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- deletes outdated language;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:

26-36a-203. Calculation of assessment.

(1) The division shall calculate the inpatient upper payment limit gap for hospitals for

each state fiscal year.

(2) (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 of the upper payment limit gap.

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

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

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

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

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

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

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

(A) $1,000,000 to offset Medicaid mandatory expenditures[~~.~~]; and

(B) the non-federal share to seed amounts needed to support capitated rates for accountable care organizations.

(3) (a) For state fiscal years 2010 and 2011, 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 as of April 1, 2009, for hospital fiscal years ending between October 1, 2007, and September 30, 2008.

(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 dated March 31, 2009:

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

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

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

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

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

(d) 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 (3)(d)(i); and

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

(4) (a) For state fiscal year 2012 and 2013, 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 as of:

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

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

(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 its applicable fiscal year discharges with supporting documentation;

(ii) the division shall determine the hospital's discharges from the information submitted under Subsection (4)(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.

(5) Except as provided in Subsection (6), 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.

(6) Notwithstanding the requirement of Subsection (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.

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

(b) The department shall adjust the assessment payable to the department under this

chapter for a hospital that is not subject to the assessment for an entire fiscal year by multiplying the annual assessment calculated under Subsection (3) or (4) by a fraction, the numerator of which is the number of days during the year that the hospital operated, and the denominator of which is 365.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) for state fiscal years 2010 and 2011:

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

(A) was not a specialty hospital; and

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

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

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

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

(A) is not a specialty hospital; and

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

(ii) inpatient hospital access payments as determined by dividing the remaining spending room available in the current year upper payment limit, after offsetting the payments authorized under Subsection (3)(a)(i), by the total 2009 Medicaid inpatient hospital payments, multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2009; and

(c) for state fiscal year 2013[~~, using state fiscal year 2010 paid Medicaid inpatient claims data.~~]:

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

(A) is not a specialty hospital; and

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

(ii) inpatient hospital access payments as determined by dividing the remaining spending room available in the current year upper payment limit, after offsetting the payments

authorized under Subsection (3)(a)(i), by the total 2010 Medicaid inpatient hospital payments, multiplied by the hospital's Medicaid inpatient payments for state fiscal year 2010.

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

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

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

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

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

(a) fee-for-service payment;

(b) per diem payment;

(c) hospital inpatient adjustment; or

(d) cost settlement payment.

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

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

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

26-36a-209. State plan amendment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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