Hospital Assessment

This Act encourages the maximization of financial resources eligible and available for Medicaid services by establishing a fund within the state department of health and welfare to receive private hospital assessments to use in securing federal matching funds under federally prescribed Upper Payment Limit programs available through the state Medicaid plan.

Submitted as:
Idaho
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Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act shall be cited as the “The Hospital Assessment Act.”

Section 2. [Legislative Intent.] It is the intent of the [legislature] to encourage the maximization of financial resources eligible and available for Medicaid services by establishing a fund within the [department of health and welfare] to receive private hospital assessments to use in securing federal matching funds under federally prescribed Upper Payment Limit programs available through the state Medicaid plan.

Section 3. [Definitions.] As used in this Act:
(1) “Governmental entity” means and includes the state and its political subdivisions.
(2) “Hospital” means that defined in [insert citation].
(3) “Political subdivision” means a county, city, municipal corporation or hospital taxing district as defined in [insert citation] and, shall include state licensed hospitals established by counties pursuant to [insert citation], or jointly by cities and counties pursuant to [insert citation].
(4) “Private hospital” means a hospital that is not owned by a governmental entity.
(5) “Upper Payment Limit” means a limitation established by federal regulations, 42 CFR 447.272 and 42 CFR 447.321, that disallows federal matching funds when state Medicaid agencies pay certain classes of hospitals an aggregate amount for inpatient and outpatient hospital services that would exceed the amount that would be paid for the same services furnished by that class of hospitals under Medicare payment principles.

Section 4. [Hospital Assessment Fund Established.]
(A) There is hereby created in the [office of the state treasurer] a dedicated fund to be known as the Hospital Assessment Fund, hereinafter “fund,” to be administered by the [department of health and welfare], hereinafter “department.” The [state treasurer] shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund.
(B) Moneys in the fund shall consist of:
(1) All moneys collected or received by the [department] from hospital assessments required by this Act;
(2) All federal matching funds received by the [department] as a result of expenditures made by the [department] that are attributable to moneys deposited in the fund;
(3) Any interest or penalties levied in conjunction with the administration of this
Act; and
(4) Any appropriations, federal funds, donations, gifts or moneys from any other
sources.
(C) The fund is created for the purpose of receiving moneys in accordance with this
section and section 5 of this Act. The fund shall not be used to replace any moneys appropriated
to the [state medical assistance program] under [insert citation] by the [legislature]. Moneys in
the fund shall be distributed by the [department] subject to appropriation for the following
purposes only:
(1) Payments to hospitals as required under the [state medical assistance program]
as set forth in [insert citation];
(2) Reimbursement of moneys collected by the [department] from hospitals
through error or mistake in performing the activities authorized under the [state medical
assistance program];
(3) Payments of administrative expenses incurred by the [department] or its agent
in performing the activities authorized by this Act;
(4) Payments made to the federal government to repay excess payments made to
hospitals from the fund if the assessment plan is deemed out of compliance and after the state has
appealed the findings. Hospitals shall refund the payments in question to the assessment fund.
The state in turn shall return funds to both the federal government and hospital providers in the
same proportion as the original financing. Individual hospitals shall be reimbursed based on the
proportion of the individual hospital’s assessment to the total assessment paid by all hospitals. If
a hospital is unable to refund payments, the state shall develop a payment plan and deduct
moneys from future Medicaid payments;
(5) Transfers to any other fund in the [state treasury], provided such transfers shall
not exceed the amount transferred previously from that other fund into the [Hospital Assessment
Fund]; and
(6) Making refunds to hospitals pursuant to section 11 of this Act.

Section 5. [Assessments.]
(A) All hospitals, except those exempted under section 9 of this Act, shall make
payments to the fund in accordance with this Act. Subject to section 9 of this Act, an annual
assessment on both inpatient and outpatient services is determined for each qualifying hospital
for [state fiscal years 2009, 2010 and 2011], in an amount calculated by multiplying the rate, as
set forth in subsection (C) of this section, by the assessment base, as set forth in subsection (D)
of this section.
(B) The [department] shall calculate the private hospital Upper Payment Limit gap for
both inpatient and outpatient services. The Upper Payment Limit gap is the difference between
the maximum allowable payments eligible for federal match, less Medicaid payments not
financed using hospital assessment funds. The Upper Payment Limit gap shall be calculated
separately for hospital inpatient and outpatient services. Medicaid disproportionate share
payments shall be excluded from the calculation.
(C) The [department] shall calculate the assessment rate for [state fiscal years 2009, 2010
and 2011] to be the percentage that, when multiplied by the assessment base as defined in
subsection (D) of this section, equals the Upper Payment Limit gap determined in subsection (B)
of this section, but is not greater than [one and one-half percent].
(D) The assessment base shall be the hospital's net patient revenue for the applicable
period. “Net patient revenue” for [state fiscal year 2009] shall be determined using the most
recent data available from each hospital's [fiscal year 2004] Medicare Cost Report on file with
the [department] on [June 30, 2008], without regard to any subsequent adjustments or changes to
such data. Net patient revenue for [state fiscal year 2010] shall be determined using the most
recent data available for each hospital's [fiscal year 2005] Medicare Cost Report on file with the
[department] on [June 30, 2009], without regard to any subsequent adjustments or changes to
such data. Net patient revenue for [state fiscal year 2011] shall be determined using the most
recent data available from each hospital's [fiscal year 2006] Medicare Cost Report on file with
the [department] on [June 30, 2010], without regard to any subsequent adjustments or changes to
such data.

Section 6. [Review of Annual Assessment Amount.] Each [state fiscal year], hospitals shall
have at least [thirty] days prior to implementation to review and verify the assessment base, rate,
and the estimated assessment amount.

Section 7. [Inpatient and Outpatient Adjustment Payments.] All hospitals, except those
exempted under section 9 of this Act, shall be eligible for inpatient and outpatient adjustments as
follows:

(1) For [state fiscal year 2009], the inpatient Upper Payment Limit gap for private
hospitals shall be divided by Medicaid inpatient days for the same hospitals from [calendar year
2007] to establish an average per diem adjustment rate. Each hospital shall receive an annual
payment that is equal to the average per diem adjustment rate multiplied by the hospital's
[calendar year 2007] Medicaid inpatient days. For purposes of this section, “hospital Medicaid
inpatient days” are days of inpatient hospitalization paid for by the [state medical assistance
program] for the applicable calendar year. For [fiscal year 2010], [calendar year 2008] inpatient
hospital Medicaid days shall be used to determine the hospital inpatient adjustment payment. For
[state fiscal year 2011], [calendar year 2009] hospital Medicaid inpatient days shall be used to
determine the hospital inpatient adjustment payment. In the event that either the inpatient Upper
Payment Limit gap for private hospitals or the available hospital assessment funding is lower
than anticipated, the [department] shall apply an across-the-board factor such that the inpatient
payment adjustments are maximized, financed entirely from hospital assessment funding, and do
not exceed the state inpatient upper payment limit for private hospitals. Payments shall be made
no later than [seven] days after the due date for the hospital assessment required in section 5 of
this Act.

(2) For [state fiscal year 2009], the outpatient Upper Payment Limit gap for private
hospitals shall be divided by Medicaid outpatient hospital reimbursement for the same hospitals
from [calendar year 2007] to establish an average percentage adjustment rate. Each hospital, except those exempt under section 9 of this Act, shall receive an annual payment that is equal to
the average percentage adjustment rate multiplied by the hospital's [calendar year 2007] hospital
Medicaid outpatient reimbursement. For purposes of this section, "hospital outpatient
reimbursement" is reimbursement for hospital outpatient services paid for by the [state medical
assistance program] for the applicable calendar year. For [state fiscal year 2010], [calendar year
2008] hospital Medicaid outpatient reimbursement shall be used to determine the outpatient
hospital adjustment payment. For [state fiscal year 2011], [calendar year 2009] hospital Medicaid
outpatient reimbursement shall be used to determine the outpatient hospital adjustment payment.
In the event that either the outpatient Upper Payment Limit gap for private hospitals or the
available hospital assessment funding is lower than anticipated, the [department] shall apply an
across-the-board factor, such that outpatient adjustment payments are maximized, financed
entirely from hospital assessment funding, and do not exceed the [state] outpatient Upper
Payment Limit for private hospitals. Payments shall be made no later than [seven] days after the due date for the hospital assessments required in section 5 of this Act.

Section 8. [Timing of Payments and Assessments.]
(A) The [department] shall establish an annual assessment schedule for all payments created under this [Act].
(B) If a hospital fails to pay the full amount of an installment when due, including any extensions granted, there shall be added to the assessment imposed by section 5 of this Act, unless waived by the [department] for reasonable cause, a penalty equal to the lesser of:
   (1) An amount equal to [five percent] of the assessment installment amount not paid on or before the due date, plus [five percent] of the portion thereof remaining unpaid on the last day of each month thereafter; or
   (2) An amount equal to [one hundred percent] of the assessment installment amount not paid on or before the due date.
(C) For purposes of subsection (B) of this section, payments shall be credited first to unpaid installment amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

Section 9. [Exemptions.]
(A) A hospital that is a governmental entity, including a state agency, is exempt from the assessment required by section 5 of this Act, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay such assessment.
(B) A private hospital that does not provide emergency services through an emergency department and is not categorized as “rehabilitation” or “psychiatric” as provided in [insert citation] is exempt from the assessment required by section 5 of this Act.

Section 10. [Multihospital Locations, Hospital Closure and New Hospitals.]
(A) If a hospital conducts, operates or maintains more than [one] hospital licensed by the [department], the hospital shall pay the assessment for each hospital separately.
(B) A hospital, subject to assessments under this Act, that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a calendar or fiscal year, shall have its required assessment adjusted by multiplying the assessment computed under section 5 of this Act, by a fraction, the numerator of which is the number of days in the year during which the hospital conducts hospital business, operates a hospital and maintains licensure, and the denominator of which is three hundred sixty-five. The hospital shall pay the required assessment computed under section 5 of this Act, on the date and in pro rata installments as required by the [department] for that portion of the state fiscal year during which the hospital operated and maintained state licensure, to the extent not previously paid.
(C) A hospital, subject to assessments under this Act, that has not been previously licensed as a hospital by the [department] and that commences hospital operations during a fiscal year, shall pay the required assessment computed under section 5 of this Act, and shall be eligible for payment adjustments under section 4 (C) of this Act, only after [two] complete state fiscal years have elapsed and [two] full fiscal year Medicare cost reports are filed with the [Center for Medicare and Medicaid services (CMS)] after the commencement of operations and on the date as required by the [department] beginning on the [first day of the next state fiscal year].

Section 11. [Applicability.]
(A) The assessment required by section 5 of this Act, shall not take effect or shall cease to be imposed, and any moneys remaining in the fund shall be refunded to hospitals in proportion to the amounts paid by such hospitals if:

(1) The appropriation for each state [fiscal year 2009, 2010 and 2011] from the [General Fund] for hospital payments under the state [Medical Assistance Program] is less than that for [fiscal year 2008];

(2) The [department] makes changes in its rules that reduce the hospital inpatient or outpatient payment rates, including adjustment payment rates, in effect on [January 1, 2008]; or

(3) The payments to hospitals required under section 4 (C) of this Act, are changed or are not eligible for federal matching funds under the [state medical assistance program].

(B) The assessment required by section 5 of this Act shall not take effect or shall cease to be required if the assessment is not approved or is determined to be impermissible under Title XIX of the Social Security Act. Moneys in the fund derived from assessments required prior thereto shall be distributed in accordance with section 4 (C) of this Act, to the extent federal matching funds are not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospitals in proportion to the amounts paid by such hospitals.

Section 12. [Severability.] [Insert severability clause.]

Section 13. [Repealer.] [Insert repealer clause.]

Section 14. [Effective Date.] [Insert effective date.]