# REAUTHORIZATION OF HOSPITAL PROVIDER ASSESSMENT ACT

2016 GENERAL SESSION

STATE OF UTAH

**Chief Sponsor: Brian E. Shiozawa**

House Sponsor: James A. Dunnigan

**LONG TITLE**

**General Description:**

This bill reauthorizes the Hospital Provider Assessment Act.

**Highlighted Provisions:**

This bill:

- amends the repeal of the assessment;
- extends the sunset of the assessment; and
- makes technical amendments.

**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 2013, Chapter 32

**26-36a-208**, as last amended by Laws of Utah 2013, Chapter 32

**63I-1-226**, as last amended by Laws of Utah 2015, Chapters 16, 31, and 258

*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) (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 26-36a-205 that is needed to support capitated rates for 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 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 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 2013, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2009, and June 30, 2010;

(ii) for state fiscal year 2014, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2010, and June 30, 2011;

(iii) for state fiscal year 2015, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2011, and June 30, 2012; [~~and~~]

(iv) for state fiscal year 2016, the hospital's cost report data for the hospital's fiscal year ending between July 1, 2012, and June 30, 2013[~~.~~]; and

(v) 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 prior to 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 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 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.

Section 2. Section **26-36a-208** is amended to read:

**26-36a-208. 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 towards 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 chapter;

(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) approval of any change in the state Medicaid plan that requires a greater percentage of Medicaid patients to enroll in Medicaid managed care plans than what is required:~~]

[~~(A) to implement accountable care organizations in the state plan; and~~]

[~~(B) by other managed care enrollment requirements in effect on or before January 1, 2012;~~]

[~~(iv)~~] (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

[~~(v)~~] (iv) a division change in rules that reduces the aggregate outpatient payments below July 1, 2011 payments; 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 26-36a-205 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.

Section 3. Section **63I-1-226** is amended to read:

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

(1) Title 26, Chapter 9f, Utah Digital Health Service Commission Act, is repealed July 1, 2025.

(2) Section 26-10-11 is repealed July 1, 2020.

(3) Section 26-21-23, Licensing of non-Medicaid nursing care facility beds, is repealed July 1, 2018.

(4) Title 26, Chapter 33a, Utah Health Data Authority Act, is repealed July 1, 2024.

(5) Title 26, Chapter 36a, Hospital Provider Assessment Act, is repealed July 1, [~~2016~~] 2019.

(6) Section 26-38-2.5 is repealed July 1, 2017.

(7) Section 26-38-2.6 is repealed July 1, 2017.

(8) Title 26, Chapter 56, Hemp Extract Registration Act, is repealed July 1, 2016.