HOSPITAL ASSESSMENT AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Lyle W. Hillyard

House Sponsor: Brad R. Wilson

LONG TITLE

General Description:

This bill amends the Hospital Provider Assessment Act.

Highlighted Provisions:

This bill:

- defines terms;
- modifies the calculation of the annual assessment;
- modifies the manner in which a hospital's discharge data is derived;
- requires the Division of Health Care Financing of the Department of Health to incorporate $154 million into the accountable care organization rate structure;
- grants rulemaking authority to the Department of Health over the penalties and interest assessed under the Act;
- repeals the assessment on July 1, 2016; and
- makes technical changes.

Money Appropriated in this Bill:

This bill appropriates in fiscal year 2013:

- to Department of Health - Medicaid Mandatory Services:
  - from Hospital Provider Assessment Special Revenue Fund, $6,300,600.

This bill appropriates in fiscal year 2014:

- to Department of Health - Medicaid Mandatory Services, as an ongoing appropriation:
  - from Hospital Provider Assessment Special Revenue Fund, $5,500,000.

Other Special Clauses:

If approved by two-thirds of all the members elected to each house, this bill takes effect on April 1, 2013.

Utah Code Sections Affected:

AMENDS:

26-36a-103, as enacted by Laws of Utah 2010, Chapter 179

26-36a-202, as enacted by Laws of Utah 2010, Chapter 179

26-36a-203, as last amended by Laws of Utah 2012, Chapter 348

26-36a-204, as enacted by Laws of Utah 2010, Chapter 179

26-36a-205, as last amended by Laws of Utah 2012, Chapter 348

26-36a-206, as enacted by Laws of Utah 2010, Chapter 179

26-36a-207, as enacted by Laws of Utah 2010, Chapter 179

26-36a-208, as last amended by Laws of Utah 2011, Chapter 118

63I-1-226, as last amended by Laws of Utah 2012, Chapters 171 and 328

REPEALS:

26-36a-209, as last amended by Laws of Utah 2012, Chapter 348

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

Section 1. Section **26-36a-103** is amended 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 Part I, column 15, lines 12, 14, and 14.01 of the 2552-96 Medicare Cost Report or on Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 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; or

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

[~~(iv)~~] (iii) 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)~~] (5) "Medicare cost report" means CMS-2552-96 or CMS-2552-10, 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)~~] (6) "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.~~]

(7) "Accountable care organization" means a managed care organization, as defined in 42 C.F.R. Sec. 438, that contracts with the department under the provisions of Section 26-18-405.

Section 2. Section **26-36a-202** is amended 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 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 non-federal portion [~~of the upper payment limit gap~~] in an amount consistent with Section 26-36a-205 that is needed to support capitated rates for accountable care organizations for purposes of hospital services provided to Medicaid enrollees.

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

(d) [~~(i) Except as provided in Subsection (2)(d)(ii), the~~] 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) 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:~~]

[~~(A)~~] (i) $1,000,000 to offset Medicaid mandatory expenditures; and

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

[~~(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)~~] (2) (a) For each 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~~]. The hospital's discharge data will be derived as follows:

[~~(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.~~]

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

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

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

(iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012, and June 30, 2013.

(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)~~] (2)(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)~~] (3) Except as provided in Subsection [~~(6)~~] (4), 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)~~] (4) Notwithstanding the requirement of Subsection [~~(5)~~] (3), 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 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 annualized amount equal to $154 million into the accountable care organization rate structure calculation 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; and~~]

[~~(ii) inpatient hospital access payments as determined by dividing the remaining spending room available in the current year upper payment limit, after offsetting the payments authorized under Subsection (3)(a)(i), by the total 2009 Medicaid inpatient hospital payments, multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2009; and~~]

[~~(c) for state fiscal year 2013:~~]

[~~(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; and~~]

[~~(ii) inpatient hospital access payments as determined by dividing the remaining spending room available in the current year upper payment limit, after offsetting the payments authorized under Subsection (3)(a)(i), by the total 2010 Medicaid inpatient hospital payments, multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2010.~~]

[~~(4) 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.~~]

[~~(5) 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.~~]

[~~(6) When the division obtains approval from the Centers for Medicare and Medicaid~~

~~Services for the Medicaid Waiver - Accountable Care Organizations, and has determined the capitated rate for the accountable care organizations, the department shall consult with the Utah Hospitals Association to develop an alternative supplemental payment methodology that can be approved by the Centers for Medicare and Medicaid Services.~~]

[~~(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 6. Section **26-36a-206** is amended 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).~~]

(c) Upon making a record of its actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this part.

Section 7. Section **26-36a-207** is amended 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~~]

(a) to support capitated rates consistent with Subsection 26-36a-203(1)(d) for accountable care organizations; 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, 2012;

(iv) a division change in rules that reduces any of the following below July 1, 2011 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[~~.~~]; and

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

(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 9. 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) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed July 1, 2016.

(4) Section 26-21-211 is repealed July 1, 2013.

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

(6) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, [~~2013~~] 2016.

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

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

Section 10. **Repealer.**

This bill repeals:

Section **26-36a-209, State plan amendment.**

Section 11. **Appropriations.**

Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for the fiscal year beginning July 1, 2012, and ending June 30, 2013, the following sums of money are appropriated from resources not otherwise appropriated, or reduced from amounts previously appropriated, out of the funds or accounts indicated. These sums of money are in addition to any amounts previously appropriated for fiscal year 2013.

To Department of Health - Medicaid Mandatory Services

From Hospital Provider Assessment Special Revenue Fund $6,300,600

Schedule of Programs:

Department of Health - Medicaid Mandatory Services $6,300,600

Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures Act, for the fiscal year beginning July 1, 2013, and ending June 30, 2014, the following sums of money are appropriated from resources not otherwise appropriated, or reduced from amounts

previously appropriated, out of the funds or accounts indicated. These sums of money are in addition to any amounts previously appropriated for fiscal year 2014.

To Department of Health - Medicaid Mandatory Services

From Hospital Provider Assessment Special Revenue Fund $5,500,000

Schedule of Programs:

Department of Health - Medicaid Mandatory Services $5,500,000

Section 12. **Effective date.**

If approved by two-thirds of all the members elected to each house, this bill takes effect on April 1, 2013.