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 3. Section **26-36a-203** is amended 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)~~] (1) (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 nonfederal portion [~~of the upper payment limit gap~~] in an amount **Ŝ→ [~~equal to the $154 million~~] consistent with 26-36a-205 ←Ŝ** that is needed to support capitated rates for accountable care organizations for purposes of hospital services provided to Medicaid

[~~(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 4. Section **26-36a-204** is amended 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~~]

Quarterly assessments imposed by this chapter shall be paid to the division within [~~10~~] 15 business days after the [~~hospital receives its Medicaid inpatient hospital access payment due for the applicable quarter under Section 26-36a-205~~] **§➔ original invoice ←§** date that appears on the invoice issued by

the division.

Section 5. Section **26-36a-205** is amended to read:

26-36a-205. Medicaid hospital adjustment under accountable care organization rates.

[~~(1)~~] To preserve and improve access to [~~hospitals~~] hospital services, 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)~~], for accountable care organization rates effective on or after April 1, 2013, incorporate an Ŝ→ **annualized** ←Ŝ amount equal to $154 million into the accountable care organization rate structure Ŝ→ **calculation** ←Ŝ consistent with the certified actuarial rate range.

[~~(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:~~]

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

[~~(A) is not a specialty hospital; and~~]

[~~(B) has less than 300 select access inpatient cases during the state fiscal year 2008;~~]

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

(a) to support capitated rates Ŝ→ **consistent with 26-36a-203(1)(d)** ←Ŝ for accountable care organizations Ŝ→ **[~~in an amount equal to $154 million~~]** ←Ŝ ; and

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

Section 8. Section **26-36a-208** is amended 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 2012;

(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:

(A) to implement accountable care organizations in the state plan; and

(B) by other managed care enrollment requirements in effect on or before January 1,