

1 **HOSPITAL ASSESSMENTS**

2 2010 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: Lyle W. Hillyard**

5 House Sponsor: Kevin S. Garn

7 **LONG TITLE**

8 **General Description:**

9 This bill enacts the Hospital Provider Assessment Act in the health code.

10 **Highlighted Provisions:**

11 This bill:

- 12 ▶ makes legislative findings;
- 13 ▶ defines terms;
- 14 ▶ clarifies the application of the chapter;
- 15 ▶ establishes the assessment and payment of the hospital provider assessment;
- 16 ▶ establishes the calculation of the assessment;
- 17 ▶ provides for quarterly assessment and payment;
- 18 ▶ establishes a Medicaid inpatient hospital access payment from the division to a
- 19 hospital;
- 20 ▶ provides for penalties if the hospital provider assessment is not paid;
- 21 ▶ creates a restricted special revenue fund;
- 22 ▶ repeals the assessment if certain events occur;
- 23 ▶ creates a Hospital Policy Review Board to review Medicaid state plan amendments
- 24 that effect hospital reimbursements;
- 25 ▶ requires the division to seek approval from the Center for Medicare and Medicaid
- 26 Services for federal matching based on the hospital provider assessment; and
- 27 ▶ repeals the hospital provider assessment on July 1, 2013.



28 **Monies Appropriated in this Bill:**

29 None

30 **Other Special Clauses:**

31 This bill has retrospective operation for taxable years beginning on or after January 1,
32 2010.

33 **Utah Code Sections Affected:**

34 AMENDS:

35 **63I-1-226**, as last amended by Laws of Utah 2009, Chapter 334

36 ENACTS:

37 **26-36a-101**, Utah Code Annotated 1953

38 **26-36a-102**, Utah Code Annotated 1953

39 **26-36a-103**, Utah Code Annotated 1953

40 **26-36a-201**, Utah Code Annotated 1953

41 **26-36a-202**, Utah Code Annotated 1953

42 **26-36a-203**, Utah Code Annotated 1953

43 **26-36a-204**, Utah Code Annotated 1953

44 **26-36a-205**, Utah Code Annotated 1953

45 **26-36a-206**, Utah Code Annotated 1953

46 **26-36a-207**, Utah Code Annotated 1953

47 **26-36a-208**, Utah Code Annotated 1953

48 **26-36a-209**, Utah Code Annotated 1953



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

51 Section 1. Section **26-36a-101** is enacted to read:

52 **CHAPTER 36a. HOSPITAL PROVIDER ASSESSMENT ACT**

53 **Part 1. General Provisions**

54 **26-36a-101. Title.**

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

56 Section 2. Section **26-36a-102** is enacted to read:

57 **26-36a-102. Legislative findings.**

58 (1) The Legislature finds that there is an important state purpose to improve the access

59 of Medicaid patients to quality care in Utah hospitals because of continuous decreases in state
60 revenues and increases in enrollment under the Utah Medicaid program.

61 (2) The Legislature finds that in order to improve this access to those persons described
62 in Subsection (1):

63 (a) the rates paid to Utah hospitals must be adequate to encourage and support
64 improved access; and

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

67 Section 3. Section **26-36a-103** is enacted to read:

68 **26-36a-103. Definitions.**

69 As used in this chapter:

70 (1) "Assessment" means the Medicaid hospital provider assessment established by this
71 chapter.

72 (2) "Discharges" means the number of total hospital discharges reported on worksheet
73 S-3, column 15, lines 12, 14, and 14.01 of the Medicare Cost Report for the applicable
74 assessment year.

75 (3) "Division" means the Division of Health Care Financing of the department.

76 (4) "Hospital":

77 (a) means a privately owned:

78 (i) general acute hospital operating in the state as defined in Section 26-21-2; and

79 (ii) specialty hospital operating in the state, which shall include a privately owned
80 hospital whose inpatient admissions are predominantly:

81 (A) rehabilitation;

82 (B) psychiatric;

83 (C) chemical dependency; or

84 (D) long-term acute care services; and

85 (b) does not include:

86 (i) a residential care or treatment facility as defined in Section 62A-2-101;

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

89 (iii) a Shriners hospital that does not charge for its services; or

90 (iv) a hospital that is owned by the state government, a state agency, or a political
91 subdivision of the state, including:

92 (A) a state-owned teaching hospital; and

93 (B) the Utah State Hospital.

94 (5) "Low volume select access hospital" means a hospital that furnished inpatient
95 hospital services during fiscal year 2008 to less than 300 Medicaid cases under the select
96 access program.

97 (6) "Medicare cost report" means CMS-2552-96, the cost report for electronic filing of
98 hospitals.

99 (7) "Select access cases" means the number of hospital inpatient cases related to
100 individuals enrolled in the state's select access program for 2008.

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

102 (9) "Upper payment limit" means the maximum ceiling imposed by federal regulation
103 on a hospital Medicaid reimbursement for inpatient services under 42 C.F.R Sec. 447.272.

104 (10) "Upper payment limit gap":

105 (a) means the difference between:

106 (i) the inpatient hospital upper payment limit for hospitals; and

107 (ii) Medicaid payments for inpatient hospital services not financed using hospital
108 assessments paid by all hospitals;

109 (b) shall be calculated separately for hospital inpatient services; and

110 (c) does not include Medicaid disproportionate share payments as part of the
111 calculation for the upper payment limit gap.

112 Section 4. Section **26-36a-201** is enacted to read:

113 **Part 2. Application of Chapter**

114 **26-36a-201. Application of chapter.**

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

118 (a) Section 501(c), as amended, of the Internal Revenue Code;

119 (b) other applicable federal law;

120 (c) any state law;

121 (d) any ad valorem property taxes;
122 (e) any sales or use taxes; or
123 (f) any other taxes, fees, or assessments, whether imposed or sought to be imposed by
124 the state or any political subdivision, county, municipality, district, authority, or any agency or
125 department thereof.

126 (2) For a hospital subject to the assessment imposed by this chapter, and also subject to
127 the corporate franchise or income tax under Title 59, Chapter 7, Corporate Franchise and
128 Income Taxes, all assessments paid under this chapter shall be allowed as a deductible expense
129 under Title 59, Chapter 7, Corporate Franchise and Income Taxes.

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

132 (4) This chapter does not authorize a political subdivision of the state to:

133 (a) license a hospital for revenue;

134 (b) impose a tax or assessment upon hospitals; or

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

136 Section 5. Section **26-36a-202** is enacted to read:

137 **26-36a-202. Assessment, collection, and payment of hospital provider assessment.**

138 (1) A uniform, broad based, assessment is imposed on each hospital as defined in
139 Subsection 26-36a-103(4)(a):

140 (a) in the amount designated in Section 26-36a-203; and

141 (b) in accordance with Section 26-36a-204, beginning when the division has obtained
142 approval from the Center for Medicare and Medicaid Services and provided notice of the
143 assessment to the hospital.

144 (2) (a) The assessment imposed by this chapter is due and payable on a quarterly basis
145 in accordance with Section 26-36a-204.

146 (b) The collecting agent for this assessment is the department which is vested with the
147 administration and enforcement of this chapter, including the right to adopt administrative rules
148 in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, necessary to:

149 (i) implement and enforce the provisions of this act; and

150 (ii) audit records of a facility:

151 (A) that is subject to the assessment imposed by this chapter; and

152 (B) does not file a Medicare cost report.

153 (c) The department shall forward proceeds from the assessment imposed by this
154 chapter to the state treasurer for deposit in the restricted special revenue fund as specified in
155 Section 26-36a-207.

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

157 Section 6. Section **26-36a-203** is enacted to read:

158 **26-36a-203. Calculation of assessment.**

159 (1) The division shall calculate the inpatient upper payment limit gap for hospitals for
160 each state fiscal year.

161 (2) (a) An annual assessment is imposed on a quarterly basis for each hospital in an
162 amount calculated at a uniform assessment rate for each hospital discharge, in accordance with
163 this section.

164 (b) The uniform assessment rate shall be determined using the total number of hospital
165 discharges for assessed hospitals divided into the total non-federal portion of the upper
166 payment limit gap.

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

169 (d) The annual uniform assessment rate may not generate more than the non-federal
170 share of the annual upper payment limit gap for each applicable fiscal year.

171 (3) (a) For state fiscal years 2010 and 2011, discharges shall be determined using the
172 data from each hospital's Medicare Cost Report contained in the Centers for Medicare and
173 Medicaid Services' Healthcare Cost Report Information System file as of April 1, 2009 for
174 hospital fiscal years ending between October 1, 2007, and September 30, 2008.

175 (b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for
176 Medicare and Medicaid Services' Healthcare Cost Report Information System file dated March
177 31, 2009:

178 (i) the hospital shall submit to the division a copy of the hospital's Medicare Cost
179 Report with a fiscal year end between October 1, 2007, and September 30, 2008; and

180 (ii) the division shall determine the hospital's discharges from the information
181 submitted under Subsection (3)(b)(i).

182 (c) If a hospital started operations after the due date for a 2007 Medicare Cost Report:

183 (i) the hospital shall submit to the division a copy of the hospital's most recent
184 complete year Medicare Cost Report; and

185 (ii) the division shall determine the hospital's discharges from the information
186 submitted under Subsection (3)(c)(i).

187 (d) If a hospital is not certified by the Medicare program and is not required to file a
188 Medicare Cost Report:

189 (i) the hospital shall submit to the division its applicable fiscal year discharges with
190 supporting documentation;

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

193 (iii) the failure to submit discharge information under Subsections (3)(d)(i) and (ii)
194 shall result in an audit of the hospital's records by the department and the imposition of a
195 penalty equal to 5% of the calculated assessment.

196 (4) (a) For state fiscal year 2012 and 2013, discharges shall be determined using the
197 data from each hospital's Medicare Cost Report contained in the Centers for Medicare and
198 Medicaid Services' Healthcare Cost Report Information System file as of:

199 (i) for state fiscal year 2012, September 30, 2010, for hospital fiscal years ending
200 between October 1, 2008, and September 30, 2009; and

201 (ii) for state fiscal year 2013, September 30, 2011, for hospital fiscal years ending
202 between October 1, 2009, and September 30, 2010.

203 (b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for
204 Medicare and Medicaid Services' Healthcare Cost Report Information System file:

205 (i) the hospital shall submit to the division a copy of the hospital's Medicare Cost
206 Report applicable to the assessment year; and

207 (ii) the division shall determine the hospital's discharges.

208 (c) If a hospital is not certified by the Medicare program and is not required to file a
209 Medicare Cost Report:

210 (i) the hospital shall submit to the division its applicable fiscal year discharges with
211 supporting documentation;

212 (ii) the division shall determine the hospital's discharges from the information
213 submitted under Subsection (4)(c)(i); and

214 (iii) the failure to submit discharge information shall result in an audit of the hospital's
215 records and a penalty equal to 5% of the calculated assessment.

216 (5) Except as provided in Subsection (6), if a hospital is owned by an organization that
217 owns more than one hospital in the state:

218 (a) the assessment for each hospital shall be separately calculated by the department;
219 and

220 (b) each separate hospital shall pay the assessment imposed by this chapter.

221 (6) Notwithstanding the requirement of Subsection (5), if multiple hospitals use the
222 same Medicaid provider number:

223 (a) the department shall calculate the assessment in the aggregate for the hospitals
224 using the same Medicaid provider number; and

225 (b) the hospitals may pay the assessment in the aggregate.

226 (7) (a) The assessment formula imposed by this section, and the inpatient access
227 payments under Section 26-36a-205, shall be adjusted in accordance with Subsection (7)(b) if a
228 hospital, for any reason, does not meet the definition of a hospital subject to the assessment
229 under Section 26-36a-103 for the entire fiscal year.

230 (b) The department shall adjust the assessment payable to the department under this
231 chapter for a hospital that is not subject to the assessment for an entire fiscal year by
232 multiplying the annual assessment calculated under Subsection (3) or (4) by a fraction, the
233 numerator of which is the number of days during the year that the hospital operated, and the
234 denominator of which is 365.

235 (c) A hospital described in Subsection (7)(a):

236 (i) that is ceasing to operate in the state, shall pay any assessment owed to the
237 department immediately upon ceasing to operate in the state; and

238 (ii) shall receive Medicaid inpatient hospital access payments under Section
239 26-36a-205 for the state fiscal year, adjusted using the same formula described in Subsection
240 (7)(b).

241 (8) A hospital that is subject to payment of the assessment at the beginning of a state
242 fiscal year, but during the state fiscal year experiences a change in status so that it no longer
243 falls under the definition of a hospital subject to the assessment in Section 26-36a-204, shall:

244 (a) not be required to pay the hospital assessment beginning on the date established by

245 the department by administrative rule; and

246 (b) not be entitled to Medicaid inpatient hospital access payments under Section
247 26-36a-205 on the date established by the department by administrative rule.

248 Section 7. Section **26-36a-204** is enacted to read:

249 **26-36a-204. Quarterly notice -- Collection.**

250 (1) (a) The division shall submit to the Center for Medicare and Medicaid Services:

251 (i) the payment methodology for the assessment imposed by this chapter; and

252 (ii) if necessary, a waiver under 42 C.F.R. Sec. 433.68.

253 (b) When the division receives notice of approval of the assessment and access
254 payments under this chapter from the Center for Medicare and Medicaid Services, the division
255 shall, within 45 days of the notice from the Center for Medicare and Medicaid Services,
256 provide a hospital that is subject to the assessment notice of:

257 (i) the approval of the assessment methodology from the Center for Medicare and
258 Medicaid Services;

259 (ii) the assessment rate;

260 (iii) the hospital's discharges subject to the assessment; and

261 (iv) the assessment amount owed by the hospital for the applicable fiscal year.

262 (2) The initial quarterly installments of the assessment imposed by this chapter are due
263 and payable if:

264 (a) the division has provided notice of the annual assessment under Subsection (1); and

265 (b) the division has made all the quarterly installments of the Medicaid inpatient
266 hospital access payments that were otherwise due under Section 26-36a-205, consistent with
267 the effective date of the approved state plan amendment.

268 (3) After the initial quarterly installments of the Medicaid inpatient hospital access
269 payments are made by the division, a hospital shall pay to the division the initial quarterly
270 assessments imposed by this chapter within 10 business days. Subsequent quarterly
271 assessments imposed by this chapter shall be paid to the division within 10 business days after
272 the hospital receives its Medicaid inpatient hospital access payment due for the applicable
273 quarter under Section 26-36a-205.

274 Section 8. Section **26-36a-205** is enacted to read:

275 **26-36a-205. Medicaid hospital inpatient access payments.**

276 (1) To preserve and improve access to hospitals, the division shall make Medicaid
277 inpatient hospital access payments to hospitals in accordance with this section, Section
278 26-36a-204, and Subsection 26-36a-203(7).

279 (2) (a) The Medicaid inpatient hospital access payment amount to a particular hospital
280 shall be established by the division.

281 (b) The aggregate of all hospital's Medicaid inpatient hospital access payments shall
282 be:

283 (i) equal to the upper payment limit gap for inpatient services for all hospitals; and

284 (ii) designated as the Medicaid inpatient hospital access payment pool.

285 (3) In addition to any other funds paid to hospitals during fiscal years 2010 and 2011
286 for inpatient hospital services to Medicaid patients, a Medicaid hospital inpatient access
287 payment shall be made:

288 (a) for state fiscal years 2010 and 2011:

289 (i) the amount of \$825 per Medicaid fee for service day, to a hospital that:

290 (A) was not a specialty hospital; and

291 (B) had less than 300 select access inpatient cases during state fiscal year 2008; and

292 (ii) inpatient hospital access payments as determined by dividing the remaining

293 spending room available in the current year UPL, after offsetting the payments authorized

294 under Subsection (3)(a)(i) by the total 2008 Medicaid inpatient hospital payments, multiplied

295 by the hospital's Medicaid inpatient payments for state fiscal year 2008, exclusive of medical
296 education and Medicaid disproportionate share payments;

297 (b) for state fiscal year 2012, using state fiscal year 2009 paid Medicaid inpatient
298 claims data; and

299 (c) for state fiscal year 2013, using state fiscal year 2010 paid Medicaid inpatient
300 claims data.

301 (4) For both state fiscal years 2012 and 2013, the division shall submit adjustments to
302 the payment rates in Subsection (3)(a) to the Hospital Policy Review Board for their review.

303 (5) Medicaid inpatient hospital access payments shall be made:

304 (a) on a quarterly basis for inpatient hospital services furnished to Medicaid individuals
305 during each quarter; and

306 (b) within 15 days after the end of each quarter.

307 (6) A hospital's Medicaid inpatient access payment shall not be used to offset any other
308 payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries,
309 including a:

- 310 (a) fee-for-service payment;
311 (b) per diem payment;
312 (c) hospital inpatient adjustment; or
313 (d) cost settlement payment.

314 (7) A hospital shall not be guaranteed that the hospital's Medicaid inpatient hospital
315 access payments will equal or exceed the amount of the hospital's assessment.

316 Section 9. Section **26-36a-206** is enacted to read:

317 **26-36a-206. Penalties and interest.**

318 (1) A facility that fails to pay any assessment or file a return as required under this
319 chapter, within the time required by this chapter, shall pay, in addition to the assessment,
320 penalties and interest established by the department.

321 (2) (a) Consistent with Subsection (2)(b), the department shall adopt rules in
322 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish
323 reasonable penalties and interest for the violations described in Subsection (1).

324 (b) If a hospital fails to timely pay the full amount of a quarterly assessment, the
325 department shall add to the assessment:

326 (i) a penalty equal to 5% of the quarterly amount not paid on or before the due date;

327 and

328 (ii) on the last day of each quarter after the due date until the assessed amount and the
329 penalty imposed under Subsection (2)(b)(i) are paid in full, an additional 5% penalty on:

330 (A) any unpaid quarterly assessment; and

331 (B) any unpaid penalty assessment.

332 (c) The division may waive, reduce, or compromise the penalties and interest provided
333 for in this section in the same manner as provided in Subsection 59-1-401(8).

334 Section 10. Section **26-36a-207** is enacted to read:

335 **26-36a-207. Restricted Special Revenue Fund -- Creation -- Deposits.**

336 (1) There is created a restricted special revenue fund known as the "Hospital Provider
337 Assessment Special Revenue Fund."

338 (2) The fund shall consist of:
339 (a) the assessments collected by the department under this chapter;
340 (b) any interest and penalties levied with the administration of this chapter; and
341 (c) any other funds received as donations for the restricted fund and appropriations
342 from other sources.

343 (3) The fund shall be separate and distinct from any other special revenue funds.

344 (4) Money in the fund shall be used:

345 (a) to make inpatient hospital access payments under Section 26-36a-205; and

346 (b) to reimburse money collected by the division from a hospital through a mistake
347 made under this chapter.

348 (5) The money in the fund is non-lapsing.

349 Section 11. Section **26-36a-208** is enacted to read:

350 **26-36a-208. Repeal of assessment.**

351 (1) The repeal of the assessment imposed by this chapter shall occur upon the
352 certification by the executive director of the department that the sooner of the following has
353 occurred:

354 (a) the effective date of any action by Congress that would disqualify the assessment
355 imposed by this chapter from counting towards state Medicaid funds available to be used to
356 determine the federal financial participation;

357 (b) the effective date of any decision, enactment, or other determination by the
358 Legislature or by any court, officer, department, or agency of the state, or of the federal
359 government that has the effect of:

360 (i) disqualifying the assessment from counting towards state Medicaid funds available
361 to be used to determine federal financial participation for Medicaid matching funds; or

362 (ii) creating for any reason a failure of the state to use the assessments for the Medicaid
363 program as described in this chapter; and

364 (c) the effective date of:

365 (i) an appropriation for any state fiscal year from the General Fund for hospital
366 payments under the state Medicaid program that is less than the amount appropriated for state
367 fiscal year 2011;

368 (ii) the annual revenues of the state General Fund budget return to the level that was

369 appropriated for fiscal year 2008; or

370 (iii) a division change in rules that reduces any of the following below July 1, 2010

371 payments:

372 (A) aggregate hospital inpatient payments;

373 (B) aggregate outpatient payments;

374 (C) adjustment payment rates; or

375 (D) any cost settlement protocol.

376 (2) If the assessment is repealed under Subsection (1), money in the fund that was

377 derived from assessments imposed by this chapter, before the determination made under

378 Subsection (1), shall be disbursed under Section 26-36a-205 to the extent federal matching is

379 not reduced due to the impermissibility of the assessments. Any funds remaining in the special

380 revenue fund shall be refunded to the hospitals in proportion to the amount paid by each

381 hospital.

382 Section 12. Section **26-36a-209** is enacted to read:

383 **26-36a-209. State plan amendment -- Hospital Policy Review Board.**

384 (1) The division shall file with the Center for Medicare and Medicaid Services a state

385 plan amendment to implement the requirements of this chapter, including the payment of

386 hospital access payments under Section 26-36a-205 no later than 45 days after the effective

387 date of this chapter.

388 (2) If the state plan amendment is not approved by the Center for Medicare and

389 Medicaid Services, the division shall:

390 (a) not implement the assessment imposed under this chapter; and

391 (b) return any assessment fees to the hospitals that paid the fees if assessment fees have

392 been collected.

393 (3) (a) The department shall establish an advisory board that is the Hospital Policy

394 Review Board.

395 (b) The board shall have five members selected as follows:

396 (i) one member appointed by the governor from a list of names submitted by the Utah

397 Hospitals and Health Systems Association;

398 (ii) two members appointed by the president of the Senate from a list of names

399 submitted by the Utah Hospitals and Health Systems Association; and

400 (iii) two members appointed by the speaker of the House from a list of names
401 submitted by the Utah Hospitals and Health Systems Association.

402 (c) Members of the board may not be compensated for their services on the board or
403 receive reimbursement for costs or per diem expenses.

404 (d) If a selection is not made by the governor, the speaker of the House, or the
405 president of the Senate within 60 days after the names are submitted by the Utah Hospitals and
406 Health Systems Association, the member shall be appointed by the Utah Hospitals and Health
407 Systems Association.

408 (e) (i) The board shall review state Medicaid plan amendments or waivers affecting
409 hospital reimbursement between the date of enactment of this chapter and the end of state fiscal
410 year 2013.

411 (ii) A majority of the board is a quorum.

412 (f) The department may not amend the state Medicaid plan or any waiver affecting
413 hospital reimbursement without submitting the amendment or waiver to the board for review.

414 Section 13. Section **63I-1-226** is amended to read:

415 **63I-1-226. Repeal dates, Title 26.**

416 (1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July
417 1, 2015.

418 (2) Section 26-18-12, Expansion of 340B drug pricing programs, is repealed July 1,
419 2013.

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

421 (4) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed
422 July 1, 2011.

423 (5) Title 26, Chapter 36a, Hospital Provider and Assessment Act, is repealed July 1,
424 2013.

425 Section 14. **Retrospective operation.**

426 This bill has retrospective operation for taxable years beginning on or after January 1,
427 2010.

Legislative Review Note
as of 2-9-10 6:14 AM

Office of Legislative Research and General Counsel

S.B. 273 - Hospital Assessments

Fiscal Note

2010 General Session

State of Utah

State Impact

Enactment of this legislation creates a new restricted special revenue fund into which an assessment on hospitals is deposited. It enacts the assessment, which is expected to generate \$7,881,900 in FY 2010, \$28,894,700 in FY 2011, and \$33,926,300 in FY 2012. It treats the assessment as a deductible expense which may forgo as much as \$300,000 per year in potential income tax revenue.

The legislation directs the Division of Health Care Financing, without appropriation, to distribute revenue deposited into the new fund to hospitals. It is estimated that expenditures associated with the bill would be \$7,881,900 from Restricted Special Revenue and \$31,118,100 from Federal Funds in FY 2010, \$28,894,700 from Restricted Special Revenue and \$89,181,500 from Federal Funds in FY 2011, and \$33,926,300 from Restricted Special Revenue and \$84,149,900 from Federal Funds in FY 2012.

	<u>FY 2010</u> <u>Approp.</u>	<u>FY 2011</u> <u>Approp.</u>	<u>FY 2012</u> <u>Approp.</u>	<u>FY 2010</u> <u>Revenue</u>	<u>FY 2011</u> <u>Revenue</u>	<u>FY 2012</u> <u>Revenue</u>
Federal Funds	\$31,118,100	\$89,181,500	\$84,149,900	\$0	\$0	\$0
Restricted Funds	\$7,881,900	\$28,894,700	\$33,926,300	\$7,881,900	\$28,894,700	\$33,926,300
Total	\$39,000,000	\$118,076,200	\$118,076,200	\$7,881,900	\$28,894,700	\$33,926,300

Individual, Business and/or Local Impact

Enactment of this bill likely will not result in direct, measurable costs and/or benefits for individuals or local governments. Some private hospitals will experience increased revenues and some will experience decreased revenues.