

# Hospital Provider Assessment Act

## Utah Code Ann. Title 26 Chapter 36a

October 31, 2012

### 26-36a-101 Title.

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

### 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 shall be adequate to encourage and support improved access; and

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

### 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.

### 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.

Enacted by Chapter 179, 2010 General Session

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

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.

### **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 shall 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) 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) \$1,000,000 to offset Medicaid mandatory expenditures; and

(B) the non-federal share to seed amounts needed to support capitated rates for accountable care organizations.

(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.

### **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.

#### **26-36a-205 Medicaid 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:

(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.

#### **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).

#### **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.

**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.

(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.

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

(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.