

HOSPITAL TAX ASSESSMENT

2012 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Lyle W. Hillyard

House Sponsor: R. Curt Webb

LONG TITLE

General Description:

This bill amends the Hospital Provider Assessment Act to adjust the calculation of the assessment.

Highlighted Provisions:

This bill:

- ▶ deletes outdated language;
- ▶ amends the calculation of the assessment; and
- ▶ deletes the requirement for an advisory board.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

26-36a-203, as last amended by Laws of Utah 2011, Chapter 297

26-36a-205, as enacted by Laws of Utah 2010, Chapter 179

26-36a-209, as enacted by Laws of Utah 2010, Chapter 179

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

Section 1. Section **26-36a-203** is amended to read:



28 **26-36a-203. Calculation of assessment.**

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

31 (2) (a) An annual assessment is payable on a quarterly basis for each hospital in an
32 amount calculated at a uniform assessment rate for each hospital discharge, in accordance with
33 this section.

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

37 (c) Any quarterly changes to the uniform assessment rate shall be applied uniformly to
38 all assessed hospitals.

39 (d) (i) Except as provided in Subsection (2)(d)(ii), the annual uniform assessment rate
40 may not generate more than the non-federal share of the annual upper payment limit gap for the
41 fiscal year.

42 ~~[(ii) (A) For fiscal year 2010 the assessment may not generate more than the
43 non-federal share of the annual upper payment limit gap for the fiscal year.]~~

44 ~~[(B) For fiscal year 2010-11 the department may generate an additional amount from
45 the assessment imposed under Subsection (2)(d)(i) in the amount of \$2,000,000 which shall be
46 used by the department and the division as follows:]~~

47 ~~[(F) \$1,000,000 to offset Medicaid mandatory expenditures; and]~~

48 ~~[(H) \$1,000,000 to offset the reduction in hospital outpatient fees in the state program.]~~

49 ~~[(E)]~~ (ii) For fiscal years 2011-12 and 2012-13 the department may generate an
50 additional amount from the assessment imposed under Subsection (2)(d)(i) in the amount of ~~Ŝ~~ :

50a **(A) ←Ŝ**

51 \$1,000,000 to offset Medicaid mandatory expenditures ~~Ŝ~~ ; **and**

51a **(B) the non-federal share to seed amounts needed to support capitated rates for**

51b **Accountable Care Organizations ←Ŝ** .

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

56 (b) If a hospital's fiscal year Medicare Cost Report is not contained in the Centers for
57 Medicare and Medicaid Services' Healthcare Cost Report Information System file dated March
58 31, 2009:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

89 (c) If a hospital is not certified by the Medicare program and is not required to file a

90 Medicare Cost Report:

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

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

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

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

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

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

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

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

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

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

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

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

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

119 (ii) shall receive Medicaid inpatient hospital access payments under Section
120 26-36a-205 for the state fiscal year, adjusted using the same formula described in Subsection

121 (7)(b).

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

125 (a) not be required to pay the hospital assessment beginning on the date established by
126 the department by administrative rule; and

127 (b) not be entitled to Medicaid inpatient hospital access payments under Section
128 26-36a-205 on the date established by the department by administrative rule.

129 Section 2. Section **26-36a-205** is amended to read:

130 **26-36a-205. Medicaid hospital inpatient access payments.**

131 (1) To preserve and improve access to hospitals, the division shall make Medicaid
132 inpatient hospital access payments to hospitals in accordance with this section, Section
133 26-36a-204, and Subsection 26-36a-203(7).

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

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

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

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

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

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

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

145 (A) was not a specialty hospital; and

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

147 (ii) inpatient hospital access payments as determined by dividing the remaining
148 spending room available in the current year UPL, after offsetting the payments authorized
149 under Subsection (3)(a)(i) by the total 2008 Medicaid inpatient hospital payments, multiplied
150 by the hospital's Medicaid inpatient payments for state fiscal year 2008, exclusive of medical
151 education and Medicaid disproportionate share payments;

152 (b) for state fiscal year 2012[~~using state fiscal year 2009 paid Medicaid inpatient~~
 153 ~~claims data; and~~];

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

155 (A) is not a specialty hospital; and

156 (B) has less than 300 select access inpatient cases during the state fiscal year 2008; and

157 (ii) inpatient hospital access payments as determined by dividing the remaining
 158 spending room available in the current year upper payment limit, after offsetting the payments
 159 authorized under Subsection (3)(a)(i), by the total 2009 Medicaid inpatient hospital payments,
 160 multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2009 ~~↗~~ **↘** [~~exclusive of~~
 161 ~~medical education and Medicaid disproportionate share payments~~] ~~↖~~ **↗** ; and

162 (c) for state fiscal year 2013[~~using state fiscal year 2010 paid Medicaid inpatient~~
 163 ~~claims data~~];

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

165 (A) is not a specialty hospital; and

166 (B) has less than 300 select access inpatient cases during the state fiscal year 2008; and

167 (ii) inpatient hospital access payments as determined by dividing the remaining
 168 spending room available in the current year upper payment limit, after offsetting the payments
 169 authorized under Subsection (3)(a)(i), by the total 2010 Medicaid inpatient hospital payments,
 170 multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2010 ~~↗~~ **↘** [~~exclusive of~~
 171 ~~medical education and Medicaid disproportionate share payments~~] ~~↖~~ **↗** .

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

174 [~~(5)~~] (4) Medicaid inpatient hospital access payments shall be made:

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

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

178 [~~(6)~~] (5) A hospital's Medicaid inpatient access payment shall not be used to offset any
 179 other payment by Medicaid for hospital inpatient or outpatient services to Medicaid
 180 beneficiaries, including a:

181 (a) fee-for-service payment;

182 (b) per diem payment;

183 (c) hospital inpatient adjustment; or

184 (d) cost settlement payment.

185 (6) When the division obtains approval from the Centers for Medicare and Medicaid
186 Services for the Medicaid Waiver - Accountable Care Organizations, and has determined the
187 capitated rate for the accountable care organizations, the department shall consult with the Utah
188 Hospitals Association to develop an alternative supplemental payment methodology that can be
189 approved by the Centers for Medicare and Medicaid Services.

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

192 Section 3. Section **26-36a-209** is amended to read:

193 **26-36a-209. State plan amendment.**

194 (1) The division shall file with the Center for Medicare and Medicaid Services a state
195 plan amendment to implement the requirements of this chapter, including the payment of
196 hospital access payments under Section 26-36a-205 no later than 45 days after the effective
197 date of this chapter.

198 (2) If the state plan amendment is not approved by the Center for Medicare and
199 Medicaid Services, the division shall:

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

201 (b) return any assessment fees to the hospitals that paid the fees if assessment fees have
202 been collected.

203 ~~[(3)(a) The department shall establish an advisory board that is the Hospital Policy~~
204 ~~Review Board.]~~

205 ~~[(b) The board shall have five members selected as follows:]~~

206 ~~[(i) one member appointed by the governor from a list of names submitted by the Utah~~
207 ~~Hospitals and Health Systems Association;]~~

208 ~~[(ii) two members appointed by the president of the Senate from a list of names~~
209 ~~submitted by the Utah Hospitals and Health Systems Association; and]~~

210 ~~[(iii) two members appointed by the speaker of the House from a list of names~~
211 ~~submitted by the Utah Hospitals and Health Systems Association;]~~

212 ~~[(c) Members of the board may not be compensated for their services on the board or~~
213 ~~receive reimbursement for costs or per diem expenses.]~~

214 ~~[(d) If a selection is not made by the governor, the speaker of the House, or the~~
215 ~~president of the Senate within 60 days after the names are submitted by the Utah Hospitals and~~
216 ~~Health Systems Association, the member shall be appointed by the Utah Hospitals and Health~~
217 ~~Systems Association.]~~

218 ~~[(e) (i) The board shall review state Medicaid plan amendments or waivers affecting~~
219 ~~hospital reimbursement between the date of enactment of this chapter and the end of state fiscal~~
220 ~~year 2013.]~~

221 ~~[(ii) A majority of the board is a quorum.]~~

222 ~~[(f) The department may not amend the state Medicaid plan or any waiver affecting~~
223 ~~hospital reimbursement without submitting the amendment or waiver to the board for review.]~~

Legislative Review Note
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Office of Legislative Research and General Counsel