

1 **REAUTHORIZATION OF HOSPITAL PROVIDER**

2 **ASSESSMENT ACT**

3 2016 GENERAL SESSION

4 STATE OF UTAH



5
6 **LONG TITLE**

7 **General Description:**

8 This bill re-authorizes the Hospital Provider Assessment Act.

9 **Highlighted Provisions:**

10 This bill:

- 11 ▶ amends the repeal of the assessment;
- 12 ▶ extends the sunset of the assessment; and
- 13 ▶ makes technical amendments.

14 **Money Appropriated in this Bill:**

15 None

16 **Other Special Clauses:**

17 None

18 **Utah Code Sections Affected:**

19 AMENDS:

20 **26-36a-203**, as last amended by Laws of Utah 2013, Chapter 32

21 **26-36a-208**, as last amended by Laws of Utah 2013, Chapter 32

22 **63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258



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

25 Section 1. Section **26-36a-203** is amended to read:

26 **26-36a-203. Calculation of assessment.**

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

30 (b) The uniform assessment rate shall be determined using the total number of hospital
31 discharges for assessed hospitals divided into the total non-federal portion in an amount

32 consistent with Section 26-36a-205 that is needed to support capitated rates for accountable
33 care organizations for purposes of hospital services provided to Medicaid enrollees.

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

36 (d) The annual uniform assessment rate may not generate more than:

37 (i) \$1,000,000 to offset Medicaid mandatory expenditures; and

38 (ii) the non-federal share to seed amounts needed to support capitated rates for
39 accountable care organizations as provided for in Subsection (1)(b).

40 (2) (a) For each state fiscal year, discharges shall be determined using the data from
41 each hospital's Medicare Cost Report contained in the Centers for Medicare and Medicaid
42 Services' Healthcare Cost Report Information System file. The hospital's discharge data will be
43 derived as follows:

44 (i) for state fiscal year 2013, the hospital's cost report data for the hospital's fiscal year
45 ending between July 1, 2009, and June 30, 2010;

46 (ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year
47 ending between July 1, 2010, and June 30, 2011;

48 (iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year
49 ending between July 1, 2011, and June 30, 2012; [~~and~~]

50 (iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year
51 ending between July 1, 2012, and June 30, 2013[~~;~~]; and

52 (vi) for each subsequent state fiscal year, the hospital's cost report data for the
53 hospital's fiscal year that ended in the state fiscal year two year's prior to the assessment fiscal
54 year.

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

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

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

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

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

63 supporting documentation;

64 (ii) the division shall determine the hospital's discharges from the information
65 submitted under Subsection (2)(c)(i); and

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

68 (3) Except as provided in Subsection (4), if a hospital is owned by an organization that
69 owns more than one hospital in the state:

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

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

73 (4) Notwithstanding the requirement of Subsection (3), if multiple hospitals use the
74 same Medicaid provider number:

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

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

78 Section 2. Section **26-36a-208** is amended to read:

79 **26-36a-208. Repeal of assessment.**

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

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

86 (b) the effective date of any decision, enactment, or other determination by the
87 Legislature or by any court, officer, department, or agency of the state, or of the federal
88 government that has the effect of:

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

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

93 (c) the effective date of:

94 (i) an appropriation for any state fiscal year from the General Fund for hospital
 95 payments under the state Medicaid program that is less than the amount appropriated for state
 96 fiscal year 2012;

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

99 ~~[(iii) approval of any change in the state Medicaid plan that requires a greater
 100 percentage of Medicaid patients to enroll in Medicaid managed care plans than what is
 101 required:]~~

102 ~~[(A) to implement accountable care organizations in the state plan; and]~~

103 ~~[(B) by other managed care enrollment requirements in effect on or before January 1,
 104 2012;]~~

105 ~~[(iv)]~~ (iii) a division change in rules that reduces any of the following below July 1,
 106 2011 payments:

107 (A) aggregate hospital inpatient payments;

108 (B) adjustment payment rates; or

109 (C) any cost settlement protocol; or

110 ~~[(v)]~~ (iv) a division change in rules that reduces the aggregate outpatient payments
 111 below July 1, 2011 payments; and

112 (d) the sunset of this chapter in accordance with Section 63I-1-226.

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

119 Section 3. Section **63I-1-226** is amended to read:

120 **63I-1-226. Repeal dates, Title 26.**

121 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
 122 1, 2025.

123 (2) Section 26-10-11 is repealed July 1, 2020.

124 (3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed

125 July 1, 2018.

126 (4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.

127 (5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, [~~2016~~]

128 2019.

129 (6) Section 26-38-2.5 is repealed July 1, 2017.

130 (7) Section 26-38-2.6 is repealed July 1, 2017.

131 (8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.