Effective 5/3/2023

Part 7
Hospital Provider Assessment

26B-3-701 Definitions.

As used in this part:

(1) "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.

(2) "Assessment" means the Medicaid hospital provider assessment established by this part.

(3) "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.

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

(5) "Hospital":

(a) means a privately owned:

(i) general acute hospital operating in the state as defined in Section 26B-2-201; 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 human services program, as defined in Section 26B-2-101;

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

(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.

(6) "Medicare Cost Report" means CMS-2552-96 or CMS-2552-10, the cost report for electronic filing of hospitals.

(7) "State plan amendment" means a change or update to the state Medicaid plan.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-702 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.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-703 Application of part.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-704 Assessment, collection, and payment of hospital provider assessment.

(1) A uniform, broad based, assessment is imposed on each hospital as defined in Subsection 26B-3-701(5)(a):
  (a) in the amount designated in Section 26B-3-705; and
  (b) in accordance with Section 26B-3-706.

(2)
  (a) The assessment imposed by this part is due and payable on a quarterly basis in accordance with Section 26B-3-706.
  (b) The collecting agent for this assessment is the department which is vested with the administration and enforcement of this part, 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 part; and
      (B) does not file a Medicare Cost Report.
  (c) The department shall forward proceeds from the assessment imposed by this part to the state treasurer for deposit in the expendable special revenue fund as specified in Section 26B-1-316.

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

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-705 Calculation of assessment.

(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 in an amount consistent with Section 26B-3-707 that is needed to support capitated rates for Medicaid 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) The annual uniform assessment rate may not generate more than:
(i) $1,000,000 to offset Medicaid mandatory expenditures; and
(ii) the non-federal share to seed amounts needed to support capitated rates for Medicaid accountable care organizations as provided for in Subsection (1)(b).

(2)
(a) For each state fiscal year, discharges shall be determined using the data from each hospital's Medicare Cost Report contained in the CMS Healthcare Cost Report Information System file. The hospital's discharge data is the hospital's cost report data for the hospital's fiscal year that ended in the state fiscal year two years prior to the assessment fiscal year.
(b) 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.
(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 (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 part.

(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.

Amended by Chapter 284, 2024 General Session

26B-3-706 Quarterly notice -- Collection.

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.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-707 Medicaid hospital adjustment under Medicaid accountable care organization rates.

(1) To preserve and improve access to hospital services, the division shall incorporate into the Medicaid accountable care organization rate structure calculation consistent with the certified actuarial rate range:
  (a) $154,000,000 to be allocated toward the hospital inpatient directed payments for the Medicaid eligibility categories covered in Utah before January 1, 2019; and
  (b) an amount equal to the difference between payments made to hospitals by Medicaid accountable care organizations for the Medicaid eligibility categories covered in Utah, based on submitted encounter data, and the maximum amount that could be paid for those services, to be used for directed payments to hospitals for inpatient and outpatient services.

(2)
  (a) To preserve and improve the quality of inpatient and outpatient hospital services authorized under Subsection (1)(b), the division shall amend its quality strategies required by 42 C.F.R. Sec. 438.340 to include quality measures selected from the CMS hospital quality improvement programs.
  (b) To better address the unique needs of rural and specialty hospitals, the division may adopt different quality standards for rural and specialty hospitals.
  (c) The division shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt the selected quality measures and prescribe penalties for not meeting the quality standards that are established by the division by rule.
  (d) The division shall apply the same quality measures and penalties under this Subsection (2) to new directed payments made to the University of Utah Hospital and Clinics.

Amended by Chapter 284, 2024 General Session

26B-3-708 Penalties and interest.

(1) A facility that fails to pay any assessment or file a return as required under this part, within the time required by this part, 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) 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.

Renumbered and Amended by Chapter 306, 2023 General Session

26B-3-709 Repeal of assessment.

(1) The repeal of the assessment imposed by this part 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 part 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 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 part;

(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) 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

(iv) a division change in rules that reduces the aggregate outpatient payments below July 1, 2011, payments; and

(d) the sunset of this part 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 part, before the determination made under Subsection (1), shall be disbursed under Section 26B-3-707 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.

Renumbered and Amended by Chapter 306, 2023 General Session