share of the annual upper payment limit gap for the fiscal year.

(B) For fiscal year 2010-11 the department may generate an additional amount from the assessment imposed under Subsection (2)(d)(i) in the amount of $2,000,000 which shall be used by the department and the division as follows:

(I) $1,000,000 to offset Medicaid mandatory expenditures; and

(II) $1,000,000 to offset the reduction in hospital outpatient fees in the state program.

(C) For fiscal years 2011-12 and 2012-13 the department may generate an additional amount from the assessment imposed under Subsection (2)(d)(i) in the amount of $1,000,000 to offset Medicaid mandatory expenditures.

(3) (a) For state fiscal years 2010 and 2011, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file as of April 1, 2009 for hospital fiscal years ending between October 1, 2007, and September 30, 2008.

(b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated March 31, 2009:

(i) the hospital shall submit to the division a copy of the hospital's Medicare Cost Report with a fiscal year end between October 1, 2007, and September 30, 2008; and

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(b)(i).

(c) If a hospital started operations after the due date for a 2007 Medicare Cost Report:

(i) the hospital shall submit to the division a copy of the hospital's most recent complete year Medicare Cost Report; and

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(c)(i).

(d) If a hospital is not certified by the Medicare program and is not required to file a Medicare Cost Report:

(i) the hospital shall submit to the division its applicable fiscal year discharges with

supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (3)(d)(i); and

(iii) the failure to submit discharge information under Subsections (3)(d)(i) and (ii) shall result in an audit of the hospital's records by the department and the imposition of a penalty equal to 5% of the calculated assessment.

(4) (a) For state fiscal year 2012 and 2013, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file as of:

(i) for state fiscal year 2012, September 30, 2010, for hospital fiscal years ending between October 1, 2008, and September 30, 2009; and

(ii) for state fiscal year 2013, September 30, 2011, for hospital fiscal years ending between October 1, 2009, and September 30, 2010.

(b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file:

(i) the hospital shall submit to the division a copy of the hospital's Medicare Cost Report applicable to the assessment year; and

(ii) the division shall determine the hospital's discharges.

(c) If a hospital is not certified by the Medicare program and is not required to file a Medicare Cost Report:

(i) the hospital shall submit to the division its applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (4)(c)(i); and

(iii) the failure to submit discharge information shall result in an audit of the hospital's records and a penalty equal to 5% of the calculated assessment.

(5) Except as provided in Subsection (6), if a hospital is owned by an organization that owns more than one hospital in the state:

(a) the assessment for each hospital shall be separately calculated by the department; and

(b) each separate hospital shall pay the assessment imposed by this chapter.

(6) Notwithstanding the requirement of Subsection (5), if multiple hospitals use the same Medicaid provider number:

(a) the department shall calculate the assessment in the aggregate for the hospitals using the same Medicaid provider number; and

(b) the hospitals may pay the assessment in the aggregate.

(7) (a) The assessment formula imposed by this section, and the inpatient access payments under Section 26-36a-205, shall be adjusted in accordance with Subsection (7)(b) if a hospital, for any reason, does not meet the definition of a hospital subject to the assessment under Section 26-36a-103 for the entire fiscal year.

(b) The department shall adjust the assessment payable to the department under this chapter for a hospital that is not subject to the assessment for an entire fiscal year by multiplying the annual assessment calculated under Subsection (3) or (4) by a fraction, the numerator of which is the number of days during the year that the hospital operated, and the denominator of which is 365.

(c) A hospital described in Subsection (7)(a):

(i) that is ceasing to operate in the state, shall pay any assessment owed to the department immediately upon ceasing to operate in the state; and

(ii) shall receive Medicaid inpatient hospital access payments under Section 26-36a-205 for the state fiscal year, adjusted using the same formula described in Subsection (7)(b).

(8) A hospital that is subject to payment of the assessment at the beginning of a state fiscal year, but during the state fiscal year experiences a change in status so that it no longer falls under the definition of a hospital subject to the assessment in Section 26-36a-204, shall:

(a) not be required to pay the hospital assessment beginning on the date established by the department by administrative rule; and

(b) not be entitled to Medicaid inpatient hospital access payments under Section 26-36a-205 on the date established by the department by administrative rule.

Section 7. Section **26-36a-204** is enacted to read:

26-36a-204. Quarterly notice -- Collection.

(1) (a) The division shall submit to the Center for Medicare and Medicaid Services:

(i) the payment methodology for the assessment imposed by this chapter; and

(ii) if necessary, a waiver under 42 C.F.R. Sec. 433.68.

(b) When the division receives notice of approval of the assessment and access payments under this chapter from the Center for Medicare and Medicaid Services, the division shall, within 45 days of the notice from the Center for Medicare and Medicaid Services, provide a hospital that is subject to the assessment notice of:

(i) the approval of the assessment methodology from the Center for Medicare and Medicaid Services;

(ii) the assessment rate;

(iii) the hospital's discharges subject to the assessment; and

(iv) the assessment amount owed by the hospital for the applicable fiscal year.

(2) The initial quarterly installments of the assessment imposed by this chapter are due and payable if:

(a) the division has provided notice of the annual assessment under Subsection (1); and

(b) the division has made all the quarterly installments of the Medicaid inpatient hospital access payments that were otherwise due under Section 26-36a-205, consistent with the effective date of the approved state plan amendment.

(3) After the initial quarterly installments of the Medicaid inpatient hospital access payments are made by the division, a hospital shall pay to the division the initial quarterly assessments imposed by this chapter within 10 business days. Subsequent quarterly assessments imposed by this chapter shall be paid to the division within 10 business days after the hospital receives its Medicaid inpatient hospital access payment due for the applicable

quarter under Section 26-36a-205.

Section 8. Section **26-36a-205** is enacted to read:

26-36a-205. Medicaid hospital inpatient access payments.

(1) To preserve and improve access to hospitals, the division shall make Medicaid inpatient hospital access payments to hospitals in accordance with this section, Section 26-36a-204, and Subsection 26-36a-203(7).

(2) (a) The Medicaid inpatient hospital access payment amount to a particular hospital shall be established by the division.

(b) The aggregate of all hospital's Medicaid inpatient hospital access payments shall be:

(i) equal to the upper payment limit gap for inpatient services for all hospitals; and

(ii) designated as the Medicaid inpatient hospital access payment pool.

(3) In addition to any other funds paid to hospitals during fiscal years 2010 and 2011 for inpatient hospital services to Medicaid patients, a Medicaid hospital inpatient access payment shall be made:

(a) for state fiscal years 2010 and 2011:

(i) the amount of $825 per Medicaid fee for service day, to a hospital that:

(A) was not a specialty hospital; and

(B) had less than 300 select access inpatient cases during state fiscal year 2008; and

(ii) inpatient hospital access payments as determined by dividing the remaining spending room available in the current year UPL, after offsetting the payments authorized under Subsection (3)(a)(i) by the total 2008 Medicaid inpatient hospital payments, multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2008, exclusive of medical education and Medicaid disproportionate share payments;

(b) for state fiscal year 2012, using state fiscal year 2009 paid Medicaid inpatient claims data; and

(c) for state fiscal year 2013, using state fiscal year 2010 paid Medicaid inpatient claims data.

(4) For both state fiscal years 2012 and 2013, the division shall submit adjustments to the payment rates in Subsection (3)(a) to the Hospital Policy Review Board for their review.

(5) Medicaid inpatient hospital access payments shall be made:

(a) on a quarterly basis for inpatient hospital services furnished to Medicaid individuals during each quarter; and

(b) within 15 days after the end of each quarter.

(6) A hospital's Medicaid inpatient access payment shall not be used to offset any other payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries, including a:

(a) fee-for-service payment;

(b) per diem payment;

(c) hospital inpatient adjustment; or

(d) cost settlement payment.

(7) A hospital shall not be guaranteed that the hospital's Medicaid inpatient hospital access payments will equal or exceed the amount of the hospital's assessment.

Section 9. Section **26-36a-206** is enacted to read:

26-36a-206. Penalties and interest.

(1) A facility that fails to pay any assessment or file a return as required under this chapter, within the time required by this chapter, shall pay, in addition to the assessment, penalties and interest established by the department.

(2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish reasonable penalties and interest for the violations described in Subsection (1).

(b) If a hospital fails to timely pay the full amount of a quarterly assessment, the department shall add to the assessment:

(i) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and

(ii) on the last day of each quarter after the due date until the assessed amount and the

penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

(A) any unpaid quarterly assessment; and

(B) any unpaid penalty assessment.

(c) The division may waive, reduce, or compromise the penalties and interest provided for in this section in the same manner as provided in Subsection 59-1-401(8).

Section 10. Section **26-36a-207** is enacted to read:

26-36a-207. Restricted Special Revenue Fund -- Creation -- Deposits.

(1) There is created a restricted special revenue fund known as the "Hospital Provider Assessment Special Revenue Fund."

(2) The fund shall consist of:

(a) the assessments collected by the department under this chapter;

(b) any interest and penalties levied with the administration of this chapter; and

(c) any other funds received as donations for the restricted fund and appropriations from other sources.

(3) Money in the fund shall be used:

(a) to make inpatient hospital access payments under Section 26-36a-205; and

(b) to reimburse money collected by the division from a hospital through a mistake made under this chapter.

Section 11. Section **26-36a-208** is enacted to read:

26-36a-208. Repeal of assessment.

(1) The repeal of the assessment imposed by this chapter shall occur upon the certification by the executive director of the department that the sooner of the following has occurred:

(a) the effective date of any action by Congress that would disqualify the assessment imposed by this chapter from counting towards state Medicaid funds available to be used to determine the federal financial participation;

(b) the effective date of any decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal

government that has the effect of:

(i) disqualifying the assessment from counting towards state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(ii) creating for any reason a failure of the state to use the assessments for the Medicaid program as described in this chapter; and

(c) the effective date of:

(i) an appropriation for any state fiscal year from the General Fund for hospital payments under the state Medicaid program that is less than the amount appropriated for state fiscal year 2011;

(ii) the annual revenues of the state General Fund budget return to the level that was appropriated for fiscal year 2008;

(iii) approval of any change in the state Medicaid plan that requires a greater percentage of Medicaid patients to enroll in Medicaid managed care plans than what is required on January 1, 2010;

(iv) a division change in rules that reduces any of the following below July 1, 2010 payments:

(A) aggregate hospital inpatient payments;

(B) adjustment payment rates; or

(C) any cost settlement protocol; or

(v) a division change in rules that reduces the aggregate outpatient payments below July 1, 2011 payments.

(2) If the assessment is repealed under Subsection (1), money in the fund that was derived from assessments imposed by this chapter, before the determination made under Subsection (1), shall be disbursed under Section 26-36a-205 to the extent federal matching is not reduced due to the impermissibility of the assessments. Any funds remaining in the special revenue fund shall be refunded to the hospitals in proportion to the amount paid by each hospital.

Section 12. Section **26-36a-209** is enacted to read:

26-36a-209. State plan amendment -- Hospital Policy Review Board.

(1) The division shall file with the Center for Medicare and Medicaid Services a state plan amendment to implement the requirements of this chapter, including the payment of hospital access payments under Section 26-36a-205 no later than 45 days after the effective date of this chapter.

(2) If the state plan amendment is not approved by the Center for Medicare and Medicaid Services, the division shall:

(a) not implement the assessment imposed under this chapter; and

(b) return any assessment fees to the hospitals that paid the fees if assessment fees have been collected.

(3) (a) The department shall establish an advisory board that is the Hospital Policy Review Board.

(b) The board shall have five members selected as follows:

(i) one member appointed by the governor from a list of names submitted by the Utah Hospitals and Health Systems Association;

(ii) two members appointed by the president of the Senate from a list of names submitted by the Utah Hospitals and Health Systems Association; and

(iii) two members appointed by the speaker of the House from a list of names submitted by the Utah Hospitals and Health Systems Association.

(c) Members of the board may not be compensated for their services on the board or receive reimbursement for costs or per diem expenses.

(d) If a selection is not made by the governor, the speaker of the House, or the president of the Senate within 60 days after the names are submitted by the Utah Hospitals and Health Systems Association, the member shall be appointed by the Utah Hospitals and Health Systems Association.

(e) (i) The board shall review state Medicaid plan amendments or waivers affecting hospital reimbursement between the date of enactment of this chapter and the end of state fiscal year 2013.

(ii) A majority of the board is a quorum.

(f) The department may not amend the state Medicaid plan or any waiver affecting hospital reimbursement without submitting the amendment or waiver to the board for review.

Section 13. Section **63I-1-226** is amended to read:

63I-1-226. Repeal dates, Title 26.

(1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July 1, 2015.

(2) Section 26-18-12, Expansion of 340B drug pricing programs, is repealed July 1, 2013.

(3) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2014.

(4) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed July 1, 2011.

(5) Title 26, Chapter 36a, Hospital Provider and Assessment Act, is repealed July 1, 2013.

Section 14. **Retrospective operation.**

This bill has retrospective operation for taxable years beginning on or after January 1, 2010.