

Effective 5/10/2016

**Part 2
Assessment and Collection**

26-36b-201 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 26-18-411; and
 - (ii) the assessment under this chapter;
 - (b) in the amount designated in Sections 26-36b-204 and 26-36b-205; and
 - (c) in accordance with Section 26-36b-202.
- (2) Subject to Section 26-36b-203, the assessment imposed by this chapter is due and payable on a quarterly basis, after payment of the outpatient upper payment limit supplemental payments under Section 26-36b-210 have been paid.
- (3) The first quarterly payment shall not be due until at least three months after the effective date of the coverage provided through the health coverage improvement program waiver under Section 26-18-411.

Enacted by Chapter 279, 2016 General Session

26-36b-202 Collection of assessment -- Deposit of revenue -- Rulemaking.

- (1) The collecting agent for the assessment imposed under Section 26-36b-201 is the department. The department 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:
 - (a) implement and enforce the provisions of this chapter;
 - (b) audit records of a facility that:
 - (i) is subject to the assessment imposed by this chapter; 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.
- (2) The department shall:
 - (a) administer the assessment in this part separate from the assessment in Chapter 36a, Hospital Provider Assessment Act; and
 - (b) deposit assessments collected under this chapter into the Medicaid Expansion Fund created by Section 26-36b-208.

Enacted by Chapter 279, 2016 General Session

26-36b-203 Quarterly notice.

Quarterly assessments imposed by this chapter shall be paid to the division within 15 business days after the original invoice date that appears on the invoice issued by the division. The department may, by rule, extend the time for paying the assessment.

Enacted by Chapter 279, 2016 General Session

26-36b-204 Hospital financing of health coverage improvement program Medicaid waiver -- Hospital share.

- (1) For purposes of this section, "hospital share":
 - (a) means 45% of the state's net cost of:
 - (i) the health coverage improvement program Medicaid waiver under Section 26-18-411;
 - (ii) Medicaid coverage for individuals with dependent children up to the federal poverty level designated under Section 26-18-411; and
 - (iii) the UPL gap, as that term is defined in Section 26-36b-210;
 - (b) for the hospital share of the additional coverage under Section 26-18-411, is capped at no more than \$13,600,000 annually, consisting of:
 - (i) an \$11,900,000 cap on the hospital's share for the programs specified in Subsections (1)(a)(i) and (ii); and
 - (ii) a \$1,700,000 cap for the program specified in Subsection (1)(a)(iii);
 - (c) for the cap specified in Subsection (1)(b), shall be prorated in any year in which the programs specified in Subsection (1)(a) are not in effect for the full fiscal year; and
 - (d) if the Medicaid program expands in a manner that is greater than the expansion described in Section 26-18-411, is capped at 33% of the state's share of the cost of the expansion that is in addition to the program described in Section 26-18-411.
- (2) The assessment for the private hospital share under Subsection (1) shall be:
 - (a) 69% of the portion of the hospital share specified in Subsections (1)(a)(i) and (ii); and
 - (b) 100% of the portion of the hospital share specified in Subsection (1)(a)(iii).
- (3)
 - (a) The department shall, on or before October 15, 2017, and on or before October 15 of each year thereafter, produce a report that calculates the state's net cost of the programs described in Subsections (1)(a)(i) and (ii).
 - (b) If the assessment collected in the previous fiscal year is above or below the private hospital's share of the state's net cost as specified in Subsection (2), 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 was issued.
- (4) 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:
 - (a) for the traditional Medicaid population, for each private hospital, state teaching hospital, and non-state government hospital provider:
 - (i) hospital inpatient payments;
 - (ii) hospital inpatient discharges;
 - (iii) hospital inpatient days; and
 - (iv) hospital outpatient payments; and
 - (b) for the Medicaid population newly eligible under Subsection 26-18-411, for each private hospital, state teaching hospital, and non-state government hospital provider:
 - (i) hospital inpatient payments;
 - (ii) hospital inpatient discharges;
 - (iii) hospital inpatient days; and
 - (iv) hospital outpatient payments.

Enacted by Chapter 279, 2016 General Session

26-36b-205 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 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 2.50 times the uniform rate established under Subsection (1)(c).
 - (c) The uniform assessment rate shall be determined using the total number of hospital discharges for assessed private hospitals, the percentages in Subsection 26-36b-204(2), and rule adopted by the department.
 - (d) Any quarterly changes to the uniform assessment rate shall be applied uniformly to all assessed private hospitals.
- (2)
- (a) For each state fiscal year, 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. The hospital's discharge data will be derived as follows:
 - (i) 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
 - (ii) 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.
 - (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 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 (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.
- (3) Except as provided in Subsection (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.
- (4) Notwithstanding the requirement of Subsection (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.

Enacted by Chapter 279, 2016 General Session

26-36b-206 State teaching hospital and non-state government hospital mandatory intergovernmental transfer.

- (1) A state teaching hospital and a non-state government hospital shall make an intergovernmental transfer to the Medicaid Expansion Fund created in Section 26-36b-208, in accordance with this section.
- (2) The intergovernmental transfer shall be paid beginning on the later of CMS approval of:
 - (a) the health improvement program waiver under Section 26-18-411;
 - (b) the assessment for private hospitals in this chapter; and
 - (c) the intergovernmental transfer in this section.
- (3) The intergovernmental transfer shall be paid in an amount divided as follows:
 - (a) the state teaching hospital is responsible for:
 - (i) 30% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a)(i) and (ii); and
 - (ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(a)(iii); and
 - (b) non-state government hospitals are responsible for:
 - (i) 1% of the portion of the hospital share specified in Subsections 26-36b-204(1)(a)(i) and (ii); and
 - (ii) 0% of the hospital share specified in Subsection 26-36b-204(1)(a)(iii).
- (4) The department shall, by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, designate the method of calculating the percentages designated in Subsection (3) and the schedule for the intergovernmental transfers.

Enacted by Chapter 279, 2016 General Session

26-36b-207 Penalties and interest.

- (1) A hospital that fails to pay any assessment, make the mandated intergovernmental transfer, or file a return as required under this chapter, within the time required by this chapter, shall pay penalties, in addition to the assessment or intergovernmental transfer, 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, that 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 or the mandated intergovernmental transfer, the department shall add to the assessment or intergovernmental transfer:
 - (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 or intergovernmental transfer; and
 - (B) any unpaid penalty assessment.
 - (c) 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 chapter.

Enacted by Chapter 279, 2016 General Session

26-36b-208 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 this chapter;

- (b) intergovernmental transfers under Section 26-36b-206;
 - (c) savings attributable to the health coverage improvement program under Section 26-18-411 as determined by the department;
 - (d) savings attributable to the inclusion of psychotropic drugs on the preferred drug list under Subsection 26-18-2.4(3) as determined by the department;
 - (e) savings attributable to the services provided by the Public Employees' Health Plan under Subsection 49-20-401(1)(u);
 - (f) gifts, grants, donations, or any other conveyance of money that may be made to the fund from private sources; and
 - (g) 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 this chapter may use money from the fund to pay the costs of the health coverage improvement Medicaid waiver under Section 26-18-411, and the outpatient UPL supplemental payments under Section 26-36b-210, not otherwise paid for with federal funds or other revenue sources, except that no funds described in Subsection (2)(b) may be used to pay the cost of outpatient UPL supplemental payments.
 - (b) Money in the fund may not be used for any other purpose.

Enacted by Chapter 279, 2016 General Session

26-36b-209 Hospital reimbursement.

The department shall, to the extent allowed by law, include in a contract with a Medicaid accountable care organization a requirement that the accountable care organization reimburse hospitals in the accountable care organization's provider network, no less than the Medicaid fee-for-service rate. Nothing in this section prohibits a Medicaid accountable care organization from paying a rate that exceeds Medicaid fee-for-service rates.

Enacted by Chapter 279, 2016 General Session

26-36b-210 Outpatient upper payment limit supplemental payments.

- (1) For purposes of this section, "UPL 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. 447.321.
- (2) Beginning on the effective date of the assessment imposed under this chapter, and for each fiscal year thereafter, 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 (3).
- (3) The supplemental payment to Utah private hospitals under Subsection (2) shall:
 - (a) not exceed the positive UPL gap; and
 - (b) be allocated based on the Medicaid state plan.
- (4) The outpatient data used to calculate the UPL gap under Subsection (1) shall be the same outpatient data used to allocate the payments under Subsection (3).
- (5) The supplemental payments to private hospitals under Subsection (2) shall be 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 under Section 26-18-411.

Enacted by Chapter 279, 2016 General Session

26-36b-211 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 toward 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 toward 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;
 - (c) the effective date of a change that reduces the aggregate hospital inpatient and outpatient payment rate below the aggregate hospital inpatient and outpatient payment rate for July 1, 2015; 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 26-36b-207 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.

Enacted by Chapter 279, 2016 General Session