Inpatient Hospital Assessment Act

Sunset Overview

Purpose

Title 26B, Chapter 3, Part 5 establishes the assessment and collection of a fee on private hospitals to offset the cost of the enhancement waiver program to the state, as well as other increased costs under "traditional" Medicaid (i.e. pre- full expansion Medicaid that occurred in 2020).

The Department of Health and Human Services administers the assessment and deposits the proceeds into an expendable special revenue fund known as the Medicaid Expansion Fund, created in 2018. The fund consists of:

- assessments collected under Title 26B, Chapter 3, Part 5, Inpatient Hospital Assessment;
- assessments collected under Title 26B, Chapter 3, Part 6, Medicaid Expansion Hospital Assessment;
- intergovernmental transfers under Section 26B-3-508;
- savings attributable to the health coverage improvement program as determined by the department;
- savings attributable to the enhancement waiver program as determined by the department;
- savings attributable to the Medicaid waiver expansion as determined by the department;
- savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26B-3-105(3) as determined by the department;
- revenues collected from the sales tax under Subsection 59-12-103(11);
- gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;
- interest earned on money in the fund; and
- additional amounts as appropriated by the Legislature.

The Medicaid Expansion Fund can be used to pay the costs, not otherwise paid for with federal funds or revenue sources, of:

- the health coverage improvement program under Section 26B-3-501;
- the enhancement waiver program under Section 26B-3-501;
- a Medicaid waiver expansion under Section 26B-3-501; and
- the outpatient upper payment limit supplemental payments under Section 26B-3-511.

MEDICAID EXPANSION FUND					
Fiscal Year	Beginning Balance	Revenues	Expenses	Transfers	Ending Balance
2016	$0.00	$0.00	$0.00	$0.00	$0.00
2017	$0.00	$0.00	$0.00	$735,564.00	$735,564.00
2018	$735,564.00	$5,089,816.00	$0.00	$266,771.00	$6,092,151.00
2019	$6,092,151.00	$30,198,469.00	$0.00	$26,440,161.00	$62,730,781.00
2020	$62,730,781.00	$125,754,448.00	$0.00	($79,168,062.00)	$109,317,167.00
2021	$109,317,167.00	$119,579,335.00	$0.00	($69,976,405.00)	$158,920,097.00
2022	$158,920,097.00	$136,927,753.00	$0.00	($98,004,071.00)	$197,843,779.00

Current Sunset Date

July 1, 2024 (Utah Code Section 63I-1-226)

Sections of Code that Sunset

- Title 26B, Chapter 3, Part 5
- 26B-1-315

26B-3-501. Definitions.

As used in this part:

(1) "Assessment" means the inpatient hospital assessment established by this part.

(2) "CMS" means the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services.

(3) "Discharges" means the number of total hospital discharges reported on:

(a) Worksheet S-3 Part I, column 15, lines 14, 16, and 17 of the 2552-10 Medicare cost report for the applicable assessment year; or

(b) a similar report adopted by the department by administrative rule, if the report under Subsection (3)(a) is no longer available.

(4) "Division" means the Division of Integrated Healthcare within the department.

(5) "Enhancement waiver program" means the program established by the Primary Care Network enhancement waiver program described in Section 26B-3-211.

(6) "Health coverage improvement program" means the health coverage improvement program described in Section 26B-3-207.

(7) "Hospital share" means the hospital share described in Section 26B-3-505.

(8) "Medicaid 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 26B-3-202.

(9)"Medicaid waiver expansion" means a Medicaid expansion in accordance with Section 26B-3-113 or 26B-3-210.

(10) "Medicare cost report" means CMS-2552-10, the cost report for electronic filing of hospitals.

(11)

(a) "Non-state government hospital" means a hospital owned by a non-state government entity.

(b) "Non-state government hospital" does not include:

(i) the Utah State Hospital; or

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

(12)

(a) "Private hospital" means:

(i) a general acute hospital, as defined in Section 26B-2-201, that is privately owned and operating in the state; and

(ii) a privately owned specialty hospital operating in the state, including a privately owned hospital whose inpatient admissions are predominantly for:

(A) rehabilitation;
(B) psychiatric care;
(C) chemical dependency services; or
(D) long-term acute care services.

(b) "Private hospital" does not include a facility for residential treatment as defined in Section 26B-2-101.

(13) "State teaching hospital" means a state owned teaching hospital that is part of an institution of higher education.

(14) "Upper payment limit gap" means the difference between the private hospital outpatient upper payment limit and the private hospital Medicaid outpatient payments, as determined in accordance with 42 C.F.R. Sec. 447.321.

26B-3-502. Application.

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

(a) state law;

(b) ad valorem property taxes;

(c) sales or use taxes; or

(d) other taxes, fees, or assessments, whether imposed or sought to be imposed, by the state or any political subdivision of the state.

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

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

(a) license a hospital for revenue;

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

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

26B-3-503. Assessment.

(1) An assessment is imposed on each private hospital:

(a) beginning upon the later of CMS approval of:

(i) the health coverage improvement program waiver under Section 26B-3-207; and

(ii) the assessment under this part;

(b) in the amount designated in Sections 26B-3-506 and 26B-3-507; and

(c) in accordance with Section 26B-3-504.

(2) Subject to Section 26B-3-505, the assessment imposed by this part is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26B-3-511 have been paid.

(3) The first quarterly payment is not due until at least three months after the earlier of the effective dates of the coverage provided through:

(a) the health coverage improvement program;

(b) the enhancement waiver program; or

(c) the Medicaid waiver expansion.

26B-3-504. Collection of assessment -- Deposit of revenue -- Rulemaking.

(1) The collecting agent for the assessment imposed under Section 26B-3-503 is the department.

(2) The department is vested with the administration and enforcement of this part, and may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

(a) collect the assessment, intergovernmental transfers, and penalties imposed under this part;

(b) audit records of a facility that:

(i) is subject to the assessment imposed by this part; and

(ii) does not file a Medicare cost report; and

(c) select a report similar to the Medicare cost report if Medicare no longer uses a Medicare cost report.

(3) The department shall:

(a) administer the assessment in this part separately from the assessment in Part 7, Hospital Provider Assessment; and

(b) deposit assessments collected under this part into the Medicaid Expansion Fund created by Section 26B-1-315.

26B-3-505. Quarterly notice.

(1) Quarterly assessments imposed by this part shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division.

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

26B-3-506. Hospital financing of health coverage improvement program Medicaid waiver expansion -- Hospital share.

(1) The hospital share is:

(a) 45% of the state's net cost of the health coverage improvement program, including Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26B-3-207;

(b) 45% of the state's net cost of the enhancement waiver program;

(c) if the waiver for the Medicaid waiver expansion is approved, $11,900,000; and

(d) 45% of the state's net cost of the upper payment limit gap.

(2)

(a) The hospital share is capped at no more than $13,600,000 annually, consisting of:

(i) an $11,900,000 cap for the programs specified in Subsections (1)(a) through (c); and

(ii) a $1,700,000 cap for the program specified in Subsection (1)(d).

(b) The department shall prorate the cap described in Subsection (2)(a) in any year in which the programs specified in Subsections (1)(a) and (d) are not in effect for the full fiscal year.

(3) Private hospitals shall be assessed under this part for:

(a) 69% of the portion of the hospital share for the programs specified in Subsections (1)(a) through (c); and

(b) 100% of the portion of the hospital share specified in Subsection (1)(d).

(4)

(a) In the report described in Subsection 26B-3-113(8), the department shall calculate the state's net cost of each of the programs described in Subsections (1)(a) through (c) that are in effect for that year.

(b) If the assessment collected in the previous fiscal year is above or below the hospital share for private hospitals for the previous fiscal year, the underpayment or overpayment of the assessment by the private hospitals shall be applied to the fiscal year in which the report is issued.

(5) A Medicaid accountable care organization shall, on or before October 15 of each year, report to the department the following data from the prior state fiscal year for each private hospital, state teaching hospital, and non-state government hospital provider that the Medicaid accountable care organization contracts with:

(a) for the traditional Medicaid population:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments; and

(b) if the Medicaid accountable care organization enrolls any individuals in the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, for the population newly eligible for any of those programs:

(i) hospital inpatient payments;

(ii) hospital inpatient discharges;

(iii) hospital inpatient days; and

(iv) hospital outpatient payments.

(6) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, provide details surrounding specific content and format for the reporting by the Medicaid accountable care organization.

26B-3-507. Calculation of assessment.

(1)

(a) Except as provided in Subsection (1)(b), an annual assessment is payable on a quarterly basis for each private hospital in an amount calculated by the division at a uniform assessment rate for each hospital discharge, in accordance with this section.

(b) A private teaching hospital with more than 425 beds and 60 residents shall pay an assessment rate 2.5 times the uniform rate established under Subsection (1)(c).

(c) The division shall calculate the uniform assessment rate described in Subsection (1)(a) by dividing the hospital share for assessed private hospitals, described in Subsections 26B-3-506(1) and (3), by the sum of:

(i) the total number of discharges for assessed private hospitals that are not a private teaching hospital; and

(ii) 2.5 times the number of discharges for a private teaching hospital, described in Subsection (1)(b).

(d) The division may, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, adjust the formula described in Subsection (1)(c) to address unforeseen circumstances in the administration of the assessment under this part.

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

(2) Except as provided in Subsection (3), for each state fiscal year, the division shall determine a hospital's discharges as follows:

(a) for state fiscal year 2017, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2013, and June 30, 2014; and

(b) for each subsequent state fiscal year, the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years before the assessment fiscal year.

(3)

(a) If a hospital's fiscal year Medicare cost report is not contained in the CMS 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.

(b) 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 the hospital's applicable fiscal year discharges with supporting documentation;

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

(iii) 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.

(4) Except as provided in Subsection (5), 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 part.

(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.

26B-3-508. State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

(1) The state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund created in Section 26B-1-315, in accordance with this section.

(2) The hospitals described in Subsection (1) shall pay the intergovernmental transfer beginning on the later of CMS approval of:

(a) the health improvement program waiver under Section 26B-3-207; or
(b) the assessment for private hospitals in this part.
(3) The intergovernmental transfer is apportioned as follows:
(a) the state teaching hospital is responsible for:
(i) 30% of the portion of the hospital share specified in Subsections 26B-3-506(1)(a) through (c); and
(ii) 0% of the hospital share specified in Subsection 26B-3-506(1)(d); and
(b) non-state government hospitals are responsible for:
(i) 1% of the portion of the hospital share specified in Subsections 26B-3-506(1)(a) through (c); and
(ii) 0% of the hospital share specified in Subsection 26B-3-506(1)(d).
(4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate:
(a) the method of calculating the amounts designated in Subsection (3); and
(b) the schedule for the intergovernmental transfers.

26B-3-509. Penalties and interest.
(1) A hospital that fails to pay a quarterly assessment, make the mandated intergovernmental transfer, or file a return as required under this part, within the time required by this part, shall pay penalties described in this section, in addition to the assessment or intergovernmental transfer.
(2) If a hospital fails to timely pay the full amount of a quarterly assessment or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:
(a) a penalty equal to 5% of the quarterly amount not paid on or before the due date; and
(b) on the last day of each quarter after the due date until the assessed amount and the penalty imposed under Subsection (2)(a) are paid in full, an additional 5% penalty on:
(i) any unpaid quarterly assessment or intergovernmental transfer; and
(ii) any unpaid penalty assessment.
(3) Upon making a record of the division's actions, and upon reasonable cause shown, the division may waive, reduce, or compromise any of the penalties imposed under this part.

26B-3-510. Hospital reimbursement.
(1) If the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion is implemented by contracting with a Medicaid accountable care organization, the department shall, to the extent allowed by law, include, in a contract to provide benefits under the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion, a requirement that the Medicaid accountable care organization reimburse hospitals in the accountable care organization's provider network at no less than the Medicaid fee-for-service rate.
(2) If the health coverage improvement program, the enhancement waiver program, or the Medicaid waiver expansion is implemented by the department as a fee-for-service program, the department shall reimburse hospitals at no less than the Medicaid fee-for-service rate.

(3) Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds the Medicaid fee-for-service rate.

26B-3-511. Outpatient upper payment limit supplemental payments.

(1) Beginning on the effective date of the assessment imposed under this part, and for each subsequent fiscal year, the department shall implement an outpatient upper payment limit program for private hospitals that shall supplement the reimbursement to private hospitals in accordance with Subsection (2).

(2) The division shall ensure that supplemental payment to Utah private hospitals under Subsection (1):

(a) does not exceed the positive upper payment limit gap; and

(b) is allocated based on the Medicaid state plan.

(3) The department shall use the same outpatient data to allocate the payments under Subsection (2) and to calculate the upper payment limit gap.

(4) The supplemental payments to private hospitals under Subsection (1) are payable for outpatient hospital services provided on or after the later of:

(a) July 1, 2016;

(b) the effective date of the Medicaid state plan amendment necessary to implement the payments under this section; or

(c) the effective date of the coverage provided through the health coverage improvement program waiver.

26B-3-512. Repeal of assessment.

(1) The assessment imposed by this part shall be repealed when:

(a) the executive director certifies that:

(i) action by Congress is in effect that disqualifies the assessment imposed by this part from counting toward state Medicaid funds available to be used to determine the amount of federal financial participation;

(ii) a decision, enactment, or other determination by the Legislature or by any court, officer, department, or agency of the state, or of the federal government, is in effect that:

(A) disqualifies the assessment from counting toward state Medicaid funds available to be used to determine federal financial participation for Medicaid matching funds; or

(B) creates for any reason a failure of the state to use the assessments for at least one of the Medicaid programs described in this part; or

(iii) a change is in effect that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; or

(b) this part is repealed in accordance with Section 63I-1-226.

(2) If the assessment is repealed under Subsection (1):

(a) the division may not collect any assessment or intergovernmental transfer under this part;

(b) the department shall disburse money in the special Medicaid Expansion Fund in accordance with the requirements in Subsection 26B-1-315(4), to the extent federal matching is not reduced by CMS due to the repeal of the assessment;
(c) any money remaining in the Medicaid Expansion Fund after the disbursement described in Subsection (2)(b) that was derived from assessments imposed by this part shall be refunded to the hospitals in proportion to the amount paid by each hospital for the last three fiscal years; and
(d) any money remaining in the Medicaid Expansion Fund after the disbursements described in Subsections (2)(b) and (c) shall be deposited into the General Fund by the end of the fiscal year that the assessment is suspended.

26B-1-315. Medicaid Expansion Fund.
(1) There is created an expendable special revenue fund known as the "Medicaid Expansion Fund."
(2) The fund consists of:
(a) assessments collected under Chapter 3, Part 5, Inpatient Hospital Assessment;
(b) intergovernmental transfers under Section 26B-3-508;
(c) savings attributable to the health coverage improvement program, as defined in Section 26B-3-501, as determined by the department;
(d) savings attributable to the enhancement waiver program, as defined in Section 26B-3-501, as determined by the department;
(e) savings attributable to the Medicaid waiver expansion, as defined in Section 26B-3-501, as determined by the department;
(f) savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26B-3-105(3) as determined by the department;
(g) revenues collected from the sales tax described in Subsection 59-12-103(11);
(h) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources;
(i) interest earned on money in the fund; and
(j) additional amounts as appropriated by the Legislature.
(3)
(a) The fund shall earn interest.
(b) All interest earned on fund money shall be deposited into the fund.
(4)
(a) A state agency administering the provisions of Chapter 3, Part 5, Inpatient Hospital Assessment, may use money from the fund to pay the costs, not otherwise paid for with federal funds or other revenue sources, of:
(i) the health coverage improvement program as defined in Section 26B-3-501;
(ii) the enhancement waiver program as defined in Section 26B-3-501;
(iii) a Medicaid waiver expansion as defined in Section 26B-3-501; and
(iv) the outpatient upper payment limit supplemental payments under Section 26B-3-511.
(b) A state agency administering the provisions of Chapter 3, Part 5, Inpatient Hospital Assessment, may not use:

(i) funds described in Subsection (2)(b) to pay the cost of private outpatient upper payment limit supplemental payments; or
(ii) money in the fund for any purpose not described in Subsection (4)(a).