Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas *As Engrossed: S3/5/09*
87th General Assembly **A Bill**
Regular Session, 2009 SENATE BILL 582

By: Senators Teague, *G. Baker, Bledsoe, Bookout, Broadway, Bryles, Glover, Horn, G. Jeffress, J. Jeffress, B. Johnson, D. Johnson, J. Key, Luker, Madison, Miller, Salmon, T. Smith, J. Taylor, R. Thompson, Trusty, D. Wyatt*
By: Representatives Reep, Pennartz, Betts, M. Burris, Cash, Cheatham, Cole, Cooper, Dunn, J. Edwards, Flowers, Garner, Gaskill, Glidewell, R. Green, Hall, House, Ingram, Kidd, Maxwell, Moore, Overbey, Pierce, Powers, Rainey, Reynolds, J. Roebuck, T. Rogers, Saunders, Shelby, Stewart, Tyler, Webb, Wells, B. Wilkins

For An Act To Be Entitled

AN ACT TO LEVY AN ASSESSMENT FEE ON HOSPITALS TO IMPROVE HEALTH CARE ACCESS FOR THE CITIZENS OF ARKANSAS; AND FOR OTHER PURPOSES.

Subtitle

AN ACT TO LEVY AN ASSESSMENT FEE ON HOSPITALS TO IMPROVE HEALTH CARE ACCESS FOR THE CITIZENS OF ARKANSAS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77 is amended to add an additional subchapter to read as follows:

20-77-1901. Definitions.

As used in this subchapter:

(1) "Division" means the Division of Medical Services of the Department of Human Services;

(2) "Hospital" means a health care facility licensed as a hospital by the Division of Health Facility Services of the Department of Health under § 20-9-213;

(3) "Medicare Cost Report" means CMS-2552-96, the Cost Report

for Electronic Filing of Hospitals, as it existed on January 1, 2009;

(4) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the Medicare Cost Report adjusted to exclude nonhospital revenue;

(5)(A) "Non-state-government-owned hospital" means a hospital that is owned and operated by an agency or a unit of a county or municipal government, including without limitation a hospital owned and operated by:

(i) A county under § 14-263- 101 et seq. *; or*

(ii) A city under § 14-264- 101 et seq..

(B) "Non-state-government-owned-hospital" does not include a hospital that is owned by an agency or unit of county or municipal government but is contracted or leased to an individual, firm, or corporation that is not a government entity;

(6) "Privately operated hospital" means a licensed hospital in Arkansas other than:

(A) Any hospital that is owned and operated by the federal government;

(B) Any hospital that is an agency or a unit of state government, including without limitation a hospital owned by a state agency or a state university; and

(C) Any non-state government owned hospital;

(7) "Specialty hospital" means an acute care general hospital that:

(D) Limits services primarily to children and qualifies as exempt from the Medicare prospective payment system regulation; or

(E) Is primarily or exclusively engaged in the care and treatment of patients with cardiac conditions;

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

(9) "Upper payment limit" means the maximum ceiling imposed by federal regulation *on privately owned* hospital Medicaid reimbursement for inpatient services under 42 C.F.R § 447.272 and outpatient services under 42 C.F.R § 447.321; and

(10) "Upper payment limit gap" means the difference between the upper payment limit and Medicaid payments not financed using hospital

assessments made to all privately operated hospitals.

(A) The upper payment limit gap shall be calculated separately for hospital inpatient and outpatient services.

(B) Medicaid disproportionate share payments shall be excluded from the calculation of the upper payment limit gap.

20-77-1902. Assessment.

(a)(1) An assessment is imposed on each hospital except those exempted under § 20-77-1905 *for each state fiscal year* in an amount calculated as a percentage of each hospital's net patient revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net patient revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap plus the annual fee to be paid to Medicaid under § 20-77-1904(f)(1)(C), but in no case greater than one percent (1%) of net patient revenue.

(b)(1)(A) Except as set forth in subdivision (b)(1)(B) or (b)(1)(C), for state fiscal year 2010, net patient revenue shall be determined using the data from each hospital's fiscal year 2007 Medicare Cost Report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated June 30, 2008.

(B) If a hospital's fiscal year 2007 Medicare Cost Report is not contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System file dated June 30, 2008, the hospital shall submit a copy of the hospital's 2007 Medicare Cost Report to the division in order to allow the division to determine the hospital's net *patient revenue for state fiscal year 2010.*

(C) If a hospital commenced operations after the due date for a 2007 Medicare Cost Report, the hospital shall *submit its 2008 Medicare Cost* Report to the division in order to allow the division to determine the *hospital's net patient revenue for state fiscal year 2010.*

(2) For each subsequent state fiscal year, net patient revenue shall be *calculated using the data* from each hospital's most recent audited Medicare Cost Report available at the time of the calculation.

(c) This subchapter does not authorize a unit of county or local government to license for revenue or impose a tax or assessment upon hospitals or a tax or assessment measured by the income or earnings of a

hospital.

20-77-1903. Program administration.

(a) The Director of the Division of Medical Services of the Department of Human Services shall administer the assessment program created in this subchapter.

(b)(1) The division shall adopt rules to implement this subchapter.

(2) Unless otherwise provided in this subchapter, the rules adopted under subdivision (b)(1) of this section shall not grant any exceptions to or exemptions from the hospital assessment imposed under § 20-77-1902.

(3) The rules adopted under subdivision (b)(1) of this section shall include forms for:

(A) The proper imposition and collection of the assessment imposed under § 20-77-1902;

(B) Enforcement of this subchapter, including without limitation letters of caution or sanctions; and

(C) Reporting of net patient revenue.

(c) To the extent practicable, the division shall administer and enforce this subchapter and collect the assessments, interest, and penalty assessments imposed under this subchapter using procedures generally employed in the administration of the division's other powers, duties, and functions.

20-77-1904. Hospital Assessment Account.

(a)(1) There is created within the Arkansas Medicaid Program Trust Fund, § 19-5-985, a designated account known as the Hospital Assessment Account.

(2) The hospital assessments imposed under § 20-77-1902 shall be deposited into the Hospital Assessment Account.

(b) Moneys in the Hospital Assessment Account shall consist of:

(1) All moneys collected or received by the division from hospital assessments imposed under § 20-77-1902;

(2) Any interest or penalties levied in conjunction with the administration of this subchapter; and

(3) Any appropriations, transfers, donations, gifts, or moneys from other sources, as applicable.

(c) The Hospital Assessment Account shall be separate and distinct from the general fund and shall be supplementary to the Arkansas Medicaid Program Trust Fund.

(d) Moneys in the Hospital Assessment Account shall not be used to replace other general revenues appropriated and funded by the General Assembly or other revenues used to support Medicaid.

(e) The Hospital Assessment Account shall be exempt from budgetary cuts, reductions, or eliminations caused by a deficiency of general revenues.

(f)(1) Except as necessary to reimburse any funds borrowed to supplement funds in the Hospital Assessment Account, the moneys in the Hospital Assessment Account shall be used only as follows:

(A) To make inpatient and outpatient hospital access payments under § 20-77-1908; or

(B) To reimburse moneys collected by the division from hospitals through error or mistake or under this subchapter; or

(C) To pay an annual fee to the Division of Medical Services of the Department of Human Services in the amount of three and three-quarters percent (3.75%) of the assessments collected from hospitals under § 20-77-1902 each state fiscal year.

(2)(A) The Hospital Assessment Account shall retain account balances remaining each fiscal year.

(B) At the end of each fiscal year, any positive balance remaining in the Hospital Assessment Account shall be factored into the calculation of the new assessment rate by reducing the amount of hospital assessment funds that must be generated during the subsequent fiscal year.

(3) A hospital shall not be guaranteed that its inpatient and outpatient hospital access payments will equal or exceed the amount of its hospital assessment.

20-77-1905. Exemptions.

(a) The following hospitals shall be exempt from the assessment imposed under § 20-77-1902 unless the exemption is adjudged to be unconstitutional or *otherwise determined to be invalid*:

(1) Hospitals that are not privately operated hospitals;

(2) Hospitals licensed by the Department of Health as rehabilitation hospitals; and

(3) Specialty hospitals.

(b) If an exemption under subdivision (a) of this section is adjudged to be unconstitutional or *otherwise determined to be invalid*, the applicable hospitals shall pay the assessment imposed under § 20-77-1902.

20-77-1906. Quarterly notice and collection.

(a)(1) The annual assessment imposed under § 20-77-1902 shall be due and payable on a quarterly basis.

(2) However, an installment payment of an assessment imposed by § 20-77-1902 shall not be due and payable until:

(A) The division issues the written notice required by § 20-77-1907(a) stating that the payment methodologies to hospitals required under § 20-77-1908 have been approved by the Centers for Medicare and Medicaid Services and the waiver under 42 C.F.R. § 433.68 for the assessment imposed by § 20-77-1902, if necessary, has been granted by the Centers for Medicare and Medicaid Services; and

(B) The thirty-day verification period required by § 20-77-1907(b) has expired; and

(C) The division has made all quarterly installments of inpatient and outpatient hospital access payments that were otherwise due under § 20-77-1908 consistent with the effective date of the approved state plan amendment and waiver.

(3) After the initial installment has been paid under this section, each subsequent quarterly installment payment of an assessment imposed by § 20-77-1902 shall be due and payable within ten (10) business days after the hospital has received its inpatient and outpatient hospital access payments due under § 20-77-1908 for the applicable quarter.

(b) The payment by the hospital of the assessment created in this subchapter shall be reported as an allowable cost for Medicaid reimbursement purposes.

(c)(1) If a hospital fails to timely pay the full amount of a quarterly assessment, the division shall add to the assessment:

(A) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and

(B) On the last day of each quarter after the due date until the assessed amount and the penalty imposed under subdivision (c)(1)(A)

of this section are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(2) Payments shall be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

20-77-1907. Notice of assessment.

(a)(1) The division shall send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount owed by the hospital for the applicable fiscal year.

(2) Except as set forth in subdivision (a)(3) of this section, annual notices of assessment shall be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each fiscal year.

(3) The first notice of assessment shall be sent within forty-five (45) days after receipt by the division of notification from the Centers for Medicare and Medicaid Services that the payments required under § 20-77-1908 and, if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(b) The hospital shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate, the hospital's net patient revenue calculation, and the estimated assessment amount.

(c)(1) If a hospital provider operates, conducts, or maintains more than one (1) hospital in the state, the hospital provider shall pay the assessment for each hospital separately.

(2) However, if the hospital provider operates more than one (1) hospital under one (1) Medicaid provider number, the hospital provider may pay the assessment for the hospitals in the aggregate.

(d)(1) For a hospital subject to the assessment imposed under § 20-77-1902 that ceases to conduct hospital operations or maintain its state license or did not conduct hospital operations throughout a state fiscal year, the assessment for the state fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment computed under § 20-77-1902 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 three hundred sixty-five (365).

(2)(A) Immediately upon ceasing to operate, the hospital shall pay the adjusted assessment for that state fiscal year to the extent not previously paid.

(B) The hospital also shall receive payments under § 20-*77-1908 for the state fiscal year in which the cessation occurs, which shall be adjusted by the same fraction as its annual* assessment.

(e) A hospital subject to an assessment under this subchapter that has not been previously licensed as a hospital in Arkansas and that commences hospital operations during a state fiscal year shall pay the required assessment computed under § 20-77-1902 and shall be eligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(f) A hospital that is exempted from payment of the assessment under § 20-77-1905 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes subject to the assessment shall pay the required assessment computed under § 20-77-1902 and shall be eligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(g) A hospital that is subject to payment of the assessment computed under § 20-77-1902 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes exempted from payment under § 20-77-1905 shall be relieved of its obligation to pay the hospital assessment and shall become ineligible for hospital access payments under § 20-77-1908 on the date specified in rules promulgated by the division under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

20-77-1908. Medicaid hospital access payments.

(a) To preserve and improve access to hospital services, for hospital inpatient and outpatient services rendered on or after July 1, 2009, the division shall make hospital access payments as set forth in this section.

(b) The division shall calculate the hospital access payment amount up to but not to exceed the upper payment limit gap for inpatient and outpatient

services.

(c) All hospitals shall be eligible for inpatient and outpatient hospital access payments each state fiscal year as set forth in this subsection other than hospitals described in § 20-77-1905.

(1)(A) A portion of the hospital access payment amount, not to exceed the upper payment limit gap for inpatient services, shall be designated as the inpatient hospital access payment pool.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital shall receive inpatient hospital access payments each state fiscal year equal to the hospital's pro rata share of the inpatient hospital access payment pool based upon the hospital's Medicaid discharges for the most recent audited fiscal period divided by the total number of Medicaid discharges of all eligible hospitals.

(C) Inpatient hospital access payments shall be made on a quarterly basis; and

(2)(A) A portion of the hospital access payment amount, not to exceed the upper payment limit gap for outpatient services, shall be designated as the outpatient hospital access payment pool.

(B)(i) In addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital shall receive outpatient hospital access payments each state fiscal year equal to a percentage adjustment determined by dividing the outpatient hospital access payment pool by Medicaid payments for outpatient services paid to all eligible hospitals.

(ii) The percentage adjustment shall be multiplied by the Medicaid payments for outpatient services paid to the eligible hospital in order to determine the amount of each eligible hospital's outpatient hospital access payment.

(C) Outpatient hospital access payments shall be made on a quarterly basis.

(d) A hospital access payment shall not be used to offset any other payment by Medicaid for hospital inpatient or outpatient services to Medicaid beneficiaries, including without limitation any fee-for-service, per diem, private hospital inpatient adjustment, or cost settlement payment.

20-77-1909. Effectiveness and cessation.

(a) The assessment imposed under § 20-77-1902 shall not take effect or shall cease to be imposed and any moneys remaining in the Hospital Assessment Account in the Arkansas Medicaid Program Trust Fund shall be refunded to hospitals in proportion to the amounts paid by them if:

(1) The appropriations for any state fiscal year from the General Revenue Fund Account of the State Apportionment Fund for hospital payments under the state Medicaid program are less than the preceding state fiscal year;

(2) The division makes changes in its rules that reduce hospital inpatient payment rates, outpatient payment rates, or adjustment payments, including any cost settlement protocol, that were in effect on January 1, 2009; or

(3) The inpatient or outpatient hospital access payments required under § 20-77-1908 are changed or the assessments imposed under § 20-77-1902 are not eligible for federal matching funds under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq.

(b)(1) The assessment imposed under § 20-77-1902 shall not take effect or shall cease to be imposed if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.

(2) Moneys in the Hospital Assessment Account in the Arkansas Medicaid Program Trust Fund derived from assessments imposed before the determination described in subdivision (b)(1) of this section shall be disbursed under § 20-77-1908 to the extent federal matching is 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 them.

20-77-1910. State plan amendment.

(a) The division shall file with the Centers for Medicare and Medicaid Services a state plan amendment to implement the requirements of this subchapter, including the payment of hospital access payments under § 20-77-1908 no later than forty-five (45) days after the effective date of this subchapter.

(b) If the state plan amendment is not approved by the Centers for

Medicare and Medicaid Services, the division shall:

(1) Not implement the assessment imposed under § 20-77-1902; and

(2) Return any assessment fees to the hospitals that paid the fees if assessment fees have been collected.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that hospitals are struggling to remain viable in providing access to health care services and the payments created in this act will allow hospitals to provide access to quality health care for the citizens of Arkansas. Therefore, an emergency is declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/ Teague